NHS
Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 03 September 2020

Session in public
11:00 – 12:30

(via video conference)

MEMBERSHIP: MEETINGS OF THE BOARD OF DIRECTORS: September 2020

Members (voting):

Chair	-	Beryl Hobson
Senior Independent Director	-	Gary Needle *(apols)*
Non-Executive Directors	-	Paul Dillon-Robinson
	-	Kevin Gould
	-	Karen Norman
Chief Executive:	-	Steve Jenkin
Medical Director	-	Keith Altman
Director of Nursing	-	Jo Thomas
Director of Finance and performance	-	Michelle Miles

In full attendance (non-voting):

Director of Operations	-	Abigail Jago
Director of Workforce & OD	-	Geraldine Opreshko *(apols)*
Director of Communications and Corporate Affairs	-	Clare Pirie
Deputy Company Secretary (minutes)	-	Hilary Saunders
Deputy Director of Nursing	-	Nicky Reeves
Deputy Director of Workforce	-	Lawrence Anderson
Lead governor	-	Peter Shore

Annual declarations by directors 2020/21

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 Deputy 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 • Director, Longmeadow Views Management Co Ltd	Part owner of Professional Governance Services Ltd	NA	Nil	PGS charity clients may contract with NHS organisations, (not QVH) and the Royal Colleges	Nil	Nil
Paul Dillon-Robinson Non-Executive Director	Nil	Nil	Nil	• Trustee of Hurstpierpoint College • Trustee of the Association of Governing Bodies of Independent Schools	Independent consultant working with Healthcare Financial Management Association (including NHS operating game, HFMA Academy and Best possible value facilitator)	Nil	Nil
Kevin Gould Non-Executive Director	• Director, Sharpthorne Services Ltd.	Nil	Nil	• Independent member of the Board of Governors at Staffordshire University • Independent Member of the Audit & Risk Committee at Grand Union Housing Group • Director, Look Ahead care and support	Nil	Nil	Nil

Gary Needle Non-Executive Director	• Director, T& G Property Ltd	Nil	Nil	• Contact Tracing Team Leader, Public Health England (self-employed on PHE bank) • Chair of Board of Trustees at East Grinstead Sports Club Ltd (registered sport and lifestyle activities charity)	Nil	Nil	Nil
Karen Norman Non-Executive Director	Nil	Nil	Nil	• Visiting professor, school of nursing, Kingston University & St Georges, University of London • Visiting professor, Doctorate in management programme, complexity and management group, business school, University of Hertfordshire	Nil	Nil	Nil
Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Keith Altman Medical Director	Director, Maxfacs Medical Ltd	Director, Maxfacs Medical Ltd	Nil	Nil	Nil	Nil	
Michelle Miles, Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Jo Thomas Director of Nursing	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other members of the board (non-voting)							
Abigail Jago Director of operations	Nil	Nil		Nil	Nil	Nil	Nil
Geraldine Opreshko Director of HR & OD	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Clare Pirie Director of Communications & Corporate Affairs	Nil	Nil	Nil	Nil	Nil	Nil	Nil

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	NA	NA	NA	NA	NA	NA	NA
Paul Dillon-Robinson Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Kevin Gould Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Gary Needle Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Karen Norman Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Keith Altman Medical Director	NA	NA	NA	NA	NA	NA	NA
Michelle Miles Director of Finance	NA	NA	NA	NA	NA	NA	NA
Jo Thomas Director of Nursing	NA	NA	NA	NA	NA	NA	NA
Other members of the board (non-voting)							
Abigail Jago Director of operations	NA	NA	NA	NA	NA	NA	NA
Geraldine Opreshko Director of HR & OD	NA	NA	NA	NA	NA	NA	NA
Clare Pirie Director of Communications & Corporate Affairs	NA	NA	NA	NA	NA	NA	NA

NHS
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Business meeting of the Board of Directors
Thursday 03 September 2020
11:00 – 12:30
via web conference

Agenda: session held in public			
Welcome			
119-20	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
120-20	**Draft minutes of the meeting held on 2 July 2020.** *Beryl Hobson, Chair*	*approval*	1
121-20	**Matters arising and actions pending** *Beryl Hobson, Chair*	*review*	8
122-20	**Chair's report** *Beryl Hobson, Chair*	*to note*	9
123-20	**Chief executive's report** *Steve Jenkin, Chief executive*	*assurance*	11
Key strategic objective 5: organisational excellence			
124-20	**Board assurance framework** *Lawrence Anderson, Deputy Director of Workforce*	*assurance*	20
125-20	**National NHS People plan** *Lawrence Anderson, Deputy Director of Workforce*	*information*	21
126-20	**BAME disparity work programme and Board Assurance** *Lawrence Anderson, Deputy Director of Workforce*	*approval*	24
127-20	**Workforce monthly report** *Lawrence Anderson, Deputy Director of Workforce*	*assurance*	34
128-20	**Formal ratification of Workforce WRES and WDES** *Lawrence Anderson, Deputy Director of Workforce*	*ratification*	47
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
129-20	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*assurance*	54
130-20	**Financial, operational and workforce performance assurance** *Paul Dillon-Robinson, Committee chair*	*assurance*	56
131-20	**Operational performance** *Abigail Jago, Director of operations*	*assurance*	59

132-20	**Financial performance** *Michelle Miles, Director of finance*	*assurance*	75
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
133-20	**Board Assurance Framework** *Jo Thomas, Director of nursing, and* *Keith Altman, Medical director*	*assurance*	92
134-20	**Quality and governance assurance** *Karen Norman, Non-executive director*	*assurance*	94
135-20	**Corporate risk register (CRR)** *Jo Thomas, Director of nursing*	*review*	99
136-20	**Quality and safety report** *Jo Thomas, Director of nursing, and* *Keith Altman, Medical director*	*assurance*	105
137-20	**Approval of annual reports** • Safeguarding • Infection, prevention & control • Patient experience • Emergency preparedness, resilience and response, (and business continuity) • Research & Development • Consultant revalidation *Jo Thomas, Director of nursing*	*approval*	134
138-20	**National inpatient survey results 2019** *Jo Thomas, Director of nursing*	*assurance*	275
Governance			
139-20	**Covid 19 Business Continuity Terms of Reference for Board and Committees** *Clare Pirie, Director of communications and corporate affairs*	*approval*	295
140-20	**Audit committee assurance update** *Kevin Gould, Committee chair*	*assurance*	298
Any other business (by application to the Chair)			
141-20	*Beryl Hobson, Chair*	*discussion*	-

Questions from members of the public			
142-20	*We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Hilary.Saunders1@nhs.net clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.* *Beryl Hobson, Chair*	*discussion*	-

Document:	Minutes (Draft & Unconfirmed)	
Meeting:	**Board of Directors (session in public)** **Thursday 2 July 2020, 11:00 – 12:30 via videoconference**	
Present:	Beryl Hobson (BH)	Trust Chair (voting)
	Keith Altman (KA)	Medical director (voting)
	Paul Dillon-Robinson (PD-R)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Steve Jenkin (SJ)	Chief executive (voting)
	Abigail Jago (AJ)	Director of operations (non-voting)
	Michelle Miles (MM)	Director of finance (voting)
	Gary Needle (GN)	Non-executive director (voting)
	Karen Norman (KN)	Non-executive director (voting)
	Geraldine Opreshko (GO)	Director of workforce and OD (non-voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
	Jo Thomas (JMT)	Director of nursing (voting)
In attendance:	Hilary Saunders (HS)	Deputy company secretary (minutes)
	Lawrence Anderson (LA)	Deputy director of workforce
	Peter Shore (PS)	Lead governor
Members of the public	Two public members of the Council of Governors	

Welcome

93-20 **Welcome, apologies and declarations of interest**

The Chair opened the meeting and welcomed LA who was observing today's meeting in addition to two Council members.

BH reminded the Board that the meeting would follow the same format as last time. Members had raised questions in advance, which would be addressed today. This was to make best use of the time available and it was important that issues were still discussed in full where needed.

There would be a change to the running order of today's business with the BAME disparity work programme and Board assurance item to follow immediately after the CEO's report. This was to allow sufficient time to address this important matter. BH stated that everyone had been very moved by the evidence emerging of the disproportionate effect COVID 19 has had on staff from a BAME background and acutely aware of the issues highlighted by the Black Lives Matter movement. The BAME disparity work programme should not be a tick-box exercise and focus would be on culture, leadership and the tone the Board set in addressing inequalities.

GN declared he had recently taken on the role of contract tracing team leader for Public Health England (on the PHE bank). This has now been recorded on the register of interests

There were no apologies.

Standing items

94-20 **Draft minutes of the meeting held on 07 May 2020**

The minutes were approved as a correct record

95-20 **Matters arising and actions pending**

The Board received the latest matters arising and actions pending document.

	Whilst there was an action pending to provide an update on Adult Burns in September, this would be deferred until later in the year if there were nothing of significance to report.
96-20	**Chair's report** The Board received the Chair's report.
97-20	**Chief executive's report** The Board received the Chief Executive's report, comprising overall BAF, integrated dashboard and media update, in addition to the main report. In response to questions from the Board, SJ clarified the following: • Many of the metrics on the integrated dashboard showed red reflecting both the impact of the pandemic and the restoration and recovery plans currently underway. SJ suggested that the dashboard should be seen alongside the BAF where there had been dramatic changes to both in the last few months; in particular KSOs 3 and 4 were now in a very different position. Activity had deteriorated recently, mirroring other trusts, but by contrast, block contract payments introduced at the start of the pandemic had moved KSO4 metrics from red to amber or green. MM suggested that additional KPIs could be added into KSO4 to measure underlying deficit. **[Action: MM]** • The shortage of masks described in the main report related to the availability of some discontinued items rather than overall stock. JMT confirmed that the Trust anaesthetic lead did not anticipate loss of activity but would continue to ensure we had the right kit and that staff knew how to use it. • Recent correspondence from NHSE/I had asked trusts to take the opportunity to 'lock in' beneficial changes that had materialised as a result of COVID. Such examples at QVH would include continuation of meetings via videoconference and business conducted in a more succinct way. 16,000 virtual consultations had been undertaken since early April and the number of video consultations was also increasing. The Head of Operational Improvement was capturing these examples and taking this initiative forward. SJ reminded the Board that it should be very proud of what the organisation had achieved in recent months. There had been good clinical engagement and the Trust had worked well with The McIndoe Centre in managing trauma patients. QVH was now well represented within the region and had generated excellent media coverage.
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services	
98-20	**Board Assurance Framework** The Board received board assurance frameworks for KSOs 1 and 2. The Board queried why the risk relating to pension tax issues had been removed from KSO2, seeking assurance that this was no longer an issue. KA noted that this had also been considered at the recent Quality and governance committee. Despite concerns that consultants may choose to go part time or reduce their job plans, there was no evidence to support this and a decision had been taken to remove this from the BAF. The situation would be monitored and the risk reinstated if appropriate. AJ concurred that this issue appeared to have been resolved since the increase in pension tax thresholds. Any private activity would have to be agreed in advance with the QVH clinical senate. The McIndoe private surgical centre continued to support QVH in managing its work as a cancer hub. A task and finish group had been established to ascertain how work could be expanded to cover out of hours. The Board noted that a bigger challenge than pension tax was of the risk to the workforce of unexpected absence, adverse test and trace outcomes and the need for staff shielding.

	There were no further comments and the Board **noted** the contents of the update.
99-20	**Quality and governance assurance** The Board received the regular Quality and governance assurance report. The Board noted deferral of the Committee's sub-group meetings during the pandemic and queried the impact of this; it also went on to seek assurance as to the value provided by these meetings. Whilst there had been no serious impact following postponement of the meetings, members of the Quality and governance committee cited the depth and diversity provided which might not be apparent in a report. KN concurred that all groups had a significant programme of work, which supported the assurance process. Meetings would be re-introduced over the next few months as part of the recovery and restoration programme. There were no further queries and the Board **noted** the contents of the update.
100-20	**Corporate risk register (CRR)** The Board received the latest corporate risk register. Additional clarification was sought in respect the following: • Risk 1182 relating to system failures around the NHS video consult programme. AJ explained that the upgrade was linked to a national programme; the contingency plan at present was patient consultation by phone. • Risk 1140 regarding the current PACs project, due to expire in June. MM agreed to email the Board with a detailed response. **[Action: MM]** There were no further questions and the Board **noted** the contents of the update.
101-20	**Quality and safety report** The Board received the regular Quality and safety report, seeking clarification in respect of the following: • Confirmation that all cancer patients were required to undertake strict self-isolation for 14 days prior to admission to QVH. There was no flexibility around this. There is no evidence that this was affecting a patient's willingness to come in; whilst a few may have chosen not to receive treatment at this time, overall this had not been identified as a problem. • Clarification that *Clinical Harm Reviews* and *Risk Stratification and Prioritisation of patients for elective surgery* were two discrete pieces of work. The former was undertaken where a patient had been deferred, the latter at the point of treatment and the process involved procedural and patient scores • Assurance that, whilst still in its early stages, the integrated governance process is working well. It is overseen by EMT with HMT sign-off where appropriate. Additional assurance is provided with JMT cross-referencing all relevant action logs to ensure nothing is overlooked. There were no further questions and the Board **noted** the contents of the update.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
102-20	**Board Assurance Framework** The Board received the BAF for KSO3, highlighting the following: • That the risk rating had been consistent at 16 for the previous three quarters and querying if there was now a case for increasing to 20 given restoration and recovery challenges becoming apparent. AJ felt that this was difficult to determine. Although performance had deteriorated due to COVID, other elements were continuing to improve. • A query as to whether the establishment of the Sussex ICS might help resolve gaps in controls linked to care pathways. Whilst this would not improve tertiary issues, AJ

	suggested that relationship development would help. She also reminded the Board that Sussex was only one area for which QVH provided services. • Assurance that all providers were working to a similar recovery trajectory and that the Trust would continue to monitor all activity, not just that which came through the Sussex ICS. • It was difficult to determine at this stage the current level of patients deferring treatment when offered an admission date, due to fears around COVID. Decisions to defer were affected by various criteria; more data may be available next month. The Board received the BAF for KSO4, and sought additional clarification as to why reference to the quality improvement programme been removed. MM confirmed that service reviews include the quality improvement element using service review methodology. There were no further questions and the Board **noted** the contents of the update.
103-20	**Financial, operational and workforce performance assurance** The Board received the financial, operational and workforce performance assurance report.

104-20	**Operational performance**
	The Board received the latest operational performance report, commending the huge amount of work undertaken on recovery and restoration planning. Additional clarification was provided in respect of the following:
	• That the most important rate limiting factors as we move from planning to delivery were ensuring pace and clarity of decision making, management capacity to deliver and cancer hub requirements
	• The top three risks to successful delivery included:
	  • Capacity (space, workforce, PPE)
	  • Patient willingness to attend
	  • Complexity of variation, eg changing guidance on a regular basis
	• Resumption of spoke activity was not dependent upon availability of PPE at QVH as this was provided by spoke sites.
	• Assurance that point of referral would not take precedence over clinical need when prioritising waiting lists.
	• Whilst activity had fallen, services requiring histopathology had increased, particularly due to a series of complex head and neck cancer cases.

105-20	**Financial performance** The Board received the latest financial performance report. It was noted that the report related to in-year performance but that the underlying deficit carried forward from last year currently stood at c£10m. MM also reminded the Board that there was still a lack of assurance in respect of financial recovery funding available to the Trust. There were no further comments and the Board **noted** the content of the update.
106-20	**Budget setting methodology update 2020/21** The Board received a report on the Trust's current budget setting methodology for 2020/21. Additional assurance was sought with regard to: • The proposed timescale for approval; MM confirmed that pay and non-pay budgets were being signed off at present, however, no organisation had yet been able to sign off fully and it wasn't clear when income guidance would be available • In response to a question regarding the drugs inflation figure, MM advised that this was a national inflationary level and an operational planning requirement. She agreed

	to provide the Board with additional information via email after today's meeting. **[Action: MM]** • The Board noted the the significant number of variables and unknowns affecting our ability to accurately set and control budgets but suggested it would be helpful to receive something on aggregate with the understanding that would change throughout the year. MM agreed it should be possible to circulate something within the next few days **[Action: MM]** There were no further questions and the Board **noted** the contents of the update.
Key strategic objective 5: organisational excellence	
107-20	**Board assurance framework** The Board received the latest board assurance framework update on KSO5
108-20	**Workforce monthly report** The Board received the latest workforce monthly report, noting in particular that good progress had been maintained on summary indicators. There were no concerns around infection control targets, despite a few fluctuations whilst staff adjusted to different ways of working. MAST training had not fallen significantly and conversion to eLearning had been successful. The Board was asked to note that there could be a hiatus during the switch from WebEx to MS Teams. There were no further questions and the Board **noted** the contents of the update.
109-20	**BAME disparity work programme and Board Assurance** GO presented a report describing the disparity of the impact of COVID19 on the BAME community; this also included a framework with which Board could assess and report on what actions can be taken forward following discussion. The Board was asked to note in particular: • Whilst the paper was evolving, it provided a succinct overview of the current workforce at QVH. Additional information would be incorporated after today's meeting and following the August seminar. • Terminology used in the report was regional and national and would be considered in more detail at the forthcoming seminar with Cavita Chapman, NHSI/E Head of Equality, Diversion and Inclusion. • This framework was not tailored to any one setting and some components may be less relevant to QVH due to our position as a specialist cancer hub (the Trust was not in the same position as neighbouring trusts with 'red' pathways). • The WRES related to 2018/19 data. The 2019/20 data would be finalised towards the end of August. • The Trust was required to achieve 100% completion of the risk assessment by the end of July. The CEO had expedited the process and was urging managers to take urgent action. • QVH had already implemented a number of specific actions, and next week would be advertising for our own BAME network lead for QVH. A number of staff had expressed an interest and the appointment process would be supported by Cavita Chapman. • Quantitative data would be included in future workforce reports. In response to questions from the Board, GO advised that: • Due to GDPR regulations, it would not be appropriate to use the Speak Up Guardian to undertake a confidential exercise with BAME staff. • Risk assessments are confidential between the line manager and staff member, but linked to personal records. They would only be shared with Occupational Health where appropriate. However, a number of actions had been implemented at the start of the pandemic, eg identification of a specific workspace for vulnerable clinicians working in virtual clinics, to mitigate risk.

	• Managers were equipped to have 'difficult' conversations with BAME staff. Notwithstanding the fact that such conversations could generate sensitivities, the Trust had provided managers with guidance on how to manage difficult conversations, (whether related to ethnicity or not) through the Leading the Way modules. CP was also investigating the possibility of accessing national charitable funding to support training in this area. • JMT was currently working with the Deputy Director of Workforce to ascertain the percentage of BAME or other high-risk staff and would continue to monitor and adapt how this cohort are screened and managed as more intelligence becomes available. • Assurance that the Trust has been proactive in this area. Emails and blogs from the CEO had been very well received by staff. • A seminar in August would take place on 26 August at which time this document would be further developed. Once the Board had had sufficient opportunity to assimilate its findings, the document would be reviewed and signed off in September. **[Action: GO]** There were no further comments and the Board **noted** the contents of the update.
Governance	
110-20	**Annual approval of Standing Financial Instructions, Standing orders and Reservation of powers/scheme of delegation** The Board received the revised corporate governance documents, noting these had previously been reviewed and recommended for approval by the Audit committee. Members sought additional clarification as follows: • Confirmation that wording to be amended to make it clear that all items over a £5k threshold would require a single tender waiver in the absence of three quotes. • MM confirmed that she would be responsible for signing all single tender waivers due to the significant issues at present. There were no further questions and the Board **approved** the Standing Financial Instructions, Standing orders and Reservation of powers/scheme of delegation for 2020/21
111-20	**Review of QVH COVID19 Business continuity Terms of Reference for Board and Committees** The Board received the revised terms of reference for QVH COVID19 business continuity. An initial version had been approved in March at the outset of the pandemic. CP commented that despite the risk of a second wave, the TORs propose a move towards normal quoracy and usual levels of discussion at Board and committee level. Plans were progressing to hold meetings in public via MS Teams as soon as practical. There were no further comments and the Board **approved** the terms of reference.
112-20	**Review of QVH/The McIndoe Centre ToRs for Oversight Group** The Board received revised Terms of reference for the QVH/TMC oversight group. SJ explained that whilst this group originated as a strategic group it had now developed as an operational oversight group. ToRs would be returned to the Board for further review at some stage in the future, but it was difficult to agree an exact date at this stage in the absence of certainty around the contract extension. There were no further comments and the Board **approved** the terms of reference.
113-20	**Audit committee assurance update** The Board received an assurance update from the Chair of the Audit committee.

Any other business	
114-20	• Transfer of existing agreements between QVH and East Grinstead Museum: Under the terms of a previous agreement, the Museum is required to ask QVH if it wishes to transfer ownership of the objects and records relating to QVH and the Guinea Pig Club. For its own administrative purposes the Museum has recently established a new Charitable incorporated organisation (CIO) and is transferring all its assets to this new charity. The Board had recently been in consultation via email and gave our consent to transfer the objects and record to the CIO. There were no further questions and this decision was formally **ratified**. • National inpatient survey results: JMT noted that due to embargo, it had not been possible to publish the Trust's results in today's Board papers; however, these had been released earlier today. The full report would be brought to the September board but in the meantime, the Board was asked to note that QVH had sustained its excellent patient experience with some very high levels of satisfaction.
Questions from members of the public	
115-20	None

Matters arising and actions pending from previous meetings of the Board of Directors									
ITEM	**MEETING Month**	**REF.**	**TOPIC**	**CATEGORY**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
1	July 2020	97-20	CEO report	Standing items	Noting that KSO4 metrics have moved from red to amber or green as a result of block payments, Board have asked that additional KPIs be added into KSO4 to measure underlying deficit.	**MM**	**ASAP**		**Pending**
2	July 2020	100-20	CRR	KSO1	MM agreed to email the Board with a detailed response to queries raised regarding current PACS project.	**MM**	**ASAP**	Email circulated to full board on 10 July 2020	**Closed**
3	July 2020	106-20	Budget setting	KSO4	MM to email Board with supplementary information regarding drug inflation figure.	**MM**	**ASAP**	Email circulated to full board on 10 July 2020	**Closed**
4	July 2020	106-20	Budget setting	KSO4	Additional information relating to 2020/21 budget to be circulated to Board	**MM**	**ASAP**	Included in September Finance report to BoD	**Closed**
5	July 2020	109-20	BAME disparity work programme	KSO5	Board to finalise Board assessment framework at its meeting in September	**GO**	**Sept. 2020**	On September agenda	**Pending**
6	March 2020	41-20	CRR	KSO1	F&PC to consider how to capture impact on performance of those corporate risks which relate to staffing.	**PD-R**	~~**May 2020**~~ ~~**July 2020**~~ **Sept 2020**	**25 08 20** F&P agreed have agreed to defer until Sept meeting	**Pending**
7	Jan 2020	10-20	Q&S report	KSO2	Board to receive written update on adult burns service	**KA**	~~**March 2020**~~ ~~**May 2020**~~ ~~**Sept 2020**~~	Nothing further to report at present. Will be returned to May Board with update after start of talks with BSUH. **07 05 20** Nothing further at present. To be brought forward in September 2020. **August 2020** No further update at this stage. Board will be kept informed as this progresses	**Closed**

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/09/2020**		**Agenda reference:**	**122-20**	
Report title:	**Chair's Report**				
Sponsor:	Beryl Hobson, Chair				
Author:	Beryl Hobson, Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on the Chair, NED and governors activities since the last board meeting.				
Summary of key issues					
Recommendation:	For the Board to **NOTE** the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board of Directors
Meeting date:	Thursday 3 September 2020
Agenda item reference no:	122-20
Report from:	Beryl Hobson, Chair
Date of report:	24 August 2020

Chairs Report

1. Chair's and NED's activities

At the board seminar in August the board discussed the future of partnership working and the CEO's report will cover this in greater depth. Since the last board meeting we have had several meetings with the Chair and CEO of BSUH/ Western, and I have set up regular meetings with their Chair, Alan McCarthy. I also attended one of the CEO briefings with staff and was impressed by the positivity and understanding regarding QVH's position from the majority of those who attended.

At the time of writing the board has added an additional board seminar in August with Cavita Chapman, NHSI/E Head of Equality, Diversity and Inclusion. This will cover Equality and Diversity issues, and BAME specific issues including developing a BAME network and its relationship to WRES, COVID etc.

As up to a third of QVH patients are from Kent and our teams work at 'spoke sites' in Kent, I have joined the Kent Providers Chairs group which meets every two weeks. At the moment, Kent is still an STP and is working towards ICS status by the end of this calendar year and I attended a stakeholder event which worked on their proposed ICS Vision and Mission. It has been helpful to understand the perspective of the Kent Chairs and to raise the issue of QVH with them. I have also been able to share some learning from the Sussex ICS experience.

Since March the NEDs have been meeting more frequently with the CEO and have established 'buddying' arrangements with the executive directors to provide support and a forum for broader discussion of issues than can be raised at board. We have of necessity changed the way we ask questions at virtual board meetings and committee meetings, with many of them being asked in advance for a response either at board or separately outside the meeting. We are monitoring how this works as we do not wish to stifle legitimate debate and have to avoid the situation where it feels as though Non-Executive Directors are simply challenging executives. As a unitary board we have to strive to challenge and support each other.

2. Governor Activity

The July Council of Governors met online with reduced attendance by Executives but a full complement of NEDs who gave their usual report to the Governors. In addition to explaining what QVH had been doing since March re Covid, the CEO touched on the recent announcement by BSUH and Western NHSFT that they would be entering a merger, rather than the previously anticipated Group structure.

We welcomed one new stakeholder Governor – Julie Holden, who is Town Clerk of East Grinstead Town Council. We have always enjoyed good working relationships with the Town Council and this addition will further enhance this.

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
We put the patient at the heart of safe, compassionate and competent care that is provided by well led teams in an environment that meets the needs of the patient and their families.	We provide world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high quality education and training and innovative R&D.	We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner	We maximize existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services.	We seek to be the best place to work by maintaining a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce

Current Risk Levels

The entire BAF and CRR were reviewed at executive management meetings in August. KSO1 and 2 were also reviewed at the Quality and Governance Committee, 20/08/20. The August Finance and Performance Committee was cancelled due to current workloads of each of the teams working on the delivery plans for phase 3. The chair of F&PC and the DoF have met regularly in the last 2 months to discuss and has seen both the finance, budget setting and land sale report. The trust finances are break even due the national requirement and we await further national /regional instruction regarding the financial flows for the second half of this financial year.
Changes since the last report are shown in underlined type on the individual KSO sheets. The integrated pandemic governance process has been embedded and the trust is proactively managing the new and emerging risks identified as part of the restoration and recovery phase Additional assurance continues to be sought internally and the evidence of this is referenced in the respective director reports to the September trust board .

	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Target risk
KSO 1	12	12	12	12	9
KSO 2	12	12	16	16	8
KSO 3	16	16	16	16	9
KSO 4	25	25	25	25	16
KSO 5	16	16	16	16	9

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/09/2020**		**Agenda reference:**	**123-20**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	1) QVH media update				
Executive summary					
Purpose of report:	To update the Board on progress and to provide an update on external issues that may have an impact on the Trust's ability to achieve its internal targets.				
Summary of key issues	• NHS inpatient survey • Covid-19 – QVH response • Establishing QVH BAME staff network				
Recommendation:	For the Board to **NOTE** the report				
Action required	Approval **Y/N**	**Information Y/N**	Discussion **Y/N**	Assurance **Y/N**	Review **Y/N**
Link to key strategic objectives (KSOs):	KSO1: **Y/N**	KSO2: **Y/N**	KSO3: **Y/N**	KSO4: **Y/N**	KSO5: **Y/N**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:					
Corporate risk register:	None				
Regulation:	N/A				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	EMT				
	Date:	22/06/20	Decision:	Review BAF	
Next steps:					

CHIEF EXECUTIVE'S REPORT
SEPTEMBER 2020

TRUST ISSUES

Patients praise QVH in annual NHS inpatient survey

The latest national NHS inpatient survey, showing that Queen Victoria Hospital continues to achieve some of the best feedback from patients in the country, received a series of media coverage. The survey also showed that we are one of only five acute specialist trusts to have consistently maintained a 'much better than expected' rating over the last six years.

The annual national survey of inpatients at all NHS hospital trusts in England published on July 2, covers all aspects of patients' care and treatment. Carried out by the Care Quality Commission (CQC), the survey asked patients for their views on aspects of their care, such as: the hospital environment, communication with staff, involvement in decisions and being treated with respect and dignity.

A total of 550 patients participated in the survey, giving the hospital a 44.72 per cent response rate against a national average of 45 per cent. Overall, QVH scored better than other trusts across in all measures in the survey. The results for trusts achieving 'much better than expected are shown below:

Results

Trusts achieving 'much better than expected' results

Nine acute trusts were classed as 'much better than expected' in 2019. Seven of these had the same banding in 2018, demonstrating consistently high levels of positive patient experience. All nine trusts are classed as specialist trusts.

	Historic results	Overall results				Core service		Overall CQC rating
	2018	2019	Most Positive (%)	Middle (%)[f]	Most Negative (%)	Medical care	Surgical	
			66	18	16			
Liverpool Heart and Chest Hospital NHS Foundation Trust	MB	MB	76	13	11	MB	MB	O
Liverpool Women's NHS Foundation Trust	S	MB	77	12	12	MB	N/A	G
Queen Victoria Hospital NHS Foundation Trust	MB	MB	81	11	9	MB	MB	G
Royal Papworth Hospital NHS Foundation Trust	B	MB	78	12	9	MB	B	O
The Christie NHS Foundation Trust	MB	MB	76	13	10	MB	B	O
The Clatterbridge Cancer Centre NHS Foundation Trust	MB	MB	76	14	9	MB	N/A	G
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	MB	MB	82	10	8	S	MB	G
The Royal Marsden NHS Foundation Trust	MB	MB	78	14	8	MB	MB	O
The Royal Orthopaedic Hospital NHS Foundation Trust	MB	MB	76	15	10	N/A	B	G

Key:					
	Trust performance	About the same (S)	Better (B)	Much better (MB)	
	CQC rating	Inadequate (I)	Requires Improvement (RI)	Good (G)	Outstanding (O)

[f] Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. For example, 'yes, sometimes' is the middle option (scored as 5/10) for the question *'When you had important questions to ask a doctor, did you get answers that you could understand?'*.

NHS celebrates 72nd birthday

QVH charity said a special thank you not only to staff at Queen Victoria Hospital (QVH) but to all the local people and companies who have generously supported the charity.

This year has been the most challenging in the history of the NHS, with hospitals finding ways to deliver services differently during the COVID-19 pandemic.

Covid-19

Progress since last Board

The Trust has redesigned surgical pathways to provide screened pathways of care to enable patient with cancer to have urgent surgery whilst minimising the additional risks of Covid-19. We continue to provide this service for the specialties of head and neck, skin and breast. Advanced infection controls measures remain in place, including screening and temperature monitoring at the front door.

NHS Phase 3

Last Board meeting I talked of the Phase 2 letter received from Sir Simon Stevens, CEO of NHSE outlining the expectations of providers. On 31 July, all providers received the Phase 3 letter. The pandemic has been downgraded from Level 4 national command and control to Level 3 regional co-ordination with effect from 1 August.

The NHS has now entered a critical phase of restarting more non-COVID care and continuing to respond to the pandemic. The letter is a stark reminder that the virus will be with us for some time to come. The letter provides clarity on the priorities and what is now expected in terms of performance; the targets set out are very stretching but it is important that we are ambitious for our patients. The challenge will be significant for all trusts with some having lost between 20 and 40% of their normal capacity and it will take time to get this back up to where it is needed to restart services.

In order to restore and recover our services as quickly and efficiently as possible with a view to maximising the use of our theatres and beds, our workforce and the independent sector provision at the McIndoe Centre, a number of ward moves took place during July and trauma activity returned to the QVH site from 3 August. The 'can do' approach from our ward staff in particular has been impressive and demonstrates their commitment to enhancing the patient experience.

Black, Asian and Minority Ethnic staff (BAME)

QVH Board has set up a seminar with Cavita Chapman, Head of Equality, Diversity and Inclusion at NHS England and NHS Improvement – South East Region as we go about establishing QVH's first BAME staff network. We have advertised for a BAME network lead from amongst our workforce and interviews are planned for later this month

Staff engagement

A number of staff briefings have taken place during August aimed and updating colleagues on our approach to the pandemic as well as our ambitions to be sustainable into the long-term future. A number of these CEO briefings have been with specific teams such as the nursing and quality forum, consultants meeting, psychological therapies team, sleep and Peanut ward, whilst three other online briefings have been open to all staff.

Integrated Performance Dashboard Summary

Our Integrated Performance Dashboard summary is omitted from this Board meeting as we go about restoring our services. An updated summary will be available at our November Board meeting.

Board Assurance Framework (BAF)

Attached is the BAF front sheet, the following points are worth noting:

The entire BAF was reviewed at executive management meeting (24/08/2020) alongside the corporate risk register. KSO 1 and 2 were reviewed at the Quality and Governance Committee, 20/08/2020. KSO 3, 4 and 5 were reviewed 27/07/20 at the Finance and Performance Committee

(no meeting in August). Changes since the last report are shown in underlined type on the individual KSO sheets.

Media
Appendix 1 shows a summary of QVH media activity during June and July 2020; reflecting the NHS 72nd birthday coverage.

Steve Jenkin
Chief Executive

QVH media update – June 2020

Cancer patients receive timely treatment at QVH

We issued a press release this month about how we have been able to help cancer patients receive timely surgery thanks to our role as a designated cancer surgical hub, the first in the South East of England back in April. We have had to change some of the ways we work to minimise the risk of Covid-19 onsite, which has included working closely with The McIndoe Centre, the private hospital which shares our grounds. They have provided us with capacity to treat patients with urgent trauma injuries to the eye, hand or face. This has included a theatre available 24 hours a day to ensure limb-threatening injuries can be treated immediately.

Ian Francis, our deputy medical director and lead for cancer and strategy, was interviewed by BBC Sussex radio about our role and how we have supported patients. It follows on from an interview Ian did for the station shortly after we became a cancer hub. RH Uncovered also featured our release on their website.

The legacy of Sir Archibald McIndoe

Doug Vince, one of the seven remaining members of the Guinea Pig Club was interviewed by The Sun newspaper about his experience of WWII and Covid-19. The group called "the most exclusive Club in the world" by Sir Archibald McIndoe, were treated for their burns at our hospital. Now 97, Doug vividly recalls how his life changed when his Stirling bomber hurtled towards the ground in flames after being blasted by bullets from a Nazi fighter plane. He explains how happy he is to be a member of such an exclusive club, one which saved him.

Nestled in the letters pages in the Daily Mail this month was an account by Lynn Cardwell, explaining how her mother's chance conversation in 1943 with a porter changed her life. Born with a bilateral cleft palate, she was called a monster and her mother told to bring Lynn back to hospital when she was seven. The long letter concludes "Modern medicine has moved on thanks to the work of Sir Archibald and the best possible care is available to children with a cleft palate."

Spreading burns awareness thanks to a Facebook post

A Facebook post made by a mum detailing the moment her two-year-old son sustained burns to his shoulder and chest after pouring a mug of hot tea over himself in an accident has not only generated over 77,000 shares on the social media platform but local and national media interest. Claire explains how her son William received treatment from our burns team. The post, and articles, explain how the quick response of her husband Edward, putting their son under cool running water in the kitchen sink, saved William from needing skin grafts.

Claire's story featured in the Daily Mail, the Rye and Battle Observer; the West Sussex County Times; and the Brinkwire websites.

This month the Daily Mail also featured an article with news presenter Natasha Kaplinsky where she talks about how her daughter still will not get into a petrol car following a boating accident in Corfu. Natasha explains how petrol leaking from a boat they were in spontaneously ignited by the heat of the engine, resulting in a sudden fireball. Natasha, her dad and her then eight-year-old daughter suffered burns to the face and arms. They spent 45 minutes in the sea before being rescued with the salt water helping diminish the worst effects of the damage to their skin. She says how she was given incredible support "nowhere more so than at the burns unit in East Grinstead".

QVH Charity and the NHS' birthday

At the end of the month we issued a press release about how our QVH Charity is marking the NHS' birthday (on 5 July) with a thank you to supporters.

It is an opportunity to say a special thank you not only to staff at Queen Victoria Hospital but to all the local people and companies who have generously supported the charity since the start of the pandemic. The release was featured on the RH Uncovered website which also dedicated its homepage to the news.

A guide to glaucoma

Gok Ratnarajan, our consultant ophthalmic and glaucoma surgeon, wrote an article on glaucoma which was syndicated in a series of local media websites including the Bexhill Observer; Bognor Regis Observer; Brighton and Hove Independent; Chichester Observer; Crawley Observer; Eastbourne Herald; Midhurst and Petworth Observer; Rye and Battle Observer; Sussex Express; and Worthing Herald.

A similar article but on cataracts was featured in the East Grinstead and Crawley editions of RH Uncovered Magazine.

Taking care of your hands during Covid-19

Bav Shergill, our consultant dermatologist, was quoted in an article in the Daily Mail about how to protect your hands when frequently washing them to reduce the spread of Covid-19. He explains that despite what it may do to our skin with repeated use, traditional soap and water is the best way to protect yourself from Covid-19. The article was also featured on the Daily Mail Online; The Irish News; Brinkwire websites. It also appeared on the Indonesian Viva website.

Professional profile

Aakshay Gulati, our consultant oral and maxillofacial surgeon is profiled on the Reigate Grammar School Foundation website as a parent associated with the school. As well as finding out more his role and interests, we discover who would play him in a Hollywood film made about his life!

Ad hoc mentions

We were mentioned in articles on the Worthing Herald and Littlehampton Gazette websites in relation to a fundraiser set up to support a family in Angmering whose house caught fire. One of the family sustained severe burns to their hands, nose and head and continues to receive outpatient treatment at our hospital.

Press releases

We issued the following press releases in June that you can read via these links:

- Cancer patients receiving timely surgery thanks to Queen Victoria Hospital
- QVH Charity marks NHS birthday with a thank you to supporters

We also published a series of website-based news stories for patients and stakeholders:

- Wearing a face covering when coming to QVH

QVH media update – July 2020

Here is a summary of the media activity secured for QVH …

Patients praise QVH in annual NHS inpatient survey

The latest national NHS inpatient survey, showing that Queen Victoria Hospital continues to achieve some of the best feedback from patients in the country, received a series of media coverage. The survey also showed that we are one of only five acute specialist trusts to have consistently maintained a 'much better than expected' rating over the last six years.

Titles to feature the news included the Crawley Observer; the Mid Sussex Times; the West Sussex County Times; RH Uncovered; The Argus, the onenewspage website and newslocker website (both quoting The Argus);

QVH Charity marks NHS birthday with a thank you to supporters

To mark the 72nd birthday of our beloved national health service on Sunday 5 July, our QVH Charity said a special thank you not only to our staff but all the local people and companies who have generously supported the charity since the start of the pandemic. This thank you received a series of media mentions including the Crawley Observer; Mid Sussex Times; and the West Sussex County Times in addition to coverage at the end of last month.

Camilla Slattery, head of fundraising for the charity, was also interviewed on the NHS' birthday on radio stations BBC Sussex and BBC Surrey.

Partnership working during COVID-19

The Independent Healthcare Providers Network has produced a report entitled "Working together... during the covid19 pandemic - how NHS and independent sector partnerships are ensuring patients get the care they need during covid19."

On page 13 it talks about how we have been working closely with The McIndoe Centre, the private hospital which shares our grounds. They have provided us with capacity to treat patients with urgent trauma injuries to the eye, hand or face. This has included a theatre available 24 hours a day to ensure limb-threatening injuries can be treated immediately. It also features a quote from Steve Jenkin, our chief executive.

Coverage in Community News

We received a series of mentions in the autumn edition of Community News which was published this month, a quarterly local publication. This included the cover, featuring an image of our staff watching the Spitfire fly pass to mark the anniversary of VE Day which was also covered as a two-page article inside, and an piece on our national inpatient survey results.

Untold stories from the Battle of Britain

The Times ran an article entitled Battle of Britain: 'We had every confidence in the pilots and that we couldn't possibly lose' to coincide with the 80th anniversary of the start of the battle. One of the recollections mentions "East Grinstead" i.e. QVH. It talks of how many pilots suffered life-changing injuries. While recovering from severe injuries after his Spitfire was shot down, George Bennions, of 41 Squadron, learned that an airman he had joined up with from school was in the same hospital.

The article says: "This chap started propelling a wheelchair down the ward. Halfway down he picked up a chair with his teeth. That's when I noticed how badly his lips were burnt. Then he brought this chair down the ward, threw it alongside me and said, 'Have a seat old boy.' And I cried. I thought, 'What have I to complain about?' "

Supporting skin cancer patients

We were mentioned in an article on the KentOnline website regarding NHS consultants taking over the care of dermatology patients from Medway, Gravesham, Swale, Dartford and Swanley following the suspension of a contract with DMC Healthcare. It talks of a number of alternative providers being put in place with "skin cancer support services provided at Queen Victoria Hospital in East Grinstead."

Ad hoc mentions

Following on from the mentions last month, Gok Ratnarajan, our consultant ophthalmic and glaucoma surgeon's article on the silent thief of sight was also featured on the RH Uncovered website.

QVH was also mentioned in articles on the Brighton and Hove news website and The Argus website in relation to a patient we treated following an attack last year. The person who injured him has now been sentenced.

Press releases

We issued the following press release in July that you can read via the link below:

- QVH remains at the top in national NHS inpatient survey

We also published a series of website-based news stories for patients and stakeholders:

- Visiting patients on our wards during the COVID-19 pandemic
- Black Lives Matter
- Coronavirus information and advice for our patients and visitors

For more information…

Please contact Michelle Baillie, Communications Manager, at michelle.baillie@nhs.net

If you use social media, please follow us on Facebook, Twitter and Instagram.

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Date: 24th August 2020

Strategic Objective
We seek to be the best place to work by maintaining a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce

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

Risk Appetite The Trust has a **moderate appetite** for risks that impact on Organisational Excellence. The engagement and motivation of the workforce, supported by evidence based research, will impact on patient experience

Rationale for risk current score
- National workforce shortages in key nursing areas particularly theatres
- Generational changes in workforce, high turnover in newly qualified Band 5 nurses in first year of employment
- 2-3 years to train registered practitioners to join the workforce
- Over 40,000 nursing vacancies in England, circa 1,700 in SHCP
- managers skill set in triangulating workforce skills mix against activity and financial planning
- We are the NHS: People Plan 20/21 to be supported by system People plan NHS Interim People Plan
- Staff survey results and SFFT staff engagement have shown improvement, continuing with the 2019 national staff survey results. Preparation underway for 2020
- Addressing reasons for retention is challenging as pressures on managers/leaders can lead to a reluctance to adopt new ways of working and support significant change
- Overseas nurses arriving starting to have a positive impact
- KPI's stable even through pandemic
- Availability and willingness of staff to undertake WLI activity
- Ongoing requirement for COVID-19 risk assessments for all vulnerable staff, with heighten risk to BAME workforce

Initial Risk 3(C)x 5(L)=15, moderate
Current Risk Rating 4(C)x 4(L)=16, major
Target Risk Rating **3**(C)x 3(L) = 9 moderate

Future risks
- An ageing workforce highlighting a significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility.
- Developing new health care roles -will change skill mix
- Unknown impact of strategic direction of Trust into management group or other options
- Unknown longer term impact of COVID-19 pandemic on workforce recruitment and retention
- Staff who are shielding/vulnerable, including BAME Staff not being able to return to full duties as pandemic continues with requirement to undertake full risk assessments

Future Opportunities
- Closer partnership working with Sussex Health and Care Partnership.
- Capitalise on our work as a cancer hub as a place to work

Controls / assurance
- more robust workforce/pay controls as part of business planning and weekly vacancy control
- Leading the Way, leadership development programme funded for a further year 2020/21
- All works streams captured in one People and OD Strategy
- monthly challenge to Business Units at Performance reviews
- Investment made in key workforce e-solutions, TRAC, E-job plan ongoing, HealthRoster implemented, Activity Manager underway, capacity of workforce team improved
- Engagement and Retention plan actions ongoing, considerable improvements in some KPI's
- Overseas recruitment continues, but with delays, with nurses on site and most with PIN
- The Trust commissioned an external Well Led review and regularly updates the resulting action plan
- Work to finalise ESR hierarchy with ledger, now regularly aligned for reporting purposes
- Some positive gains from the 2019 NHS Staff survey results and SFFT
- Stay Well Team, health and wellbeing initiative established to support staff through the pandemic

Gaps in controls / assurance
- Management competency in workforce planning
- Continuing resources to support the development of staff – optimal use of apprenticeship levy budget
- Unknown longer term impact on overseas recruitment due to pandemic

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03 September 2020**		**Agenda reference:**	**125-20**	
Report title:	**National NHS People Pan**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Author:	Geraldine Opreshko, Director of Workforce and OD				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide the Board with an abridged overview of the first national NHS people plan and Our NHS People Promise.				
Summary of key issues	The NHS People plan was launched on 30th July 2020 It highlights key sections of the plan and expectations around regional and system response.				
Recommendation:	The Board is asked to **note** the report				
Action required *[highlight **one** only]*	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	KSO5: Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care KSO1: Engaged and motivated staff deliver better quality care				
Corporate risk register:	Impact of pandemic on workforce availability				
Regulation:	Well Led				
Legal:	n/a				
Resources:	Managed by HR/OD with support from finance, operations and nursing				
Assurance route					
Previously considered by:					
	Date:		Decision:	Information	
Next steps:					

‘We are the NHS: People Plan 2020/21 action for us’

On 30th July 2020 the NHS launched the NHS People plan 2020/21. The plan has been talked about, and consulted on for some time.

The pandemic caused further delays to its launch so this version has been written to take account of what has been happening in the NHS since March 2020 and is a two year rather than five year view.

Launched alongside the People Plan is the NHS People Promise.

The documents can be found at : www.england.nhs.uk/ournhspeople

Based on feedback from NHS staff **Our NHS People Promise** sets out what staff can expect from working within the NHS and sets out ambitions for what people working in the NHS say about it by 2024.

For many, some parts of the Promise will already match their current experience. For others, it may feel out of reach. We must pledge as colleagues, line managers, employers and central bodies to work together to make these ambitions a reality for all of us, within the next five years.

From 2020/21 the annual NHS Staff Survey will be re-designed to align with Our People Promise.

A further People Plan publication (Winter/Spring 2020/21) is expected post spending review following further sector engagement and prioritisation

We are the NHS: People Plan for 2020/21

This plan aims to make real and lasting change, building on the creativity and drive shown by our NHS people in their response to the pandemic. It is practical and ambitious, setting out the focused action that NHS people have told us they need right now, and for the rest of the financial year. It includes specific commitments around:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a focus on tackling the discrimination that some staff face
- **New ways of working** – effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit, train and keep our people, and welcome back colleagues who want to return

The Ask to Employers and Systems

Within each of the four categories above there is a detailed ask for both employers and systems.

The focus currently is however currently on each ICS, rather than organisation, to develop a local People Plan with the first draft requested by the end of September 2020.

This planning is underway in the Sussex HCP and will be reviewed by regional and system level People Boards.

Further metrics will be developed later in September 2020 with the intention to track progress using the NHS Oversight Framework.

Regular updates will be provided to Board through the Workforce Report.

-ends-

19th August 2020

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03 September 2020**		**Agenda reference:**	**126-20**	
Report title:	**BAME disparity work programme and Board Assurance**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Author:	Geraldine Opreshko, Director of Workforce and OD				
Appendices:	NA				
Executive summary					
Purpose of report:	The purpose of this report is to provide the Board with an update on the disparity of the impact of COVID-19 on BAME people and also the completed board assurance assessment framework with which to assess progress in supporting our workforce				
Summary of key issues	The appendix provides details of the QVH actions taken in relation to the identified risks and mitigations discussed in detail at the last Board meeting against the regionally provided Board Assurance checklist. The Board is ask to **review** the QVH actions and response Due to reporting deadlines, this report was submitted prior to the dedicated Board seminar hosted by Cavita Chapman, NHSI/E Head of EDI.				
Recommendation:	The Board is asked to review the QVH position				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	**KSO1:** ***Outstanding patient experience*** ✓	**KSO2:** ***World-class clinical services*** ✓	**KSO3:** ***Operational excellence*** ✓	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence*** ✓
Implications					
Board assurance framework:	KSO5. Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care KSO1: Engaged and motivated staff deliver better quality care				
Corporate risk register:	Impact of pandemic on workforce availability including the requirement to undertake risk assessments for all vulnerable staff				
Regulation:	Well Led				
Legal:	n/a				
Resources:	Overseen and managed by HR/OD with input, support and engagement from finance, operations and nursing Support from NHS Charities Together bid				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:	KPIs and progress will be reviewed regularly as part of the governance arrangements of the Trust.				

BAME disparity work programme

Board Assurance Checklist

The Board checklist below was shared in its basic form at the QVH Board Meeting in July. It is a tool to help demonstrate that there is effective Board oversight over the risks outlined. As previously stated research clearly has shown that specific staff groups, most notably BAME, are more likely to have health conditions that make then vulnerable to COVID-19. It also shows that BAME staff may be vulnerable to adverse treatment within the workplace which could exacerbate other risks. So it is important to pay particular attention to the risks for these staff.

The list of factors outlined in the table below is intended to support the work that QVH and other organisations has begun and to help ensure that risks from COVID-19 are minimised. There are a small number of these that have metrics (marked with *) and these will form part of the workforce report in future where possible and relevant. We are also likely to be required to report these on a regional basis.

The table below highlights the position of QVH in relation to the stated risks and mitigations at August 2020

Risk	Potential risk mitigation	QVH Position and Response
1. Governance		
1.1 *Is the Board sighted on and has it put in place **appropriate accountability and resource into Covid-19 workforce assessment and support**?	Spot checks on any areas where higher than expected infection rates indicated by data or soft intelligence including concerns to Speak Up Guardians.	Information is collected daily by HealthRoster on all absence data The freedom to speak up guardian reports directly to the CEO and will raise any concerns Through the pandemic we have not been open to symptomatic patients and we have taken significant additional precautions to protect our staff and patients.

1.2 *Does your organisation hold **data** (disaggregated by White/BAME) that will demonstrate the effectiveness of engagement on COVID-19 and BAME staff?	*Collect **data** (disaggregated by White/BAME) on the following: a. Numbers of risk assessments as a proportion of the overall employed workforce b. Overall staff Covid-19 sickness absence (days) c. Proportion of staff (White/BAME) moved following a risk assessment d. Proportion of these groups of staff who have had a risk assessment **i.** returners, **ii.** agency staff, **iii.** newly qualified staff, **iv.** staff returning from sick and permanent night shift staff	All workforce data can be disaggregated by white/BAME. All data on risk assessments on white and BAME staff are now reported on a monthly basis in the standard workforce report through the governance structure at QVH We report 5 days a week to NHSEI on all COVID absence days We have achieved 100% of BAME risk assessments. It should be noted that this might fluctuate by 1 or 2 % as people join/leave the organisation and we have Jnr Dr's rotations
1.3 *Is the Board clear on the additional risks BAME staff face? 1.4 Has the board considered the medium-term implications of the impact of Covid-19? 1.5 Is Occupational Health centrally involved in oversight and support?	*Describe how your organisation and system have used this data to influence your preparations for restoration and recovery planning?	The impact of COVID-19 on BAME staff has been discussed at Board, by EMT and HMT. The CEO has written to all staff to highlight and reinforce the risks for BAME staff and has also written a blog on the concerns. The Occupational Health providers are proactively involved in our risk assessment process and triage those who have been shielding or identified as vulnerable

1.6 Is there **BAME representation** in senior decision making/oversight? 1.7 Is your BAME Network fully involved in decision making around the risks to BAME staff?	Collect information on demographic make up of Gold Command.	Gold command for the pandemic has a wide cross section of clinical and non clinical roles within its membership but has had limited BAME representation; this will be reviewed QVH has not had a BAME network lead. COVID-19 has bought this into sharp focus and we are working with the EDI lead for NHSEI to promote this role and the development opportunity it brings. Interviews are planned for September
1.8 Is there an emphasis, wherever possible on strong **staff engagement** to both receive suggestions and hear concerns, before significant changes in working practices? Bear in mind research, for example, the Francis Freedom to Speak Up report 2015 and recent reports indicate some groups of BAME staff are less likely to raise concerns either because they don't believe they will be heard or because of possible adverse consequences for them.	Clear, repeated messages from CEO Minimise redeployment of Speak Up Guardians. Ensure staff are signposted to them if they have concerns. Highlight examples where concerns were raised and have been were addressed. Where necessary, remind professional registrants that requirement to raise concerns remains in place.	The CEO has sent out a number of messages to the workforce as blogs, emails and news items in Connect and this continues. These do attract some positive feedback from staff. All staff have recently been reminded of the role of the Freedom to Speak up Guardian through Connect.
1.9 Does your organisation hold **data** on staff Covid-19 sickness and staff Covid-19 deaths by department, grade, and protected characteristic? 1.10 Are you being proactive in using such data to triangulate with soft	Such data, used effectively, can enable early interventions to listen, support and act on concerns	QVH regularly reviews data in relation to COVID-19 against all characteristics and job roles. Given our position as a cancer hub, not treating symptomatic patients and screening our patients and staff, we have had no areas of

intelligence from areas of concern – and with other workforce data e.g. WRES and WDES - especially data for reported bullying?		concern highlighted either through data or through concerns being raised.
2.0 Risk assessment and deployment		
2.1 Is there a focus to ensure some staff groups are specifically included in risk assessments e.g. **returners, agency staff, newly qualified staff, staff returning from sick or annual leave, and night shift staff**? It is important to ensure these groups are assessed as they may be especially vulnerable (e.g. RCN survey indicates temporary agency nurses are currently much less likely to be offered tests).	Is there clarity about the role of the agency in risk assessments and the role of the Trust in ensure safe working arrangements?	Our risk assessments have been in place from very early on in the pandemic and have been updated as more information came out from Public Health England – for instance in relation to BAME. We can confirm all the staff groups specified have been considered. We also developed an on-line self-risk assessment so that every member of staff can self-assess if they choose. This is automatically sent to the HR Advisory Team who will alert the line manager if a full risk assessment is required. Risk assessments are available to all temporary staff.
2.2 Is there effective management and governance to **follow up risk assessments** both for individuals and at employer wide basis?		All risk assessments are be sent to the HR Advisory Team where a central secure log is kept of all assessments. These are cross referenced on a detailed spreadsheet with shielding information, working at home, other vulnerabilities and details of occupational health follow ups to keep staff safe, well and working.

2.3 Do **deployment decisions** correlate with risk assessments i.e. done fairly and proportionately? There is growing evidence that BAME staff may be disproportionately redeployed to Covid-19 wards.	Monitor such decisions and ensure concerns raised are addressed – especially if deployment is not accompanied by safe PPE and working practices Some trusts have been collecting such data. You may want to do so going forward.	QVH does not have COVID wards. The only area of QVH that could be deemed to have been 're-deployment' is the virtual hub (NEST). Here a number of clinically vulnerable and risk assessed clinical staff worked in a protected environment running virtual assessments for patients
2.4 Are specific steps being taken proactively to ensure **BAME staff are specifically being risk assessed** not just for health risks but for exacerbating workplace treatment factors?		The risk assessment process is comprehensive.
3.0 Protection		
3.1 Is the **PPE Fit** process effective without disproportionate impact on some staff groups, notably BAME and female staff? Note: HSJ reports that younger female workers are twice as likely to die as other staff NHS Confederation, has published guidance about the use of PPE for staff, which includes information about cultural considerations.	Monitoring should specifically include BAME staff Be clear on consistent response if a staff member 'fails' a fit test - a particular BAME issue.	We have an effective PPE fit testing programme which has resulted in a number of different pieces of kit being sourced to meet different needs This has not been concern amongst BAME staff at QVH
3.2 Are managers clear that **social distancing** must be observed in role/function including in spaces such as rest areas? How is that validated?		Messages around social distancing, hand washing, wearing of face masks have been regularly and effectively communicated and there is clear signage around the hospital.

4. Removal from risk areas		
4.1 Is the default position for staff who could effectively **work from home** or who have vulnerable family members at home that they work from home?	Ensure clarity in policy and monitor	QVH very quickly and effectively mobilised agile working with more that 20% of the workforce able to work remotely and/or on a rota basis. We have a review process for staff returning to site from home working which takes into account the impact on other staff in the same office space and/or using the same shared facilities
4. 2 In reaching decisions about working from home or site, is there an acknowledgement of risks from travelling on **public transport** which should avoided wherever possible?	Revisit whether additional staff could work from home all or part of the time or be enabled to travel at quieter periods?	We can confirm that the Trust acknowledges the risks from travelling on public transport and this was one element of the rationale for our swift action to facilitate home working. As part of the Workforce Restoration and Recovery work there is an IT/Agile Working group that reviews the home working position every 2 weeks. No person can return to site permanently without, as a minimum, General manager approval and a review of risk.
4.3 Is **social contact with co-workers** minimised with audit of open plan offices, shared workstations or hub environments and maximum use of homeworking? Are all possible similar steps taken in Outpatient clinics and reception areas?		All shared office areas have been subject to a shared office risk assessment, which will be updated should circumstances change, for example more staff returning to work. Any shared spaces are disinfected between use, offices are staffed on a rota basis where needed.
5.0 Tests		
5.1 Is there a transparent policy of **prioritisation** to include all staff identified by risk assessment as being at		The use of our onsite testing facility is considered within the risk assessment process.

greater risk and any staff with additional exposure e.g. travelling to work?		
5.2 Do all staff know about rapid access testing for symptomatic staff and household members? 5.3 Are testing arrangements in place for staff in isolation or working from home?	Insert link to local test site here	There has been good communication with all staff about not coming to work if symptomatic and how to access testing for staff and household members. This is supported through the incident room helpline.
5.4 Are all staff aware of the voluntary screening programme for asymptomatic staff?	Have managers reviewed whether the staff member has a means to access this testing programme and support them with this?	On site testing is provided on a regular basis for all frontline staff and is well used.
6.0 Engagement, communications and support		
6.1 Are managers confident (and do they get support) in having **honest and difficult conversations with BAME staff** about their circumstances?	Specific support should be offered to managers wherever possible	We have not previously asked managers this specific question. The management development Leading the Way programme includes a module on having difficult conversations. We are planning to commission specific training/support through NHS Charities Together funding in partnership with other Sussex trusts.
6. 2 Are BAME staff prominent in decision making on COVID 19 both through staff networks with access at Board level but also via other means e.g. senior BAME managers?		Aiming to establish and support a BAME staff network. Comms programme in place and post is promoted Gold command for the pandemic has a wide cross section of clinical and non clinical roles within its membership but has had limited BAME representation; this will be reviewed

6.3 Is there a clear **narrative** about this work, including EDI implications, owned by leaders and managers who are confident in sharing it?		This process is beginning. Narrative to date primarily in chief executive communication direct to all staff.
6.4 Are arrangements in place through STPs and more widely to identify, understand and **share better practice?**		This is being considered through all relevant ICS networks including HR directors, communication directors, charity leads strategic network (specific funds available nationally)
7.0 Mental and other health support		
7.1 What steps have been taken to understand the staff needs during and after the COVID 19 pandemic with particular attention to **BAME staf**f?		QVH set up the Stay Well Team initiative which includes the psychological therapy team. A major focus throughout has been to promote health and wellbeing in its widest sense including a focus on mental health, anxiety and PTSD
7.2 What support is in place for staff in **self-isolation** or who are or have been ill with COVID 19?		We have a full Occupational Health service, employee assistance programme as well as the Stay Well Team initiative and have promoted regional and national NHS interventions
7.3 Are staff aware that **psychological suppor**t is available for any staff member concerned about their vulnerability to COVID 19?		Psychological therapy team are part of the StayWell initiative. When any requests for help have been made the team have been able to respond almost immediately.
7.4 Staff who do not wish to be withdrawn from an area contrary to their risk assessment–Should there be any staff who have been advised to not work in their current role or location, but		Fortunately managers and staff have worked in partnership and so far communication has worked well

who then wish to continue working in a role or location deemed unsafe for them, then the employer's duty of care is likely to be that such an outcome of their risk assessment would result in an instruction to follow the outcome.		

Source of table:

Guidance to support Risk Assessment for staff with potential work related exposure to COVID-19
Produced by COVID-19 BAME Mortality Disparity Advisory Panel, South East Region, NHS England and NHS Improvement
19th May 2020

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03 September 2020**	**Agenda reference:**	**127-20**		
Report title:	**Workforce Report – August Report – July Data**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Authors:	Felicity King, Workforce Services Manager Lawrence Anderson, Deputy Director of Workforce				
Appendices:	NA				
Executive summary					
Purpose of report:	The purpose of this report is to provide narrative to place KPIs in context together with an overview of the impact of COVID-19 on different aspects of workforce activity; this includes concerns about the disproportionate impact on staff from a BAME background. This report submitted in August 2020 (July 2020 data) includes workforce KPIs and trajectories, and the quarterly starters and leavers report.				
Summary of key issues	Improving trends in key workforce indicators are generally continuing and are likely to stabilise in some areas.				
Recommendation:	The Board is asked to **note** the report				
Action required *[highlight **one** only]*	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	KSO5: Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care KS01: Engaged and motivated staff deliver better quality care				
Corporate risk register:	Impact of pandemic on workforce availability				
Regulation:	Well Led				
Legal:	n/a				
Resources:	Managed by HR/OD with support from finance, operations and nursing				
Assurance route					
Previously considered by:					
	Date:		Decision:	Information	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Workforce & Organisational Development

Workforce Report – August 2020

(Data Reporting Period - July 2020)

KPI Summary

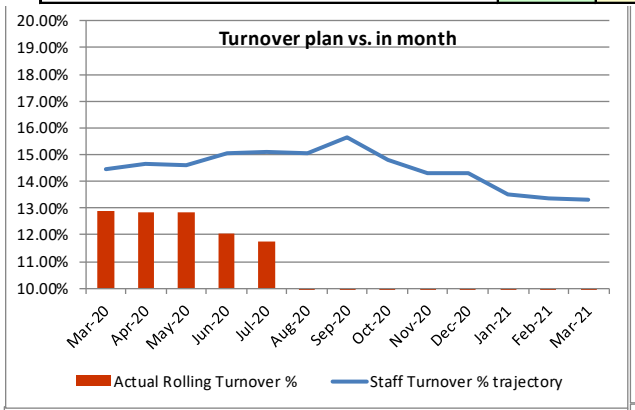
Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020/21			Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Compared to Previous Month
Establishment WTE *Note 1				1000.54	1000.54	1007.59	1007.59	1007.59	1007.59	1007.59	1007.59	1028.35	1028.35	1028.35	1028.35	**1028.35**	◄►
Staff In Post WTE				887.06	889.53	890.03	896.27	897.82	893.60	891.18	901.25	914.01	907.53	913.06	921.43	**922.58**	▲
Vacancies WTE				113.48	111.01	117.56	111.32	109.77	113.99	116.41	106.34	114.34	120.82	115.29	106.92	**105.77**	▼
Vacancies %	>12%	8%<>12%	<8%	11.34%	11.10%	11.67%	11.05%	10.89%	11.31%	11.55%	10.55%	11.12%	11.75%	11.21%	10.40%	**10.29%**	▼
Agency WTE				33.40	28.17	23.73	16.06	12.88	15.25	15.53	13.27	13.72	6.22	3.77	5.13	**5.70**	▲
Bank WTE *Note 2				74.90	77.85	76.20	72.24	72.98	63.86	70.34	71.63	72.90	34.07	31.38	33.72	**47.47**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	16.38%	16.42%	14.94%	14.79%	14.55%	13.49%	13.75%	13.65%	12.90%	12.86%	12.84%	12.05%	**11.74%**	▼
Monthly Turnover				1.09%	1.56%	1.33%	1.22%	0.85%	0.38%	1.48%	0.45%	0.96%	0.68%	1.05%	0.68%	**0.75%**	▲
12 Month Rolling Stability % *Note 3	<70%	70%<>85%	>=85%	83.40%	83.52%	82.12%	82.25%	81.95%	81.63%	80.99%	81.35%	85.53%	85.33%	85.46%	86.39%	**86.25%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	2.58%	1.83%	2.57%	3.25%	3.41%	3.45%	3.01%	3.08%	4.37%	3.06%	2.09%	**2.01%**	*TBC*	▼
% staff appraisal compliant (Permanent & Fixed Term staff)	<80%	80%<>95%	>=95%	87.41%	88.24%	89.01%	84.62%	87.34%	87.94%	87.05%	86.44%	84.36%	81.40%	80.02%	78.61%	**78.27%**	▼
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 4	<80%	80%<>90%	>=90%	92.88%	93.32%	92.51%	92.26%	91.75%	92.46%	92.11%	94.47%	92.35%	91.51%	91.91%	92.18%	**91.88%**	▼

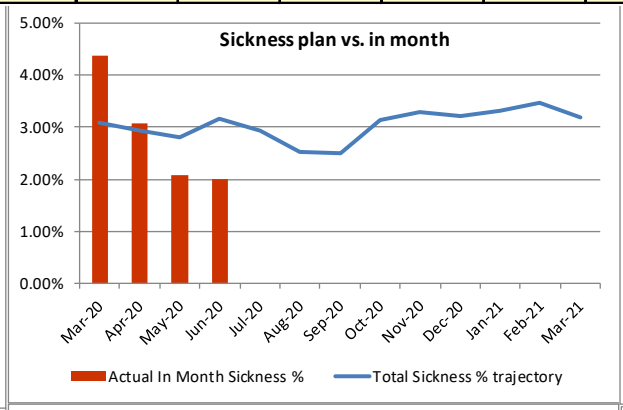
	Measure	2018-19 Quarter 4: Of 182 responses: 96.15% : 1.09%	2019-20 Quarter 1: Of 126 responses: 97.62% : 1.59%	2019-20 Quarter 2: Of 189 responses: 97.35% : 1.06%	2019-20 National Survey Of 572 responses: 92% : 2%	2019-20 Quarter 4: Of 344 responses: 95.35% : 2.61%	
Friends & Family Test - Treatment Quarterly staff survey to indicate likelihood of recommending QVH to friends & family to receive care or treatment	Extremely likely / likely %: Extremely unlikely / unlikely%						Q2 19-20 & Q4 19-20 ▲Responses ▼ Likely ▲Unlikely
Friends & Family Test - Work Quarterly staff survey to indicate likelihood of recommending QVH to friends & family as a place of work	Extremely likely / likely %: Extremely unlikely / unlikely%	2018-19 Quarter 4: Of 182 responses: 73.62% : 13.73%	2019-20 Quarter 1: Of 126 responses: 74.60% : 14.29%	2019-20 Quarter 2: Of 189 responses: 71.73% : 12.07%	2019-20 National Survey Of 560 responses: 72% : 10%	2019-20 Quarter 4 Of 344 responses: 74.71% : 10.17%	Q2 19-20 & Q4 19-20 ▲Responses ▲ Likely ▼Unlikely

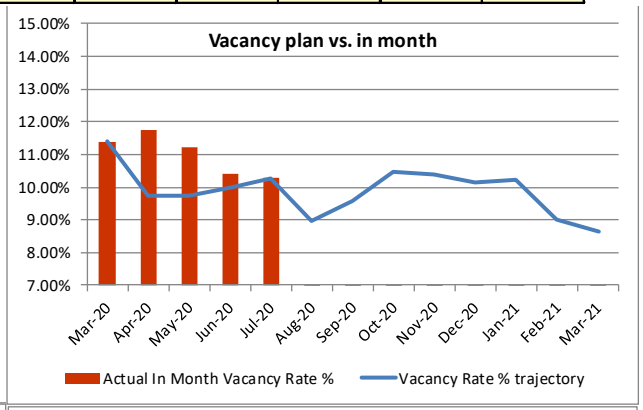
*Note 1 -2019/20 Establishment updated in March 20 with end of year position. 2020/21 awaiting establishment
*Note 2 - Bank WTE does not include extra hours worked by medical staff within establishment or overtime worked by all staff groups.
*Note 3 - 12 month rolling stability index added as an additional measure. This shows % of employees that have remained in employment for the 12 month period.
*Note 4 - RAG rating updated in June 2019 for Statutory & Mandatory Training. Compliance changed from 95% to 90% however,individual compliance remains at 100%

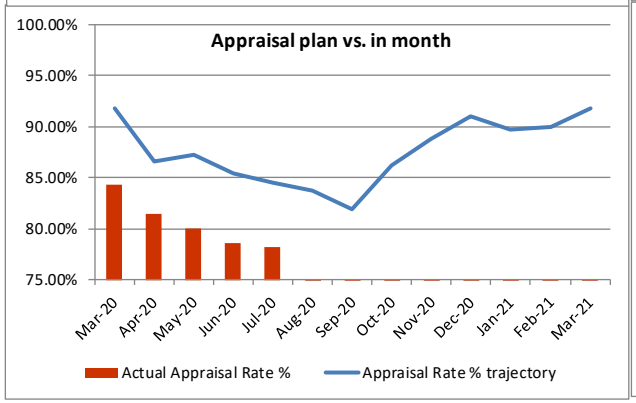
Trajectories

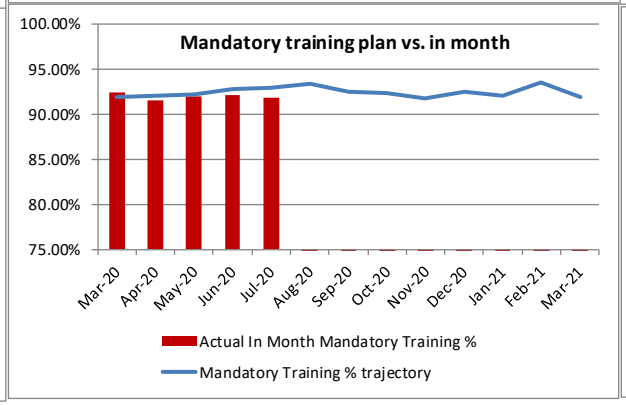
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Staff Turnover % trajectory	14.46%	14.66%	14.58%	15.04%	15.09%	15.06%	15.66%	14.79%	14.29%	14.29%	13.49%	13.38%	13.31%
Actual Rolling Turnover %	12.90%	12.86%	12.84%	12.05%	11.74%								
Total Sickness % trajectory	3.08%	2.93%	2.80%	3.15%	2.94%	2.53%	2.50%	3.14%	3.29%	3.21%	3.32%	3.46%	3.19%
Actual In Month Sickness %	4.37%	3.06%	2.09%	2.01%									
Vacancy Rate % trajectory	11.39%	9.73%	9.75%	9.97%	10.27%	8.98%	9.59%	10.47%	10.40%	10.16%	10.21%	9.00%	8.63%
Actual In Month Vacancy Rate %	11.39%	11.75%	11.21%	10.40%	10.29%								
Agency WTE usage trajectory	18.9	18.6	18.7	17.8	18.0	19.7	17.9	17.7	15.2	14.1	15.7	15.4	17.4
Actual agency WTE usage	13.7	6.2	3.8	5.1	5.7								
Appraisal Rate % trajectory	91.81%	86.64%	87.20%	85.40%	84.55%	83.71%	81.89%	86.18%	88.76%	90.94%	89.64%	89.91%	91.81%
Actual Appraisal Rate %	84.36%	81.40%	80.02%	78.61%	78.27%								
Mandatory Training % trajectory	91.96%	91.98%	92.23%	92.71%	92.88%	93.32%	92.51%	92.26%	91.75%	92.46%	92.11%	93.46%	91.96%
Actual In Month Mandatory Training %	92.35%	91.51%	91.91%	92.18%	91.88%								

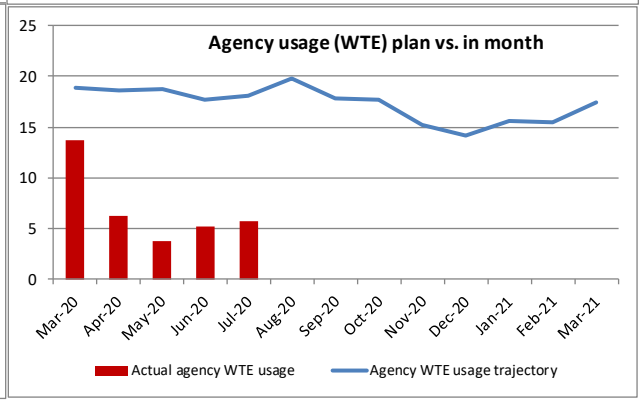












August QVH Workforce Summary - July 2020 Data

Headlines:

- Staff in post numbers have increased slightly with an in month position of 922.58wte, bringing vacancies to 10.29%
  There were 6.61wte starters in July, which is less than previously reported years for July but not surprising in the current climate. A qualified nurse started in burns (0.61wte), 2wte in Corporate and Sleep, 1wte in eyes and Plastics.
- There were 6.11wte leavers in July, which is slightly lower than in most previously reported years for July. 2.31wte were from qualified nursing (Macmillan, burns and ITU). Other leavers were spread across Access and Outpatients, Clinical support, Eyes and Sleep directorates. 2.8wte of leavers were retirements and all are returning on fixed term contracts in August.
- The Trust's bank and agency usage has increased from June. Agency increased slightly by 0.57wte and bank increased by 13.75wte. Agency increases were mostly seen in Perioperative Services directorate and were from the Nursing/Theatre OPD's staff group. Bank increases were seen in all business units apart from Access and Outpatients. Operational Nursing and Perioperative Services directorates saw the biggest usage increase both approximately 3.6WTE. Plastics also increased by 2.18wte which were mostly medical shifts All staff groups bank usage increased however Qualified Nursing had the biggest increase (6.87wte) followed by non-clinical (3.53wte).
- The 12 month Rolling turnover has decreased again to 11.74% Our 12 monthly rolling turnover rate is now within our Amber RAG rating for the first time since we started recording using these KPI's. The monthly turnover position for July was 0.75%.
- Rolling stability has remained at the same level as last month.
- Sickness for June has decreased again to 2.01% with Covid-19 related sickness accounting for 0.03% (total 2 occasions both in June for the same employee). All business units were below the 3% KPI target apart from Access and Outpatients, Corporate and Oral. The top 3 absence reasons by occurrences were Anxiety/stress/depression/other psychiatric illnesses (15), Headache/Migraine (15), and Gastrointestinal problems (14). Indicative figures for July are 2.75% and for Covid-19 0.03% 3 staff members 3 occasions.
- Appraisals have decreased by a small amount with an in month position of 78.27%. The lowest performing directorate was Plastics (50.53%), followed by Oral (57.33%) and Eyes (55.88%). Perioperative Services, Operational Nursing, and Access and Outpatients directorates have increased from last month. Highest performing business unit is Director of Nursing at 97.5%
- Mast compliance figures have reduced slightly to 91.88%. The lowest performing business unit is Plastics (79.80%) followed by Corporate (91.11%). The highest performing remains as Access and Outpatients (96.94). The lowest competency compliance is infection control level 1 1yearly 65.79% and the highest is infection control 3 yearly at 95.82%. Information Governance in July ended with a position of 92.37%.

COVID-19 July Summary including support for the BAME workforce

Indicative figures for July 20 suggest sickness figures are 2.75% of which 0.03% was Covid -19 related. Absence figures have reduced as managers are correctly recording as self/household isolation rather than general sickness. In total there were 61 occurrences of self/household isolation for July

We have investigated at QVH whether Covid- 19 is disproportionately effecting our BAME staff compared to staff who identified as white. Our findings are that;

- For July out of the total of 61 isolation occurrences 6 staff members (9.84%) identified as BAME.
- In July of the 3 recorded sickness occasions 0 were from staff who identified as BAME.

The Trust has continued to be proactive to ensure that all staff that have identified themselves as being from a BAME background are recorded accurately.

NHSI/E have mandated that all BAME staff must have a risk assessment in place with the Trust that they work for. Their expectation was that by the end of July 2020 100% of all BAME staff are to have a Risk Assessment in place. In our final submission QVH had achieved a 99% compliance with this, with the 2 individual's outstanding being out of the country but assurances received that these would be completed upon return.

The Trust continues to keep our BAME staff at the forefront of our support, and our focus has now turned to ensuring all the BAME who have commenced with the Trust since July have an assessment in place. The Trust is leading on a number of actions to actively support our BAME workforce. Currently we are seeking expressions of interest for a QVH BAME network lead to help establish a network at QVH. Along with this we are undertaking a Board Seminar in August for all Trust Board members on the importance of Equality and Diversity which is being undertaken by Cavita Chapman Head of Equality, Diversity and Inclusion for NHSI/E.

Since the last board report the official shielding period for staff who are high risk or vulnerable ended on 31st July 2020. We now have a key focus in making sure that these staff are supported if returning to the workplace and have the appropriate risk assessment in partnership with Occupational Health. To aid this the Trust has introduced an on-line self-assessment that is open to all staff to complete which will highlight whether any further actions can be taken by line managers.

We have been successful in being awarded £50,000 from the NHS Charities Together Fund which will be used to develop and support the BAME network and related training opportunities

Recruitment Update

Due to COVID-19 International Recruitment and OSCE testing was put on hold and no processing has taken place since March 2020.

The new contract with Yeovil to source an additional 6 Theatre nurses has now commenced and we currently have 2 approved CV's with nurses due to start in January and they are still at the very early stages currently; with the remaining 4 to start in March and May 2021 (2 per cohort)

Our remaining candidate from the original Yeovil contract now has flights booked and will be arriving in the UK on 13 September; due to quarantine rules for those traveling from UAE he has been booked into a local hotel for his first 2 weeks; this time will be used to do online training, participate in MS Teams meetings with colleagues and pastoral care will be provided by QVH staff to ensure he is as included as possible during this period. He will then move into House 10 Meridian Way.

It is anticipated that by July 2021 we have all international nurses in post with only 2 pending OSCE. With 26 in total from Yeovil and 5 from Medway our nursing establishment will have increased by 31 since starting the sourcing internationally in April 2018.

As OSCE centres are now reopened we have booked 2 of our current nurses who were on the temporary register for 24 September and one nurse already sat hers but unfortunately failed on one element and is rebooked for 4 September. Day to day recruitment is starting to pick up again and those candidates that were put on hold for start dates being booked prior to COVID are now being booked in and we have 19 candidates either with start date's booked or ready for a start date; advertising is still lower than normal at this time of the year.

August HEE intake of Junior Dr's went well and we are now preparing for September and October with a reduced intake compared to August. With general recruitment starting to pick up again the team are working hard to get KPI's back up from where due to COVID time to recruit had increased where start dates were delayed.

Bank usage has slightly increased with the testing and temperature pods, and service starting to resume in theatres and across the trust.

Returners to the NHS to support the pandemic

This has now stopped with the two student nurses we had coming to the end of their contract soon and no other returners information being provided by HEE.

Maintaining Mandatory and Statutory Training (MAST) (national guidance)

At this time, all face-to-face training has been postponed with a few exceptions, where possible Covid-19 training is offered that covers some clinical required competencies. However, managers and staff are being encouraged to maintain their Statutory and Mandatory Training via eLearning or other

available methods. The uptake of staff completing MAST training via eLearning has significantly increased and MAST compliance is being maintained at a steady level. Only 36 staff in total require the Infection Control Level 1, 1yrly competency so when a small number of staff expires it means the % compliance drops significantly. We are working with the IC lead and the department to organise a bespoke session for those that have expired. This is happening at the beginning of September and the results will show a vast improvement on compliance for September 2020.

We now deliver training sessions via Microsoft Teams for Safeguarding Adults and Children Level 1 as well as Level 2 with our Subject Matter Experts (SME's) as this has been well received by staff. We will now look at other areas where this could be made available to run in conjunction with eLearning. Now we have Microsoft Teams in place, we are looking at its functionality to run training sessions.

Appraisals

The appraisal rates have dipped since Covid-19 began and there is a concern that managers should be having more regular conversations with staff at this time. As a result, managers are being encouraged via the Workforce Brief to have continuous conversations with staff at this time. It is recognised that whilst people are socially distancing and in some cases, working from home, it is important for 1-2-1 conversations' to happen. We are also advertising in Connect that appraisals must continue to be carried out whilst adhering to social distancing measures and to notify Workforce Services once completed. We are now running sessions via Microsoft Teams for anyone that undertakes appraisals to answer any questions they have. We are also running reports, which show anyone's appraisal that expired more than 18mnths ago so we can target managers to complete appraisals.

Induction

Induction for new starters continues to be based on small socially distanced groups focused on a bespoke one-to-one input and covers MAST sessions delivered through a variety of methods including eLearning and some additional input for clinical staff based on risk assessments. We are modifying the current induction programme to 1 day non-clinical and 1 ½ days clinical once we are back to normal ways of working. There will be an expectation that a variety of delivery methods will be used (including pre-hire eLearning) which will enable us to streamline the programme. We are liaising with Resourcing and Workforce services to consider the implications and processes in order to enable this.

A successful socially distanced August doctors' induction was completed for 18 attendees. The Medical Education team will now review with trainers and all those involved to revise the plans as needed so that the September and October inductions can also safely take place. The latest round of Local Faculty Group meetings were facilitated by the Medical Education team via WebEx. These meetings were well attended by Educational Supervisors and trainee reps. The next Local Academic Board meeting will also take place online, using MS Teams. The Medical Education team continue to work with departments to ensure that teaching is facilitated and that educational opportunities are accessible for trainees.

Apprenticeships

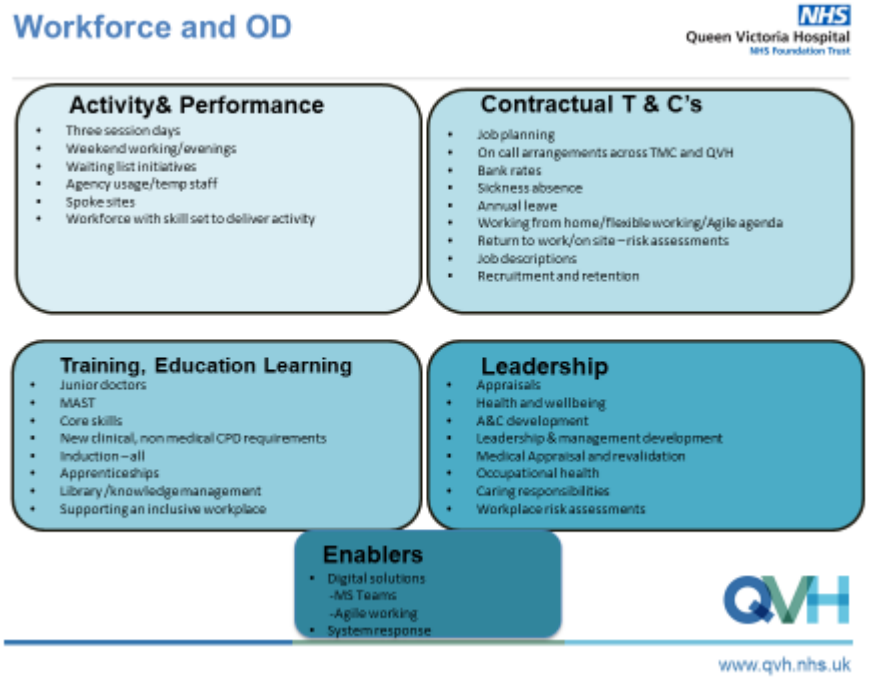
There is increased interest in apprenticeships including new offerings:

- Recruitment for a level 3
- Pharmacy level 3
- Senior healthcare support worker level 3
- Estates level 3

The operating department practitioner degree is starting in Autumn for 2 theatre staff at Canterbury Christ Church University. They are offering to deliver to a Sussex cohort within region rather than travel to Medway.

Workforce Restoration and Recovery

This work stream is one of four in the Trust and sits alongside Activity and Performance, Finance and Clinical Governance R&R meetings. The areas covered are split into five main headings as below with sub groups meeting on a regular basis. The most recent focus has been on activity and performance and joint working with IT on the Agile working agenda.



Staff Engagement through COVID-19

Through our internal communication channel we offered the staff the opportunity to request customised certificates as a thank you for their children. These have been a great success. So far around 85 certificates have been sent out.

Some of the comments from our staff:

- Thank you, I am working from home and would really appreciate this, what a wonderful idea!
- Many thanks for such a lovely idea. I have felt guilty about leaving them some days, so this will be lovely for them to receive.
- This is a great idea and thank you for doing it for us. It nice to know the trust understand that the children are part of the QVH team as well.
- This is such a lovely idea! My daughter is going to be insanely proud to get this.
- This is a great idea! Well thought of.
- I think this is a lovely idea and will make them feel really special.
- Thank you so much for doing this for the children, it is such a lovely idea.
- Many thanks for this, they will be so pleased.
- I saw in connect today that you are very kindly making certificates for children. Please may I request one for my son as he is constantly complaining that I am at work and not spending time with him at home like his friends parents.
- Such a lovely idea – thank you!
- It is a fabulous gesture, and something we can keep for their memory boxes about this whole period.

-ENDS-

In the last Quarter we have had 21.65wte starters and 22.26wte leavers.

By Staff Group the Starters are as follows

Staff Group	Sum of WTE
Add Prof Scientific and Technic	2.00
Additional Clinical Services	3.00
Administrative and Clerical	5.40
Allied Health Professionals	0.40
Estates and Ancillary	2.00
Healthcare Scientists	1.00
Medical and Dental	3.00
Nursing and Midwifery Registered	4.85
Total	**21.65**

By Business Unit Starters are as follows

Business Unit	Sum of WTE
276 Clinical Support (Div)	1.00
276 Director of Nursing (Div)	1.00
276 Eye (Div)	2.00
276 Operational Nursing (Div)	2.61
276 Perioperative Care (Div)	4.24
276 Plastics (Div)	2.80
276 Sleep (Div)	3.00
276 Corporate (Div)	5.00
Total	**21.65**

Admin and Clerical staff group had the most new starters that accounted for a quarter of the total (5.4wte), Qualified Nursing followed as the second highest staff group with 4.85wte. Of the Qualified Nurses, 2.24wte were within Perioperative services, 1wte Site Practitioner and 1.61wte in Operational Nursing (1wte paediatric Nurse, 0.61 Burns staff nurse).

Perioperative services also had 2wte HCA start while Maxillofacial Nursing had 1wte Dental nurse start. Of the admin and clerical staff, 3wte were in Corporate directorate, 2wte Medical secretary's started in Plastic Surgery and Corneo Plastics. Also starting in Corporate were 2wte Domestic Assistants. Diagnostic Imaging had 3.03wte start which consisted of receptionists/clerks and coordinators in clinical areas.
Sleep had 2wte Trainee Sleep Physiology Technicians start in July and a Sleep Physiology manager start in June.
Medical and Dental Staff Group had 1wte consultants and 1wte trust Register started in Plastic Surgery, along with 1wte Fellow in Corneo Plastics.

The recruitment source for 10.84wte starters were from other NHS organisations, 2wte from other public sectors, 6.21wte from private sectors, 1.6wte from Education Sector and 1wte from no employment.

By Staff Group the Leavers are as follows:

Staff Group	Sum of WTE
Add Prof Scientific and Technic	1.80
Additional Clinical Services	0.80
Administrative and Clerical	8.60
Allied Health Professionals	1.50
Estates and Ancillary	1.00
Medical and Dental	3.25
Nursing and Midwifery Registered	5.31
Total	22.26

By Business Unit the Leavers are as follows:

Business Unit	Sum of WTE
276 Access and Outpatients (Div)	3.00
276 Clinical Support (Div)	3.30
276 Corporate (Div)	2.60
276 Director of Nursing (Div)	1.00
276 Eye (Div)	3.40
276 Operational Nursing (Div)	1.31
276 Oral (Div)	1.85
276 Perioperative Care (Div)	3.00
276 Plastics (Div)	2.00
276 Sleep (Div)	0.80
Total	22.26

There were leavers all of the 10 business units and were spread across the staff groups. The highest group of leavers were admin and clerical with 8.60wte leavers spread across Access and Outpatients (3wte), Corporate (1.6wte), Eyes (2wte), Oral (1.6wte) and Clinical Support (0.4wte) directorates, of these there were 1.8 Medical Secretary's, 2.2wte Health records clerks, 1.2 Secretaries, all other leavers did not share the same job role type. Medical and Dental staff group had 3.25wte leavers, including a consultant, Trust register and fellows in Plastics, Oral and Eyes. Nursing and Midwifery had 5.31wte of which 2wte were staff nurses, and 1wte Theatre Practitioner Perioperative Services. 1.31wte left in Operational Nursing (0.31wte senior staff Nurse and 1wte Ward Manager). Director of Nursing had 1wte qualified Specialist Nurse leave.

In Clinical Support 1.8wte staff left who were Add Prof and Tech and Allied Health professionals as Specialist Pharmacists.
Sleep had an Assistant Practitioner (0.8wte) leave and 1wte ancillary staff in Corporate directorate.

Reasons for leaving were 6.4wte retirement/flexi retirement, 2.85wte end of fixed term contract, 1wte dismissal and all other were for various voluntary reasons but most notably relocation (4wte).

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03 September 2020**		**Agenda reference:**	**128-20**	
Report title:	**Formal ratification of Workforce WRES and WDES**				
Sponsor:	Geraldine Opreshko, Director of Workforce & OD				
Author:	Lawrence Anderson, Deputy Director of Workforce				
Appendices:	Annual WRES report 2019/20 Annual WDES report 2019/20				
Executive summary					
Purpose of report:	The Board is asked to formally ratify the decision made in August to approve the WRES and WDES annual reports for 2019/20 prior to submission to the regulator.				
Summary of key issues	In order to meet the regulator deadline, and as permitted under the Trust's standing orders, Board approval was obtained via email for both reports. The Board is now asked to formally ratify that decision. The Board has been asked to note in particular: • Some improving trends particularly the increase in the diversity of the QVH Workforce. • Action plans are being developed in conjunction with support from the EDI leads at NHSEI				
Recommendation:	The Board is asked to ratify its decision to approve the WRES and WDES annual reports for 2019/20				
Action required *[highlight **one** only]*	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience* ✓	KSO2: *World-class clinical services* ✓	KSO3: *Operational excellence* ✓	KSO4: *Financial sustainability*	KSO5: *Organisational excellence* ✓
Implications					
Board assurance framework:	KSO5 will highlight any risks that may be identified				
Corporate risk register:	n/a				
Regulation:	Well led				
Legal:	n/a				
Resources:	Some funding secured from NHS Charities Together to support action plans from the annual reports				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Workforce Race Equality Standards (WRES 2020)

Annual Report 2019/2020

Introduction

The Workforce Race Equality Scheme (WRES) provides data to facilitate the Trust's ability to make informed decisions and take action to actively promote equality of opportunity, as well as to reduce discrimination which may exist, ultimately to improve the working lives and wellbeing of staff, patients and service users.

This report is based on 2019/2020 data and is a comparison between 1st April 2019 and 31st March 2020. Accompanying this report is the full data set to be submitted nationally by the Trust. This report highlights the improvements that have been made, but also the areas that maybe cause for concern and further action.

Findings

Overall Workforce

The percentage of BAME staff employed by the Trust has increased from 14.8% in 2018/19 to 16% during this period.

By analysing our headline workforce figures in more detail, the data shows that the Trust has increased its entire workforce overall in both Clinical and Non Clinical roles in the last 12 months. These increases have shown a proportional increase in our BAME workforce in clinical roles. In the period 19/20 our BAME clinical workforce has increased by 23% (a headcount increase of 19 people). There was a 10% increase in non-clinical roles over the same period however to provide some context this accounts for a headcount increase of 3 people.

The Trust's BAME medical workforce however has not increased in the same period, and has remained at a headcount of 62 people for both years. In contrast our white medical workforce has increased by a headcount of 10, eight of which are at Consultant level. This therefore reduces our BAME representation from 63.2% in 2019 to 57.4% in 2020*.

**A caveat to these figures is that there are 8 individuals (all trainee doctors) who have not declared their ethnic origin to the Trust during this period.*

Senior Workforce Representation

In 2019 the Trust had a total of 63 individuals employed at band 8A or above. In 2020 this increased to 69 individuals. However when analysing the data the proportion of BAME individuals in senior roles has decreased. In 2019 10.5% (a headcount of 6) of the Trust's senior workforce (not including medical) were from a declared BAME background, this contrasts to 9.5% (also a headcount of 6) in 2020.

At consultant level, although there is a much higher BAME proportion in these senior roles at the Trust, there has been a reduction in the BAME representation. In 2019 46.9% of our consultant workforce were from BAME backgrounds however this has reduced to 40.3% in 2020. The number of BAME individuals has remained constant at a head count of 23 however white colleagues have increase from a headcount of 49 in 2019 to 57 in 2020.

Junior Workforce Representation

Our junior workforce (Agenda for Change Bands 2-7) have seen the largest increases in BAME representation between 2019 and 2020, an increase from 10.3% in 2019 to 19.8% in 2020.

This increase has been seen in both clinical and non-clinical roles which have both dramatically increased over the last 12 months. In this time period our clinical representation increased from 15% in 2019 to 19.8% (a headcount increase of 20) in 2020 and our non-clinical representation rose from 7.6% in 2019 to 8.7% (a headcount increase of 4) in 2020.

There has been a reduction of BAME representation amongst our junior doctor workforce between 2019 and 2020. In 2019 49.3% of our junior doctor workforce was from a declared BAME background whereas in 2020 this reduced to 42.2%. However with these figures the same caveat as identified earlier in this report applies*. The recruitment Trainee Junior Doctors is undertaken by the Deanery and allocated to the Trust.

Recruitment

There has been an increase in the likelihood in candidates being appointed from shortlisting if they were from a white background. The number of shortlisted applicants from a white background to being appointed had a 1.47 comparative likelihood (with 1 being an equal comparison) compared to a 1.32 comparative likelihood the previous year.

The data demonstrates that in 2019 a white applicant had a 26.84% chance of being appointed after being shortlisted and this has increased to 29.5% in 2020. The figures for BAME applicants have remained broadly similar. The data demonstrates that in 2019 a BAME applicant had a 20.36% chance of being appointed after being shortlisted and this has decreased to 20.13% in 2020 (0.23% variance and given the small numbers this is not statistically relevant)

Currently shortlisting for posts is anonymised (personal identifiable information) however there is still the ability for the shortlister to make assumptions based on a candidates education background or work history. All shortlisters are asked to provide reasons for not shortlisting candidates, this is provided in free text rather than a list of options and is very dependent shortlisters providing this information. The data shows:

171 appointments made from 637 White shortlisted applicants in 2019 (26.8%) 172 appointments made from 583 White shortlisted applicants in 2020 (29.5%)
[redacted]
34 appointments made from 167 BME shortlisted applicants in 2019 (20.3%) 31 appointments made from 154 BME shortlisted applicants in 2019 (20.1%)
[redacted]
59 appointments made from 82 undeclared shortlisted applicants in 2019 (71.9%) 52 appointments made from 116 undeclared shortlisted applicants in 2020 (44.8%)

Formal Disciplinary Processes

At QVH there is a minimal disciplinary caseload in comparison to most other Trusts, however the data shows that there has been a slight increase in the likelihood of entering a formal disciplinary process if a member of staff has declared they are from a BAME background. The numbers of cases (5 for the year) are so low the statistical relevance is questionable. Of the 5 formal cases during 2019/2020 1 was for a BAME individual and 4 were non-BAME

Access to Training and Development

The data shows that the number of BAME staff accessing non-mandatory training and CPD has fallen from 72.85% in 2019 to 43.60% in 2020. This is concerning taking into account increases in the numbers of BAME staff being employed during this period.

It is important to highlight however that only data captured through ESR is taken into account for this measure, and therefore doesn't not account for training and CPD outside of these parameters. A further consideration is due to the increase in BAME individuals joining the organisation during this period, it could be assumed that the vast majority of these will be focussed on gaining statutory and mandatory compliance, successful probation and their first appraisal with the Trust before embarking on CPD and non-mandatory training opportunities.

Data has been analysed from the Trust's Educational Funding Panel for 2019/2020. Data received shows out of a total of 157 educational funding panel awards made 22 were for BAME applicants (14%) which is slightly below our 16% overall Trust representation.

Trust Board Representation

The numbers relating to Trust Board members remain unchanged between 2019 and 2020. Both the voting Board and non-voting Board's representation remains at 8.3% (a head count of one individual)

There are areas that have changed. Whilst these figures have remained stable, this is against a backdrop where the organisation has increased its proportion of BAME workforce. This therefore has a negative impact upon the Boards representation against the Trust workforce which now accounts for 16% BAME representation. This difference has increased from 6.5% in 2019 to 7.6% in 2020.

Conclusions

Although it is encouraging that the proportion of BAME representation across the whole workforce has increased from 14.8% to 16%, it is important to recognise the complexities within this.

Analysis of the data shows that the increase in proportion has come at more junior levels mainly as a result of our hard work and success with our overseas nursing recruitment. Careful reflection is needed in regard to our BAME representation at senior levels (8a and above and Medical Consultant) where the Trust has reduced its representation at these levels and are not representative of the workforce as a whole.

Lawrence Anderson
Deputy Director of Workforce

July 2020

Action	Timeframe
Appointment of a BAME Network Lead	September 2020
Trust Board Seminar to take be undertake to deliver long term commitment to our BAME workforce	August 2020
Understand how we identify talent in Bands 2-7 and support progression and development into more senior roles Considerations • Are opportunities in open competition • Understand barriers to entry • Are there targeted development needs needed? • Do the trust encourage opportunities? • BAME Representation on 8a and above interview panels?	January 2021
Look at ways to address the discrepancy in shortlisting for roles for BAME candidates Considerations • Are we doing enough to promote equality of opportunity • Are Applications sufficiently anonymised • Unconscious Bias training • Increase Recruitment and Selection training	January 2021
Increase staff engagement to disclose their ethnic origin to the Trust Considerations • Communication to all staff who haven't disclosed • Increase knowledge of ESR Self Service • Understand what barriers prevent disclosure	January 2021
Increase candidate engagement to disclose their ethnic origin to the Trust when applying for roles Considerations • Understand what barriers prevent disclosure • Mandate individuals to disclose at application stage-Linked to understand barriers.	January 2021

*Please note it is intended that these actions will be discussed both with Cavita Chapman, Head of Equality, Diversity and Inclusion at NHSI/E and the Trust's BAME network Lead (once Appointed) to ensure tangible and measurable actions are provided.

Further actions may also be identified following the Trust Board seminar session with Cavita Chapman and incorporated into this report at a later stage.

Workforce Disability Equality Standards (WDES 2020)

Annual Report 2019/2020

Introduction

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff. NHS trusts use the metrics data to develop and publish an action plan. Year on year comparison enables trusts to demonstrate progress against the indicators of disability equality.

This report is based on 2019/2020 data and is a comparison between 1st April 2019 and 31st March 2020. Accompanying this report is the full data set to be submitted nationally by the Trust. This report highlights the improvements that have been made, but also the areas that maybe cause for concern and further action.

Findings

Overall Workforce

In 2020's data, 5% of the QVH workforce have disclosed a disability (n = 54), which is slightly lower than last year's overall percentage (-0.2%) but an increase in headcount (n =1).

Staff with 'unknown' or 'non declared' disabilities in the Trust totals 7.88%. This is an improvement on last year where we reported 16.3% as 'unknown' or 'non declared' in our 2019 return. The 7.88% is a proportion of the overall Trust workforce and will therefore have an impact upon the on data quality and accuracy of the information.

Senior Workforce Representation

The proportion of staff declaring a disability is slightly lower for Bands 8a and above (6.1%) than those in Bands 1-7 (8%). However for context the Trust has 837 staff occupying a band 7 or lower posts and 68 staff occupying a Band 8a or above post. The number of non-medical staff not declaring a disability to the Trust is also consistent with these (6.3%).

2.44% of the Trust's Consultant workforce have a declared disability (a head count of 2). This is put into context when the non-disclosure rate amongst consultants is 19.51% (a head count of 16).

Junior Workforce Representation

As mentioned earlier, 8% of those staff who work at a level of Band 7 or lower have declared a disability (a headcount of 49)

However, the main concern lies with the Trust's Junior Doctor Workforce. The Trust has no individuals below that of Consultant with a declared disability. As of 1st April 2020 the Trust employed 89 junior doctors. The non-disclosure rate amongst junior doctors was 21.3% (a headcount of 19)

Recruitment

The data demonstrates a variation in the number of disabled shortlisted applicants being appointed.

There is only a 1.71 comparative likelihood of disabled applicant being appointed of a non-disabled applicant. Whilst this is a concern this is an improvement on last year's figure of 2.18.

To put this into context, 28% of non-disabled applicants are successful from being shortlisted to being offered the role, compared to 16% of disabled applicants being appointed. This represents an increase of 4% of disabled applicants being appointed from last year.

Trust Board Representation

There are no Trust Board members both voting and non-voting members with a declared disability.

Conclusions

The results from the 2019/2020 WDES return are encouraging and show that improvements are being seen through our recruitment efforts and increased inclusivity. It is important to consider that as our numbers are relatively low, statistical relevance is challenging

Real concerns remain with our Medical Workforce, and the lack of declarations being made. Effort needs to be made as to why this is, and whether there are professional or cultural barriers for this disclosure.

Lawrence Anderson
Deputy Director of Workforce

July 2020

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed : 25 August 2020

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

Risk Appetite The trust has a **low appetite** for risks that impact on operational delivery of services and is working with a range of stakeholders to redesign and improve effectiveness and efficiency to improve patient experience, safety and quality.

Initial Risk 5 (c) x3 (L) =15, moderate
Current Risk Rating 4(C) x 4 (L) = 16
Target Risk Rating 3 (C) x 3 (L) = 9, low

Risk
Sustained delivery of constitutional access 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.

Rationale for current score
- Increased level of patients deferring treatment due to COVID-19
- Underlying capacity challenges for RTT restoration and recovery phase given role of cancer hub
- PPE and infection control limitations for maximising activity
- Waiting list size and challenge with RTT52 long wait patients [CRR 1125]
- Anaesthetic gaps and cover for all site requirements
- Gaps in staff not currently working due to COVID-19
- Isolation requirements impacting booking take up, timescales to book and ability to utilise capacity following cancellations
- Vacancy levels in sleep [CRR 1116]
- Specialist nature / complexity of some activity
- Late referrals from referring organisations
- Vacancies in non consultant level medical staff in and OMFS
- Sentinel Lymph Node demand [CRR 1122]

Future risks
- COVID-19 second surge
- National Policy changes to access and targets
- NHS funding and fines changes & volatility
- Reputation as a consequence of recovery

Future Opportunities
- Closer ICS working
- Closer working between providers
- Partnership with BSUH/WSHFT

Controls / Assurance
- Mobilising of virtual outpatient opportunities to support activity during COVID-19
- Additional reporting to monitor COVID-19 impact
- Restoration and recovery implementation underway
- Agreed system approach to capacity and demand
- Weekly RTT and cancer PTL meetings ongoing
- Development of revised operational processes underway to enhance assurance and grip
- Monthly business unit performance review meetings & dashboard in place with a focus on exceptions, actions and forward planning
- Bank staff for appointments being recruited to
- Planned launch of theatre productivity work programme
- Adapt and adopt and system recovery initatives

Gaps in controls / assurance
- Capacity challenges with cancer hub provision
- Reduced capacity due to infection control requirements for some services
- Not all spoke sites on QVH PAS so access to timely information is limited
- Shared pathways for cancer cases with late referrals from other trusts
- Late referrals for 18RTT and cancer patients from neighbouring trusts
- Residual gaps in theatre staffing
- Capacity challenges for both admitted and non admitted pathways
- Informatics capacity
- Impact of patient choice that is a risk to delivery of plan to eliminate RTT waits > 52 weeks

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance | **Committee: Finance & Performance** | **Date last reviewed 26 August 2020**

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

Risk Appetite The Trust has a **moderate appetite** for risks that impact on the Trusts financial position. A higher level of rigor is being placed to fully understand the implications of service developments and business cases moving forward to ensure informed decision making can be undertaken.

Initial Risk 3 (C) x 5(L) = 15, moderate
Current Risk Rating 4 (C) x 4(L)= 16, moderate
Target Risk Rating 4(C) x 3(L) = 12, moderate

Rationale for current score (at Month 4)

- Break even position for month 4. This was a requirement for all NHS Trusts.
- Uncertainty as to the next steps for the business planning and contract agreement post 31st October and the block arrangements from August till October, two financial returns in September will support this process along with activity and workforce returns
- Guidance issued on activity planning which requires significant increase in activity levels over the coming months which is linked to penalties if the ICS do not achieve the activity levels required
- Finance & Use of Resources – 4 (planned 4)
- High risk factor –availability of staffing - Medical, Nursing and non clinical posts and impact on capacity/ clinical activity
- Commissioner challenge and scrutiny post M1-4 Block arrangement
- Potential changes to commissioning agendas
- Significant activity drop due to Covid
- Unknown costs of redesigned pathways
- Potential for a second wave to effect activity in the coming months

Future Risks

NHS Sector financial landscape Regulatory Intervention

- Block income arrangement – future guidance to be released to better understand how these may change and develop over the coming months
- National guidance is developing to understand how the financial regime will impact Trusts over the coming months.
- Capped expenditure process
- Single Oversight Framework
- Commissioning intentions – Clinical effective commissioning
- NHSI/E control total expectation of annual breakeven within the LTFM trajectory (2020/21-2024/25)
- Central control total for the ICS which is allocated to organisations

Future Opportunities

- New workforce model, strategic partnerships; increased trust resilience / support wider health economy
- Develop the significant work already undertaken using IT as a platform to support innovative solutions and new ways of working
- Increase in efficiency and scheduling through whole of the patient pathway through service redesign
- Spoke site activity repatriation and new model of care
- Strategic alliances \ franchise chains and networks
- Increase partnership working across both Sussex and Kent and Medway with greater emphasis on pathway design

Controls / Assurances

- Performance Management regime in place and performance reports to the Board.
- Contract monitoring process and CIP Governance processes strengthened.
- Finance & Performance Committee in place, forecasting from month ~~4~~ 7 onwards subject to caveats with regards to the NHS environmental changes
- Audit Committee with a strengthened Internal Audit Plan.
- Budget Setting and Business Planning Processes (including capital) ~~to be all~~ approved for all areas.
- Income / Activity capture and coding processes embedded and regularly audited
- Weekly activity information per Business unit, specialty and POD reflected against plan and prior year.
- Spoke site, Service line reporting and service review information widely circulated.
- Service reviews started and working with a combined lead from the DoO and DoF

Gaps in controls / assurances

- Structure, systems and process redesign and enhanced cost control
- Model Hospital Review and implementation
- Identification and Development of transformation schemes to support long term sustainability
- Service reviews required to understand efficiencies against payments
- Non achievement of efficiencies to achieve lower cost profile
- Understanding of payment mechanisms in future periods
- Budgets set in excess of current establishment work required to understand establishment levels required for phase 3

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**3 September 2020**		**Agenda reference:**	**130-20**	
Report title:	**Financial, operational and workforce performance assurance**				
Sponsor:	Paul Dillon-Robinson, committee chair				
Author:	Paul Dillon-Robinson, committee chair				
Appendices:	NA				
Executive summary					
Purpose of report:	Board Assurance on matters discussed at the F&P meeting on 27 July and subsequent considerations.				
Summary of key issues	The Trust, along with all others, faces major challenges in restoring and recovering as part of Phase 3. There is still need for clarity, in some areas, of the requirements and regime that the Trust will operate within, both in terms of performance outcomes and financial regime. Once established there will then need to be a focus on managing key dependencies. The F&P Committee has been looking to take a lighter touch role, until there is sufficient clarity about the expectations, plans and framework that the Trust will be operating within. The current expectation is that greater clarity should be due by the September meeting. The committee remain keen for financial management to be kept robust, and a further paper on budget setting is coming to the Board meeting. Whilst financial results, year to date, are break-even under the current regime, this does not lessen the risk going forward.				
Recommendation:	The Board is asked to **NOTE** the contents of the report, the **ASSURANCE** (where given), and the ongoing uncertainty and challenges in all three areas.				
Action required	~~Approval~~	~~Information~~	**Assurance**	**Assurance**	**Assurance**
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: x *Operational excellence*	KSO4: x *Financial sustainability*	KSO5: x *Organisational excellence*
Implications					
Board assurance framework:	• KS05 – Organisational Excellence – remains major as dependent on a number of factors • KS04 – Financial Sustainability – remains at "catastrophic", although block contract arrangements provide temporary relief, whilst a longer-term solution is developed • KS03 – Operational Excellence – risk remains high as plans for restoration and recovery are developed				
Corporate risk register:	Reflected in BAF scores				
Regulation:	All areas are subject to some form of regulation – none specific				
Legal:	All areas are subject to some form of legal duty – none specific				
Resources:	Performance is dependent, to a large extent, on availability of staff in various areas of the Trust, and the financial arrangements				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	Board of Directors
Meeting date:	3 September 2020
Reference no:	130-20
Report from:	Paul Dillon-Robinson, Committee Chair
Report date:	26 August 2020

Financial, operational and workforce performance assurance

Background
The F&P Committee had intended to meet in August but, due to continuing uncertainty on the future finance and activity regimes, it was agreed to cancel the meeting. This report gives an update from the July F&P meeting and discussions in August with the executives. These included NED meetings with the Chief Executive, the resumption of weekly update meetings between the Director of Finance and myself and Kevin Gould, and a call with the Director of Operations.

1. Workforce performance
In July, Lawrence Anderson presented the Workforce report and there continue to be a number of very positive indicators of a stable workforce, despite the current environment, including low levels of sickness absence. The committee discussed issues around BAME risk assessments, infection control training, the change from annual appraisals to quarterly conversations and changes in bank staff rates.

The committee wish to get a better understanding of the link between activity and workforce, particularly the dependencies on areas with vacancies or key staff, or where staffing would be needed for waiting list initiatives.

2. Financial performance
The current financial regime remains one of block payments and top-ups to ensure break-even, although there is still a bit of a lack of clarity on the regime for the rest of the financial year, with final funding arrangements due to be managed at the ICS level and concern about the regime of fines and incentives and their potential impact on the Trust.

The July committee noted a number of changes to some of the detailed analysis in the financial report as the new reporting system and uploaded budget were settling in. Some areas of overspending needed to be checked to ensure that the expenditure was correctly allocated (aligning the ledger and ESR).

The committee were informed of an additional £500k capital and about the change in the regime for Covid spend; from retrospective to approval in advance. The level of NHS Debtors and Creditors was discussed, with the assurance that work was being undertaken to clear these, but was reliant on business managers whose time was focussed, understandably, on operational issues.

The July committee received a further update on the budget setting for the year; noting the methodology, accepting that there are fundamental uncertainties about the financial regime for the year, but questioning the size of the budgeted deficit figure, primarily because of uncertainty of income and the increase in the pay costs.

There is a significant concern that the Trust, with others, is being expected to proceed at risk to deliver the restoration and recovery by March 2021 without knowledge of its funding implications.

3. Operational performance

Substantial work is being undertaken on capacity and demand modelling, in the light of implementing the Phase 2 requirements and planning for the Phase 3 ones – and this will no doubt be a substantive discussion for the Board on the demands being made on the Trust to recover waiting lists and the work being done at ICS level.

The July committee recognised the tremendous amount of work that had been undertake on the amber / green pathways, elective lists at McIndoe and return of trauma to QVH, with the changes to wards / departments. However, it also noted the growth in 52 week waits and the ongoing growth in this, and other, indicators. It was further recognised that there were constraints on activity; reduced theatre capacity through infection control requirements, theatre/anaesthetic workforce capacity, utilisation of capacity due to isolation requirement / ability to maximise short notice gaps and patient choice, availability of independent sector capacity, etc.

It is likely that the September F&P will focus on the plans and understanding the key dependencies in delivering the high level targets.

4. Other

July's meeting was Andrew Lane's first meeting as the governor representative and he was kept informed of the changes in August and the actions being taken.

The July committee reviewed the Workforce Race Equality Standard Annual Report and suggested some amendments, that were subsequently made, whilst noting that the Action Plan would need to be developed further. This report, and the equivalent one for Disability, were subsequently agreed by the Board, rather than F&P, by email.

The committee also reviewed the Bad Debt Provision, following an increase in its level at the year-end. The root cause appears to be inadequate specification of contracts, so that debts can be disputed / deferred. Work is being undertaken to address these issues and the committee will now review this on a quarterly basis, with greater analysis on the nature of the reasons for dispute.

The committee received an update on Coding and the options being considered. This was felt to be an executive decision, but the committee were keen for the backlog to be reduced and the new arrangements to be in place.

Other updates were received on Covid-19 capital, Service Reviews, Infrastructure and Estates

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**3 September 2020**		**Agenda reference:**	**131-20**	
Report title:	**Operational Performance**				
Sponsor:	Abigail Jago, Director of Operations				
Author:	Operations Team				
Appendices:					
Executive summary					
Purpose of report:	To provide an update regarding operational performance				
Summary of key issues	The operational report sets out 3 key areas: • Recovery and restoration requirements and progress (phase 2 and phase 3) • Cancer hub update • Operational performance update Key items to note in regard to operational performance: • Improving DM01 diagnostic wait performance. Challenges remain with sleep studies. • Delivery of histology and imaging reporting turnaround times • Significant performance challenge for RTT18 and RTT52 performance • Delivery of 62day cancer standard • 31 day and 2ww standard not met in month Key items for discussion: • Phase 2 progress • Phase 3 requirements and performance impact • Cancer hub provision				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required				Assurance	
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	**KSO3:** ***Operational excellence***	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	**Controls / Assurance:** As described on BAF KSO3				
Corporate risk register:	**Risks:** As described on BAF KSO3				
Regulation:	CQC – operational performance covers all 5 domains				
Legal:	The NHS Constitution, states that patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, (i.e. patients should wait no longer than 18 weeks from GP referral to treatment) or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'.				
Resources:	Nil above current resources				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:	NA				

Operational Performance Board Report

Abigail Jago, Director of Operations

August 2020

Summary

The operational report sets out 3 key areas:

- Recovery and restoration requirements and progress (phase 2 and phase 3)
- Cancer hub update
- Operational performance update

Key items to note in regard to operational performance:

- Improving DM01 diagnostic wait performance. Challenges remain with sleep studies.
- Delivery of histology and imaging reporting turnaround times
- Significant performance challenges for RTT18 and RTT52
- Delivery of 62 day cancer standard
- 31 day and 2ww standard not met in month

Key items for discussion:

- Phase 2 progress
- Phase 3 requirements and performance impact
- Cancer hub provision

Phase 2 requirements - update

NHSE REQUIREMENT	QVH ACTION TO DATE	FURTHER ACTION REQUIRED
Continue testing on non electives on admission and electives PAC	• Screening and testing in place for trauma and elective patients • NICE guidelines for isolation	• **Complete**
Staff testing	• Optigene on site and protocol for staff testing in place	• **Complete**
Scale up technology enabled care and A&G / Video now the default for OP rather than the exception	• Video outpatient appointments in place • Telephone appointments in place • Advice and guidance in place through eRS • Further A&G / information sheets for GPs	• **Partially Complete**
Increase patient initiated followed up		• ***Outstanding*** *Sussex commissioning work shop planned for September*
Hot clinics / pre booked appointments	• Hot clinic per se not in place however virtual clinics established for non elective patients	• **Complete** - No further action required
Direct access for urgent diagnostics as pre covid levels	• In place	• **Complete**
Where capacity is available restart electives, tackling long waiters first	• Electives taking place in clinical priority and then long waiters • Clinical senate in place to oversee clinical decisions	• Capacity challenges due to cancer hub activity
Patient risk stratification and education	• Risk stratification of waiting list completed • Agreed outpatients do not need risk stratification process due to virtual appointments	• **Complete**
Continue to identify ring fenced capacity for cancer and diagnostics	• Capacity at TMC for elective work but not sufficient to cover theatre lists given over to cancer hub work	• **Complete**
Urgent action should be take by hospitals re receiving 2ww and provide appointments	• In place	• **Complete**
Ensure cancer hubs are fully operational; full use of independent sector	• Cancer hub in place for skin – see and treat, breast and head and neck	• **Complete**

Phase 2 activity as a % of pre covid-19 baseline

Queen Victoria Hospital NHS Foundation Trust

Activity Type	May-20 Plan	Jun-20 Plan	Jul-20 Plan	Comments
OP New	53%	55%	65%	July actual - 67% achieved re pre COVID -19 levels.
OP F-up	51%	55%	65%	July actual - 83% Fup, OP Proc 29%
EL DC	26%	29%	35%	July actual - 38%. Restricted recovery capacity due to cancer hub provision and impact of revision to independent sector contract.
EL Ord	24%	25%	40%	July actual - 38% - Restricted recovery capacity due to cancer hub provision and impact of revision to independent sector contract

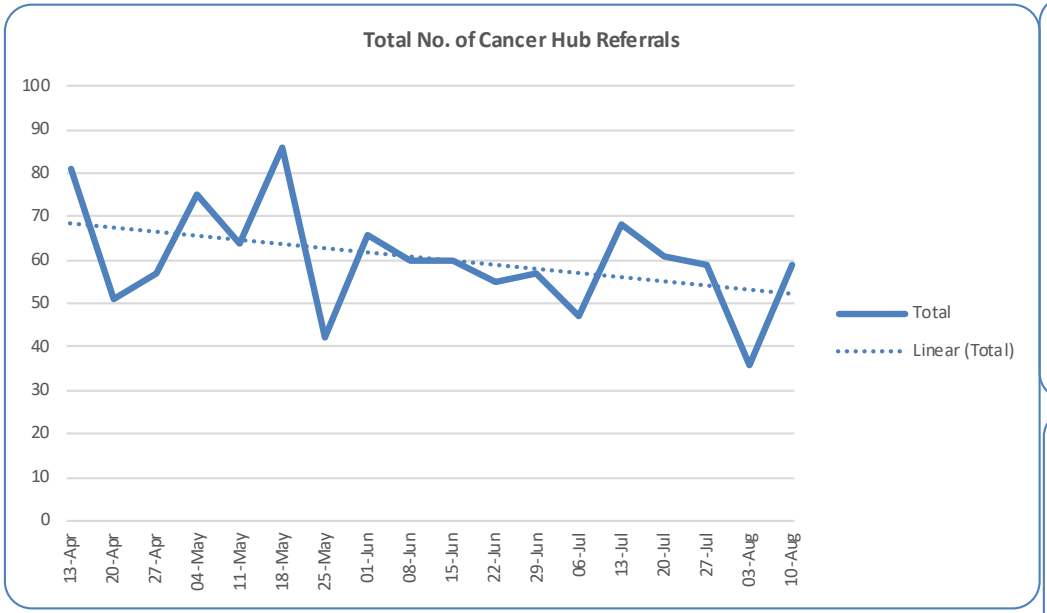
Activity Type	Apr-20 Plan	Jun-20 Plan	Jul-20 Plan	Comments
CT	47%	50%	60%	July actual – 89%
NOUS	27%	60%	65%	July actual – 51% (under performance resulting from driven by referral rates)
MRI	26%	35%	45%	July actual - 43% (under performance resulting from referral rates)

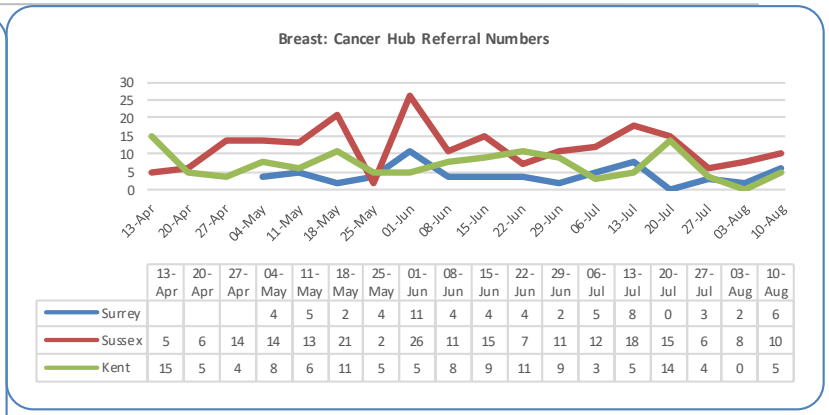
Phase 3 letter

Queen Victoria Hospital NHS Foundation Trust

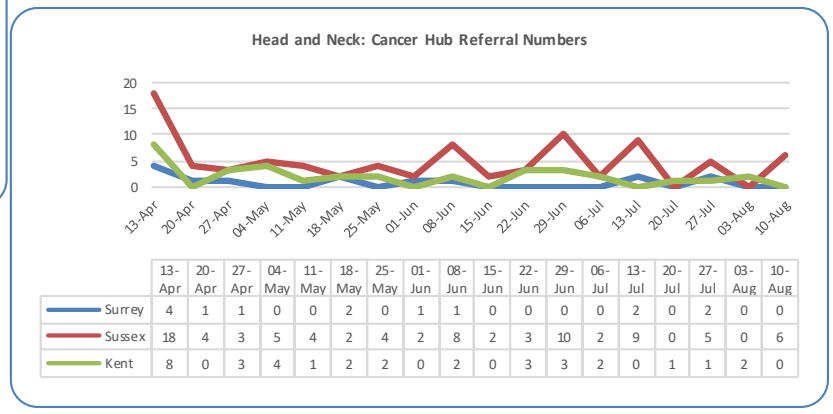
A. Accelerating the return to near-normal levels of non-COVID health services		
1. Restore full operation of all cancer services.	**Action to date**	**Further action required**
Provide sufficient diagnostic capacity in Covid19 secure environments, development of Community Diagnostic Hubs and Rapid Diagnostic Centres	• Diagnostic capacity at pre COVID levels • Providing mutual support to Sussex trusts • Part of Diagnostic Group for Sussex ICS	• Development of case for Community Diagnostic Hub
Expand capacity of surgical hubs to meet demand in Covid19 secure environments.	• Cancer hub in place.	• Future capacity and role to be reviewed in light phase 3 and potential IS contract implications
Reduce patients waiting for diagnostics and/or treatment > 62 days, >31 days and >104 days.	• Cancer services in place • Performance against standards reported	• Continued reduction of 62 day and 104 day backlog • Review of current skin pathway and development of best practice pathway
2. Recover the maximum elective activity possible between now and winter		
In September at least 80% of last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October (70% in Aug)	• Demand and capacity work underway • Performance against standards and phased plan reported	• Establish capacity allocation group • Initiate theatre improvement initiative • Mobilise out of hours capacity • Review of cancer hub provision
At least 90% of last year's levels of MRI/CT, with ambition to reach 100% by October.	• Being met in regard to referred activity	
100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September to year end (90% in August).	• Outpatient activity increasing including virtual • Performance against standard reported	• Ongoing roll out of virtual programme • Review of infection control requirements and clinic flow
Clinically urgent patients to be treated first, with next priority to longest waiting patients, those breaching or at risk of breaching 52 weeks by end March 2021	• Clinical senate in place and all bar clinically vulnerable patients approved • Performance against standard reported • Weekly PTL resumed	• Mobilise weekend waiting list initiatives • Capacity allocation workstream established with clinical leadership • Review of breast cancer capacity provision

Cancer Hub

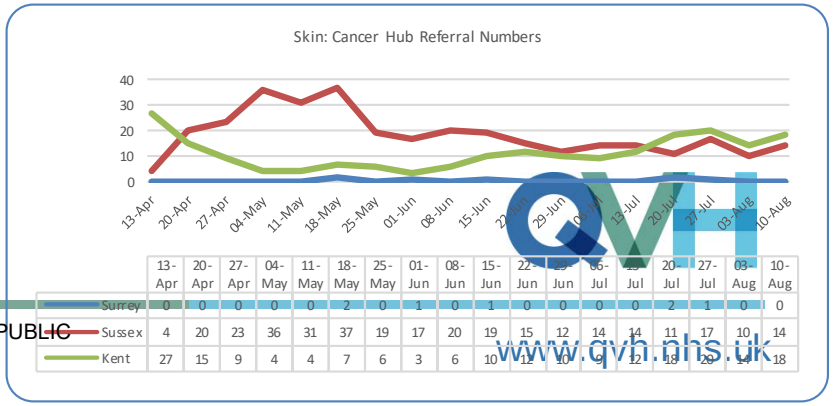




	13-Apr	20-Apr	27-Apr	04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun	22-Jun	29-Jun	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug
Surrey				4	5	2	4	11	4	4	4	2	5	8	0	3	2	6
Sussex	5	6	14	14	13	21	2	26	11	15	7	11	12	18	15	6	8	10
Kent	15	5	4	8	6	11	5	5	8	9	11	9	3	5	14	4	0	5



	13-Apr	20-Apr	27-Apr	04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun	22-Jun	29-Jun	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug
Surrey	4	1	1	0	0	2	0	1	1	0	0	0	0	2	0	2	0	0
Sussex	18	4	3	5	4	2	4	2	8	2	3	10	2	9	0	5	0	6
Kent	8	0	3	4	1	2	2	0	2	0	3	3	2	0	1	1	2	0



	13-Apr	20-Apr	27-Apr	04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun	22-Jun	29-Jun	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug
Surrey	0	0	0	0	0	2	0	1	0	1	0	0	0	0	2	1	0	0
Sussex	4	20	23	36	31	37	19	17	20	19	15	12	14	14	11	17	10	14
Kent	27	15	9	4	4	7	6	3	6	10	12	10	9	12	18	20	14	18

Cancer hub activity continues. There has been a decline in the breast referrals and use of breast lists as services from referring trusts begin to recover. This has prompted a review of breast cancer activity provision at QVH. Discussion are underway at an ICS and system level.

To date 377 breast cancer patients have received treatment at QVH and 122 head and neck patients (over and above direct head and neck referrals to QVH)

Performance summary – 19/20 YTD

Queen Victoria Hospital
NHS Foundation Trust

KPI	TARGET / METRIC	TARGET SOURCE	SEP19	OCT19	NOV19	DEC19	JAN20	FEB20	MAR20	APR20	MAY20	JUN20	JUL20
DMO1 Diagnostic waits	99% < 6 weeks	National	99.11%	99.76%	99.61%	98.18%	98.23%	99.20%	90.07%	72.4%	28.09%	73.3%	84.9%
Histology Turnaround Time	90% < 10 days	Local	76%	38%	59%	71%	90%	94%	94%	93%	96%	95%	99%
Imaging reporting	% < 7 days	Local	97.98%	98.75%	95.8%	99.11%	99.37%	98.8%	98.18%	99.0%	98.6%	99.4%	98.5%
RTT – % patients <18 week	Agreed commissioner trajectory	National	81.62%	82.28	82.9%	82.77%	82.1%	81.37%	78.5%	69.5%	59.22%	50.48%	42.16%
RTT52	Agreed commissioner trajectory	National	25	22	19	15	19	16	18	38	100	185	320
Total waiting list size	Reduction in waiting list size	National	10516	10663	10529	10429	10333	10178	10123	9604	9397	9854	10059
MIU- % pt treated/ discharge in 4 hrs	95%	National	99.26%	99.7%	99.47%	100%	99.89%	100%	100%	100%	100%	100%	100%
Cancer 2WW	93%	National	89.3%	88.9%	89.5%	96%	93.3%	97.7%	90.8%	83.8%	89.5%	77.1%	
Cancer 62 day	85%	National	82.9%	85.7%	70% (83.3% actual)	80%	83.7%	82.1%	87.8%	90.9%	95.9%	88.2%	
Cancer 31 day	96%	National	94.9%	93.0%	87.1%	94.7%	89.9%	89.5%	94.6%	98.2%	98.5%	93.1%	
Faster Diagnosis Shadow Report	75%	National Apr20	81.5%	84.4%	88.1%	86.6%	77.2%	88.1%	84.5%	67.4%	79.9%	77.1%	

RTT Performance against plan – 2020/21

Queen Victoria Hospital NHS Foundation Trust

	Quarter 4 19/20			Quarter 1 20/21			Quarter 2 20/21			Quarter 3 20/21			Quarter 4 20/21		
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	87.7%	90.3%	92%												
RTT Actual	82.10%	81.37%	78.5%	69.5%	59.22%	50.48%	42.16%								
52 week actual (total)	19	16	18	38	100	185	320								
52 week patient deferred	13	11	7												

Corneo plastic	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	86.3%	89.4%	92%												
RTT Actual	73.89%	72.79%	69.58%	57.8%	46.57%	38.56%	26.04%								
52 weeks actual (total)	0	1	0	1	22	44	109								
52 week patient deferred	0	1	0												

OMFS	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	90.1%	90.1%	92%												
RTT Actual	84.13%	83.88%	79.92%	68.0%	54.95%	40.36%	34.67%								
52 weeks actual	5	4	2	7	19	40	71								
52 week patient deferred	3	3	1												

Plastics	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	87.8%	87.8%	92%												
RTT Actual	80.52%	79.21%	77.07%	70.9%	63.23%	58.07%	49.95%								
52 weeks actual	14	11	16	30	58	100	137								
52 week patient deferred	10	7	6												

Sleep	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	92%	92%	92%												
RTT Actual	95.25%	95.13%	94.55%	91.2%	83.20%	73.74%	69.98%								
52 weeks actual	0	0	0	0	1	1	2								

Clinical Support	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	95%	95%	95%												
RTT Actual	96.26%	97.15%	96.34%	92.0%	85.50%	72.55%	47.76%								
52 weeks actual	0	0	0	0	0	0	1								

RTT18 – Incomplete pathways

Trust level performance

Queen Victoria Hospital NHS Foundation Trust

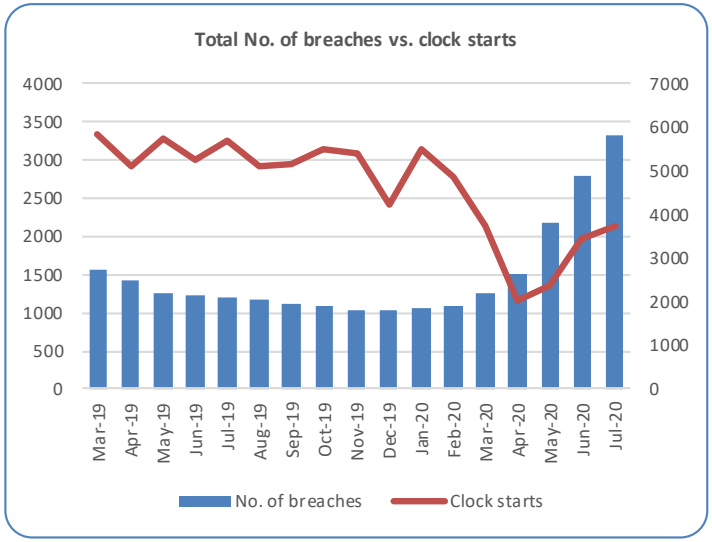
Weeks wait	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Change from last month	Change from last month
0-17 (<18)	8790	8915	8583	8774	8729	8632	8483	8282	7947	6682	5565	4974	4241	↓	-733
18-26	1271	1169	1085	1083	984	1008	1089	1149	1344	1625	1903	2236	2544	↑	308
27-33	402	490	447	380	397	405	403	416	451	702	997	1215	1234	↑	19
34-40	253	205	243	269	240	209	212	207	248	347	480	740	954	↑	214
41-51	149	158	133	135	160	160	127	108	115	210	352	504	766	↑	262
>52	37	29	25	22	19	15	19	16	18	38	100	185	320	↑	135
Total Pathways	10902	10966	10516	10663	10529	10429	10333	10178	10123	9604	9397	9854	10059	↑	205
Breaches	2112	2051	1933	1889	1800	1797	1850	1896	2176	2922	3832	4880	5818	↑	938
Performance	80.63%	81.30%	81.62%	82.28%	82.90%	82.77%	82.10%	81.37%	78.50%	69.58%	59.22%	50.48%	42.16%	↓	-8.32%
Clock starts	3240	2923	2947	3152	3099	2407	3152	2790	2128	1163	1353	1957	2133	↑	176

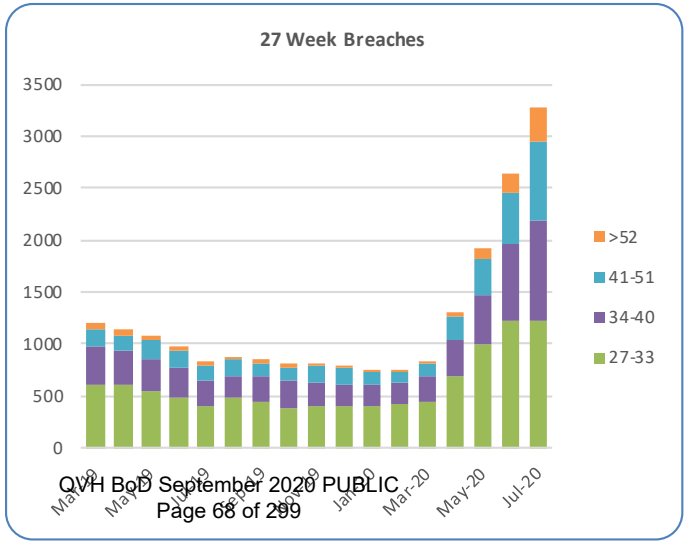
PERFORMANCE COMMENTARY

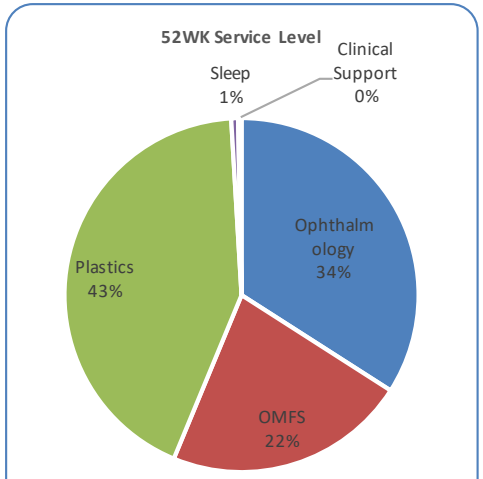
- Performance fell by 8.32%, reporting a total of 938 breaches
- Since the outbreak we are recording an average of 9.09% decrease in performance each month
- Patients waiting between 41-51wks continues to rise, increasing by 262

52 WK COMMENTARY

- The number of 52wk breaches increased by 135 in month, the biggest increase in 1 month since the outbreak, reporting a total of 320 breaches
- Out of the 320 breaches, 262 are awaiting a TCI date and 58 are in the outpatient phase of their pathway







COVID-19 Impact On RTT

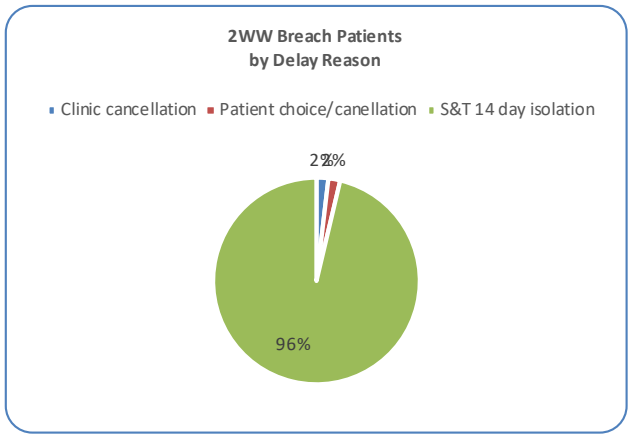
Queen Victoria Hospital
NHS Foundation Trust

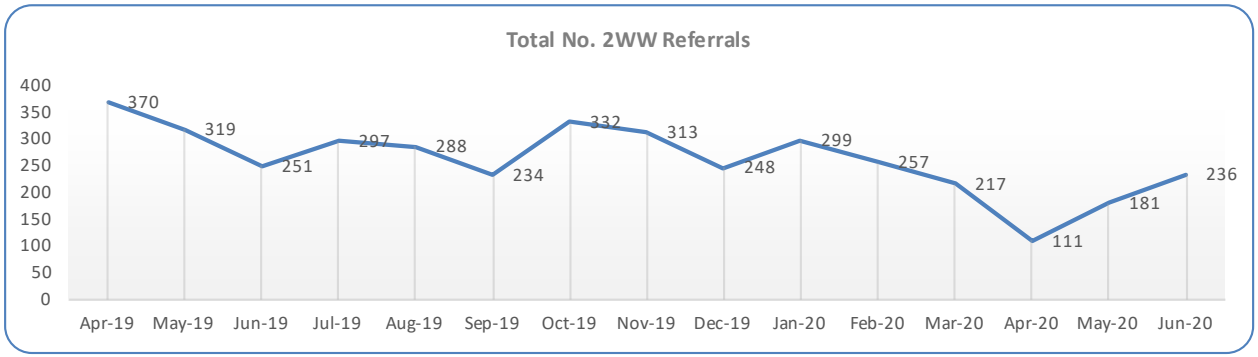
Trust Wide	Average of last 6 months (Sep19-Feb20 Inc.)	Mar20 actual	Variance from six month Average for March			Apr20 Actual	Variance from six month Average for April			May20 Actual	Variance from six month Average for May			June20 Actual	Variance from six month Average for June			July20 Actual	Variance from six month Average for July		
Open Pathway Weeks Wait			Mar-Ave	Mar/Ave	Var/Ave		Apr-Ave	Apr/Ave	Var/Ave		May-Ave	May/Ave	Var/Ave		June-Ave	June/Ave	Var/Ave	July act	July-Ave	July/Ave	Var/Ave
0-17 (<18)	8,581	7,947	-634	93%	-7%	6682	-1,899	78%	-22%	5565	-3,016	65%	-35%	4974	-3,607	58%	-42%	4241	-4,340	49%	-51%
18-26	1,066	1,344	278	126%	26%	1625	559	152%	52%	1903	837	178%	78%	2236	1,170	210%	110%	2544	1,478	239%	139%
27-33	408	451	43	111%	11%	702	294	172%	72%	997	589	244%	144%	1215	807	298%	198%	1234	826	302%	202%
34-40	230	248	18	108%	8%	347	117	151%	51%	480	250	209%	109%	740	510	322%	222%	954	724	415%	315%
41-51	137	115	-22	84%	-16%	210	73	153%	53%	352	215	257%	157%	504	367	367%	267%	766	629	558%	458%
>52	19	18	-1	93%	-7%	38	19	197%	97%	100	81	517%	417%	185	166	957%	857%	320	301	1655%	1555%
Total open Pathways	10,441	10,123	-318	97%	-3%	9604	-837	92%	-8%	9397	-1,044	90%	-10%	9854	-587	94%	-6%	10059	-382	96%	-4%
18 week Breaches	1,861	2,176	315	117%	17%	2922	1,061	157%	57%	3832	1,971	206%	106%	4880	3,019	262%	162%	5818	3,957	313%	213%
Clock Start	2,925	2,128	-797	73%	-27%	1163	-1,762	40%	-60%	1353	-1,572	46%	-54%	1957	-968	67%	-33%	2133	-792	73%	-27%
Admitted Clock stops	1,051	820	-231	78%	-22%	292	-759	28%	-72%	312	-739	30%	-70%	464	-587	44%	-56%	512	-539	49%	-51%
Non admitted clock stops	1,710	1,324	-386	77%	-23%	913	-797	53%	-47%	721	-989	42%	-58%	790	-920	46%	-54%	917	-793	54%	-46%

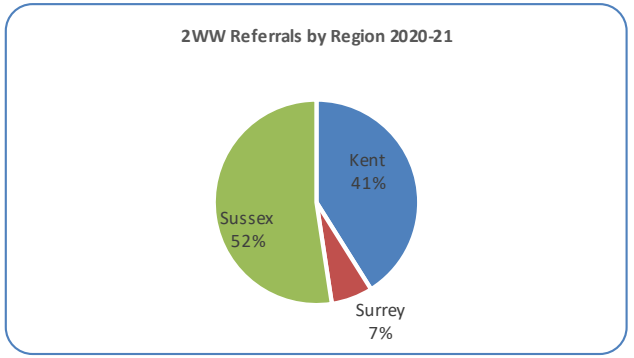
Cancer Performance

Queen Victoria Hospital NHS Foundation Trust

Trust Level	Quarter 4 2019-20			Quarter 1 2020-21			Change from last month
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	
Two Week Wait	93.3%	97.7%	90.8%	83.8%	89.5%	77.1%	↓
62 Day Referral to Tx	83.7%	82.1%	87.8%	90.9%	95.9%	88.2%	↓
Faster Diagnosis				67.4%	79.9%	77.1%	↓
62 Day Screening	0.0%		0.0%				
62 Day Con Upgrade	87.5%	88.9%	93.8%	100.0%	57.1%	100%	↑
31Day Decision to Tx	89.9%	89.5%	94.6%	98.2%	98.5%	93.1%	↓
31 Day Sub Treat	100.0%	75.0%	100.0%	100.0%	100.0%	85.7%	↓





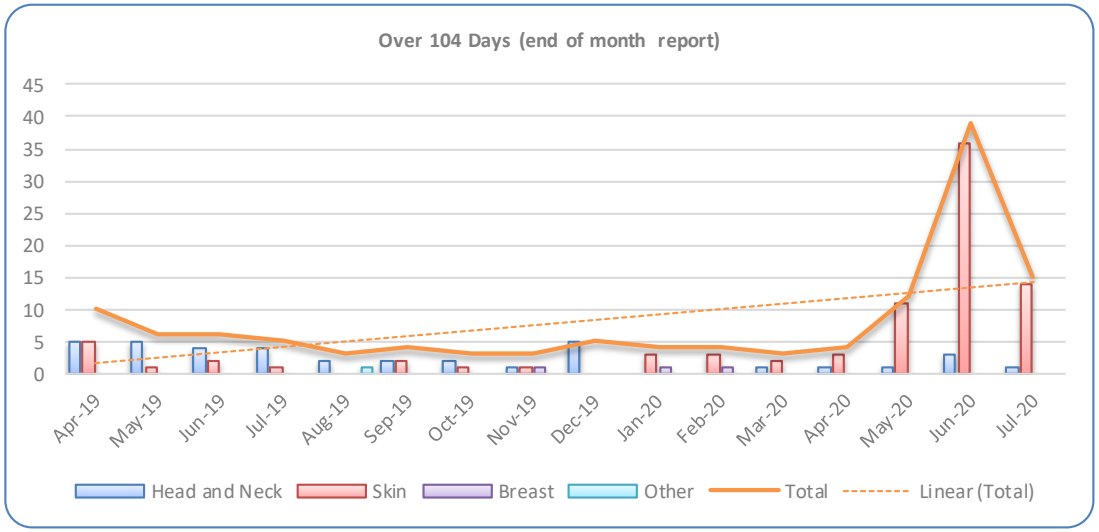


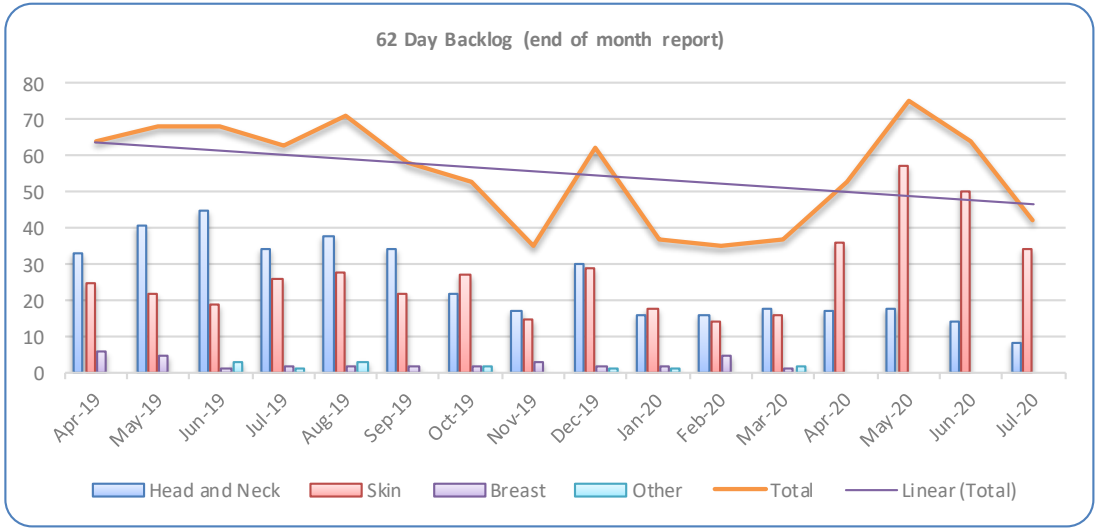
May Key Performance Highlights

- The 2WW target in June remained a challenge for skin due to the 14 day self-isolation needed for the See and Treat clinic. This will improve going forward with changes to isolation. H&N are continuing to see an improvement in the 2WW performance, reporting only 1 breach.
- 62D performance was delivered for a fourth month, recording the highest number of treatments on a 62D pathway since Aug 2019.
- The predicted July 62D performance will be 76.5%, reporting 7.5 breaches, 6.5 in skin. This is due to the treatment of a number of skin patients in the backlog (due to COVID19).
- Faster Diagnosis Standard [FDS] remained in a passing position, achieving 77.1%
- 31D performance saw a dip in June, skin reporting all 5 breaches with a performance of 93.1%
- The number of patients over 62 days and 104 days have seen a decline and are expected to decline further. This will impact performance.

104 Days and 62D Backlog

Queen Victoria Hospital
NHS Foundation Trust

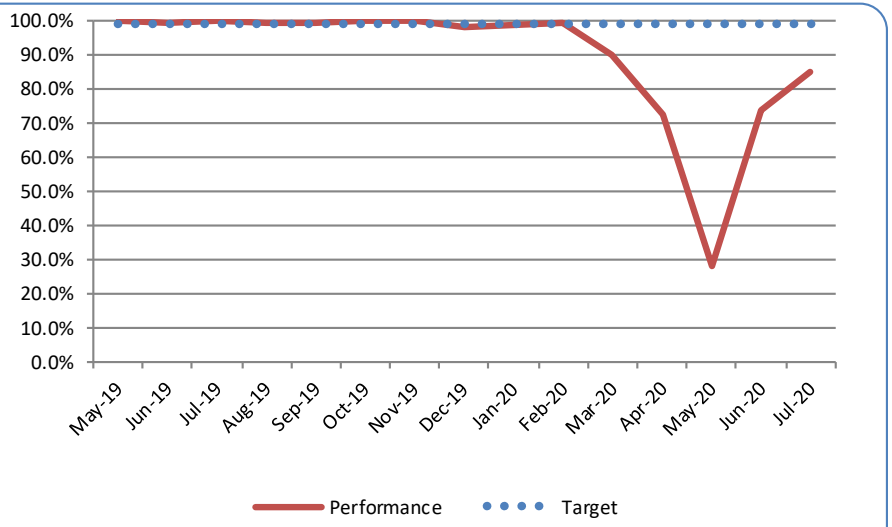


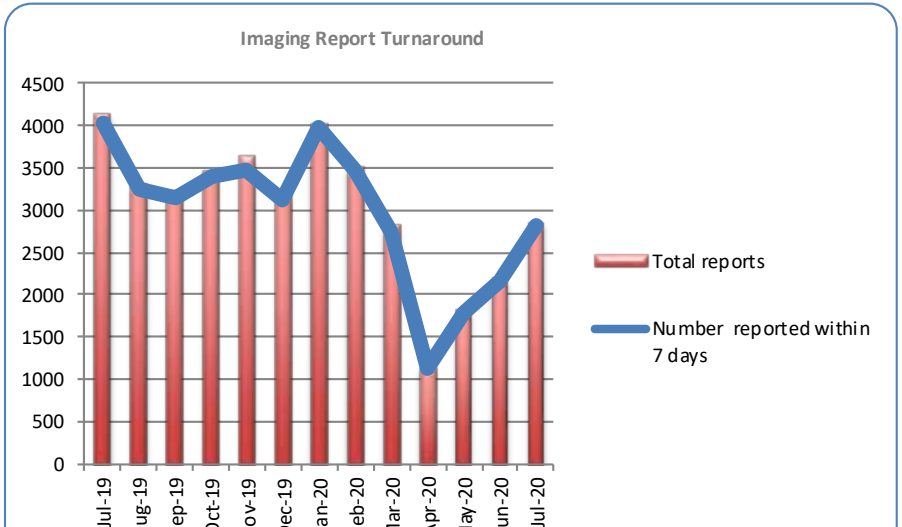


62D Backlog	104 Days
• The number of patients waiting over 62 days is declining since the outbreak of COVID-19 as increased patients deemed as vulnerable or previously not willing to come in are starting to attend. • All patients are still remaining on the PTL tracking list until a non-cancer diagnosis is confirmed and communicated to the patient or the patient has received treatment for a cancer diagnosis. • In the months of April and May QVH received a high volume of tertiary referrals over 62 days, this has declined since June and is continuing to decline.	• Patients waiting over 104 days since the outbreak of COVID-19 is declining • For July QVH reported a total of 15 patients over 104 days – 1 in head and neck and 14 in skin • Patients that have had their pathways paused or changed due to COVID-19 are reviewed by a clinician alongside the Risk and Patient Safety Team. • Further reduction forecast for August.

Diagnostic Performance

Queen Victoria Hospital
NHS Foundation Trust





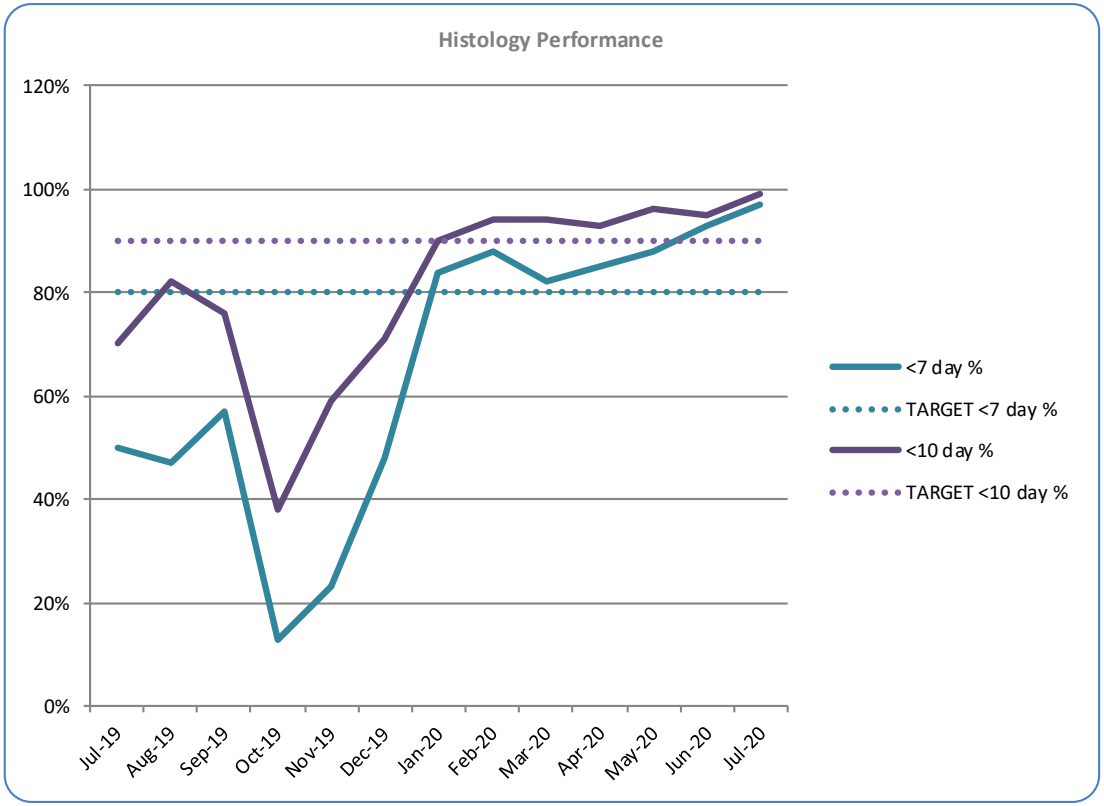
PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
Diagnostic Imaging • 87 breaches at month end approximately half were patient choice for MRI/US. CT was mainly CBCT not conventional CT. • Routine activity has shown a increase in the reporting period. • Reporting targets being met • Breaches improving week on week **Sleep Studies** • 65+ breaches July. Overnight studies have restarted at 9 per week. • All DM01 patients have been re-triaged in line with strict protocol for overnight studies.	**Diagnostic imaging** • Medical workforce remains an ongoing risk. 2 bank consultants are now supporting service. • Mutual aid is being offered to other Sussex trusts supporting delivering of system backlogs for CT, MRI and US **Sleep Studies** • Stringent triaging going forward. • Plans to increase throughput are being reviewed in line with infection control, requirements

Last reporting period – JUNE20			This reporting period – JULY20		
Modality / test	Breaches	Perf.	Modality / test	Breaches	Perf.
CT	48	67.1%	CT	5	94.7%
ECHO-CARDIOGRAPHY	0	100%	ECHO-CARDIOGRAPHY	0	100%
MRI	15	75%	MRI	1	98.9%
NON-OBSTETRIC ULTRASOUND	28	89.4%	NON-OBSTETRIC ULTRASOUND	1	99.4%
SLEEP STUDIES	58	33%	SLEEP STUDIES	73	30.5%

Histology Turnaround Time (TAT)

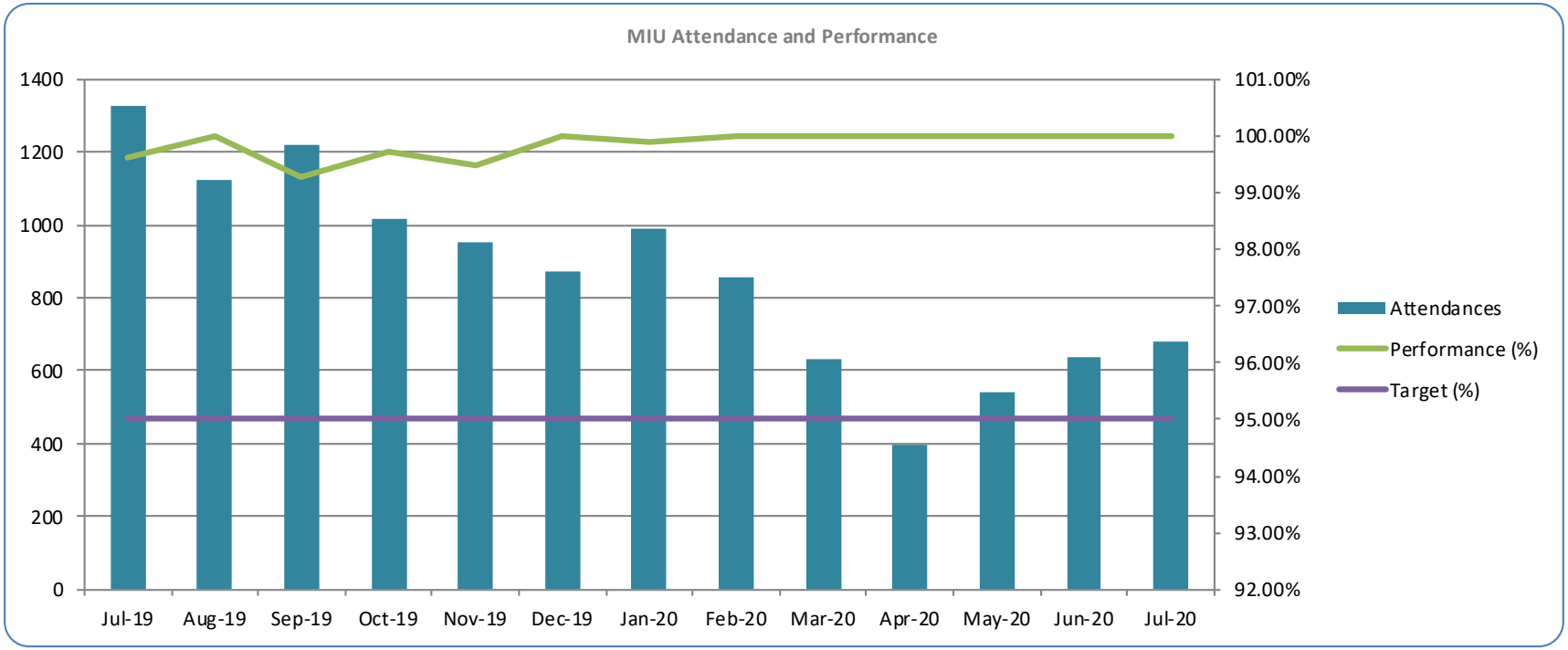
Queen Victoria Hospital
NHS Foundation Trust

Month	Total Specimens Received	Total Cases Reported
Dec-18	1433	1149
Jan-19	1519	954
Feb-19	1413	1004
Mar-19	1413	1004
Apr-19	1322	870
May-19	1317	1024
Jun-19	1383	1422
Jul-19	1526	1171
Aug-19	1362	862
Sep-19	1275	955
Oct-19	1683	1210
Nov-19	1466	1059
Dec-19	1244	1145
Jan-20	1476	932
Feb-20	1337	997
Mar-20	1222	945
Apr-20	467	340
May-20	552	338
Jun-20	827	551
Jul-20	855	648



PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
• Improved performance position • Appointment of one pathologist vacancy. Start date anticipated in September. • On going cover through temporary staffing arrangements.	• Ongoing vacancies present performance risks but mitigated through temporary arrangements in place

Minor Injuries Unit (MIU)



PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
• Performance delivery continues to be on track	• Ongoing work towards the primary care/integrated service in line with NHSE and CCG proposals. • Decreased activity relative to last year, but slowly increasing since initial dip at the start of Covid • New clinical service lead commences September 2020

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03 September 2020`**		**Agenda reference:**	**132-20**	
Report title:	**Financial performance**				
Sponsor:	Michelle Miles Director of Finance and Performance				
Author:	Michelle Miles Director of Finance and Performance				
Appendices:	Budget setting update				
Executive summary					
Purpose of report:	To provide the Board with an overview of the Trust's financial performance for months 1-4 of 2020/21. To highlight the current budgets for the phase 2 of the current financial year.				
Summary of key issues	The current financial regime is for all organisations to be reporting to a break-even position to month 4 during phase 2 of the current regime. This report highlights that the Trust is reducing its top up payment to break even i.e. in effect would be making a surplus in the current funding arrangements due to lower pay and non-pay spend. Capital remains an issue for the Trust due to the covid capital not yet receiving approval, all Trusts are still waiting on approval for phase 2 capital covid spend. The budget setting paper highlights where budgets will be set on the basis of approved establishment levels and outturn of non-pay spend from 2019/20. The overarching deficit has significantly reduced due to the current funding regime. Further work on budgets to remove vacant posts and improve efficiencies is required and update the changes in funding when full guidance has been released.				
Recommendation:	To note the financial performance in line with DHSC reporting and to approve the current budgets in line with phase 2 of the financial year.				
Action required *[highlight **one** only]*	**Approval**				
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
			Operational excellence	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	KS04				
Corporate risk register:	Corporate risk of Financial Sustainability - 877				
Regulation:	DHSC financial regime				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Trust Board Finance Report
July 2020-21

Michelle Miles – Director of Finance and Performance

202021 M4 - Financial Performance

Queen Victoria Hospital NHS
NHS Foundation Trust

Income and Expenditure

	In Month £'000				Year to Date £'000			
	Prior year Outturn	Plan	Actual	Variance	Prior year Outturn	Plan	Actual	Variance
Income								
Patient Activity Income	5,061	5,654	5,635	(19)	21,581	22,617	22,718	101
Other Operating Income	383	197	155	(42)	1,550	788	959	171
Block Projected Top Up	0	556	556	(0)	0	2,226	2,226	0
Total Income	**6,344**	**6,408**	**6,346**	**(61)**	**23,131**	**25,631**	**25,903**	**272**
Pay								
Substantive	(3,769)	(1,537)	(4,434)	(2,897)	(15,205)	(18,059)	(16,431)	1,628
Bank	(330)	(21)	(99)	(78)	(1,061)	(293)	(410)	(117)
Agency	(248)	(3)	(33)	(30)	(836)	(72)	(102)	(30)
Total Pay	**(4,347)**	**(1,561)**	**(4,566)**	**(3,006)**	**(17,103)**	**(18,424)**	**(16,944)**	**1,481**
Non Pay								
Clinical Services & Supplies	(540)	(131)	(630)	(499)	(2,152)	(1,710)	(1,737)	(27)
Clinical Services & Supplies - Med & Surg	(548)	(198)	(491)	(293)	(2,182)	(2,390)	(1,511)	879
Drugs	(142)	(59)	(95)	(36)	(406)	(506)	(309)	197
Establishment Expenses	(347)	(27)	(178)	(151)	(1,077)	(829)	(780)	50
Consultancy	(1)	(13)	2	15	(4)	(85)	(57)	28
Other non pay	(298)	75	(633)	(708)	(1,551)	(1,454)	(2,262)	(808)
Total Non Pay	**(1,876)**	**(353)**	**(2,025)**	**(1,672)**	**(7,462)**	**(6,974)**	**(6,656)**	**318**
Non Operational Expenditure	(100)	(51)	(174)	(123)	(533)	(623)	(636)	(13)
Non Operating Income	0	0	0	0	0	0	0	0
Depreciation and amortisation	(287)	(110)	(278)	(168)	(1,174)	(1,316)	(1,127)	189
Total Expenditure	**(6,609)**	**(2,075)**	**(7,044)**	**(4,969)**	**(26,272)**	**(27,338)**	**(25,363)**	**1,975**
Surplus / (Deficit)	**(265)**	**4,332**	**(698)**	**(5,030)**	**(3,141)**	**(1,707)**	**541**	**2,247**
Top up to be reclaimed			698				0	
Adjustment to B/E							(541)	
Surplus / (Deficit)			**0**				**(0)**	

Summary

YTD @ Month 4 the Trust is reporting a Break even position. This is a national requirement.

The Trust is in receipt of the top up payment to support the block contract arrangement currently in place. Due to the significant lower levels of expenditure the top up payment actually provides the Trust with a surplus which is reduced to a break even position.

Due to current Pandemic its not business as usual for the trust and resultantly activity levels are down, the spend levels are down relative to the activity with Pay spend £158k and Non Pay by £709k lighter than the same period last financial year.

Income

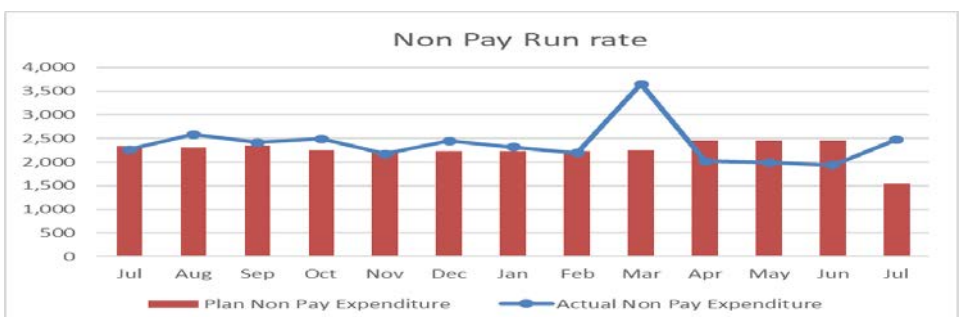
YTD Patient Activity Income- Block Contract £22.7m, Other Income £1m of which, c£500k LDA, c£300k for P21.

Financial Performance Month 4 2020/21

Queen Victoria Hospital NHS
NHS Foundation Trust

Operating Expenditure

	In Month £'000				Year to Date £'000			
	Prior year Outturn	Plan	Actual	Variance	*Prior year Outturn*	Plan	Actual	Variance
Pay								
Nursing & Healthcare Assistant	*(1,166)*	(1,195)	(1,021)	174	*(4,418)*	(4,781)	(4,108)	674
Allied Health Professionals & Healthcare Scientis	*(601)*	(562)	(597)	(35)	*(2,437)*	(2,248)	(2,321)	(73)
Admin & Clerical	*(998)*	(1,090)	(1,282)	(191)	*(3,649)*	(4,362)	(3,887)	475
Support Staff	*(146)*	(180)	(136)	44	*(592)*	(721)	(552)	169
Medical	*(1,437)*	(1,532)	(1,531)	1	*(6,008)*	(6,129)	(6,077)	52
Pay Total	***(4,347)***	**(4,560)**	**(4,566)**	**(6)**	***(17,103)***	**(18,241)**	**(16,944)**	**1,297**
Non Pay								
Clinical Services & Supplies	*(540)*	(395)	(630)	(235)	*(2,152)*	(1,579)	(1,737)	(158)
Clinical Services & Supplies - Med & Surg	*(548)*	(599)	(491)	108	*(2,182)*	(2,394)	(1,511)	883
Drugs	*(142)*	(127)	(95)	32	*(496)*	(509)	(309)	200
Tariff - excluded drugs	*0*	0	0	0	*0*	0	0	0
Establishment Expenses	*(347)*	(259)	(178)	82	*(1,077)*	(1,037)	(780)	257
Consultancy	*(1)*	(17)	2	19	*(4)*	(68)	(57)	11
Other non pay	*(298)*	(560)	(633)	(73)	*(1,551)*	(2,242)	(2,262)	(20)
Non Pay Total	***(1,876)***	**(1,957)**	**(2,025)**	**(68)**	***(7,462)***	**(7,829)**	**(6,656)**	**1,173**
Total Expenditure	***(6,223)***	**(6,517)**	**(6,592)**	(74)	***(24,565)***	**(26,070)**	**(23,600)**	2,470



Overall Expenditure is underspend proportionate to the Activity levels. In month variance position is skewed due to the finalization of the budget setting process in moth. YTD shows the variance against the current plan.

Pay- There are currently 123 vacancies (budgeted vs contracted WTE) not backfilled. This translates to a significant underspend YTD on pay. Work is now needed to highlight the non backfilled posts and review if they can be removed from the establishment.

N**on Pay-** Lower levels of activity resulting into reduced spend run rates for CPAP devices, Outsourcing, Sterile Services, Medical and Surgical equipment and deposable and Drugs.

Phase 3 of the recovery of COVID planning is underway. A series of national returns are currently being submitted over the next 6 weeks for activity, workforce and finance.

Workforce Financial performance –Month 4 2020/21

Queen Victoria Hospital NHS
NHS Foundation Trust

	In Month WTE				In Month £'000					Year to Date £'000				
	Plan	Actual	Variance	Total Pay Variance	*Prior Year Outturn*	Plan	Actual	Variance	Total Pay Variance	*Prior Year Outturn*	Plan	Actual	Variance	Total Pay Variance
Substantive														
Admin & Clerical	321	267	(54)	(40)	*(859)*	(1,086)	(1,238)	(151)	(183)	*(3,177)*	(4,345)	(3,751)	594	509
Allied Health Professionals	145	149	4	7	*(571)*	(558)	(591)	(33)	(35)	*(2,372)*	(2,233)	(2,359)	(127)	(73)
Medical	161	158	(3)	1	*(1,267)*	(1,528)	(1,481)	46	1	*(5,582)*	(6,110)	(5,868)	243	52
Nursing & Healthcare Assist	348	278	(69)	(66)	*(938)*	(1,128)	(989)	139	166	*(3,524)*	(4,513)	(3,900)	613	640
Support Staff	77	57	(20)	(25)	*(133)*	(161)	(136)	25	44	*(550)*	(645)	(554)	91	169
Substantive Total	**1,050**	**909**	**(142)**	**(123)**	***(3,769)***	**(4,461)**	**(4,434)**	**27**	**(6)**	***(15,205)***	**(17,846)**	**(16,431)**	**1,414**	**1,297**
Bank														
Admin & Clerical	4	17	13		*(56)*	(13)	(29)	(16)		*(246)*	(51)	(112)	(61)	
Allied Health Professionals	0	1	1		*(20)*	(3)	(4)	(1)		*(38)*	(12)	(14)	(3)	
Medical	0	5	5		*(114)*	(2)	(40)	(38)		*(210)*	(6)	(150)	(144)	
Nursing & Healthcare Assist	12	15	3		*(133)*	(42)	(27)	16		*(545)*	(169)	(129)	40	
Support Staff	7	1	(6)		*(7)*	(19)	(0)	19		*(23)*	(76)	(5)	71	
Bank Total	**24**	**40**	**16**		***(330)***	**(79)**	**(99)**	**(21)**		***(1,061)***	**(315)**	**(410)**	**(96)**	
Agency														
Admin & Clerical	0	1	1		*(82)*	(0)	(15)	(15)		*(226)*	(0)	(24)	(24)	
Allied Health Professionals	0	2	2		*(10)*	(1)	(3)	(2)		*(27)*	(3)	53	56	
Medical	0	0	(0)		*(55)*	(3)	(10)	(7)		*(216)*	(12)	(59)	(47)	
Nursing & Healthcare Assist	0	0	0		*(95)*	(16)	(5)	11		*(349)*	(65)	(79)	(14)	
Support Staff	0	0	0		*(6)*	0	(0)	(0)		*(19)*	(0)	6	6	
Agency Total	**0**	**3**	**3**		***(248)***	**(20)**	**(33)**	**(13)**		***(836)***	**(80)**	**(102)**	**(22)**	
Workforce Total	**1,075**	**952**	**(123)**		***(4,347)***	**(4,560)**	**(4,566)**	**(6)**		***(17,103)***	**(18,241)**	**(16,944)**	**1,297**	

In month figures show a break even position due to the finalisation of the budget setting process and is not a reflection of the in month performance. YTD shows a significant underspend due to lower levels of activity and pay budgets being set in excess of requirements to allow establishment continuity

The next steps will be to identify which vacant and non backfilled posts can be removed. This will not effect the run rate, but will reduce the ability to increase the run rate in the future. It will also help with improved business planning in future years.

The slight over establishement in AHP's is offset against Nursing in Perioperative.

Finance Report Month 4

Business Unit Performance Year to Date

1.1 Plastics

Year to Date £'000

	Plan	Actual	Variance
Income	192	189	(2)
Pay Expenditure	(2,536)	(2,461)	75
Non Pay Expenditure	(482)	(411)	71
	(2,827)	(2,683)	144

Narratives

Pay-YTD favourable variance driven by vacancies (1.47 A&C,0.82 Medical) agency spend has gone down with the departure of agency Plastic surgeon

Non Pay- Clinical supplies and Drugs with the respective underspend of £37k and £26k are main drivers behind the YTD underspend which are activity driven

1.2 Oral

Year to Date £'000

	Plan	Actual	Variance
Income	25	49	24
Pay Expenditure	(1,782)	(1,695)	87
Non Pay Expenditure	(750)	(488)	262
	(2,507)	(2,134)	373

Narratives

Pay- Vacancies not backfilled driving the YTD favourable variance (3.69 WTE A&C and 0.80 AHP)

Non Pay- Activity driven Clinical supplies underspend mainly Implants and

Sterile products chief contributors towards YTD underspend

1.3 Eyes

Year to Date £'000

	Plan	Actual	Variance
Income	37	41	4
Pay Expenditure	(684)	(616)	68
Non Pay Expenditure	(339)	(164)	175
	(986)	(739)	247

Narratives

Pay- 1.67 WTE Medical and 2.14 WTE A&C vacancies not fully backfilled driving the YTD favourable variance, service has not incurred any agency cost YTD

Non Pay- Proportionate to the activity Cost of Implants and contact lenses are substantially underspend YTD(£38k and £27k respectively) Drugs cost £56k underspend YTD

1.4 Sleep

Year to Date £'000

	Plan	Actual	Variance
Income	0	1	1
Pay Expenditure	(436)	(376)	60
Non Pay Expenditure	(671)	(294)	377
	(1,106)	(669)	437

Narratives

Pay- Medical vacancies (1.15 WTE) not backfilled is the main driver behind the YTD favourable variance

Non Pay- Underspend on High cost CPAP devices (380k) is the main contributing factor which is proportionate to the activity levels

1.5 Clinical Support

Year to Date £'000

	Plan	Actual	Variance
Income	127	150	23
Pay Expenditure	(2,530)	(2,326)	204
Non Pay Expenditure	(890)	(699)	191
	(3,294)	(2,875)	418

Narratives

Pay- High level of vacancies which are not fully backfilled resulting into YTD with 4.56 WTE Medical, 3.39 Healthcare Scientists and 2.00 AHP vacancies

Non Pay- Lower activity levels driving the underspend with cost of clinical supplies underspend by £119k and drugs by £37k

1.6 Perioperative Care

Year to Date £'000

	Plan	Actual	Variance
Income	19	37	17
Pay Expenditure	(3,494)	(3,095)	399
Non Pay Expenditure	(1,204)	(729)	476
	(4,679)	(3,787)	892

Narratives

Pay- The service is currently carrying 44 WTE vacancies mainly Nursing and Healthcare assistants which are not fully backfilled. Agency & Bank cost is down in line with activity levels

Non Pay- In line with activity, non pay cost is substantially underspend against the plan with clinical supplies £384k underspend against the plan and Drugs by £66k

1.7 Operational Nursing

Year to Date £'000

	Plan	Actual	Variance
Income	11	14	3
Pay Expenditure	(2,456)	(2,245)	211
Non Pay Expenditure	(342)	(259)	83
	(2,787)	(2,490)	297

Narratives

Pay- Vacancies at various levels within Burns (5.27 WTE), Canadian Wing (5.96) Corneoplastics (3.56 WTE) Maxillofacial (4.42 WTE) and Main Outpatients (3.61) not fully backfilled are driving the YTD underspend

Non Pay- In line with current levels of activity, clinical supplies are underspend by £50k, General supplies by £16k and Drugs by £6k

2.1 Access & Performance

Year to Date £'000

	Plan	Actual	Variance
Income	24	13	(10)
Pay Expenditure	(383)	(332)	51
Non Pay Expenditure	(46)	(23)	23
	(405)	(341)	64

Narratives

Pay-Underspend is driven by vacancies with Healthcare Records (4.89 WTE) and Cancer alliance funded posts within RTT and Cancer team (1.73 WTE)

Non Pay- There is £20k under spend on postage cost in line with current levels of activity

2.5 Director Of Nursing

Year to Date £'000

	Plan	Actual	Variance
Income	78	88	10
Pay Expenditure	(808)	(967)	(158)
Non Pay Expenditure	(509)	(870)	(360)
	(1,239)	(1,748)	(508)

Narratives

Overspend on both Pay and non pay driven by Covid19 related (Major Incident) for which YTD incurred Pay cost is £136k and Non pay cost £406k a total spend of £541k, excluding this cost the service would be £33k underspend

3.1 Non Clinical Infrastructure

Year to Date £'000

	Plan	Actual	Variance
Income	27	88	60
Pay Expenditure	(696)	(690)	6
Non Pay Expenditure	(1,161)	(1,247)	(86)
	(1,830)	(1,849)	(20)

Narratives

Income: YTD Overachievement is driven by Charity funded catering income

Non Pay- Overspend is driven mainly by unplanned and reactive maintenance cost

Corporate

Year to Date £'000

	Plan	Actual	Variance
Income	569	579	10
Pay Expenditure	(1,921)	(1,699)	222
Non Pay Expenditure	(615)	(620)	(5)
	(1,967)	(1,739)	228

Narratives

Pay Expenditure underspend driven by vacancies under IM&T, BIU, HR and Corporate services (Mainly Cancer alliance funded posts)

Corporate Inc. Finance, HR, Corporate

Capital – M4 2020/21

Queen Victoria Hospital NHS Foundation Trust

	Year to Date £'000			Forecast Outturn £'000			
	Plan	Actual	Variance	Original Plan	Revised Plan	Actual	Variance
Estates Projects							
Outpatients department upgrades	0	0	0	200	200	200	0
Replacement theatre pendants	0	0	0	150	150	150	0
Rehab. unit refurbishment	0	0	0	120	120	120	0
Fire door replacements	0	0	0	102	102	102	0
Critical infrastructure	0	0	0	0	500	500	0
Other	49	67	(18)	391	515	515	(0)
Total Estates Projects	**49**	**67**	**(18)**	**963**	**1,587**	**1,587**	**(0)**
Medical Equipment							
Fluoroscopy	0	0	0	396	396	396	0
Other	35	28	7	127	234	157	77
Toatl Medical Equipment	**35**	**28**	**7**	**523**	**630**	**553**	**77**
Information Management & Technology (IM&T)							
Clincal portal	0	0	0	372	372	372	0
Other	149	120	29	431	533	541	(7)
Total Information Management & Technology (IM&T)	**149**	**120**	**29**	**803**	**905**	**913**	**(7)**
Contingency				**738**	**405**	**474**	**(69)**
Total 2020/21 Programme	**233**	**215**	**18**	**3,027**	**3,527**	**3,527**	**(0)**
Covid-19 Expenditure	160	160	0		634	634	0
Total Capital	**393**	**375**	**18**		**4,161**	**4,161**	**0**

The 2020/21 capital programme was originally set at £3,027k, excluding Covid-19 expenditure. This was QVH's apportioned share of the overall Sussex and East Surrey STP capital envelope allocated by NHSE/I and was funded from the Trust's own resources, i.e. depreciation. In July a further £500k funding was secured for improvements to critical infrastructure.

Capital expenditure incurred as a result of Covid-19 requires approval at national level, as yet no approval has been secured and the Trust has continued at risk. Year to date and forecast expenditure shown here is still awaiting final approval and is therefore at risk. Phase 3 capital requirements are currently being calculated.

Balance Sheet – M4 2020/21

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet

	Prior Year Outturn	Month 3	Month 4	Change In Month	Change In Year
Non Current Assets					
Fixed Assets	52,655	52,064	51,861	(203)	(793)
Other Receivables	227	227	227	0	0
Total Non Current Assets	**52,882**	**52,291**	**52,088**	**(203)**	**(793)**
Current Assets					
Inventories	1,153	1,150	1,140	(10)	(12)
Trade and other Receviables	8,543	6,226	5,332	(894)	(3,211)
Cash and Cash Equivalents	2,910	9,792	10,300	508	7,389
Total Current Assets	**12,606**	**17,168**	**16,772**	**(396)**	**4,166**
Current Liabilities					
Trade and other Payables	(11,792)	(8,992)	(8,293)	699	3,499
Borrowings	(7,332)	(7,297)	(7,308)	(11)	24
Provisions	(62)	(62)	(62)	0	0
Other Liabilities	(437)	(7,668)	(7,684)	(16)	(7,247)
Total Current Liabilities	**(19,622)**	**(24,018)**	**(23,347)**	**0**	**(4,396)**
Subtotal Net Current Assets	**(7,016)**	**(6,851)**	**(6,575)**	**(396)**	**(230)**
Total Assets less Current liabilties	**45,865**	**45,441**	**45,513**	**(599)**	**(1,024)**
Non Current Liabilties					
Provisions	(881)	(881)	(881)	0	0
Borrowings	(4,512)	(4,123)	(4,123)	0	389
Total Non Current Liabilties	**(5,393)**	**(5,004)**	**(5,004)**	**0**	**389**
Total assets Employed	**40,472**	**40,437**	**40,509**	**(599)**	**(635)**
Tax Payers Equity					
Public Dividend Capital	13,106	13,106	13,144	38	38
Revaluation Reserve	13,689	13,689	13,688	(1)	(1)
Income and Expenditure Reserve	13,677	13,642	13,678	36	1
Total Tax Payers Equity	**40,472**	**40,437**	**40,509**	**72**	**37**

Non current assets have reduced in value over the year in line with the capital plan profile.

Trade receivables has reduced in year as the block income regime has reduced the need for activity invoicing and avoids delay in payment. Cash held is higher than previous balances due to the current DHSC operating regime of monthly advance block funding receipts (approx. 6.1m) and a surplus operating position.

Trade payables has reduced in year reflecting steps to clear process and authorise payables and also reduced activity.

Current borrowings mainly reflect the NHSi revenue support loans taken last year to support the previous cash deficit operating position.

These revenue loans of £6.391m will not be payable in cash but will be redeemed through the issue of public dividend capital later in the year.

Other liabilities reflects the receipt in advance of £6m of monthly block income. This is "deferred income" and is only a nominal timing liability.

Non current borrowings have been reduced in year by repayment of £389k of the principal of the theatre loan.

Public dividend capital has increased by £38k following receipt of PDC capital cash from DHSC for Covid related capital funding 2019-20.

The forecast outturn will be updated following the resumption and completion of 20-21 operational planning process.

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance Month 4 2020/21

Cashflow Report

	Actual £'000				Forecast £'000							
	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Opening Balance	**2,911**	**7,874**	**9,571**	**9,791**	**10,300**	**10,570**	**9,445**	**9,714**	**9,984**	**9,800**	**10,070**	**10,340**
Receipts												
Receipts from contract income	11,713	6,842	6,042	6,575	5,543	5,543	5,543	5,543	5,543	5,543	5,543	5,543
Top up block income	1,113	557	557	557	557	16	557	557	557	557	557	557
Receipts from other income	132	439	76	190	209	209	209	209	209	209	209	209
Public Dividend Capital Received	0	0	0	39	0	0	0	0	0	0	0	0
PDC Cash Support Received	0	0	0	0	0	0	0	0	0	0	0	0
Total Receipts	**12,958**	**7,838**	**6,675**	**7,361**	**6,309**	**5,768**	**6,309**	**6,309**	**6,309**	**6,309**	**6,309**	**6,309**
Payments												
Payments to NHS Bodies	(453)	(254)	(356)	(1,445)	(400)	(400)	(400)	(400)	(400)	(400)	(400)	(400)
Payments to non-NHS bodies	(3,440)	(1,789)	(1,602)	(1,273)	(1,546)	(1,546)	(1,546)	(1,546)	(1,546)	(1,546)	(1,546)	(1,546)
Net payroll payment	(2,333)	(2,261)	(2,280)	(2,331)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)
Payroll Taxes	(1,113)	(1,154)	(1,082)	(1,126)	(1,120)	(1,120)	(1,120)	(1,120)	(1,120)	(1,120)	(1,120)	(1,120)
Pensions Payment	(656)	(683)	(675)	(677)	(673)	(673)	(673)	(673)	(673)	(673)	(673)	(673)
PDC Dividends Payment	-	-	-	-	-	(854)	-	-	-	-	-	(854)
Capital Loan Interest & Repayment	-	-	(460)	0	-	-	-	-	(454)	-	-	-
Total Payments	**(7,995)**	**(6,141)**	**(6,455)**	**(6,852)**	**(6,039)**	**(6,893)**	**(6,039)**	**(6,039)**	**(6,493)**	**(6,039)**	**(6,039)**	**(6,893)**
Net Cash Movement	**4,963**	**1,697**	**220**	**509**	**270**	**(1,125)**	**270**	**270**	**(184)**	**270**	**270**	**(584)**
Actual Closing Balance	**7,874**	**9,571**	**9,791**	**10,300**								
Forecast Closing Balance					**10,570**	**9,445**	**9,714**	**9,984**	**9,800**	**10,070**	**10,340**	**9,755**
20/21 NHSI Plan	**1,556**	**1,652**	**1,333**	**1,490**	**1,466**	**1,069**	**1,395**	**1,766**	**1,067**	**1,012**	**1,083**	**1,263**
Variance to NHSI Plan	n/app	n/app	n/app	n/app	n/app	n/app	n/app	n/app	n/app	n/app	n/app	n/app

There is currently a high cash balance which covers about 1.5 months of average spend. This is due to the current covid response finance regime of block payment in advance (being £5.5m per month) and receipt of block top up payments ahead of need. There is also receipt of some prior year contract performance income.

Payments to NHS bodies was high in July due to the resolution of a significant number of queries on AP invoices.

The cash position will continue to be reviewed and managed on a daily basis and loan requirements assessed monthly.

Financial services will work with commissioners and other providers to ensure payments are made in a timely manner and older debts controlled.

The NHSi Operating Plan has been superseded by the Covid regime and so is left here as a note only and not a performance to plan measure.

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance Month 4 2020/21

Debtors

	Aug 19/20 £'000	Sep 19/20 £'000	Oct 19/20 £'000	Nov 19/20 £'000	Dec 19/20 £'000	Jan 19/20 £000	Feb 19/20 £000	Mar 19/20 £000	Apr 20/21 £000	May 20/21 £'000	Jun 20/21 £'000	Jul 20/21 £'000	In Month Change £000
NHS Debtors													
0-30 Days Past Invoice Due Date	736	2,417	2,051	778	918	774	2,477	3,570	2,277	345	222	221	(0)
31-60 Days Past Invoice Due Date	384	(506)	124	601	139	156	(150)	(86)	242	1,769	70	75	5
61-90 Days Past Invoice Due Date	(72)	148	87	385	741	103	75	20	376	(276)	1,466	112	(1,354)
Over 90 Days Past Invoice Due Date	2,234	2,348	1,458	1,913	2,062	2,640	2,658	1,935	2,307	2,609	2,586	3,840	1,254
Total NHS Debtors	**3,282**	**4,408**	**3,721**	**3,677**	**3,861**	**3,673**	**5,061**	**5,440**	**5,202**	**4,447**	**4,343**	**4,248**	(96)
Non NHS Debtors													
0-30 Days Past Invoice Due Date	78	68	76	190	164	245	155	757	709	80	147	150	3
31-60 Days Past Invoice Due Date	26	17	9	3	10	107	17	7	112	596	184	16	(168)
61-90 Days Past Invoice Due Date	146	28	12	1	3	5	88	17	7	110	130	21	(109)
Over 90 Days Past Invoice Due Date	755	647	674	707	406	422	367	474	461	340	434	556	122
Total Non NHS Debtors	**1,006**	**759**	**771**	**902**	**582**	**779**	**626**	**1,256**	**1,288**	**1,126**	**896**	**743**	(152)
Other Debtors Less Than One Year	2,262	1,873	2,389	1,976	1,881	1,495	1,558	1,847	7,787	14,008	19,642	341	
Total Debtors	**6,550**	**7,040**	**6,881**	**6,555**	**6,324**	**5,947**	**7,245**	**8,542**	**14,278**	**19,581**	**24,881**	**5,332**	
NHS : Non NHS ratio	*0.77*	*0.85*	*0.83*	*0.80*	*0.87*	*0.82*	*0.89*	*0.81*	*0.80*	*0.80*	*0.83*	*0.85*	

The month 4 total debtor balance of £5.3m is 26% lower than the average monthly balance of £7.2m in 2019-20. This is largely due to the covid block regime that removes the time lags created by flex and freeze arrangements.

The Trade debtors balance reduced by £0.25m (6%) from month 3. The top 5 NHS Debtors are NHS England, Brighton and Sussex University Hospital, Health Education England, Surrey and Sussex Healthcare and NHS Coastal West Sussex CCG. The top Non NHS debtors are Sussex Community Dermatology Service and Surrey and Sussex Cancer Alliance. Financial services will continue to review Aged Debts with the aim of resolving any disputes.

Next Step- Financial Services would continue working closely with Business Managers and the Contracting team to ensure billing is accurate, timely and resolutions to queries are being actively pursued.

Creditors- M4 2020/21

Queen Victoria Hospital NHS
NHS Foundation Trust

Creditors

	Aug 19/20 £'000	Sep 19/20 £'000	Oct 19/20 £'000	Nov 19/20 £'000	Dec 19/20 £'000	Jan 19/20 £000	Feb 19/20 £000	Mar 19/20 £000	Apr 20/21 £000	May 20/21 £'000	Jun 20/21 £'000	Jul 20/21 £'000	In Month Change £'000
NHS Creditors													
0-30 Days Past Invoice Due Date	830	474	636	818	497	665	663	950	1,115	1,182	558	446	(112)
31-60 Days Past Invoice Due Date	88	593	195	84	483	122	35	485	165	163	133	107	(26)
61-90 Days Past Invoice Due Date	75	74	620	208	138	568	135	44	416	412	769	66	(703)
Over 90 Days Past Invoice Due Date	1,081	1,048	1,160	1,480	1,541	1,399	1,669	1,806	1,790	1,821	2,250	1,772	(478)
Total NHS Creditors	**2,073**	**2,189**	**2,612**	**2,591**	**2,660**	**2,754**	**2,503**	**3,285**	**3,486**	**3,577**	**3,711**	**2,391**	**(1,320)**
Non NHS Creditors													
0-30 Days Past Invoice Due Date	1,448	741	1,243	1,316	1,510	1,293	2,080	2,318	993	764	402	358	(44)
31-60 Days Past Invoice Due Date	94	147	229	252	208	109	87	149	170	72	57	146	89
61-90 Days Past Invoice Due Date	115	103	95	15	78	238	178	78	20	7	75	35	(40)
Over 90 Days Past Invoice Due Date	263	204	202	163	278	245	117	266	230	111	153	10	(143)
Total Non NHS Creditors	**1,922**	**1,196**	**1,769**	**1,746**	**2,074**	**1,885**	**2,462**	**2,811**	**1,414**	**954**	**688**	**550**	**(138)**
Other Creditors Less Than One Year	(858)	(55)	(530)	(214)	(941)	(973)	(860)	(660)	(570)	(716)	(548)	(74)	
Total Creditors	**3,136**	**3,330**	**3,851**	**4,123**	**3,792**	**3,666**	**4,105**	**5,435**	**4,330**	**3,816**	**3,850**	**2,867**	
NHS : Non NHS ratio	***0.52***	***0.65***	***0.60***	***0.60***	***0.56***	***0.59***	***0.50***	***0.54***	***0.71***	***0.79***	***0.84***	***0.81***	

The total creditors balance at month 4 is £2.9m compared to an average of £4.0m during 2019-20.

The Trade creditors balance reduced by £1.5m (33%) from month 3. This is largely due to payments made to Medway NHS Foundation Trust, Brighton And Sussex University Hospitals NHS Trust and Dartford And Gravesham NHS Trust for invoices which had previously been on hold but have now been resolved. The top 5 NHS Creditors are Dartford And Gravesham NHS Trust, Medway, East Sussex Healthcare NHS Trust, Medway NHS Foundation Trust, Brighton And Sussex University Hospitals NHS Trust and East Kent Hospitals University NHS Foundation Trust.

.The Trust's BPPC percentage has increased in month by 8% and the average days to payment has reduced to 28 days.

Next Steps

Financial services will continue to review older NHS SLA balances with our key partner Trusts with the aim of resolving any disputes. Financial services are continuing to review areas where invoice authorisation is delayed in order to target and support training needs. NHSI/E has released guidance to speed up payments in light of the Covid crisis. The team are working with all budget holder to clear invoices as quickly as possible.

Queen Victoria Hospital
NHS Foundation Trust

Budget Setting Update 20/21

Michelle Miles – Director of Finance and Performance

Budget setting update

Queen Victoria Hospital NHS
NHS Foundation Trust

This paper is to provide an update on the 2020/21 Budget setting process and approval for the current financial regime. Further updates will be required when the financial guidance for Phase 3 of the plan is released. These budgets are based upon current funding arrangements and the current approved establishment levels within the Trust. Budgets have been reviewed and signed off with all budget holders. The principles for reviewing and signing the budgets were as follows.

Income

- Budget for Block contract to be set in line with current block payments for months 1-7 extrapolated.
- Provider to provider contracts budgets to be set based on current contract levels
- Other income to be reviewed during block contract arrangement period and budget set as appropriate including HEE income etc.
- Top up of the block contract (This is not a retrospective top up as current spend is below income levels)
- Income apart from service specific to be held centrally in this financial year.

Pay

- 19/20 Budget based on original Budget which equated to the WTE (Appendix 1)
- Agreed Cost pressures – as reviewed by EMT
- Incremental drift & Inflation
- 20/21 Budget

Non Pay

- 19/20 Outturn
- 19/20 Non recurrent items adjustments
- 19/20 Recurrent Baseline
- Agreed Cost Pressures
- Inflation
- CNST
- 20/21 Budget

Budget setting update

Queen Victoria Hospital NHS
NHS Foundation Trust

Final Accounts Line		20-21 Start Position	Non Recurrent Items-Full Years Value	Cost Pressures	Incremental Drift & Pay inflation	Non Pay Inflation	CNST Contribution inflation	Reserves	20/21 Budgets
Income	Patient Activity Income	68,065							68,065
	Other Income	2,365							2,365
	Comprehensive Income	0							0
	Top- Up Payment	6,679							6,679
Total		**77,109**	**0**	**0**	**0**	**0**	**0**	**0**	**77,109**
Pay	Substantive	51,445		248	1,310			400	53,403
	Bank	819		47	79				945
	Agency	218		0	64				282
Total		**52,482**	**0**	**295**	**1,453**	**0**	**0**	**400**	**54,630**
Non Pay	Clinical Services & Supplies	12,900	(1,307)	269	0	178	0		12,040
	Consultancy	204	(4)		0	3	0		203
	Drugs	1,472			0		0		1,472
	Other non pay	9,470	(232)	408	0	108	24		9,778
	Financing	4,993	0	720	0	75	0	0	5,788
Total		**29,039**	**(1,543)**	**1,397**	**0**	**364**	**24**	**0**	**29,281**
Surplus/(Deficit)		**(4,412)**	**1,543**	**(1,692)**	**(1,453)**	**(364)**	**(24)**	**(400)**	**(6,802)**

Income:

Patient Income: Block payment for M1-7 extrapolated

Other Income: mainly education & training (inc. CEAs), R&D and estates income e.g. catering/parking etc.

Top – Up Payment for Covid

Pay: Budget set at 19/20 budget, this is £3.8m higher than 19/20 outturn. 19/20 had a favourable variance compared to the original budget, the based budget for 20/21 was based upon the 19/20 original budget due to the establishment levels being clear – further work will be required to remove where vacancies can be removed.

The budgets presented does not include any additional income or expenditure required from the Recover and restore work. Work is ongoing to assess the impact.

Budget setting update

Queen Victoria Hospital NHS
NHS Foundation Trust

This year to date position is break even in line with national guidance. However due to lower levels of pay and non pay spend compared to the top up payment has had to be reduced by c£500k to allow us to report a break even position. IE at present the Trust is currently in a surplus position with the current levels of spend and block payment arrangements.

This is in contrast of the budgets that have been agreed based on the agreement methodology. This approach leads to a deficit budget of £6.8m. However

- This position is reflective of the pay budgets starting position £1.5m higher than 19/20 outturn so that the agreed establishment is known and consistent. As previously reported significant work will be needed in the removal of vacant posts in the following areas
    - Clinical Support
    - Operational Nursing
    - Clinical Infrastructure
    - Director of Nursing
- Further details of the current financial outcomes can be seen in the month 4 Board Report
- This budget setting position includes a contingency of £400k and £700k for outsourcing capacity.
- Phase 3 financial guidance will include restarting efficiencies, at present the level of require efficiencies is yet unknown.
- For 20/21 the ICS will be allocated a financial envelope, the ICS will need to breakeven in total. As yet the financial envelope is not known.
- Financial penalties will be applied if the required levels of activity are not met in phase 3 – this is again the ICS as a total.
- Financial plans will be submitted on the 7th of September and the 24th of September, full guidance is still awaited.

Appendix

Prior year outturn

Queen Victoria Hospital NHS
NHS Foundation Trust

Final Accounts Line	Board Line	Annual budget 19-20	Revised budget 19-20	Outturn 2019-20	Variance v's Original Budget	Variance v's Revised Budget
Income	Patient Activity Income	67,689	64,592	66,804	885	(2,212)
	Other Income	4,734	4,723	3,440	1,294	1,283
	Comprehensive Income			665	(665)	(665)
	Top- Up Payment				0	0
Total		**72,424**	**69,315**	**70,909**	**1,515**	**(1,594)**
Pay	Substantive	51,445	45,739	45,587	5,858	152
	Bank	819	2,742	2,879	(2,060)	(137)
	Agency	218	2,357	2,361	(2,143)	(4)
Total		**52,482**	**50,838**	**50,827**	**1,655**	**11**
Non Pay	Clinical Services & Supplies	12,860	13,138	12,900	(40)	238
	Consultancy	96	207	204	(108)	3
	Depreciation and amortisation				0	0
	Drugs	1,532	1,485	1,472	60	13
	Non Operating Income				0	0
	Non Operational Expenditure				0	0
	Other non pay	7,892	8,162	9,470	(1,578)	(1,308)
	Financing	4,766	4,691	5,221	(455)	(530)
Total		**27,146**	**27,683**	**29,267**	**(2,121)**	**(1,584)**
Surplus/(Deficit)		**(7,204)**	**(9,206)**	**(9,185)**	**1,981**	**(21)**

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed 25th August 2020

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 1) Trust is not able to recruit and retain workforce with right skills at the right time.
2.In a complex and changing health system commissioner or provider led changes in patient pathways, service specifications and location of services may have an unintended negative impact on patient experience.

Risk Appetite The Trust has a **moderate appetite** for risks that impact on patient experience but it is higher than the appetite for those that impact on patient safety. This recognises that when patient experience is in conflict with providing a safe service safety will always be the highest priority

Rationale for risk current score

- Compliance with regulatory standards
- Meeting national quality standards/bench marks
- Very strong FFT recommendations
- Sustained excellent performance in CQC 2019 inpatient survey, trust continues to be in the group who performed much better than national average
- Patient safety incidents triangulated with complaints and outcomes monthly no early warning triggers
- International recruitment continues staff now embedded in workforce
- Not meeting RTT18 and 52 week Performance and access standards but meeting agreed recovery trajectories
- Sustained CQC rating of good overall and outstanding for care

Initial Risk	4(C) x 2(L) = 8 low
Current Risk Rating	3(C) x 4(L) = 12 mod
Target Risk Rating	3(C) x 3(L) = 9 low

Future risks

- Additional ~~Unknown impact on~~ patients with longer waiting times and additional52 week breaches , due to COVID-19 , new CHR process being developed
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility.
- Developing new health care roles -will change skill mix
- Impact of Sussex partnership plans on QVH clinical and non clinical strategies
- Impact of Covid-19 pandemic on patient experience

Future Opportunities

- international recruitment with another local Trust

Controls / assurance

- Robust Governance and clinical quality standards managed and monitored at the Q&GC, CGG and the JHGM, safer nursing care metrics, FFT and annual CQC audits , 6/12 CIP
- External assurance and assessment undertaken by regulator and commissioners
- Quality Strategy, Quality Report, CQUINS, low complaint numbers
- Benchmarking of services against NICE guidance, and priority audits undertaken
- Trust recruitment and retention strategy mobilised, NHSI nursing retention initiative.
- Burns and Paediatric services not currently meeting all national guidance. CCG and Regulators fully aware of this, mitigation in place including interim divert of inpatient paed burns from 1 August via existing referral pathway. No inpatient paeds during pandemic
- QVH simulation faculty to enhance safety and learning culture in theatres
- Working with NHS E on inpatient paediatric burns service move and presentation at KSS HOSC chairs meeting / communication with SE burns network, COG, regulators and Healthwatch July 2019
- Compiling Burn Case for Change in collaboration with BSUH AND NHSE
- New R&R governance group approving clinical changes, established amber and green pathways in theatres, staff screening lab being mobilised, comprehensive IPC board assurance document, patient screening pathways updated each time new guidance issues, breast and virtual clinic patient questionnaire introduced.

Gaps in controls / assurance

- Unknown Specialist commissioning intention for some of QVH services eg inpatient paediatric Sussex based service and head and neck pathway 968,1059
- Full patient assurance about management of covid-19 risks associated with hospital attendance/admission
- ~~National pause of FFT~~
- Administrative process of trauma activity at TMC 1187

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Date last reviewed: 24th August 2020

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 research and innovation.

Risk
Patients, clinicians & commissioners lose confidence in services due to inability to show external assurance by outcome measurement, reduction in research output, fall in teaching standards., or lack of effective clinical governance.

Risk Appetite. The trust has a **low appetite for risks that impact on patient safety**, which is of the highest priority. The trust has a moderate appetite for risks in innovation of clinical practice, research and education methodology, if patient safety is maintained.

Initial Risk Rating 5(C)x3(L) =15, moderate
Current Risk Rating 4(C)x4(L)=16, moderate
Target Risk Rating 4(C)x2 L) = 8, low

Rationale for current score

- Adult burns ITU and paediatric burn derogation
- Paediatric inpatient standards and co-location
- Compliance with 7 day services standards
- Spoke site clinical governance.
- Sleep disorder centre staffing of medical staff ~~and sleep physiologists~~
- Histopathology and radiology consultant staffing
- Non-compliant RTT 18 week and increasing 52 week breaches due to COVID-19
- Commissioning and STP reconfiguration of head and neck services
- ~~CCU – network arrangements for CPD and support require further development~~
- COVID-19. QVH undertaking head/neck cancer, breast cancer, skin cancer. ~~Trauma undertaken at McIndoe Centre by QVH staff~~
- COVID-19-new urgently developed regional referral pathways, reduced availability of routine surgery (eg, breast reconstruction, orthognathic, dentoalveolar), hon contracts for surgeons from other trusts coming to operate on their cases at QVH
- Restoration & recovery: risk stratification and prioritisation of patients for surgery.

Future Risks

- ICS and NHSE re-configuration of services and specialised commissioning future intentions.
- Commissioning risks to lower priority services – sleep, orthognathic surgery
- Commissioning risks to major head and neck surgery

Future Opportunities

- Sussex Acute Care Network Collaboration
- ICS networks and collaboration
- Efficient team job planning
- Research collaboration with BSMS
- ~~CEA scheme and potential for incentive~~
- New services – glaucoma, virtual clinics & sentinel node expansion, transgender facial surgery
- Multi-disciplinary education, human factors training and simulation
- QVH-led specialised commissioning
- E-Obs and easier access to systems data

Controls and assurances:

- Clinical governance leads and reporting structure
- Clinical indicators, NICE reviews and implementation
- Relevant staff engaged in risks OOH and management
- Networks for QVH cover-e.g. burns, surgery, imaging, lower limb and trauma
- Training and supervision of all trainees with deanery model
- ~~Creation of QVH Clinical Research strategy~~
- Local Academic Board, Local Faculty Groups and Educational Supervisors
- Electronic job planning
- Harm reviews of 52+ week waits
- Temporary diversion of inpatient paediatric burns patients to alternative network providers

Gaps in controls and assurances:

- ~~Limited extent of reporting /evidence on internal and external standards~~
- Link between internal data systems & external audit requirements & programs
- Creation of QVH clinical research strategy
- Limited data from spokes/lack of service specifications
- ~~Scope of delivering and monitoring seven day services (OOH), particularly those provided by other trusts (RR845)~~
- ~~Plan for sustainable ITU on QVH site (CRR1059)~~
- Achieving sustainable research investment
- ~~Balance service delivery with medical training cost (CRR789)~~
- ~~Detailed prospective partnership agreement with acute hospital (CRR1059)~~
- Sleep disorder centre sustainable medical staffing model & network
- Inadequate Consultant radiologist cover (CRR 1163)
- Significantly reduced Consultant Histopathologist cover (CRR 1168)

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03.09.20**		**Agenda reference:**	**134-20**	
Report title:	**Quality and governance assurance**				
Sponsor:	Karen Norman, committee chair				
Author:	Karen Norman, committee chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the board on quality and governance assurance issues (by exception) arising since the last Board meeting on 02.07.20				
Summary of key issues	1) Assurance issues arising from the Q&GC annual reports, (MRSA screening, poor compliance with infection control policies, EPRR issues, data security and medical devices). 2) Issues arising from the Covid-19 pandemic, and matters requiring further assurance 3) Findings of SI/NE reviews and need to strengthen compliance with WHO checklist.				
Recommendation:	The Board is asked to **NOTE** this report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	The Committee received updates on relevant BAF summaries and was assured of appropriate revisions to the Corporate Risk Register and the BAF reviews, in line with assurance issues raised within the reporting period.				
Corporate risk register:	To consider a recommendation to maintain existing risk threshold of CRR at 12.				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2008 and the CQC essential standards of quality and safety.				
Legal:	As above				
Resources:	N/A				
Assurance route					
Previously considered by:	Items raised considered by relevant sub-committees as detailed in Q&GC minutes.				
	Date:	As above	Decision:		

Previously considered by:				
	Date:		Decision:	

Report to:	Board Directors
Agenda item:	**134-20**
Date of meeting:	16.7.20 (Annual Reports) 20.8.20 (Q&GC)
Report from:	Karen Norman
Report author:	Karen Norman
Date of report:	26 August 2020
Appendices:	None

1)Quality and governance assurance

Annual Reports.

The Q&GC held its annual Extraordinary Meeting to receive the annual reports from its sub-committees and other relevant areas of responsibility identified its annual work plan. Members took into account the increase in workload in many of these areas as a consequence of responding to the Covid-19 Pandemic and service reconfigurations required on site, commending all for the progress demonstrated in year.

The list below confirms reports received, noted, and/or approved.

A brief summary (by exception) is also provided below for areas where further assurance was sought, which the committee wished to bring to the attention of the board.

1) Patient Safety annual report 2019/20. Received and approved.
2) Health and Safety annual report 2019/20. Received and approved. Q&GC noted plans to revise the strategy and the need for a confirmation of the timeframe.
3) Infection Prevention and Control annual report 2019/20. Received and recommended for submission to the board in its current format. Further assurance sought regarding need for improvement with regard to compliance with MRSA screening, compliance with hand hygiene, bare below the elbow policy and dress code policy.
4) Clinical Audit annual report 2019/20. Received and approved
5) Research and Development annual report 2019/20. Received and approved.
6) Safeguarding (adults and children) annual report 2019/20. Received and approved,.
7) Patient experience annual report 2019/20. Approved and recommended for submission to the board,
8) Emergency preparedness, resilience and response and business continuity annual report 2019/20. Received and approved and items for further assurance with regard to partial compliance noted.(See below).
9) Information governance annual report 2019/20. Received, noting it was not anticipated the Trust will meet data security standard one: staff training as required by NHS Digital. Further assurance on this item was requested from EMT and also regarding access to IT spine links regarding child protection.
10) Medical devices annual report 2019/20. Received, with further assurance sought from EMT regarding a strategy for upgrading devices and capacity of IT Team to service these. Further assurance also sought regarding timely staff training for use of medical devices.
11) Medication safety annual report 2019/20. This report was approved by the medicines management group for submission to Q&GC. Q&GC took assurance from the report.
12) Antimicrobial annual report 2019/20. Received for assurance.
13) Appraisal and revalidation report 2019/20. Received.

14) Guardian of safe working annual report 2019/20. Received. Noted the concerns regarding the impact of Covid-19 on educational opportunities in practice for trainees.

2) Matters raised in meeting of 20.8.20.

The Q&GC wish to bring the following matters (by exception) from those considered at our meeting to the attention of the Board.

2.1 Covid-19 Update
Assurance was taken from the comprehensive detail in the NHSE Infection Prevention and Control Document submitted for Q&GC's consideration. The committee accepted the recommendation that this document be submitted in full to the board for assurance, following advice that this is the process followed in most other Trusts.
Assurance was offered confirming the Recovery & Restoration (R&R) Clinical Governance Group, which is now well-established and planning for services to safely resume. The group comprises of clinical, managerial and expert staff with links strategic groups such as the Cancer Alliance, operational R&R group and CNO Groups. This provides QVH with a wider reference for advice, support and scrutiny for decisions taken, as evidenced by the change in national guidance around patients self-isolating.
Assurance was given that should the Optigene technology fail or swabs not be available, QVH could revert back to the amber and green pathways. However, Q&GC were advised this would have an impact on efficiency.
In response to questions regarding the impact of the return of the Trauma work on site and undertaking cancer work for other organisations, Q&GC noted with concern the significant impact this will have on our waiting lists. Other risks for the Trust in terms of recovery noted were: reduced theatre capacity through infection control requirements, theatre/anaesthetic workforce capacity, utilisation of capacity due to isolation requirements, and our reduced ability to maximise short notice cancellations. Getting patients to attend the hospital because of their concerns about Covid-19 was acknowledged as a significant challenge. However, assurance was taken from noting that our pathways include guidance for clinicians regarding advising patients of the comparative risks from Covid and any potential consequences to delaying their treatment, so that patients can make an informed decision about how they wish to proceed.
Assurance was given that risk stratification for admitted PTL is now complete and that the Clinical Senate is working well. The Medical Director confirmed the arrangements for strengthening the process of clinical harm reviews in anticipation of the need for these increasing as waiting lists rise.

2.2.Serious incident and never event review
Three reports were received.
Progression of the effective use of the World Health Organisation (WHO) checklist
Q&GC welcomed this report and progress made, given that issues contained therein have featured as contributing factors in a number of recent incident investigations. It noted the author had concerns with respect to the need for further progress, specifically with regard to non-compliance with Operating Theatre 'sign outs'. Q&GC supported the importance of the resolution of this issue and confirmed that the item will remain on the agenda for ongoing scrutiny and assurance until compliance is achieved.
Serious Incident Investigation (Never Event)
The report outlined the investigation into an incident which concluded this was a wholly preventable case of wrong site block and surgery. Lessons learned and actions planned were noted, as was the fact that these reflected similar findings to other recent incidents and also in the above cited report on compliance with the WHO checklist.
Serious Incident Investigation (Formal Internal Investigation)
This report detailed the investigation of a data protection incident. The report concluded a case of human error and lack of a double checking process in place, which led to an avoidable data breech, affecting one patient, who has been informed and apologies given. Assurance was given that a new Standard Operating Procedure has since been drafted. It was declared as a serious incident with the ICO, who have noted the actions taken, made recommendations which have been incorporated into our action plan and confirmed they do not wish to take any further action. The report was approved by Q&GC for submission to CCG.

Corporate Risk Register (CRR) (risks scoring 12 and above)
Q&GC considered Internal Audit's observation that a number of risks on our CRR are scored as 12. It considered their recommendation to either conduct a one-time review and increase or decrease the score of all of risks or to increase the corporate risk register threshold score to 15 or above. Q&GC agreed they recommend to the board that the threshold for the corporate risk register score remains at a risk score of 12.

2.3 Emergency preparedness, resilience and response and business continuity
Our EPRR lead noted actions in progress to address the issues of partial compliance reported in the EPRR annual report, confirming the importance of the need to update our lockdown policy and plans to ensure this and other items required for full compliance are completed expediently. It is a concern that their resolution is often dependent on the same staff who are currently heavily involved in dealing with the Covid pandemic.
Since our Q&GC meeting, the CCG have confirmed that we can expect our annual letter regarding EPRR assurance in early September. It is anticipated that normal core standards will be set aside in favour of an assurance statement, which should contain reference to winter preparedness and our Covid response for submission to NHSE by 31 October. They have advised that there does not appear to be a requirement for the board to sign this off this year.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/09/20 2020**		**Agenda reference:**	**135-20**	
Report title:	**Corporate Risk Register**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Karen Carter-Woods, Head of Risk and Patient Safety				
Appendices:	None				
Executive summary					
Purpose of report:	For assurance that the Trust risk management process is being followed; new risks identified and current risks reviewed and updated in a timely way.				
Summary of key issues	Key changes to the CRR this period: • One new corporate risk added • Two corporate risks rescored: both moving to LRR				
Recommendation:	The Board is asked to note the Corporate Risk Register information and the progress from the previous report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	The entire BAF has been reviewed by EMT alongside the CRR, The corresponding KSOs have been linked to the corporate risks.				
Corporate risk register:	This document				
Regulation:	All NHS trust are required to have a corporate risk register and systems in HMT place to identify & manage risk effectively.				
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.				
Resources:	Actions required are currently being delivered within existing trust resources				
Assurance route					
Previously considered by:	The Corporate Risk Register is reviewed monthly by EMT				
	Date:	10/8/20	Decision:	Reviewed and updated	
Previously considered by:	Q&GC				
	Date:	**20/08/20**	Decision:	For assurance	

Corporate Risk Register Report
June and July 2020 Data

Key updates

Corporate Risks added between 01/06/2020 and 31/07/2020: 1

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x4=12	1187	Administrative processes relating to QVH trauma activity taking place at The McIndoe Centre	Director of Operations

Corporate Risks closed this period: Nil

No of Corporate Risks rescored this period: 2

Risk ID	Service / Directorate	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore	Committee where change(s) agreed/ proposed
1170	Ops	Understaffing within Appointments Team	3x4=12	2x3=6	Two new staff recruited into the team. In addition, attendance levels (including sickness and maternity) have improved	R/V by Director of Ops
1122	Plastics	Sentinel Node Biopsy: increase in demand	3x4=12	3x3=9	June 2020 - Capacity in place due to cancer hub status	R/V by Director of Ops

The Corporate Risk Register is reviewed monthly at Executive Management Team meetings (EMT), quarterly at Hospital Management Team meetings (HMT) and presented at Quality & Governance Committee meetings for assurance. It is also scheduled bimonthly in the public section of the Trust Board.

Risk Register management

There are 70 risks currently on the Trust Risk Register as at 10th August 2020, of which 17 are corporate, with the following modifications occurring during this reporting period (June / July):

- Six new risks added: one corporate
- Six risks closed: all local
- Two risks rescored: both corporate reducing to Local RR

Risk registers are reviewed & updated at the Specialty Governance Meetings, Team Meetings and with individual risk owners including regrading of scores and closures; risk register management shows ongoing improvement as staff own & manage their respective risks accordingly.

Risk Register Heat map

The heat map shows the 70 risks open on the trust risk registers: risks that score 12 or more are managed via the Corporate Risk Register.
Six of the 17 corporate risks are within the higher grading category:

	No harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2		1	9	3	2
Possible 3		4	30	3 ID: 968, 1152, 1182	
Likely 4		2	8 ID: 1040, 1077, 1117, 1136, 1139, 1148, 1168, 1187	4 ID: 1125, 1163, 1167, 1179	0
Certain 5		2	1 ID1140	0	1 ID: 877

Implications of results reported

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

Action required

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

Link to Key Strategic Objectives

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

5. The attached risks can be seen to impact on all the Trust's KSOs.

Implications for BAF or Corporate Risk Register

6. Significant corporate risks have been triangulated with the Trust's Board Assurance Framework.

Regulatory impacts

7. The attached risk register would inform the CQC but does not have any impact on our ability to comply with CQC authorisation and does not indicate that the Trust is not:

- Safe
- Effective
- Caring
- Well led
- Responsive

Recommendation: The Board is asked to **note** the contents of the report.

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Ratino	Target Ratino	Progress/Updates	KSO
1187	18/06/2020	Administrative processes relating to QVH trauma activity taking place at The McIndoe Centre	Trauma administrative processes deviating from the agreed pathway leading to inadequate documentation, incorrect coding and risk of missed follow-up.	1.Agreed process in place and documented. Accessible to staff via QNet and has been distributed to all members of trauma pathway team. □ 2.Clear further guidance has been given, with regular meetings of core staff to confirm process and training implemented.□ 3.Patients with incomplete patient centre admissions are retrospectively reviewed to ensure actions in place. Pre-admission always on system when booked for surgery.□ 4. TMC have reminded all staff not to retain any original documentation.□	Abigail Jago	Paul Gable	Compliance (Targets / Assessments / Standards)	12	6	18.6.20 Continuing with regular meetings and training to ensure correct process followed and attempting to identify if this is a resource issue. Reinforced message to TMC staff that no original documentation to be retained at TMC.	KSO1 KSO3
1182	20/05/2020	NHS VideoConsult: system failures	NHSE has promoted to use of Videoconferencing for OPD appointments using the Attend Anywhere software. This is a national project. QVH has established an internal project team and has run a series of pilot clinics to inform a comprehensive roll out programme across QVH. Unfortunately, Attend Anywhere has failed nationwide on 3 separate occasions in the past 2 weeks.	Business continuity in the event of systems failure□ □	Abigail Jago	Philip Kennedy	Information Management and Technology	12	6	June 2020: National upgrade is underway. Performance remains stable. TO REDUCE RISK TO A 9?□ 29/5/20□ NHSE national lead for Attend Anywhere presented to Regional COVID update meeting and provided assurances around additional support to improve the product stability and a major upgrade is scheduled for June. Several members of QVH Project Group were on that WebEx and agreed we should reduce the likelihood of further failure from probably recur to may recur, which will reduce the overall Risk score.	KSO1 KSO2 KSO3
1179	07/04/2020	Pandemic Flu Covid-19 challenges	Requirement to establish new clinical pathways and work in different ways□ Yet to understand impact on safety, effectiveness & experience with new governance processes in place□ Workforce restraints / issues	*Daily panel to review cases plus bi-weekly review of referrals □ *Daily conference call / Webex to update local and regional issues & activity□ *staff working from home / remotely: IT workstream □ *Review of Ethics panel / guidance which is being developed regionally for difficult treatment decisions□ *SOP for H&N, breast, skin and trauma infection screening pathways□ *Virtual clinics□ *monitoring completion of actions and issues via EPRR Incident Log	Abigail Jago	Nicola Reeves	Compliance (Targets / Assessments / Standards)	16	8	26.06.20: Cancer SOP's updated in line with National Guidance. Site reconfiguration led by DoN underway; Clinical Senate in place to review clinical priorities for admission. Amber / Green pathways implemented. Incident Control Centre remains open 7/7. PPE supply challenging for some specifics - hoods available for use where required.□ 20.05.20: DoO established review panel for H&N, breast & skin pathways. Cases for surgery approved at MDT □ Cancer Alliance / NHSE approval of all new pathways / SOPS□ Trust widely utilizing remote access to meetings & multiple staff working from home□ Virtual clinics implemented□ Health & wellbeing initiatives (specific BAME guidance)□ Extensive IPC measures across trust incl PPE, patient / staff screening and sickness absence due to C-19 captured	KSO2 KSO3 KSO5
1168	20/12/2019	Significantly reduced Consultant Histopathologist cover	Significantly reduced Consultant Histopathologist cover causing failure to meet turn around times and national cancer targets.	Locum Consultant currently employed until mid January 2020□ Previous consultant covering additional cases on bank basis□ Plans in place for remote reporting by Skin lead at neighbouring trust for ad hoc work.	Abigail Jago	Fiona Lawson	Compliance (Targets / Assessments / Standards)	12	6	June 2020: Additional bank support in place. Successful international appointment delayed due to COVID-19 lockdown. Service and KPIs being delivered currently. ? rescore to 9?□ May 2020: overseas consultant visit / start date on hold due to Covid-19. Work being covered / shared by two consultants currently.□ 14/1/20: 1wte consultant recruited - overseas appointment, start date awaited.	KSO2 KSO3
1167	01/01/2020	Lack of Failsafe Officer	GIRFT and HII recommendations state that every Ophthalmology Department should have a dedicated Failsafe Officer to reduce the risk of patients being lost to follow up and to reduce the risk of undue delays to follow up appointments.□	Current Failsafe duties reside with Business Manager, Service Manager and Service Co-ordinator. However, there is insufficient resource to manage failsafe procedures adequately.	Abigail Jago	Marc Tramontin	Patient Safety	16	8	June 2020: No further update. Service reviewing options / mitigation□ May 2020: Reviewing internal efficiencies to fund post; currently on hold due to COVID□ March 2020: reviewed at business meeting - cost pressure for post not prioritised at this time□ 4/2/20: reviewing internal efficiencies to support; post identified within Business Planning.□ HSIB National report published with multiple recommendations	KSO1 KSO2 KSO3
1163	06/11/2019	Inadequate Consultant radiologist cover	- As of the beginning of December, there will be 1 radiologist covering the entire department for both on-call and business as usual work□ - There will be no radiologist cover for MSK/Neuro CT/MRI□ - OOH is a patient and staff safety risk as 1 consultant cannot cover on-call alone	- outsourcing CT/MRI for neuro/MSK□ - Agency Reporting radiographer to report chest imaging□ - Bank MSK sonographer to aid service provision□ □ OOH remains the largest risk	Abigail Jago	Sarah Solanki	Patient Safety	16	8	July 2020: Bank consultants to support on-call to enable substantive consultant to have leave.□ July 2020: interviews held - post not appointed to□ June 2020: Bank staff in place / remote working established. Interview scheduled for 6/7/2020. ? rescore to 12□ 27-04-2020 - bank consultants supporting service. Recruitment on hold until COVID crisis more clear. Global fellowship options have been stopped due to COVID - not possible to rescore currently.□ 04-02-2020 - adverts are back out for the consultant posts. Global fellowship conversations on-going between the clinical lead and the programme team.□ 14-01-2020 - Vacancies to go back out to advert. developing SLA with Worthing for Consultant support 1 day per week. Global fellowship programme also being explored by lead clinician.□ 18-12-2019- new substantive H&N consultant now not coming. one post - candidates may not be suitable and 1 has been withdrawn.□ To support current radiologist, we have a bank consultant sonographer to support the MSK US service. □ MRI/CT reporting normally covered by LC will be outsourced. On-call doctor has agreed to cover weekend on call to help support for the interim period until the beginning of January.□ There is a residual risk to the service if our only consultant has sickness.	KSO1 KSO3 KSO5
1152	02/09/2019	Internal audit - Fire Risk Assessment reviews not taking place	If Fire Risk Assessments (FRA's)are not taking place and they are not being reviewed annually, hazards do not get identified.□ The estate may not be compliant and people may be at risk	FRA's are reviewed on annual basis□ Head of Estates working with the Fire Safety Advisor, re-writing / reviewing FRA's where required.□ Key focus of work since Q1: Hospital Estate is up to date now, with no areas outstanding.□ Calendar reminders in place to ensure that they will not go out of date; Fire Safety Advisor and Technical Services Assistant leading□ Regular training to all staff: high compliance rate, continuously improving.□ □	Michelle Miles	Phil Montague	Estates Infrastructure & Environment	12	6	03/06/20 FRA still current, up to date and revised to show the changes due to COVID. Further reviews set to commence July 20 and action plans from these reviews will be prioritised as part the upcoming 5 year plan for capital and backlog maintenance programs. Phased upgrade of the fire system was approved for capital program 20-21 along with the continuation of fire door replacements and the compartmentation of the plant room within A-Wing, all cited as previous risks within the FRA□ 06/11/2019 All FRA's now up to date and progressing. □ October:□ Update of all FRA's: □ Start: 1/5/19□ Due: 1/11/19□ Completed: 22/10/19□	KSO3
1148	24/07/2019	Clinical coding backlog	Coding backlog now at significant level □ Potential to impact income recovery□ Clinical indicator data unavailable	-overtime approved□ -agency approved: restraints obtaining agency workers□ -monitoring reports 3x weekly□	Michelle Miles	Banu Thiagaraj	Finance	12	6	09/12/2019□ - Onsite & Remote coding support in place with external company□ - All untrained staff completing their training by Week Ending 15/12/2019□ - EDM new process implemented to reduce time from Discharge to being available on Evolve□ - Options paper being written to look at how to structure service from 2020□ □ 02/09/2019 □ - Agency clinical coders now working during week and weekends□ - Internal staff are working overtime□ - External outsourcing company doing remote coding for all notes on EDM□ - Proposal being produced for a blended onsite and remote coding support from external company□	KSO4
1140	19/03/2019	Current PACS contract ending in June 2020	QVH is in a consortium for PACS/RIS/VNA with 5 other trusts from Surrey & Sussex. □ Philips provide a managed PACS/RIS/VNA (Vendor neutral archive) service to QVH and the other 5 trusts. The current contract was extended in 2016 to allow the contract to run until June 2020 under the 5+2 terms of the original contract. □ All 6 trusts have stated they want to remain in this consortium and potentially expand it to include another Surrey trust. □ There is now limited time available to re-procure PACS/RIS/VNA before the current contract runs out; without which there will be no PACS system.□ There is currently no project board or business case aligned to this procurement process. □ ESHT has said they are happy to lead on the project, with input from all trusts as and when requested.□ The data in the VNA is known to be incorrect across all sites, and if the S&S PACS consortium approve a plan to move PACS providers then the migration of data may need to occur from PACS to PACS - this will add a delay for migration.□	ESHT have said they will lead on a re-procurement process for the consortium. □ Philips have said they will extend the current contract - costs will need to be agreed as hardware will need replacing.	Michelle Miles	Sarah Solanki	Information Management and Technology	12	4	July2020: VNA reconciliation work ongoing. Start date of 10th August unlikely. No risk to our images as current space in local PACS will not run out until 2022.□ July 2020: PACS Project Manager commencing in post 20th July□ 27-04-2020 - VNA extension been agreed with contract signed with Hyland. Timelines have slipped for this part. Hyland & Phillips have had communication issues which should improve now named contacts shared. PACS extension meetings still ongoing via online forums. Some costs not clear - Phillips to confirm. Next meeting 01/05/2020□ 04-02-2020 - PACS consortium meeting on30th Jan: presentation from Hyland for the VNA extension. Trusts need to formally agree to this work by mid February at Trust board level as work needs to proceed ASAP to ensure the tight timeline.□ 14-01-2020 - I raised concerns to the programme manager around the timeline as there was a lot that needed to be completed by the 20th Jan and our next meeting is the 30th Jan. I have asked DDOF and others at QVH for any updates (in case they have had meetings that I am not abreast of). I vocalised my concerns to the programme manager around resourcing, business as usual arrangements around migration. Reply sent was not really reassuring as it still had a lot of unknowns on it. Awaiting update locally and we will arrange a local meeting prior to the formal PACS meeting on the 30th.□ 18-12-2019 - PACS meeting cancelled today. Call re VNA specification 19-12-2019. Timeline is incredibly tight and there are large risks around this. This may need re-scoring in January if some actions have not be completed.□ 06-11-2019 - PACS meeting 16th Oct and 30th Oct. VNA is not included in the contract extension proposal by Phillips. VNA end of life. Critical that decision amongst consortium is timely in terms of VNA solution. QVH keen to not do extension for 12-18 and feel that 5-10 year VNA contract could progress separately to PACS extension. Hyland presented - 50% cheaper than Phillips for VNA work.□ 19-09-19 DDOF and RSM attended the meeting. Update - All consortium trusts accepting of extension. ToR/MoU issued to each trust for discussion and formal acceptance by all trust boards. Work to be done by PACS managers in terms of completing spreadsheet prior to next meeting. Phillips are presenting to consortium at October meeting about proposed solutions and costs. There is more clarity and less risk around the legality of contract extension. Procurement leads in regular contact. □ 13-08-2019 DDoF and CIO attended the PACS meeting at the end of July. update - Consortium remain undecided in terms of preferred solution/option. There is a clear risk that we won't re-procure in time. Clear need to extend the contract in the interim. Score increased, added to CRR□ 09-07-2019 - Meeting held to discuss the risks surrounding this project. Agreed that the score needs to be revised to Corporate due risk to QVH. □	KSO1 KSO2 KSO3 KSO4

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Ratino	Target Ratino	Progress/Updates	KSO
1139	14/01/2019	Risk to patients with complex open lower limb fractures	Patients with open complex lower limb fractures require time-critical shared care between plastics & orthopaedic service, in line with BOAST 4 and NICE recommendations.□ This is sometimes not achievable with the current configuration of services and available personnel & equipment plus theatre time.	Current SLA in place for plastic surgery provision to BSUH:□ -onsite plastic provision most weekdays□ -when possible, patients receive orthopaedic treatment in BSUH prior to transfer to QVH for soft tissue surgery□ □ Planned SLA: by end of 2019□ - 24/7 cover at BSUH for plastic surgery provision to achieve joint operating to comply with BOAST 4 & NICE recommendations□ - Interim SOP in development for lower limb patients to be transferred to QVH□ Equipment required: 'C-Arm' in Capital Planning 2019/20	Keith Altman	Paul Gable	Patient Safety	12	6	July 2020: one consultant in post, others to be in post by September□ April 2020: all posts recruited to - commence July / August□ January 2020: x3 posts to be advertised stat □ Dec: nil further to update□ October: awaiting update from BSUH □ August update: agreement to recruit to three posts and establish rota enabling a robust, sustainable on-call and lower limb trauma service to the region.□ July update: Provisional agreement for three new consultant appointments jointly to QVH & BSUH. Temporary diversion of complex lower limb trauma to other network providers. Flowchart and SOP for cases that can be undertaken at QVH developed.□ June update: Director of Strategy and MD met with BSUH regarding QVH proposal for lower limb orthoplastics service; response awaited from BSUH & Western MD's□ May update: discussions with BSUH ongoing □ March update: R/V by Medical Director BC in development for 24/7 Plastics cover. BOAST 4 compliance remains poor; presentation to April Board Seminar	KSO1 KSO2 KSO3
1136	20/12/2018	Evolve: risk analysis has identified current risk within system processes and deployment	There are a significant risk with the current provision of the EDM service within the Trust. The Chief Clinical Information officer has completed a risk analysis which has identified current risk within system processes and deployment.□ □ There are hazards which remain at level 4 and above using the NHS digital clinical risk management risk matrix indicating the need for: "mandatory elimination or control to reduce risk to an acceptable level".□ □ Unacceptable level of risk have been identified in the following areas:□ • documentation availability and scanning quality□ • partial rollout of EDM - operating a hybrid model□ • event packs not sent for scanning□ • system speed□ • E form instability□ • incorrect patient data being uploaded to EDM (internal scanning)	An urgent clinical safety review of EDM was undertaken in May 2018 (version 1.1), this review (version 2.3) is a follow-up from that document. -New project manager appointed in August 2018 & analysis undertaken of the extent of the hazards within EDM: new team built to manage the business as usual, and to plan further rollout of EDM. -Project remediation plan developed to address critical issues and to roll out EDM to all remaining areas.□ □ -Quality assurance of scanning now in place with improved administration process. □ -On-site Documentation availability process improved with centralisation of pre scan preparation: further work needed to increase collection frequency.□ □ -Off-site availability of clinical documentation: rollout of laptops with 4G functionality and remote access in place for those sites that do have native connectivity through the host network. □ □ -Incorrect patient data being uploaded to EDM: centralisation of EDM process has achieved greater quality assurance of scanning (introduction of order communications system - no longer a requirement for reports to be uploaded to evolve)□ □ - Event packs: existing scanning pickup service is 2 days a week - inevitable that notes will not be available in time for review following discharge from surgery; to avoid notes not being available, the event packs are made available physically.□ □ -System speed: series of measures being evaluated to address including	Michelle Miles	James Cooper	Patient Safety	12	6	January 2020:□ Issues with eForms within Max-Fax, Sleep and Orthodontics where an error screen is displayed when a user attempts to save a recently typed notation into the eForm: the technology affected is a 'middleware' application provided by a 3rd party - pre-defined escalation route is currently being followed.□ October update: Trust reporting on a monthly basis to NHS digital as part of the TSSM (trust system support model) process.□ Partial deployment remains the single biggest risk: significant progress towards resolving this.□ Go live in plastics: planned for November 18. Prior to this rollout, evolve is to be upgraded to the latest available version in preparation for trust deployment of Windows 10.□ E-form instability issues resolve; completed rollout of iPads to clinical areas.□ Daily pickup of event packs now place.□ □ August update: following the NHS digital feedback, the progress made with scanning volumes, improved training stats and the momentum with preparing Plastics score reduced to 12□ 1/6/2019 update: changes to the configuration of the anti-virus software in the trust have improved speed of application. Accelerated scanning of active health records library now underway. IPads running evolve in native app now deployed to a number of Ward clinic and theatre areas. New process for charging iPads within theatres have been implemented and are currently bedding in as part of an end-to-end admissions / theatre processes review. Patients with scanned notes are now being seen in Plastics (not live) as part of multi-disciplinary and/or parallel care pathways. Options to mitigate this impact and associated risk are urgently being investigated.□ 14/02/19 5 days a week collection now in place - System speed. There are series of measures being evaluated to address this including the longer term upgrade of operating system to windows 10.- □ 28/1/19 Update: EDM Project Board reviewing options □ Event packs - With the existing scanning pickup service only being 2 days a week on Tuesday and Thursday it is almost inevitable that notes will not be available in time for review following discharge from surgery. To avoid the notes not being available, the event packs are not sent for scanning and made available physically.	KSO3 KSO4
1125	30/08/2018	RTT Delivery and Performance	- The Trust's RTT position is significantly below the national standard of 92% of patients waiting <18 weeks on open pathways. This position has reduced further in July following the identified of a cohort of patients that have historically not been included in the RTT waiting list position□ - 52 week position has deteriorated following identification of additional patients	July 18□ -Comprehensive review of spoke site activity has taken plan to identify all patients that should be included in the Trust RTT position□ Data upload now in place to enable the reporting of PTL data from Dartford spoke site that was previously not identified□ Weekly PTL meeting in place (Chair DOO) that reviews patient level data for all patients >38 weeks for each speciality□ - Additional theatre capacity is being identified through PS (McIndoe) and NHS (ESHT Uckfield theatres)□ Recovery plan in place □ -4 additional validators to start in post 29th August□ -IST supporting capacity and demand work□ - commissioners have identified capacity outside of the trust for dental T1/T2 referrals□ - commissioner are in the process of identifying capacity for other long wait patients	Abigail Jago	Victoria Worrell	Compliance (Targets / Assessments / Standards)	16	9	26 June 2020: routine elective activity stood down in line with NHSE direction due to C-19 response; significant impact on RTT with 20% reduction in performance plus as of May 2020 x 100 52ww. R&R has started, focus is on clinical priority with anticiapted ongoing reduction in performance.□ 4/2/20: ongoing reduction in 52 week waits - RTT Action Plan continues; operational overview through weekly PTL meeting.□ 22/11/19: remain behind trajectory with ongoing improvement of RTT position including reduction in numbers of 52ww patients and patients waiting over 18wks; ongoing challenges with patients deferring treatment through choice - score reviewed with Exec Lead and amended□ 11/9/19: ongoing delivery of RTT recovery plan. Trust open pathway performance on track; challenges remain with corneo plastic trajectory due to non-consultant medical cover - full service review underway. 52WW trajectory behind plan due to high levels of patients choosing to defer treatment.□ 5/7/19: R/V with Exec Lead - RTT open pathway performance on track with trajectory; 52 week waits challenges ongoing regarding patient choice - national issue, escalated to NHSI and commissioners□ 5/4/19: R/V with Exec Lead - capacity planning complete; activity to deliver 2019/20 plan has been signed off with Commissioners and on track with revised trajectory□ 8/3/19: 2019/20 capacity planning underway including potential independent sector activity - on track with performance plan□ 14/2/19: Exec lead r/v - RTT plan agreed with commissioners and on track re: 52 wk waits and percentage performance□ Update (Oct '18): RTT validation programme complete. RTT Action Plan in place & being monitored through fortnightly System Task & Finish group, weekly assurance call with NHSI & via internal assurance processes. Revised trajectories being agreed with Commissioners. Clinical Harm Reviews underway.	KSO1 KSO2 KSO3 KSO4 KSO5
1117	26/06/2018	Inability to meet legislative requirements of the Falsified Medicines Directive	Falsified Medicines directive due to come into force in February 2019, Trust will be unable to comply with the legislation when first in place.□ Under the Directive, all new packs of prescription medicines placed on the market in Europe from February 2019 onwards will have to bear two safety features: a unique identifier (UI) in the form of a 2D data matrix (barcode) and an anti-tamper device (ATD).□ □ Anti-tampering device□ □ Pharmacies, and those who are authorised to supply medicines to the public, will be required to authenticate products, which means visually checking the ATD and performing a verification and decommissioning scan, "at the time of supplying it to the public".	1. Information on actions being gathered.□ 2. On-going discussions at KSS Chief Pharmacists meetings and concerns being fed back to NHS England.□ 3. Nov 18 Quote has been sent form JAC regarding implementation. Included in business planning. □ 4. Planning underway for upgrade to current JAC version. Will include ability to link FMD software although may not initially be switched on.□ □	Abigail Jago	Judy Busby	Compliance (Targets / Assessments / Standards)	12	2	2/7/20 JAC finished DM+D matching but only able to match 28% of records. QVH will have to manually match the rest themselves.□ 11/6/20 No change from previous update□ 17/5/20 JAC working on DM+D compliance for system. Other work currently halted due to Covid□ 7/2/20 No change from previous update□ 17/1/2020 JAC upgraded and working well. Waiting for DM+D compliance work to be completed by JAC. Funding for JAC option for FMD compliance submitted in business plan□ 11/10/19 JAC upgrading 16th Oct 2019. Will be able to start working towards FMD compliance once complete□ 27/8/19 Still trying to move forward with JAC upgrade - delays in progress due to JAC. Looking into alternative options.□ July 2019 Moving forward with JAC upgrade □ May 2019 Currently working with JAC to upgrade Pharmacy IT system. FMD software still in testing so a further will upgrade will be needed at at later date once working fully.□ March 2019: Reviewed at the Clinical Support Services Governance meeting (19/03/2019) - □ Software currently not available, this is an issue for all Trusts nationally: work underway externally to devise programme, will not be before December 2019□ 1/10/18 - Information is still being gathered. Concern by all KSS Chief pharmacists that there is not enough information available. Brexit may also affect the data□ 21/11/18 - controls updated - JAC has sent quote for software. Included in business planning	KSO2 KSO3
1077	22/08/2017	Recruitment and retention in theatres	* Theatres vacancy rate is increasing.□ * Pre-assessment vacancy rate is increasing□ * Age demographic of QVH nursing workforce: 20% of staff are at retirement age□ * Impact on waiting lists as staff are covering gaps in normal week & therefore not available to cover additional activity at weekends□ June 2018:□ * loss of theatre lists due to staff vacancies	1. HR Team review difficult to fill vacancies with operational managers.□ 2. Targeted recruitment continues: Business Case progressing via EMT to utilise recruitment & retention via social media□ 3. Specialist Agency used to supply cover: approval over cap to sustain safe provision of service / capacity□ 4. Trust is signed up to the NHSI nursing retention initiative□ 5. Trust incorporated best practice examples from other providers into QVH initiatives□ 6. Assessment of agency nurse skills to improve safe transition for working in QVH theatres□ 7. Management of activity in the event that staffing falls below safe levels.□ 8. SA: Action to improve recruitment time frame to reduce avoidable delays	Abigail Jago	Sue Aston	Patient Safety	12	4	26th June 2020: Scrub Practitioners establishment has improved following overseas recruitment; this has not however improved Anaesthetic Practitioner provision.□ January 2020: currently covering long term sickness & mat leave in addition to staff cross covering PAC and recovery. 6 new B5 recruits currently supernumerary: 1 to mid Jan, others to Mid Feb continued recruitment to 3 B5 vacancies one Feb/March timeframe. Working to be at full establishment or as near as by late spring□ Increase in regular bank staff, decreasing agency use□ Dec: Theatres Registered Practitioner vacancies at 4wte. □ Ten new recruits currently working supernumary awaiting PIN / on orientation□ 2/10/19: Theatres Registered Practitioner vacancies at 10.45wte Overseas & local recruits require period of supernumerary to gain PIN & orientate to department respectively. Potential five recruits in system (full update in 'documents')□ 11/9/19: ongoing work with overseas nursing / local recruitment campaign / introduction incentive. Apprenticeship programme for associates underway.□ July 2019 recruitment campaign continuing. Overseas nurses working through a programme to be able to obtain PIN numbers. Score reviewed.□ March update: four overseas recruits due to start April / May plus four local recruits by end of May □ February update:□ International recruit gained NMC PIN, further posts offered with start dates April 2019□ October update: some success with recruitment, CCG reviewed Theatre services 11/10/18 - no safety or quality issues were identified written report awaited.□ 13/8/18: x4 WTE Staff Nurse posts recruited to, all with theatre experience.□ □ Recruitment process underway for new staff to include international recruits.□ Dubai recruitment: +/- 45 posts offered: awaiting uptake and detail□ 9/7/18: TUG agreed to pilot different minor procedure staffing model from July '18□ Practice Educator in Dubai to interview potential staff□ 12/6/18: further work on theatre establishment & budget. Testing feedback from staff re: skill mix□ 14/5 (CCG): Pre-assessment almost at full establishment□ 12/2/18: recruitment to pre-op assessment plus social media recruitment drive□ January 2018 update:all HCA's now in post	KSO1 KSO2

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Ratino	Target Ratino	Progress/Updates	KSO
1040	13/02/2017	Age of X-ray equipment in radiology	Significant numbers of Radiology equipment are reaching end of life with multiple breakdowns throughout the last 2 year period.□ □ No Capital Replacement Plan in place at QVH for radiology equipment	All equipment is under a maintenance contract, and is subject to QA checks by the maintenance company and by Medical Physics.□ □ Plain Film-Radiology has now 1 CR x-ray room and 1 Fluoroscopy /CR room therefore patients capacity can be flexed should 1 room breakdown, but there will be an operational impact to the end user as not all patients are suitable to be imaged in the CR/Fluoro room. These patients would have to be out-sourced to another imaging provider.□ □ Mobile - QVH has 2 machines on site. Plan to replace 1 mobile machine for 2019-2020□ □ □ Fluoroscopy- was leased by the trust in 2006 and is included in 1 of these general rooms. Control would be to outsource all Fluoroscopy work to suitable hospitals during periods of extended downtime. Plan to replace Fluoro/CR room in 2019-2020□ □ Ultrasound- 2 US units are over the Royal College of Radiologists (RCR)7 year's recommended life cycle for clinical use. Plan to replace 1 US machine for 2019-2020□	Abigail Jago	Paul Gable	Patient Safety	12	2	July 2020: Advised of potential delay due to COVID/Boris CT scanners being built and taking priority. Possible November install. Chased estates re quotes around electrical work they said they could handle - these remain outstanding. New head of estates aware and now handling this.□ June 2020: Fluoroscopy contract awarded - advised that project should be completed within around 14-16 weeks. □ 27-04-2020 -Interim MRI solution is place for up to 2 years. New Ultrasound procured. MES option - asked to present paper - this was done but then everything put on hold due to staff sickness and subsequently COVID planning. This project to start again in the coming weeks.□ 04-02-2020 - The MES option is moving forward but will take around 9-12 months. A framework solution is preferred due to the risk and size of the project. An interim modular MRI solution is being scoped for April onward. We will staff this ourselves and have been recruiting staff. Given the fragility of the Fluoroscopy suite, the trust have decided to purchase this from capital for 20/21. Supply chain have been approached for quotes.□ 14-01-2020 - developing a strategy with procurement around the MES option. Meeting on Friday 10th and actions for both RSM/head of procurement. The CEO has asked for funding for MRI from the government and has local CCG/STP/MP support - no update re centralised funding for MRI.□ 18-12-2019 - the CEO has applied for government funding for the MRI and has support from the STP/Cancer alliance networks and commissioners. MES still to be kept moving in case the centralised funding does not get agreed.□ 22/11: submission for emergency capital made□ 01-11-2019 - LOF not going to fund Fluoroscopy. MRI contract - cannot go out for same as current provision. Decision to investigate MES for a total radiology long term solution for all equipment.□ 19-09-2019 The fluoroscopy business case has been shared with the LOF - this was meant to be presented at their recent AGM but this was cancelled. The Ultrasound Business case is being discussed at October meeting. The MRI Business case should have financials completed today.□ 11/9/19: successful software repair undertaken - six months warranty in place. BC with LoF.□ 13-08-2019 - Trust supportive of fluoro replacement via the LOF. US funded by trust. Fluoro room has now had critical failure which means that resilience of current x-ray service is poor and non-existent for the barium/video swallow service. We have a hired C arm which we can utilise for the sialogram/plasty service. Escalated to director of operations □ 09-07-2019- Asked to provide more information about the fluoroscopy equipment for EMT so they can prioritise their urgent needs to charitable funds. US may have been agreed by trust.□ 18-06-19 - Radiology asked to prioritise equipment. Fluoroscopy and US machine requested. Requested for charitable funds to fund fluoroscopy equipment - decision awaited.□ June update: Bid to charity funds / League of Friends□	KSO1 KSO2 KSO3
968	20/06/2016	Delivery of commissioned services whilst not meeting all national standards/criteria for Burns and Paeds	-Potential increase in the risk to patient safety□ -on-call paediatrician is 1 hour away in Brighton□ -Potential loss of income if burns derogation lost□ -no dedicated paediatric anaesthetic lists	*Paeds review group in place□ *Mitigation protocol in place surrounding transfer in and off site of Paeds patients□ *Established safeguarding processes in place to ensure children are triaged appropriately, managed safely□ *Robust clinical support for Paeds by specialist consultants within the Trust□ *All registered nursing staff working within paediatrics hold an appropriate NMC registration *Robust incident reporting in place□ *Named Paeds safeguarding consultant in post□ *Strict admittance criteria based on pre-existing and presenting medical problems, including extent of burn scaled to age..□ *Surgery only offered at selected times based on age group (no under 3 years OOH)□ *Paediatric anaesthetic oversight of all children having general anaesthesia under 3 years of age..□ *SLA with BSUH for paediatrician cover: 24/7 telephone advice & 3 sessions per week on site at QVH	Jo Thomas	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	4	May 2020: as a risk reduction inpatient paediatric services suspended due to Covid-19 pandemic, in agreement with BSUH / QVH lead paediatrician □ Dec: update from commissioners still awaited; re-requested at CQRPM Dec 4th□ Nov: interim inpatient paeds burns divert continues - no reported issues. Update on number of diverts requested from commissioners.□ Working group QVH / BSUH to consider options; adult burns service aligned to provision of major trauma centre at BSUH□ Sept 30th: Review of Paeds SLA & service provision□ DoN met with BSUH W&C CD to discuss impact of inpatient paeds burns move with regards to BSUH paediatrician appetite to continue providing paediatric service at QVH. Further discussions planned once respective Directors briefed.□ July update: KSS HOSC Chairs meeting (10/7) to share interim divert plans - QVH patient pathway continuing to follow established larger burns protocol with patients being treated at C&W or Chelmsford; HOSC supportive of safety rationale & aware that further engagement & review of commissioned pathway required - to be led by NHSE Specialist commissioning. □ June update: Inpatient paeds BC for transfer of services to BSUH not approved. Interim arrangements with Burns Centres commenced. Plan for QVH inpatient paeds burns to go to other providers from 1st August. LSEBN aware & involved in discussions.□	KSO2 KSO3 KSO5
877	21/10/2015	Financial sustainability	1) Failure to achieve key financial targets would adversely impact the NHSI "Financial Sustainability Risk rating and breach the Trust's continuity of service licence. □ 2)Failure to generate surpluses to fund future operational and strategic investment	1) Annual financial and activity plan□ 2) Standing financial Instructions □ 3) Contract Management framework □ 4) Monthly monitoring of financial performance to Board and Finance and Performance committee 5) Performance Management framework including monthly service Performance review meetings 6) Audit Committee reports on internal controls□ 7) Internal audit plan	Michelle Miles	Jason Mcintyre	Finance	25	16	June 2020□ At present the Trust is operating under a block contract arrangement. Due to the national guidance the Trust is reporting a break even position. Further guidance is awaited with regards to the length of time for the block contract arrangements and any amendments to the current values. While the Trust would still be facing a deficit in the old financial regime, it is unclear at this present time as to the level of the current deficit.□ □ January 2020□ 2019/20 □ Performance M8: deficit of £5.6m YTD; £0.8m less than plan. Clinical income under-recovery has been partially offset by expenditure underspends.□ Full year forecast deficit of £8.4m; £1.0m worse than plan□ Cost savings of £0.8m YTD; Savings of £1.2m identified; £0.5m less than plan□ Finance & Use of Resources – 3 (Planned 4)□ November□ 2019/20 Performance M6: deficit of £4.1m YTD; £61k better than plan. Clinical income under-recovery has been partially offset by expenditure underspends.□ Full year forecast deficit of £8.1m; £0.6m worse than plan □ Cost savings of £1.2m identified; £0.5m less than plan□ Finance & Use of Resources – 3 (Planned 4)□ August □ 2019/20 Performance Month 3 YTD £438k behind plan due to income shortfall □ Current run rate forecast deficit of £11m (□ CIP performance £205k/£178k for YTD Month 3 □ Finance & Use of Resources – 3 (Planned 4)□	KSO4

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**03/09/2020**		**Agenda reference:**	**136-20**	
Report title:	Quality & Safety Board Report				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	1)NHSE Infection prevention and control board assurance framework (IPC BAF)				
Executive summary					
Purpose of report:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Summary of key issues	• Review of the Clinical Harm Reviews Group for or 52-week breaches • Implementation of LAMP testing in response to Covid-19 to ensure rapid testing results • IPC BAF version 2 previously presented at June and August Q&GC for transparency and assurance about the actions taken by the trust to mitigate the risk of acquiring COVID-19 whilst under the care of QVH and the actions taken to protect staff patients and public. • Appointment of a new Chief Clinical Information Officer (CCIO),				
Recommendation:	The Board is asked to note that the contents of the report reflect the quality and safety of care provided by QVH during this time				
Action required	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:	The Quality Report contributes directly to the delivery of KSO 1 and 2, elements of KSO 3 and 5 also impact on this.				
Corporate risk register:	CRR reviewed as part of the report compilation –and the workforce and RTT18 risk impact the most on quality, safety and patient experience.				
Regulation:	The Quality Report contributes and provides evidence of compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's Essential Standards of Quality and Safety.				
Legal:	As above: The Quality and Safety Report uphold the principles and values of The NHS Constitution for England and the communities and people it serves – patients and public – and staff.				
Resources:	None				
Assurance route					
Previously considered by:	EMT				
	Date:	17/08/20	Decision:	Noted	
Previously considered by:	Q&GC				
	Date:	20 /08/20	Decision:	To add IPC BAF to the Board Q&S report	
Next steps:	As above				

Executive Summary - Quality and Safety Report, September 2020

Domain	Highlights
Director of Nursing and Quality	The CQC 2019 inpatient survey (published 2 July) shows QVH has sustained its position for the sixth consecutive year as one of a small number of hospitals receiving much better than expected results for patient experience. 49 of the comparable 60 questions responded to were better than the national average and no responses were worse than the national average. There are no statistical difference in the comparison with QVH 2018 and 2019 data where 57 of the questioned showed the same, very high levels of satisfaction. The survey of adults involved 143 NHS acute trusts in England with responses from 76,915 patients. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital during July 2019. The questionnaires were sent out and returned took place between September and December 2019. Safety of our patients and staff continues to be the primary focus for the trust. Further refinement of the elective and trauma pathways fully utilising the LAMP technology which the trust invested in as part of the Covid-19 response means that all patients going to theatre or having an aerosolised generating procedure can be tested to establish that the do not have Coivd-19 at the time of the procedure. This testing alongside staff testing and screening of all patients and visitors to site contributes to the almost zero Covid -19 prevalence in our staff and patient results The pandemic has been downgraded from Level 4 national command and control to Level 3 regional co-ordination . Simon Stevens letter(31 July) to all providers states that from the 1 August the 3 NHS priorities are acceleration the restoration of service, preparing for winter and identifying lessons learned. The safe restoration of services continues with the restoration and recovery clinical governance weekly meeting being fully utilise to agree and accelerate services to be restored and addressing clinical governance requirements was functional standard operating procedure and protocols to ensures quality and sustain patient experience. Winter planning has begun for the flu campaign has commenced. There are many examples of learning post Covid-19 internally and externally, one being the review of Infection Prevention and Control Assurance Framework. This has been previously presented at the June quality and governance committee, and will be assessed by the coca with the trust 11 August. The trust prioritised patient liaison and complaints services as an essential service during the pandemic whilst FFT was suspended nationally. The trust introduced new patients surveys to sample patient experience. This was done as both a patient experience measure and a safety measure as adverse changes in patient experience can often the first indicator to change when other safety and quality indicators have not. The trust complaints are at the lowest level in the past 6 years when comparing the same 4 month period (April to July).

Medical Director	**Paediatrics** The chief nurse and medical director have met virtually with the medical director and the chief of the women and children's division at BSUH to discuss their continued post-Covid support of medical paediatric out of hours telephone cover for in-patient paediatric services at QVH, which they have confirmed, especially for forthcoming senate-approved cases. We have also shared three years of in-patient paediatric overnight stays activity data with them to progress ongoing discussions about the future provision of in-patient paediatrics on the QVH site. **Clinical Harm Reviews** Due to Covid-19 the number of 52-week breaches has increased significantly. All these cases will require clinical harm reviews. In the past, a Clinical Harm Review Group for 52-week breaches with defined Terms of Reference was developed but did not become established due to various issues. In light of Covid-19, it is the aim to resurrect this group, which will review all 52-week breaches, assess the potential for harm caused by the breach and identify cases where there is the potential that significant harm has been caused and escalating accordingly to an in-depth internal investigation wherever appropriate. This group will report to CGG. The PTL listing early August 2020 demonstrated 341 52-week breaches: 111 Corneo-plastics, 119 plastics, 53 maxillofacial, 49 orthodontics and 9 facial plastics/dermatology. **CCIO/CSO** Paul Drake, Consultant Plastic Surgeon is the new Chief Clinical Information Officer (CCIO), taking over from Mr Jeremy Collyer, Deputy Medical Director/Consultant Maxillofacial Surgeon. Recruitment to the Chief Safety Officer (CSO) role is currently underway.

Report by Exception - Key Messages

Domain	Issue raised	Action taken
Safe: clinical harm reviews	Clinical Harm Review meetings: Trust continues to review the 52 week breaches against an agreed trajectory with regulators and commissioners to achieve zero 52 week breaches by April 2020. Due to the Covid-19 pandemic the 52 week breaches have increased and the trusts is awaiting guidance on how this will be reported	Clinical Harm Review meetings were established from July 2018 for patients waiting over 52 weeks and cancer patients waiting over 104 days as per the national guidance 'Delivering Cancer Waiting Times'. Membership includes Head of Risk & Patient Safety, Director of Nursing and Medical Director with clinical team representation, this is usually the CD. The majority of cases are Mafic (Dental) and Plastics and any that cannot be confirmed at the time of review as 'no harm' are followed up until point of treatment to ascertain if any harm has been caused: there have been nil harms identified so far. To the end of July 2020 728 reviews have been undertaken: July: 40 – MaxFac and plastics; Aug: 129 – MaxFac and plastics; Sept: 75 – plastics / Corneo / H&N plus Medway MaxFac; Oct: 35 – MaxFac / H&N / plastics and skin; - Nov: 30 – plastics, MaxFac and Corneo; Dec / Jan: 36 – MaxFac and plastics; Feb: 53 - MaxFac and plastics; March: 32 – plastics; April / May: 10 – MaxFac and plastics; June / July: 55 – MaxFac and plastics (incl. D Valley); August / September: 65; October / November: 37; January 10 Maxfac; Feb / Mar 35 (Plastics & Maxfac); May 14 (Plastics); June 44 (Plastics & Maxfac); July 28 (Plastics) Patients have been under surveillance so far are all confirmed as no harm; One MF patient is currently under surveillance. The clinical harm review process will extend into 2020/21 due to the increased numbers of delayed elective care due to the government requirements to cease this work during the pandemic to date. This new CHR process is being redesigned to ensure that the review tool is sensitive to a different cohort of patients delayed due to COVID-19. This work will led by the Medical Director going forwards.

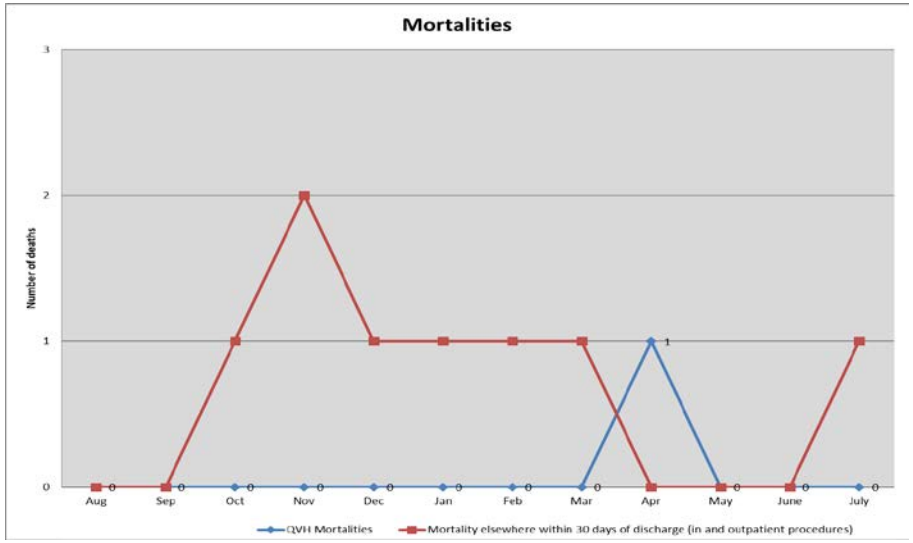
Responsive: Coronavirus pandemic-	Minimise infection risk to staff and patients: local testing does not meet QVH's needs in a timely manner	Testing plan developed by a task and finish group, plan presented to EMT and approved in May. Due to the changes in the NICE patient self-isolation guidance in July the screening pathways for patients have been reviewed and new SOP signed off at the clinical governance group. The trust is undertaking LAMP testing instead of the PCR as the result are at least as accurate and the sensitivity is greater. This also allows the trust to have result back within 30 mins if required which means all elective patients who have not self-isolated for 14 days and had a negative PCR at 72 hours pre operatively can be screened on the day of surgery or aerosolised generating procedure and only proceed if negative result. We are also testing all trauma patients going to theatres or having an aerosolised generating procedure which gives the trust hugely more flexibly use of theatres and theatres teams. This contributes to patient and staff safety and assists the trust in bringing higher risk staff safely back to work. The increased workforce will then be available to support the accelerated recovery and restoration process.
Well- Led: introduction of Regulatory pandemic assurance process	NHSE Infection Prevention and Control Board Assurance framework (IPC BAF) has been sent to all providers for assurance. The CQC will review this assurance as part of their overarching regulatory requirement during Covid-19	The Covid-19 pandemic has created huge challenges for the delivery of safe healthcare across the country and at CQC we have been trying to find the best way of gathering information to support their regulatory function during this period. A priority at this stage in the pandemic for the CQC is to ensure infection prevention and control measures are effective to reduce the risk of transmission of Covid-19. The IPC BAF has been updated and sent to the CQC in preparation for the assessment review on the 27 August. The full IPC BAF is in appendix 1 .

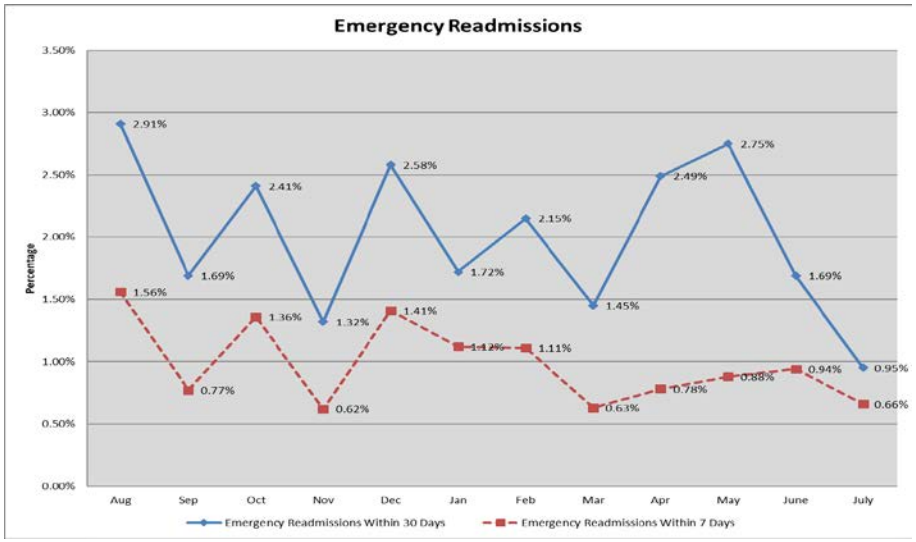
Safe - Performance Indicators

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)	Target	Q2 2019/20			Q3 2019/20			Q4 2019/20			Q1 2020/21				12 month total/ rolling average
		Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	
Infection Control															
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA hospital acquired	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2
Gram negative bloodstream infections (including E.coli)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA screening - elective	95%	94%	95%	92%	94%	98%	95%	94%	91%	90%	99%	90%	98%	81%	93%
MRSA screening - trauma	95%	98%	97%	94%	98%	94%	98%	98%	95%	95%	*88.9%	61%	84%	94%	92%
Incidents															
Never Events	0	0	0	0	0	0	0	0	1	0	0	0	1	0	2
Serious Incidents	0	0	0	1	0	1	0	2	0	0	0	0	1	0	5
Theatre metrics															
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	6	3	5	0	0	2	3	4	1	3	2	3	4	30
Paediatrics under 3 years: Induction of anaesthetic was between 18:00 and 08:00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WHO quantitative compliance		99%	98%	99%	99%	99%	99%	98%	99%	99%	99%	99%	99%	98%	99%
Non-clinical cancellations on the day		31	29	15	13	12	13	19	5	8	5	1	1	0	121
Needlestick injuries	0	1	1	3	1	2	1	1	1	0	1	0	0	0	11
Paediatric transfers out (<18 years)		1	0	0	0	1	0	1	1	1	1	0	1	0	6
Medication errors															
Total number of incidents involving drug / prescribing errors		23	24	27	25	30	11	33	12	7	7	11	10	5	202
No & Low harm incidents involving drug / prescribing errors		21	23	26	21	30	11	30	11	6	6	9	9	4	186
Moderate, Severe or Fatal incidents involving drug / prescribing errors		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medication administration errors per 1000 spells		1.1	0.6	0.6	2.1	0.0	0.0	1.8	0.6	0.8	1.5	2.1	0.9	0.9	1.0
Pressure Ulcers															
Pressure ulcers (all grades)(Theatre metric)		0	1	2	0	0	1	1	7	2	0	1	1	1	17
Hospital acquired - category 2 or above		0	1	1	1	0	2	1	1	0	0	1	0	2	10
VTE initial assessment (Safety Thermometer)	95%	100%	100%	100%	97%	100%	100%	100%	100%	96%	nc	nc	91%	nc	98%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	95%	100%	100%	100%	100%	96%	97%	95%	100%	91%	nc	nc	100%	nc	98%
Patient Falls resulting in no or low harm (inpatients)		3	3	1	6	4	3	1	2	3	2	0	2	4	31
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	0	0	0	0	0	1	0	0	0	0	0	0	1
Patient falls per 1000 bed days		2.4	2.4	0.8	4.7	3.4	2.6	2.0	1.7	3.3	4.0	0.0	3.0	9.3	3.1

*MRSA April 20 - the revised score following a meeting between QVH & MCIndoe and screening process reviewed.
nc = not collected or not reported

Effective - Performance Indicators





	Quarter 2		Quarter 3			Quarter 4			Quarter 1 2019/20			Quarter 2
	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Number of deaths on QVH site	0	0	0	0	0	0	0	0	1	0	0	0
Number of deaths off- site within 30 days of IP or OP procedure	1	0	1	2	1	1	1	1	1	2	0	1
No of completed preliminary reviews	0	0	1	1	1	Awaiting coroners report	0	1	2	1	0	0 COD nto yet known
No of deaths subject to a Structured Judgement Review	0	0	0	0	0	Awaiting coroners report	0	Awaiting coroners report	1	1	0	0
No of deaths in patients with co-existing learning difficulties	0	0	0	0	0	0	0	0	0	0	0	0

Nursing Workforce - Performance Indicators, Safe staffing data

In June the actual care hours on shift were 69 hours less hours than planned. The clinical areas have been staffed to safe levels on some shifts there has been more care hours available than required in order to maintain the minimum requirement of 2 qualified nurses per shift. A small amount of flex was factored in to the staffing templates to allow for the staffing of an isolation area at short notice or support to TMC. There were no shifts where planned hours did not meet actual hours required for the occupancy and acuity .These were no safety metrics and incidents recorded on Datix relating to staffing levels during June. Apart from agency usage for mental health nurses there was no agency used to cover nursing or HCA posts in June in the ward or outpatient areas.

Combined Staffing exc. Site — *Target 95%*

Jun-20

	Planned staff		Actual staff			Planned staff		Actual staff	
	RN	HCA	RN	HCA		RN	HCA	RN	HCA
DAY	4370	1771	4347	1748	*Total Hrs Planned and Actual*	3312	667	3255	701.5
			99.5%	99%	*% Planned Hrs Met*			98.3%	105.2%
		6141		6095	*Total Hrs Planned & Actual - Combined reg & support*		3979		3956
				99.3%	*% Planned Hrs Met - Combined reg & support*				99.4%

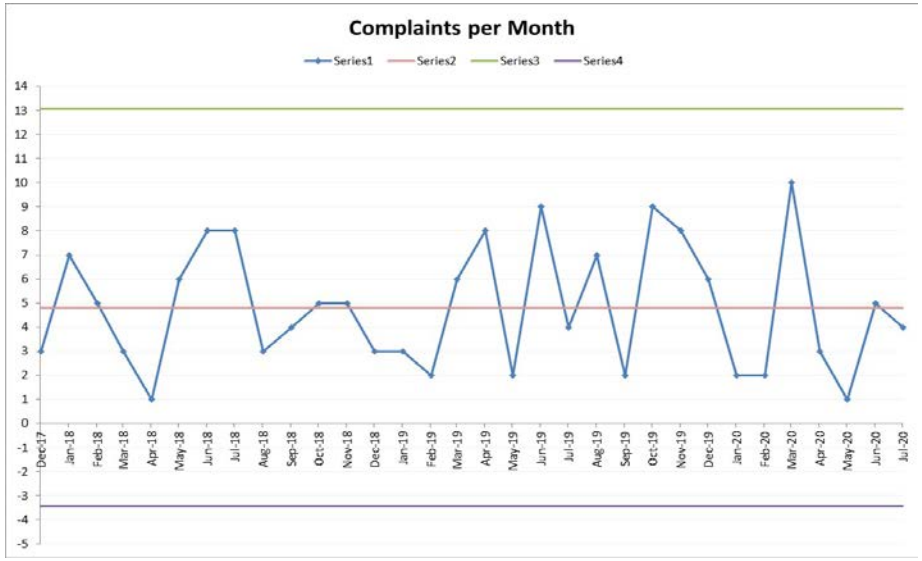
In July the actual care hours on shift were 46 hours more than planned. The clinical areas have been staffed to safe levels on some shifts there has been more care hours available than required in order to maintain the minimum requirement of 2 qualified nurses per shift. A small amount of flex was factored in to the staffing templates to allow for the staffing of an isolation are or TMC at short notice. There were 2 shifts where planned hours did not meet actual hours and the care was completely safe and required no escalation. These were triangulated with safety metrics and incidents recorded on Datix and there is no correlation between these incidents and slightly decreases staffing level on the shift. Apart from agency usage for mental health nurses there was no agency used to cover nursing or HCA posts in July in the ward or outpatient areas.

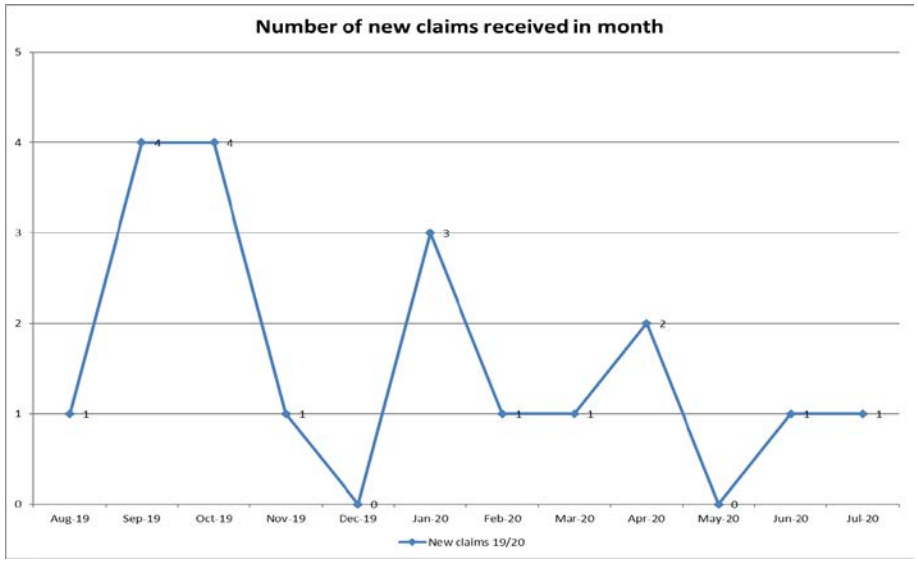
Combined Staffing exc. Site — *Target 95%*

Jul-20

	Planned staff		Actual staff			Planned staff		Actual staff	
	RN	HCA	RN	HCA		RN	HCA	RN	HCA
DAY	4589	1978	4577	1978	*Total Hrs Planned and Actual*	3565	540.5	3554	540.5
			99.7%	100%	*% Planned Hrs Met*			99.7%	100.0%
		6567		6555	*Total Hrs Planned & Actual - Combined reg & support*		4106		4094
				99.8%	*% Planned Hrs Met - Combined reg & support*				99.7%

Caring - Current Compliance - Complaints and Claims





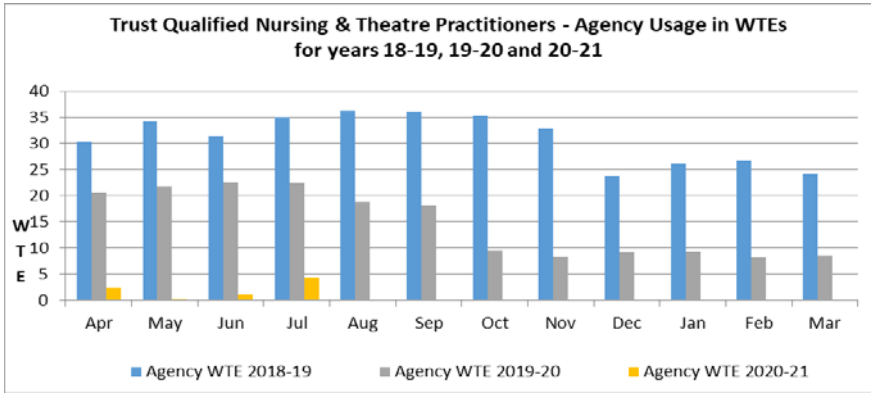
	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Complaints	7	2	9	8	6	2	2	10	3	1	5	4
Complaints per 100 contacts	0.37	0.11	0.43	0.42	0.37	0.1	0.12	0.65	0.18	0.09	0.4	0.28
Number of complaints referred to the Ombudsman for 2nd stage review	0	0	0	0	0	0	0	0	0	0	0	0
Number of complaints re-opened	1	1	0	0	0	3	0	1	0	1	1	1

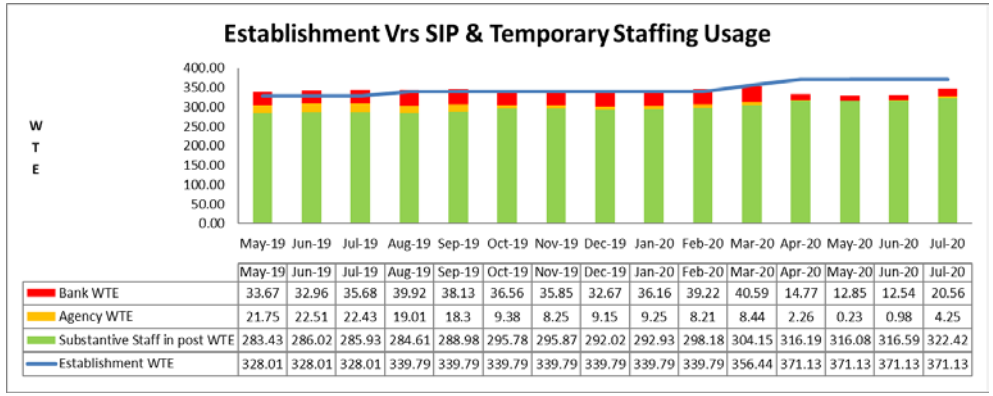
Nursing Workforce - Performance Indicators

ALL QUALIFIED & UQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020-21			Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)				328.01	339.79	339.79	339.79	339.79	339.79	339.79	339.79	356.44	371.13	371.13	371.13	371.13	◄►
Staff In Post WTE				285.93	284.61	288.98	295.78	295.87	292.02	292.93	298.18	304.15	316.19	316.08	322.52	322.42	▲
Vacancies WTE				42.08	55.18	50.81	44.01	43.92	47.77	46.86	41.61	52.29	54.94	55.05	48.61	48.71	▼
Vacancies %	>18%	12%<>18%	<12%	12.83%	16.24%	14.95%	12.95%	12.93%	14.06%	13.79%	12.25%	14.67%	14.80%	14.83%	13.10%	13.12%	▼
STARTERS WTE (Excluding rotational doctors)				2.00	4.64	7.43	6.00	2.00	1.51	1.00	5.43	4.41	0.51	2.23	5.01	0.61	▼
LEAVERS WTE (Excluding rotational doctors)				3.00	3.47	2.00	2.00	1.76	1.50	6.00	0.00	1.02	3.91	3.00	0.00	2.32	▲
Starters & Leavers balance				-1.00	1.17	5.43	4.00	0.24	0.01	-5.00	5.43	3.39	-3.40	-0.77	5.01	-1.71	
Agency WTE (Data From Healthroster)				22.43	19.01	18.30	9.38	8.25	9.15	9.25	8.21	8.44	2.26	0.23	0.98	2.45	▲
Bank WTE (Data From Healthroster)				35.68	39.92	38.13	36.56	35.85	32.67	36.16	39.22	40.59	14.77	12.85	12.54	20.56	▲
Trust rolling Annual Turnover %	>=12%	10%<>12%	<10%	16.20%	15.22%	12.52%	15.15%	12.46%	9.67%	10.50%	9.94%	9.71%	9.95%	10.27%	8.67%	8.48%	▼
Monthly Turnover				1.08%	1.26%	0.71%	1.51%	0.60%	0.37%	1.44%	1.42%	0.00%	1.31%	1.01%	0.00%	0.77%	▲
Sickness Absence %	>=4%	4%<>3%	<3%	3.66%	1.86%	2.04%	4.17%	5.11%	4.82%	3.63%	2.67%	6.30%	3.64%	2.21%	1.67%	TBC	

Note 1. 2019/20 budget updated July 20 backdated to March 20 to show most current position, taken from Finance Ledger
Note 2. All data taken from ESR unless stated otherwise.
Note 3. Staff included are Qualified Nurses, Emergency Practitioners, Theatre Practitioners, HCA's,Student OPD's, Trainee Nurse Associates/Practitioners,Nurse Associates, Play Specialists, Oversea's Nursing awaiting PIN. Dental Nurses included in figures from 1.4.2020
Note 4. Of Qualified Staff approximately 4wte are Maxillo facial Nurses and 23.5wte are ODP Theatre Practioners
Note 5. Of Unqualified staff approximately 10.5wte are Dental Nurses





	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Bank WTE	33.67	32.96	35.68	39.92	38.13	36.56	35.85	32.67	36.16	39.22	40.59	14.77	12.85	12.54	20.56
Agency WTE	21.75	22.51	22.43	19.01	18.3	9.38	8.25	9.15	9.25	8.21	8.44	2.26	0.23	0.98	4.25
Substantive Staff in post WTE	283.43	286.02	285.93	284.61	288.98	295.78	295.87	292.02	292.93	298.18	304.15	316.19	316.08	316.59	322.42
Establishment WTE	328.01	328.01	328.01	339.79	339.79	339.79	339.79	339.79	339.79	339.79	356.44	371.13	371.13	371.13	371.13

Medical Workforce - Performance Indicators

Metrics	2017/18 total / average	Target	Quarter 2 2019/20		Quarter 3			Quarter 4			Quarter 1 2020/21			Quarter 2	Year to date actual/ average
			Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	
Medical Workforce															
Turnover rate in month, excluding trainees	21.63% 12Mth rolling	<1%	1.16%	1.54%	1.18%	1.15%	1.25%	1.14%	0.00%	2.93%	0.00%	0.28%	1.12%	0.00%	11.90% 12 mth Rolling
Turnover in month including trainees 9%	45.43% 12Mth rolling		12.42%	6.08%	2.82%	1.39%	2.80%	0.70%	9.57%	2.82%	0.70%	0.17%	1.42%	0.71%	41.54% 12 mth rolling
Management cases monthly		**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Sickness rate monthly on total medical/dental headcount	1.43%		1.07%	2.34%	1.5%	2.00%	0.99%	0.53	1.55%	1.99%	1.63%	1.52%	0.65%	TBC	1.46%
Appraisal rate monthly (including deanery trainees)	88.96% Mar 18		81.62%	86.00%	83.66%	85.53%	89.74%	87.60%	88.44%	91.36%	81.40%	74.85%	62.05%	57.74%	80.83%
Mandatory training monthly		**95%**	88.50%	84.81%	84.99%	85.93%	86%	85%	88.50%	86%	87%	87%	86%	86%	86.00%
Exception Reporting – Education and Training			2	5	2	1	1	0	5	0	0	0	0	1	17
Exception Reporting – Hours			0	5	1	1	2	2	1	0	0	0	0	5	17

Medical & Dental Staffing

In August 18 new junior doctors started with QVH, mostly in Anaesthetics and Core Surgery. A carefully planned day ensured that they were given an appropriate and useful induction to the Trust.

Plans are now underway to ensure that the doctors' inductions in September and October are equally successful.

Work is underway with managers, consultants and trainees in plastic surgery to ensure that suitable rotas are implemented for doctors, which takes into account new service requirements as well as ensuring continued access to training.

Education	Following the successful installation of the simulation suite in the Education Centre, plans are in place for a final add-on to allow footage to be screened in the main education centre room as well as the debrief room, this will allow for greater flexibility and social distancing while delivering training. The medical education manager and simulation lead are grateful for the League of Friends' support with this project. Teaching continues to take place using a variety of mediums. The consultants mandatory training update in September will be delivered using a mix of MS Teams and e-learning. The Junior Doctors' forum continues to meet monthly to ensure that trainees feel supported during this transition period.

Queen Victoria Hospital
NHS Foundation Trust

Appendix 1

NHSE Infection, prevention and control board assurance framework

The impact of the Coronavirus pandemic is a challenge to the way we are delivering services in our organisations, across Kent, Surrey and Sussex and nationally.

NHSE Infection Prevention and Control Board Assurance framework (IPC BAF) has been sent to all providers to complete for assurance purposes.

A priority at this stage in the pandemic for the CQC is to ensure infection prevention and control measures are effective to reduce the risk of transmission of Covid-19. The Trust has redesigned surgical pathways to provide screened pathways of care to enable patient with cancer to have urgent surgery whilst minimising the additional risk of acquiring of Covid-19 whilst a patient at QVH.

The IPC BAF has been updated and the version below was sent to the CQC in preparation for the assessment review on the 27 August (postponed by the CQC from the 11 August).
The first version of the IPC BAF document was presented at the June quality and governance committee.

Queen Victoria Hospital
NHS Foundation Trust

Infection Prevention and Control board assurance framework July 2020 update

Document completed May/June 2020 monthly updates for EMT for Q&GC and Board

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission • compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients • patients and staff are protected with PPE, as per the PHE national guidance	• All elective admissions are assessed as to whether they are urgent ie cancer surgery. Patients are pre-assessed and given instructions to self isolate for 14 days they are then swabbed for COVID 72 hours before admission. • Trauma patients are cared for in a separate section of the Trust, temperature checks and health questions asked before entry. During core hours trauma patients requiring GA's are swabbed from throat and nose which is tested using optigene, a negative result is required before surgery • Separate theatre areas are available for patients who are not swabbed due to low risk surgery e.g. hand trauma • Patients with suspected or confirmed Covid-19 are cared for in a designated	Governance process needed to reflect new ways of working- addressed see mitigating action	Revised governance process in place from May 2020 with a recovery and restoration clinical governance group for clinical decision making to provide assurance about what and where and when decisions are made to ensure the right level of scrutiny and oversight from ward to board Additional governance processes presented at Q&GC in June 2020

	area with full precautions- due to cancer hub corona 'lite 'status of the site this has not been required at time of completing this document which shows the screening measures are working. • Patients who remain inpatients are screened again at day 5 and all those being discharged to a healthcare environment are screened no greater than 48 hours before discharge • Fluid resistant surgical masks are available in all departments for staff to wear anyone non able to tolerate masks is referred to occupational health • All areas re-starting patient facing work are assessed to ensure staff are aware of the right PPE they need • FIT testing is an ongoing process to ensure all staff who are required to wear FFP3 are safe to do so, for those who are unable to be FIT tested there is a supply of air powered hoods available for use. • All requirements for PPE are in line with current PHE recommendations		

• national IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• All staff are trained on donning and doffing of PPE. PPE is available in all staff areas and surgical masks at the front gate for patients • PPE guidance updated as PHE guidance has been amended – additional training given to staff as required • Standard infection control precautions and measures remain unchanged to safeguard against non COVID-19 infections. MRSA screening policy in place, and strict Burns management. • Screening booth at the main entrance to site. All staff patients, delivery drivers and visitors have temp check and asked if any COVID-19 symptoms. This is in operation 7 days per week. • Regular reminders to staff and updates on changes in twice a week corona briefings • Additional signage and updates on public facing website and message on the hospital telephone system	Potential for guidance to be overlooked due to vast quantities of information being pushed out to providers Second entrance at rear of building. Visitors walking around site looking for beverages and use of toilets	Single point of access email and phone introduced via EPRR route for key changes and immediate action email requests. This is monitored by the incident room 0800-1800 and by oncall manager out of hours and at weekend Screening and swabbing SOPs in place reflecting relevant national guidance and updated each time guidance changes Screening staff deployed to this entrance point Staff restaurant closed to patients and visitors, water and biscuits available at the screening booth free of charge. Toilets designated for visitor use which doesn't require them to enter main hospital site

• changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Changes to PHE guidance are communicated via twice a week briefing which is circulated to all staff	Potential that all staff may not read briefing	Team leads communicating changes at team briefs/huddles and meetings.
	• Corona risk added to the CRR and is reflected in elements of the BAF, key risk is delays to treatment and health and wellbeing of staff	Unknown impact of delay on patient outcome	Clinical Harm review process in place for continued review of 52 week and 104 day breaches. Looking to share learning meeting with another provider 4/8/20 to facilitate this
	• No changes to processes and practice for Non COVID-19 IPC. Regularly audits and screening and reporting has continued throughout.	Burns ward relocated during pandemic	IC lead working with Burns ward completed risk assessment of new area and burns theatre

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Antimicrobial stewardship continues with a new antimicrobial pharmacist in post. Monthly reporting continues. • Antibiotic prophylaxis and alternative antibiotic therapy discussed with consultant microbiologist • All mandatory reporting continues as normal with quarterly reports produced for Board.		Antibiotic stewardship review and meeting continue with reporting to the medicines management group, plans for 'alternative ' antibiotic preparations agreed

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	• Visiting is restricted in line with PHE guidance. • Plan in place for EOLC to allow compassionate visiting • Signage throughout the trust marking ward areas closed to visiting and do not enter signs	Unknown if all visitors, patients and staff have fully adhered to social isolation	Screening of all persons on site, ambulatory care patients and visitors asked to wear a mask while on site and in waiting areas. Written visitors guidance updates on trust webpage, continue to limit visitors due to cancer hub status in line with revised national guidance.

• information and guidance on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Information on trust website and the hospital telephone system has been updated Plan in place for this – no patients in this category to date		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection • patients with suspected COVID-19 are tested promptly	• The Trust has been separated to create COVID-19 clear areas for all elective admissions who have undertaken the required isolation and screening. • There is separate area for trauma and elective patients who are non-symptomatic but have not under taken the isolation and screening • All patient are met at the front entrance where they are temperature checked and then directed to the appropriate area. • Any patient with symptoms whilst • an inpatient is transferred to a designated area to await swab results. • If a patient presents with symptoms then the reason for admission /attendance is assessed as to whether they need to be seen on that day if it is deemed urgent then they are cared for in a designated area.	Ventilation in CCU and Burns resolved see mitigation	Burns ward relocated to another area so green status of CCU is not compromised. New head and neck ward established in this green Zone. Use of independent sector beds to provide a screened pathway(green) for cancer patients

• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re- tested • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	All in patient's elective or trauma are swabbed. All patients returning to care home are screened 48 hours in advance		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it • a record of staff training is maintained	• All staff have received training to ensure they are working in a safe environment. • Communication to staff around social distancing, hand washing, good respiratory etiquette has been reinforced • All staff are now screened for Covid-19 on a rolling basis. High risk areas are screened more regularly on a weekly basis. This is monitored on a departmental basis and overseen by a dedicated research team • All staff providing care have been trained on the use of PPE with physical demonstrations and posters produced to ensure they know which PPE to use when and how to put it on and take it off correctly. • All staff are FIT tested before they can use an FFP3 mask		Addition donning and doffing training and FIT testing have continued throughout the pandemic. Training has also been provided to THC to ensure same standards for all patients irrespective of which site they are treated on.

	• Re-use of PPE is in place following PHE guidance with clear instructions on decontamination of PPE. • Monthly hand hygiene and uniform audits are undertaken. • Staff are reminded of the importance of hand hygiene and the correct wearing of uniforms/work clothes and scrubs. • Colour coded scrubs are in place to show designated areas of the Trust • All staff have been provided information and communication around the symptoms of COVID-19 and what to do if either they or a family members displays any of them. –Staff screening is available. • IPC team keep numbers of staff trained , individual training is recorded by staff member		

• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their household display any of the symptoms.	• PPE has not needed to be reused at this time. CAS alert guidance would be followed if the situation were to change • The trust follows the national PPE guidance and has a QVH visual guide as well displayed in all clinical areas. Spot check are undertaken by IPC team • This monitoring continues as per normal process • Guidance has been provided to staff via daily bulletins • Numerous reminders have been sent to staff and updates have included new symptoms to look out for	If a staff member or group is not following national guidance this is escalated to relevant manger or clinical director	Staff are challenging each other and where required this is picked up by line manager/service lead to promote adherence
7. Provide or secure adequate isolation facilities			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• If a patient is suspected of or confirmed to be COVID-19 positive then there is a designated area that they will be cared for, this has been set up with a clear entry and exit room, donning and doffing areas, shower facilities for staff, areas to care for the symptomatic well patient and the deteriorating patients. This area is distanced from other areas within the Trust to minimise the risk of spread. • Any patient with an infectious organism would be managed as per standard infection control precautions. • Departments relocated to different areas within the Trust in order to facilitate trauma patients being brought back to site whist still being able to segregate green and amber patients • All areas assessed by the MDT including department leads, IPACT and estates		Screening and swabbing guidance updated to reflect these changes. Patient information letters changed
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance • screening for other potential infections takes place	• All staff required to screen patients have been given training on the correct way to swab a patient. Staff are trained on the approved way to label and package swabs to ensure safe transport to the laboratory for testing. • Patient screening is done either preadmission in line with the national cancer pathway or on admission for all overnight stays, on discharge if the patient is being discharged to a care home facility or if the patient displays any symptoms of Covid-19. Staff displaying symptoms are screened following PHE guidance • Trust policy on screening patients for other infections remains in place. • Staff testing lab is now in place with a 2 week prevalence having been completed showing a 0% rate of Covid carriage amongst all staff groups. Regular testing continues with frequency being dictated by area worked.		Optigene testing lab has been commissioned to provide further assurance to patients , commissioners and Cancer Alliance that we are doing everything we can to minimise the risk of transmission of COVID-19 from staff to patient. This will include testing patients and the workforce to establish the prevalence at QVH and then regular testing of high risk staff (BAME , personnel who move between sites or work at other hospitals) or staff operating on major cases.

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance • PPE stock is appropriately stored and accessible to staff who require it •	• The infection control team has increased visibility in all wards and departments to ensure staff feel supported with all IPC policies and changes in guidance • The IPACT has provided contact details for out of hours advice to maintain a constant support and advice ethos • Any changes in PHE guidance is disseminated in a timely manner to fit with the Trust environment • All waste is disposed of in accordance with PHE guidance and following assurance from the waste providers • Stores of PPE is monitored, stored and controlled by the supplies department in a way that ensures staff have appropriate access.		Visible and virtual leadership from DIPC, EPRR Lead and deputy medical director on questions and queries re IC issues, which has been well utilised by staff Daily return via incident control room of PPE submitted 7 days per week
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff that test positive have adequate information and support to aid their recovery and return to work.	• Staff are risk assessed by their department leads to identify safe working practices on an individual basis following guidance from PHE • HR have developed and circulated extensive health and wellbeing information and tips. • We currently do not have reusable respirators within the Trust but all staff required to wear a disposable respirator are FIT tested to do so and a log maintained. • Any staff member who tests positive is given information about isolation and keeping well, they are able to contact the infection control team at any time for further advice or support. Support is offered via incident control room and line manager. Return to work advice follows national guidance and this is confirmed with IPC Team or EPRR lead if any queries re this		HR co-ordinating review of risk assessments to ensure accurate information on all vulnerable groups and oversight Weekly optigene screening available for staff returning from shielding.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	3 September 2020		**Agenda reference:**	**137-20**	
Report title:	Approval of annual reports				
Sponsor:	Jo Thomas				
Author:	Nursing Directorate Team members				
Appendices:					
Executive summary					
Purpose of report:	The purpose of this report is to gain board approval for a series of annual reports within the nursing directorate, as recommended by the Quality and governance committee				
Summary of key issues	Annual reports for approval comprise: • Safeguarding • Infection, prevention & control • Patient experience • Emergency preparedness, resilience and response, (and business continuity) • Research & Development • Consultant revalidation				
Recommendation:	The Board is asked to **approve** the attached annual reports for 2020/21				
Action required *[highlight **one** only]*	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*

Implications				
Board assurance framework:	None			
Corporate risk register:	None			
Regulation:	None			
Legal:	None			
Resources:	None			
Assurance route				
Previously considered by:	Quality and governance committee			
	Date:	16.07.20	Decision:	Recommended for approval
Previously considered by:				
	Date:		Decision:	
Next steps:				

Queen Victoria Hospital
NHS Foundation Trust
Holtve Road.
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RH19 3DZ

Safeguarding

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2019 to March 2020

Document Control: committees and groups who have approved this report
Executive sponsor: Jo Thomas, Director of Nursing

Authors: **Pauline Lambert, Safeguarding Adults and MCA Named Nurse**
Katy Fowler, Safeguarding Children and LAC Named Nurse
Ms Tania Cubison, Safeguarding Named Doctor

Date: April 2020

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1.	Executive Summary
	Each year a Safeguarding Report is produced for QVH Board to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively. The report is reviewed and scrutinised by the Quality and Governance Committee before being shared with the Board for information. QVH safeguarding systems and arrangements continue to be improved and strengthened. Safeguarding support for staff is well established. Safeguarding Audits continue to provide assurance for the organisation and also identify any key development areas. **Current challenges are:** COVID-19: This is currently causing significant disruption across the NHS and the country. We are significantly changing the way we work to ensure that the needs of the service can be accommodated in the face of staff sickness; during this time we need to work together to safeguard the most vulnerable patients. The safeguarding team have produced a Business Continuity Plan, which has been shared with the Sussex CCG's. The action log is regularly reviewed and updated. We continue to offer support across the hospital and have offered to provide an out-of-hours advice service to support staff during this unprecedented time. QVH compliance with Mental Capacity Act is improving, re-audit was underway in January 2020 but has been paused due to the COVID 19 situation. A QVH MCA Task and Finish group has also been paused until normal working arrangements are back in place. Liberty Safeguard Protection (LSP) was due to be launched September 2020. Was then delayed. During COVID 19 urgent DOLS guidance and form has been provided. **Current achievements are:** Adult safeguarding level 3 training was introduced in 2019 with a starting point of 0% uptake and by march 2020 reached 91.8% uptake. Exceeding the planned target for level 3 during 2019. QVH Named Doctor for Safeguarding appointed Ms Tania Cubison has recently joined the safeguarding team. Our thanks to Dr Rahman who has been our Named Doctor for safeguarding children for a number of years and who provided a robust advice and support to QVH colleagues. Demonstrating compliance with WRAP training to the required 85% target, currently 89% an improvement of 7% on the previous year. All WRAP Level 3 training is now completed online. Changes to the structure of the safeguarding team; appointment of Named Nurse for Safeguarding Children and Looked After Children (LAC), Katy Fowler. Who has worked at QVH for 18 years and brings a wealth of experience and commitment to the role. Continuing engagement of staff and recognition of safeguarding responsibilities

	Datix reporting systems working effectively enabling production of monthly Board metrics Robust connections with West Sussex Safeguarding Adults Board and Safeguarding Children Partnership and the establishment of an Acute Children's Safeguarding Network. Systematic review of relevant QVH safeguarding polices, protocols, standards and guidance. QNet intranet safeguarding and MCA pages are kept updated. National Child Protection Information Sharing system (CP-IS) being used by MIU and Paediatric Ward; an audit of this is currently underway. Strengthened Looked After Children (LAC) safeguarding systems across the trust. Safeguarding children Neglect Tool roll out has begun in the trust in line with West Sussex Local Children's Safeguarding Partnership priorities.

2.	**Introduction**
2.1	Each year a Safeguarding Report is produced for QVH Board to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.
2.2	QVH is registered with the Care Quality Commission (CQC). To be registered, QVH must be assured that those who use the services are safeguarded and that staff are suitably skilled and supported to provide effective safeguarding as part of health care delivery. As a Foundation Trust, QVH is licensed via NHS Improvement, which is conditional upon registration with the CQC. In the last CQC inspection report (2019) the CQC report said: 'There were arrangements to keep service users safe from abuse which were in line with relevant legislation. The majority of staff had received training, were able to identify who might be at risk of potential harm and knew how to seek support or advice', 'Staff understood and complied with the relevant consent and decision-making requirements of legislation, including the Mental Capacity Act, 2005'. Mandatory training rates were changed to 90%, safeguarding Level 1, 2 and 3 uptake is achieving well over 90%. Only WRAP Level 3 is below the target and is currently at 89% uptake. QVH had a CCG Safeguarding Site visit in July 2019 where representatives from the CCG assessed the safeguarding service that the QVH offered; this covered various topics from across the safeguarding Adult and Children agenda. Feedback from the CCG representatives were that QVH has 'clear safeguarding processes in place' and 'staff are aware of the escalation process and are confident to raise concerns'. QVH must demonstrate that there is safeguarding leadership and commitment at all levels of the organisation and that staff are fully engaged. To support local accountability and assurance structures QVH safeguarding leaders need to engage with West Sussex Safeguarding Children Partnership (WSSCP), West Sussex Safeguarding Adults Board (WSSAB) and relevant commissioners.

	QVH must ensure a culture exists where safeguarding is every bodies business and poor practice is identified and addressed. QVH must have in place effective safeguarding arrangements to safeguard children and adults who are at risk of abuse or neglect. These arrangements include: safe recruitment, effective training for staff, effective supervision arrangements, working in partnership with other agencies, identification of a Named Doctor and Named Nurse for safeguarding children, plus a Named Nurse for adult safeguarding and Mental Capacity Act lead. The named professionals have a key role in promoting good professional practice within QVH, supporting local safeguarding systems and processes, providing advice and expertise, and ensuring safeguarding training is in place, is delivered and of a suitable quality. They are expected to work closely with QVH Director of Nursing, West Sussex Designated Professionals, WSSCP and WSSAB.
2.3	The effectiveness of safeguarding systems is assured and regulated by a number of mechanisms. They include: • Internal assurance processes and Board accountability • Partnership working with WSSCP and WSSAB • External regulation and inspection by Care Quality Commission (CQC) and NHS England. • Local safeguarding peer review and assurance processes • Effective contract monitoring
2.4	QVH Board members review monthly safeguarding metrics at the Quality and Governance Committee and receive an annual safeguarding report which is provided so that the Board can be assured that the Trust is undertaking its safeguarding duties and responsibilities, as well as delivering its statutory safeguarding responsibilities safely and effectively. The Board should critically appraise the QVH safeguarding report by making sure patient safety, staff activity, governance arrangements and safeguarding data are transparent and clear so that they can confirm they are assured.

3.	**Legislative Frameworks and National Safeguarding Agenda.**
3.1	**Safeguarding Adults:** Safeguarding means *"protecting an adult's right to live in safety, free from abuse and neglect" (Care Act 2014).* To implement this Act a three-step test is applied to patient circumstances: does the patient have care and support needs, are they at risk of or experiencing abuse or neglect, and are they unable to protect themselves. The arena for safeguarding adults continues to evolve since the implementation of the Care Act (2014). However, the aims of safeguarding adults remain unchanged. Organisations such as QVH, must stop abuse or neglect wherever possible, prevent harm and reduce the risk of

	abuse or neglect to adults with care and support needs. They should safeguard adults in a way that supports them in making choices about how they want to live their lives and provide information in accessible ways to help adults understand how to stay safe and what to do to raise a concern. In order for staff at QVH to achieve these aims, it is necessary to ensure that all staff are clear about roles and responsibilities, create strong multi-agency partnerships and support the development of a positive learning environment. As an organisation, QVH adhere to the Sussex Safeguarding Adults policy & procedures as this provides an overarching framework to coordinate all activity undertaken where a concern relates to an adult experiencing or at risk of abuse or neglect. These procedures represent standards for best practice in Sussex and have been endorsed by Brighton & Hove, East Sussex and West Sussex Safeguarding Adults Boards. They are available online, with links to the website via the internal intranet (QNET). This document is reviewed and updated by the West Sussex Safeguarding Adults Board.
3.2	**Safeguarding Children:** *'The welfare of the child is paramount'* principle was enshrined in the Children Act 1989 and has driven the development of systems and arrangements used to safeguard and/or protect children since that time. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to ensure that services are designed to safeguard and promote the welfare of children. National guidance also stipulates that each NHS trust must identify a lead nurse for Child Sexual Exploitation (CSE) and Looked After Children (LAC, sometimes referred to as 'children in care'). These responsibilities are part of the Safeguarding Named Nurse Job Description. The Local authority have requested that we make them aware of any children who are not in education or privately fostered to enable them to undertake their statutory duties; we have ensured that this is completed for all children throughout the geographical area that QVH cover.
3.3	**Mental Capacity Act (MCA) 2005 & Deprivation of Liberty Safeguards (DoLS):** The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) have placed an emphasis on ensuring that the rights of vulnerable people (aged 16 and over) to make decisions are protected. Decisions made on behalf of people who lack capcity to do so themselves should only be made using the MCA legal framework. Capacity is described as a person's ability to make a specific decision at a specific time, for example - for specific serious medical treatment. The DOLS were added into the MCA and is an additional Safeguard providing guidance on procedures that ensures care and treatment for those who lack capacity to consent to their accommodation is only delivered in their best interest and using the least restrictive options to ensure their safety. To be lawful, it needs to be authorized by the local authority, but in the hospital urgent self-authorization can be used when necessary. QVH staff are required to understand and comply with the requirements set out in the MCA 2005.

	The QVH Mental Capacity and Deprivation of Liberties Policy was reviewed and updated during 2018. The existing QVH orange mental capacity assessment and best interest form continues to be used. The QVH MCA Task and Finish Group was set up but has had to pause during the COVID 19 situation. Hopefully MCA development work will recommence during 2020. At year-end compliance rates for Mental Capacity Act training are currently at **92%** across the organisation. A departmental risk assessment for MCA is in place until a clear organisational overview of implementation in practice is embedded using Datix to capture the required data. Currently the organisation is aware of cases reported to the MCA lead, re-audit of MCA processes was started but has been paused due to COVID 19. Liberty Protection Safeguards should be introduced to replace DOLS this year.
3.4	**PREVENT** The United Kingdom's long-term strategy for countering international terrorism is called 'CONTEST'. Published in 2006 and updated in 2009 and 2011, its aim is 'to reduce the risk to the UK and its interests overseas from terrorism, so that people can go about their daily lives freely and with confidence'. CONTEST comprises of four key elements: • Pursue: to stop terrorist attacks ~ detecting and disrupting threats of terrorism. It is targeted at those who have committed a crime or are planning to commit a crime. • Protect: to strengthen our protection against a terrorist attack ~ strengthening our infrastructure from an attack including buildings, public spaces and our borders. • Prepare: to mitigate the impact of a terrorist attack. Focuses on where an attack cannot be stopped and aims to reduce its impact by ensuring we can respond effectively. • Prevent: to stop people becoming terrorists or supporting terrorism. 'Prevent' is different from the other three in that it focuses on early intervention before any illegal activity takes place and hence operates in the non-criminal sphere. Involving a broad range of partners, it is about minimising the risk, at an early stage, of people adopting extremist views which support violence or terrorism. NHS providers are expected to contribute to the Prevent agenda. All clinical staff are expected to undertake Level 3 Prevent training which is currently at 89%. Prevent basic awareness training is provided to all QVH staff as part of safeguarding training sessions at levels 1 and 2 and is currently uptake is at 95%.

4.0	**Sussex Clinical Commissioning Groups (CCGs) Safeguarding Standards**
	During 2016-2017 the CCGs used the *Safeguarding Vulnerable People in the Reformed NHS : Accountability and Assurance Framework* (March 2013) to produce a set of Sussex Safeguarding Standards to make explicit their expectations of NHS providers in relation to safeguarding.

	The CCGs across Sussex have in place quality and safety systems, and processes in order to enable continuous improvements and the 'safeguarding standards guidance' now forms part of these arrangements. The nine standards were developed to enable assurance to be provided to demonstrate patients of all ages are safeguarded effectively. The standards enable all parties to identify key benchmarks to ensure an effective, systematic, auditable approach to enable the safeguarding of all patients, whatever their age. The Sussex standards were reviewed and updated by the CCGs during 2019.These standards were shared with QVH Board at a safeguarding seminar during November 2019. The standards enable the safeguarding team at QVH, as well as commissioners to audit against benchmarks to ensure effective measures are in place. This section of the report is organised based on these standards. Additional standards for Looked After children (LAC) have been added which the safeguarding team reports on via the CCG exception reporting system.
4.1	**STANDARD 1: Strategic Leadership**
	The Executive Board Lead for safeguarding vulnerable people, MCA & DOLS is the Director of Nursing who oversees compliance with safeguarding legislation and trust responsibilities. The purpose of this role is to monitor protection of people who use services at QVH and to ensure these are understood by staff and implemented throughout the organisation**.** The QVH Safeguarding Strategy (2019) supports a progressive response to the changing landscape framing the delivery of healthcare services at QVH was reviewed and updated in 2019. An action plan sits under this strategy and this can be reviewed in Appendix A. QVH has robust safeguarding governance arrangements in place, which are led and supported by a team of specialist safeguarding clinicians. The QVH governance structure provides transparent lines of accountability, clear partnership connections with internal QVH meetings which are in place to support learning from practice and delivery of effective safeguarding. Due to the current COVID-19 situation the safeguarding steering group meetings have been suspended until September 2020. In the meantime staff are updated by safeguarding messages shared via daily COVID 19 updates, through Connect, QNET and the Safeguarding team. The Safeguarding team currently links with the Designates and the wider Sussex safeguarding network via regular meetings to ensure that QVH is kept updated on the fast-changing local safeguarding picture. During COVID 19 weekly safeguarding children and two weekly safeguarding adult virtual meetings are used to manage safeguarding pressures across the county. The safeguarding team disseminate relevant information to staff in a timely way. QNET safeguarding and MCA pages both have COVID 19 sections which staff can also access. The QVH safeguarding team comprises of; • Jo Thomas, Director of Nursing and Quality, Executive Board Lead for Safeguarding • Pauline Lambert, Named Nurse for Safeguarding Adults (covers: Adults, MCA & DoLS Lead and Prevent Lead)

- Katy Fowler, Named Nurse for safeguarding Children (covers: Children, Child Sexual Exploitation (CSE) lead and Looked After Children (LAC) lead and Prevent Lead)
- Ms Tania Cubison, Named Doctor Safeguarding.
- Debra Yeoh, Nurse Specialist Safeguarding Children.

The purpose of this team is to continuously work to improve and update all staff including volunteers regarding their safeguarding knowledge and responsibilities. This is achieved through case discussions and supervision, advice, practice review and audit; provision of training; provision of policy, procedures, protocols and guidance.

The Non-Executive Director who chairs the Quality and Governance Committee is working to support scrutiny of the agenda with 'Safeguarding' identified as a discreet responsibility.

Across QVH there is a network of link champions for safeguarding from service areas. They attend a safeguarding steering group (currently paused for safety reasons due to COVID-19) to discuss clinical issues, access information, review learning and to share practice improvement across the organisation.

The Joint Hospital Governance Group provides a far-reaching internal audience where safeguarding discussions are also undertaken, such as sharing learning from Safeguarding Reviews and Audit, and how improvements in practice might be applied in QVH. It is a useful conduit for learning from case examples and experiences. At the beginning of 2020 a consultant anaesthetist presented a challenging case at the Joint hospital Governance Group; this generated much discussion regarding MCA, MHA and QVH Restrictive Interventions policy in practice.

Driving improvement in all aspects of safeguarding practice is a continuous process and as such has to be reviewed, evaluated, developed and adapted over time. There is a safeguarding learning and development strategy for the organisation to steer and facilitate staff competency development in all aspects of safeguarding. This year we have moved to incorporate all level 1 and 2 safeguarding training into a single session to allow staff to be up dated on all safeguarding issues and reduce repetition. This has been well received by staff who have evaluated the change positively; a sample of staff training evaluation summaries is included in APPENDIX B. We continue to offer level 3 Adult and Child Safeguarding sessions separately for those members of staff who require this additional level of training. These sessions are undertaken twice yearly. Staff also have the opportunity to access other level 3 training off site including those run by the local safeguarding Boards and Partnerships and external conferences and workshops. Recently the Sussex CCG's ran an Exploring Exploitation event which has been attended by staff from different areas of the hospital.

The delivery of effective safeguarding is dependent on multiagency working. Across agency strategic work is set by the children and adult Safeguarding Board and Partnership in West Sussex and translated into work streams which are monitored by QVH Strategic Safeguarding Group or QVH Safeguarding Team to ensure relevant involvement and contributions from the trust.

QVH through the safeguarding team has well established links with local and regional safeguarding networks and committees. During the year, the responsibility to attend these meetings have been shared between the Named Nurses and Director of Nursing.

West Sussex Adult Safeguarding NHS Professionals Network:
This group is chaired by the Designated Nurse for safeguarding adults from Coastal West Sussex CCG. The Adult Safeguarding NHS Professionals group meet quarterly. Membership of these groups includes all adult safeguarding leads from across Sussex & Surrey, including Safeguarding Adult's Board representation. The forum is an arena in which to share learning, reflect on practice and support peers. QVH Safeguarding Adults Named Nurse is a member of this group.

West Sussex Safeguarding Children NHS professional Networks:
This group is chaired by the West Sussex Designated Nurse for safeguarding children. The group meets quarterly and is attended by all West Sussex NHS Provider Trusts Named Nurses. It provides a forum which can share learning from practice, inform and influence the WSSCP. QVH Named Nurse and Safeguarding Children Specialist Nurse are members of this group.

QVH has a case peer review system in place in the Burns Unit. Meetings to discuss child and adult cases occur every Monday (except Bank Holidays). These meetings review injury mechanism and explanation, medical and nursing treatment, risk assess, discuss any safeguarding issues, patient capacity and agree actions required.

Safeguarding supervision is offered to all QVH staff as required on a case by case basis and also via bespoke training sessions for teams or individuals, or via discussions in team meetings. The purpose of these activities is to strengthen communication, networking and dissemination of safeguarding information and practice across the organisation. QVH Safeguarding supervision guidance is currently under development.

Safeguarding supervision is provided to the Safeguarding team on a regular basis by the West Sussex Designated Nurses for Safeguarding Children and Adult Safeguarding; during the COVID-19 period QVH has been designated as 'a clean hospital' meaning we will not be expected to care for COVID patients on site, therefore to reduce movement across the QVH site safeguarding supervision will continue via telephone to prevent additional traffic coming onsite and minimise infection risk.

A regional Safeguarding Children's Acute Network has been set up with its aim being to share learning from practice, guidance and training with the emphasis on delivery of the safeguarding agenda in an acute environment. We recently discussed the value of simulation in safeguarding training and how this might be able to be incorporated to enhance our training programmes. Currently suspended due to COVID-19.

The Safeguarding Named Nurse's continue to network with hospital consultants to discuss and review whether safeguarding systems are working for them and their teams.

Safeguarding priorities are central to achieving high quality and safe care. Quality and component parts of safety, effectiveness and patient experience are at the heart of QVH values. As an organisation QVH are committed to the protection and prevention of abuse & neglect for all vulnerable people whilst in the care of Queen Victoria Hospital NHS Foundation Trust (QVH). The safeguarding team continue to review and strengthen systems, methods and arrangements for managing episodes where it might be considering or suspecting that abuse/neglect has occurred either within the organisation or prior to admission. The safeguarding team are actively involved in the most challenging and complex safeguarding cases and situations.

	Staff are provided with support to manage any concerns identified. Human Rights: Protecting the vulnerable and those at risk, is a key component of our trust objectives. Focussing on quality and patient experience we work alongside partner agencies to promote the safety, health and well-being of people who use our services. QVH has effective systems in place to highlight and respond to shortfalls in capacity which have an impact on the ability to meet safeguarding responsibilities. These are highlighted to the board through the internal DATIX reporting system, and regularly discussed at the strategic safeguarding group meetings and reviewed by the Safeguarding Named Nurse's. There is currently one safeguarding corporate risk: • The introduction of Liberty Protection Safeguards (LPS) to replace DOLs during 2020. Corporate risk (Risk rating 12): legislation due to be implemented this year. Records will be subject to legal scrutiny for this aspect of care delivery There are four safeguarding departmental risks: • Not able to demonstrate full compliance with implementation of the MCA, currently data captured on the Datix system covers cases brought to the attention of the safeguarding team (risk rating 9 - LOW) Nursing and Quality department. MCA task and finish group convened but paused due to COVID-19. • MIU risk (Risk rating 6- LOW) relating to access to previous information held in the trust about patients re-attending. Staff in MIU do not access the full records of patients when they attend, this poses a risk in terms of safeguarding. MIU records are not routinely combined with previous records. • COVID-19: The suspension of level 1 and 2 safeguarding update training for 6 months. Induction reading to provide cover for 1 year. Monthly monitoring of training data occurring. Safeguarding team are providing safeguarding and MCA updates to trust staff as per the Safeguarding Business Continuity Plan. • COVID-19: Level 4 updates for Named Nurses suspended during the current COVID-19 situation. Monthly monitoring of training data occurring. QVH has a 3-year rolling safeguarding audit programme in place, which includes information on the audit methodology being used, involvement of managers and staff and how the findings from audit will be disseminated. QVH Safeguarding Audit programme is currently paused due to COVID-19 situation. Overview of the rolling audit programme can be found in Appendix C.
4.2	**STANDARD 2: Lead effectively to reduce the potential of abuse**
	QVH has policies, processes and procedures in place to enable staff to manage and when required to report any concerns they have for patients or members of the public attending QVH sites. If their concerns are not heard there are escalation processes which can be used.

Escalation processes were used once for a young adult patient during 2019-20. This case involved QVH Named Nurse and Director of Nursing, the West Sussex Designated Nurse, the Kent Designated Professional, Kent Social Care Safeguarding team and Kent community nursing services. The patient was at risk of dying and trying to get the right support and treatment services in place was proving a challenge. A joint agency meeting enabled the situation to be transferred and to be managed by Kent.

Training and procedures help to highlight how people's diversity, beliefs and values may influence the identification, prevention and response to safeguarding concerns. The QVH safeguarding 'documents and information overview' is provided for the organisation in APPENDIX D to demonstrate interaction between a range of policies and procedures when safeguarding is might be under consideration.

QVH has a clear, accessible and well-publicised complaints procedure. This includes information about how to complain to external bodies such as regulators and service commissioners, as well as relevant advocacy and advisory services. Information regarding Gillick competence, mental capacity and Lasting Powers of Attorneys (LPAs) is cross-referenced with other policies (such as consent) and safeguarding procedures.

A data collection system to capture safeguarding (adults, children and MCA) practice and learning was set up using Datix for recording purposes. Safeguarding Datix reports are shared across the organisation to aid case discussion and to share learning via the Steering group.

QVH place great importance on ensuring patients have an excellent experience. The trust continues to develop ways to engage and listen to patients, collecting views, comments and ideas from them, their families and carers which then inform future plans to further improve patient experience. Board committees review results from Family and Friends Tests (currently suspended nationally due to COVID-19) and the NHS Annual Staff Survey.

QVH safeguarding team review and update information produced for patients and their families. Including:

- QVH safeguarding children and young people leaflet for families.
- Information leaflet regarding attendance at the trust with dog bite injuries for all patients.
- Next of Kin: understanding decision making authorities
- Mental Capacity Act Guide for patients and their families
- Young People in Work experience from Health and Safety Executive. This can be provided for those YP who are injured at work

The Safeguarding Team are producing additional leaflets to support patients; once approved they are made available on our website, such as 'Children not in Education leaflet'

Work on a set of QVH posters and leaflets encouraging patients to talk to staff, clinical managers, PALs and the safeguarding team if they have any concerns about a patient are available for services to display and can be seen across the hospital site. Safeguarding and MCA Team posters have been distributed across all patient facing departments to ensure staff have rapid access to contact details. Work is underway to make sure all clinical areas have Domestic Abuse support contact posters on display too.

During 2019-20 Mac-fax adult safeguarding and Safeguarding referrals audits were undertaken as part of a rolling programme of safeguarding audits. These audits are useful to inform

	development of practice, policy and training. The Mac-Fax team have produced two audit papers and submitted them for publication following on from the safeguarding children and adult safeguarding audits they undertook. This is to provide opportunity for shared learning and peer scrutiny with a wider audience. During COVID-19 induction level 1 and 2 training is currently provided as a list of reading resources followed by audit questions, responses to the audit questions are reviewed by the safeguarding team. This helps the safeguarding team to monitor induction effectiveness and staff understanding. This on the spot training audit after training may continue after COVD 19 has passed. An audit assessing the current level of knowledge of the NICE guidance CG89 (When to Suspect Child Maltreatment) and Domestic Abuse (QS116) was underway; the results will inform our training and development programme. The audit is currently paused but data has been collected and will be reviewed as soon as possible.
4.3	**STANDARD 3: Responding effectively to allegations of abuse**
	QVH have arrangements in place to ensure that patients are safeguarded by responding appropriately to any allegation of abuse or neglect. <u>Safeguarding Adults Activity</u> The Safeguarding Named Nurse receives notification of any safeguarding concerns relating to adults via the DATIX reporting system. Each DATIX report is reviewed and investigated. Process issues and learning from each event is now shared using monthly and quarterly safeguarding Datix Reports. This approach provides oversight of all safeguarding adult referrals made to social care services across the region. The table in Appendix E provides details of the monthly safeguarding adult activity reported on DATIX for the past year. <u>Safeguarding Children Activity</u> The Children's Safeguarding Team receive reports of any safeguarding children concerns, which occur within QVH via a centralised email address and through DATIX. These are followed up by the Children's Safeguarding Team; providing support for staff managing these situations as well as a means to review case management, following up outcomes with statutory partners and to enable learning to be shared. All safeguarding children concerns are captured on the DATIX system. Enabling monthly Board metric reports to be provided to the Director of Nursing and Clinical Governance group. See Appendix B for overview of paediatric safeguarding activity during the past year. The QVH Electronic Document Management system (also known as Evolve) is currently being used it is not yet fully rolled out across the trust. There is a safeguarding section for all patients which can be used to file safeguarding information to make sure it is available for staff seeing the patient. There is a restricted access audit system in place so that anyone accessing this section is aware their access is being audited and they need give a reason for access to open the folder; staff are encouraged to access this section as required to enable them to plan, deliver care and safeguard appropriately.

	The safeguarding section added to the QVH Electronic Discharge Summary was to be audited this year but has been delayed until Autumn 2020. The purpose of this section is to enable handover of care to GP and other community health services and can provide an opportunity to inform others of concerns or create a contact request to obtain more information. The National Child Protection Information systems (CP-IS) is used by Minor Injuries Unit and Peanut Ward to check whether children or young people have a child protection plan or are looked after by a local authority. This national database provides the means for robust communication regarding vulnerable children across and between NHS and local authority systems nationwide, although there are limits to the system. The QVH CP-IS procedure has been reviewed and updated this year. When Looked After Children (LAC) attend the hospital for treatment, we check who can provide consent, contact details for their Social Worker and which Looked After Children nursing team to liaise with. QVH safeguarding training includes LAC and is backed up by QVH prompt cards. These cards also provide guidance on managing information regarding privately fostered children as well as for those in the care of a local authority. The QVH safeguarding team have utilised the LAC Designated Nurse system to expedite treatment consent for a Looked After Child to prevent further delay to his planned surgery. <u>Allegations Against Staff</u> The Director/Deputy Director of Human Resources would be involved in the management of the Trust response to any allegations against trust staff. *'Allegations against staff'* procedures are followed. During the last year, two concerns which required investigation relating to staff have been raised. One situation involved numerous allegations which were found to be unsubstantiated. The second allegation resulted in a full investigation under Disciplinary Policy. Advice was sought from West Sussex County Council Local Authority Designated Officer and the Safeguarding Children Designated Nurse. This member of staff was dismissed. We do not currently have any National *Allegations against staff* data with which to compare against other trusts.
4.4	**Standard 4: Safeguarding practice and procedures**
	The Safeguarding Team develop a wide range of guidance for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. For a list of what is in place for QVH please refer to Appendix B. Documents are placed on the Website or QNET intranet. All documents are systematically reviewed and updated in collaboration with relevant services and governance groups. Information is monitored and reviewed regularly and updated on the QNET, including information on who to contact for advice and support. QVH prompt cards have been updated in 2020 and are available on the Intranet for staff. The safeguarding team are keen to develop these in an App form for staff. We are also promoting the use of the national safeguarding guide App at governance events and during training. Which provides useful safeguarding information in an easy to access form.

Prevent:

The delivery of the '*Prevent*' agenda in the trust, is led by the Safeguarding Named Nurses who are both 'Prevent Leads' for the trust. Level 3 PREVENT training is now delivered via a National eLearning package. Staff refresh reminders are incorporated into Level 1, level 2 and level 3 face to face training events. The PREVENT approach is explained in the QVH Safeguarding Policy. The Prevent delivery plan which is a tool kit for staff is available to staff via the QNET.

Level 3 Prevent training compliance data has increased to 89% across QVH; a figure of 85% compliance is required nationally. The safeguarding team provide face-to-face refresh update training with staff as part of safeguarding training sessions. QVH report Prevent data to NHS England quarterly, no Prevent referrals were made during 2019-20.

Safeguarding referral:

Many safeguarding referral forms are now provided on line by local authorities, staff are supported to complete these when help is requested.

Restrictive interventions:

Where a patient is identified as needing any form of control, restraint or therapeutic holding QVH have policies in place to protect all patients against the risk of such control or restraint being unlawful or excessive. The recent case discussed at Joint Hospital Governance group highlighted the need to review this policy, this work is underway and will be consulted on during 2020.

MCA:

All QVH staff are required to understand their legal responsibilities under the Mental Capacity Act including undertaking mental capacity assessment, best interest decision making processes and when to complete a deprivation of liberties safeguard process. MCA data is now captured on the Datix system. Monthly reports are shared to aid case discussion and to share learning. The data captured includes cases brought to the attention of the MCA lead. A MCA Task and Finish Group has been set up to review practice implementation and development, but has had to pause to the COVID 19 situation.

Domestic violence and abuse (DVA)

Managing domestic violence and abuse situations can be challenging for staff. Managing risks, keeping individuals safe and seeking the right specialist advice are all important aspects of patient care when DVA is being considered a possibility or has been confirmed. Raising awareness of and managing DVA situations is included in level 2 and 3 safeguarding training.

The QVH psychological therapies team and some of the QVH safeguarding team can undertake Domestic Abuse Stalking Honour (DASH) risk assessments to help inform next steps for a patient. Worth DVA specialist services and the police can provide advice and support to staff at QVH.

Patient DVA procedures are in place. Staff experiencing DVA policy is in place. Two members of staff experiencing DVA have been supported this year.

It has been recognised both nationally and locally that the incidence of Domestic Abuse cases have increased due to COVID-19. The safeguarding team have been raising awareness with regard to DVA using the COVID 19 daily update system and QNET There is a 24 hour helpline available for members of the public run by refuge, links are on the QNET.

Safeguarding Audit

Audit of service efficacy is an integral element of the work of the Safeguarding Team. A three year cycle of audit activity has been developed including core elements such as NICE guidance alongside aspects of clinical practice. (see Appendix C)

During 2019-20 the following audits were completed or paused. Reports and action plans are reviewed and monitored either in the QVH strategic safeguarding group or on of the QVH safeguarding steering groups.

2017 Topic/s	Progress	Next Steps
Referrals audit – adult and children	Final report completed December 2019.	Repeat next 2020
Child not brought to appointment protocol audit	Delayed	Delayed to 2019 due to long term staff absence
EDN safeguarding audit	Delayed	Delayed to 2019 due to long term staff absence
ASG MaxFax audit	Completed 2019	Audit paper drafted and sent for publication
NICE CG89 and CG161	Paused due to COVID 19	
CP-IS audit in Burns MDT	Paused due to COVID 19	
SG Induction training Audits	Underway during COVID 19	

Child Sexual Exploitation.

Recognition of Child Sexual Exploitation (CSE) or child sexual abuse requires careful assessment and consideration when concerns arise. The Safeguarding Children Named Nurse is the CSE lead for QVH and supports staff to access specialist support if required. Exploitation training for staff was being rolled out but has been paused due to COVID 19.

Looked After Children.

Looked after children (LAC) or Children in Care are a group of children and young people who are cared for by the local authority. There can be consent implications for these children and clinicians needs to understand what voluntary or court agreement is in place for each child. The Safeguarding Children Named Nurse is the LAC lead for QVH and supports staff to understand court orders and how to make contact with a child's social worker or NHS LAC team from the area in which they live. In 2020 a Named and Designated Professionals Strategic Group for Looked After Children was set up across Sussex and Brighton and Hove, QVH Named Nurse for Safeguarding Children attends this group.

If QVH staff comes across private fostering arrangements for children less than 16 years of age they need to notify social care services so that a social care assessment can be undertaken of

the situation. Raising awareness of staff responsibilities in these situations is included in safeguarding training sessions.

Modern Slavery

No form of slavery and/or human trafficking (as defined by the Modern Slavery Act 2015) is permitted by its employees, subcontractors, contractors, agents, partners or any other organisation, entity, body, business or individual that the Trust engages or does business with.

Policies and procedures which relate to the Trust's corporate responsibility for slavery and human trafficking are reviewed and updated regularly.

The Procurement Team work with the NHS Terms and Conditions, which require suppliers to comply with relevant legislation. Procurement frameworks are also largely used in the Trust to procure goods and services, under which suppliers such as Crown Commercial Services and NHS Supply Chain adhere to a code of conduct on forced labour. Relevant pass/fail criteria has also been introduced on Procurement led tenders and quotations not conducted via framework.

The Trust has not been informed of any incidents of slavery or human trafficking during the year. In the event of a slavery or human trafficking incident occurring or an allegation being made the matter will be reported and investigated using the Trust's safeguarding procedures to determine appropriate action. Data relating to these aspects of safeguarding is now being collected by the safeguarding.

We have encouraged staff to access exploitation training session set up by the safeguarding Boards. This training commenced during 2019 but was paused during early 2020 due to the COVID 19 situation- these sessions are now planned to be delivered by Webinar during 2020. In the last year there have been a few patient presentations which have caused concerns and these have been followed up with social care services and/or the police.

The Trust's recruitment and selection procedures include appropriate pre-employment screening of all staff to determine right to work in the UK, and all salaries are above the National Living Wage. All employment agencies that are engaged also meet these standards as a minimum entitlement.

The Trust supply chain entails the purchasing of goods and services that support the operation of our core business of healthcare. Consumables purchased include medical supplies and equipment, office supplies, marketing materials, ICT equipment and estate and facilities services such as cleaning, waste management, office fixtures and fittings, security services and uniforms. Operating with integrity governs our approach and therefore our aspiration to be recognised by our stakeholders as an organisation which is a responsible corporate citizen in all our relationships.

The NHS Standard Terms and Conditions 2018 are referenced on all Trust purchase orders which include clauses around anti-slavery and human trafficking. The Trust also, where possible, will use the NHS Standard Terms and Conditions 2018 for its contracts or use NHS Framework Terms and Conditions.

The Trust has not been informed of any incidents of slavery or human trafficking during the year. In the event of a slavery or human trafficking incident occurring or an allegation being

made the matter will be reported and investigated using the Trust's safeguarding procedures to determine appropriate action.

The Trust is committed to better understanding its supply chains and collaborating with stakeholders to improve transparency of its arrangements to ensure adequate safeguards in place to prevent incidents of slavery or human trafficking.

Working with QVH communications team:

The safeguarding team have close links with the communications team at QVH where there are strict guidelines for dissemination of information internally for all staff across the organisation, including updates and reviews.

4.5 STANDARD 5: Staff competence

QVH Staff have access to a comprehensive Safeguarding training programme which includes: safeguarding adults, safeguarding children, Mental Capacity Act and Prevent training programme across levels 1, 2 and 3 internally. Levels 1 and 2 are a combined session including all aspects of safeguarding, MCA, Prevent, CSE, LAC, FGM and DVA. Level 3 sessions are provided in site twice a year for Safeguarding Children & LAC, as well as Adult safeguarding & MCA.

In addition to this, external training and conferences are also offered as options for staff requiring level 3 development to enhance knowledge and competencies where required. A portfolio of eLearning opportunities are made available via ESR. Staff and teams can also request bespoke training when the need arises.

Safeguarding Learning and development Strategy.
QVH Safeguarding learning and development strategy was produced in October 2018. This was reviewed and updated in 2019. This document is aligned with the core skills framework document and with national guidance from the NHS England regarding roles and competences for health care staff – from 4 intercollegiate documents (Prevent, LAC, Adults and Children).
It provides transparent QVH expectations for staff including the Board with regard to safeguarding training and development.

Safeguarding Training:
During 2019 the safeguarding training programme on offer at QVH has been reviewed and updated.

Session	**Participants**	**At end of year training uptake is currently:**
Safeguarding **Induction** Level 1 (includes: children, adults, Prevent, DVA, LAC and CSE)	Non-clinical staff	100%
Safeguarding **Induction** Level 2 (includes: children, adults, Prevent, DVA, LAC and CSE)	Clinical Staff (includes level 1 competencies)	100%
Safeguarding **Refresh Level 1**	Non-clinical staff Required every three years	97%

(covers children and adults) (includes: Prevent, DVA, LAC, CSE)		
Safeguarding **Refresh Level 2** (covers children and adults) (includes: Prevent, DVA, LAC, CSE)	Clinical Staff (includes level 1 competencies) Required every three years	95%
Safeguarding Children **Refresh level 3** (includes: Prevent, DVA, LAC and CSE)	For specified clinical staff (includes Level 1 and level 2 competencies) Required every three years Consultants attend QVH in-house training session, or undertake specified eLearning, or passport existing training evidence from another NHS trust	97%
Adult Safeguarding and MCA **Refresh Level 3** (includes: Prevent and DVA)	For specified clinical staff (includes Level 1 and level2 competencies) Required every three years Consultants attend QVH in-house training session, or undertake specified eLearning, or passport existing training evidence from another NHS trust	93% (started September 2018)
DVA DASH Workshops Level 3 Once every three years	For specified clinical staff	100%
Safeguarding Children and LAC **Refresh level 4**	Safeguarding Named Nurse as part of personal development Safeguarding Children Named Doctor as part of personal development	33% Two new post holders waiting for additional training
Adult Safeguarding and MCA **Refresh Level 4**	Safeguarding Named Nurse as part of personal development	33% Two new post holders waiting for additional training
Safeguarding **Induction**	Trainee Doctors Passport existing safeguarding training over or update to Level 2 (children and adults) whilst at QVH	100%
WRAP	All clinical staffx1	89%

	Specialist Support Provision of clinical supervision and support for specialist safeguarding staff is provided by West Sussex Designated professionals who are employed by Clinical Commissioning Groups. Trust policy requires that provision of specialist safeguarding advice and support to QVH staff is accessed on a case by case arrangement from safeguarding team members when required. All staff job descriptions include a safeguarding section which identifies responsibilities for safeguarding and these are reviewed through an annual appraisal and personal development planning process. COVID 19 will impact on training uptake data in the coming year. All Safeguarding refresh training has been paused until September 2020. Training data is being reviewed monthly, because uptake has been above 95% it was assessed as acceptable to pause refresh training for 6 months.
4.6	**STANDARD 6: Safer recruitment**
	QVH work to ensure that those working or who are in contact with children, young people and adults are safely recruited and Human Resource processes take account of the need to safeguard and promote the welfare of all. Making sure that QVH do everything we can to prevent appointing people who pose a risk to vulnerable people is an essential part of safeguarding practice and QVH recruit staff and volunteers following safer recruitment procedures. All staff at the Trust are employed in accordance with the NHS Employers safe recruitment pre-employment check standards. As part of their induction, new employees, including volunteers are expected to undertake mandatory training in safeguarding at either level 1 or 2. In March 2019 the Trust approved a new 'Disclosure and Barring Service (DBS) Checks Policy' which confirmed the process for Disclosure and Barring Service (DBS) checks for applicants and employees within the Trust and the responsibilities of Recruiting Managers, the Recruitment and Workforce Services teams to ensure that suitable DBS checks are completed as required. This includes a new provision for undertaking 3-yearly periodic checks for current staff within the high risk areas of Paediatrics and Critical Care.
4.7	**STANDARD 7: Learning from incidents**
	Statutory Safeguarding Reviews: <u>Safeguarding Adult Reviews (SAR)</u> Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. QVH were not directly involved in any SAR during 2019-20. But learning form SARs undertaken by WSSAB during 2019-20 were reviewed and shared via the QVH Strategic Safeguarding group and steering group.

	Serious Case Reviews (SCRs) When a child dies or is seriously harmed, including death by suspected suicide, and abuse or neglect is known or suspected to be a factor in the death, West Sussex safeguarding Children Board (WSSCB) is required to conduct a Serious Case Review into the involvement of organisations and professionals in the lives of the child and the family. The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and, as a consequence, improve multi-agency working to better safeguard and promote the welfare of children. QVH were not directly involved in any SCR during 2018-19. But learning form SCR undertaken by WSSCP during 2019-20 were reviewed and shared via the QVH Strategic Safeguarding group and steering group. Child Death Reviews. The WSSCB is also required to conduct a review of every child death to identify whether there are any lessons to be learned to prevent child deaths in the future. QVH has not contributed to any child death reviews this year. Other types of reviews. The WSSCP carry out a range of learning activities in order to understand how to improve safeguarding. This includes reviews into individual cases and reviews of practice across areas of safeguarding. QVH has not contributed to other case reviews during the year. QVH Staff have access to specialist advice and support through the named nurse, specialist nurses and link staff. Where appropriate, staff and staff groups are provided with debriefing/supervision sessions by the Named Nurse and/or other senior staff at QVH. Bespoke safeguarding and MCA training sessions are all offered to teams and services.
4.8	**STANDARD 8: Commissioning**
	Contract Monitoring -Sussex Clinical Commissioning Groups (CCG's) Safeguarding Standards CCG's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective safeguarding arrangements in place. A self-assessment tool is completed bi-annually for adult safeguarding and also a section 11 self-assessment audit for safeguarding children. These contribute to providing evidence of assurance in conjunction with assurance site visits and submission of quarterly exception reports.

	The section 11 safeguarding children self-assessment audit submitted to WSSCB during 2018 provided assurance to WSSCB scrutiny panel that QVH has a good understanding of statutory requirements and is working in a positive way to ensure standards are met. The panel noted that evidence provided was excellent. Overall that a really good report was provided. The next review is due 2020. A self-assessment tool was completed in 2019 for adult safeguarding. The action plan is reviewee and updated 6 monthly. An updated Safeguarding Supervision policy is being developed. Prompt Cards have been reviewed and updated and a business case to develop and App is being processed. CCG exception reports are provided by QVH Safeguarding Team in April, July, October and January of each year. No issues of concern were raised during the last year. **External regulation and inspection by CQC and NHSE** QVH CQC re-inspection during February 2019 overall the Trust sustained 'good' rating and also an 'outstanding' for care. There was no concerns raised regarding safeguarding. The CQC reported: 'Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. They were knowledgeable about the issues and priorities for the quality and sustainability of the service, understood the challenges and how to address them. All staff we met spoke positively about the leadership, both at local and executive level. They described leaders as being visible and approachable and supporting them to deliver the best possible patient experience.' Any safeguarding issues or concerns are captured and reported to the Board alongside the Board's monthly safeguarding metrics. • No specific paediatric safeguarding concerns were raised for QVH during the last year. • No adult safeguarding alerts were raised for QVH during the year.
4.9	**STANDARD 9: Safeguarding data requested by Department of Health**
	<u>Female Genital Mutilation (FGM)</u> Understanding of FGM and mandatory reporting duty is incorporated into QVH mandatory safeguarding training for staff. DH/NHS approved and recommended FGM e-Learning packages are also available to staff to enhance their knowledge and understanding of this subject and required practice. FGM guidance and information, with particular regard to risk assessment, mandatory reporting and recording, can be accessed by staff via the Trust QNET Safeguarding page. At QVH no FGM risk assessments were undertaken on any patients during the last year. <u>Prevent Returns</u> QVH submit quarterly reports to Regional Coordinator at NHS England with prevent information which reflects the number of prevent referrals and details of staff compliance with training. This information is also copied to the CCG for assurance.

	At QVH no PREVENT referrals were made during the last year.

5.0	Activity analysis/ achievement
5.1	Health care at QVH is patient centred and QVH works closely with partners to manage achievement of effective safeguarding for all vulnerable patients whether they are children, young people, adults or other family members. National metrics are reported on a quarterly basis to CQC and DH including: FGM assessments and PREVENT referrals. QVH continuously strive to develop staff knowledge, competence and to support its staff to achieve the best outcomes for patients at risk of harm. A streamlined safeguarding training programme for level 1 and Level 2 are well evaluated by staff. Level 3 adult safeguarding and Safeguarding children training sessions are part of their consultant mandatory training days and have reached over 90% uptake. QVH promotes a culture where staff are encouraged to raise concerns and to whistle blow without fear, this is evidenced in the staff survey. QVH also promotes feedback from patients and encourages them to raise concerns about anything they see and are worried about. There are close working links with the Patient Experience Manager and the Director of Nursing. There have been 2 safeguarding plaudits this year.
5.2	Training for staff is reviewed annually and updated in line with legislative requirements. Training data uptake continues to improve each year and is above 90% required by the Board. Paediatric safeguarding systems in QVH have been well established for many years. They continue to be strengthened. There is a transparent overview of what is in place and of safeguarding children activity occurring in the organisation. There is now a dedicated Safeguarding Children Named Nurse Katy Fowler who has put her own mark on the role and is seen by staff as supportive and well informed. The embedding of Adult Safeguarding has continued through 2019-2020. There is now a dedicated Adult Safeguarding and MCA Named Nurse Pauline Lambert this has provided opportunities to streamline and rationalise systems and processes. Feedback from staff has been positive. Succession planning is underway for 2021. We now have a Safeguarding Named Doctor who is a member of QVH staff one of the Burns Consultants and Deputy medical Director Ms Tania Cubison. Our thanks to Dr Oli Rahman from BSUH who provided good quality support whilst he was QVH safeguarding children Named Doctor. Safeguarding governance arrangements are well embedded.
5.3	QVH has a range of internal assurance processes in place. An overview of adult safeguarding and safeguarding children, and MCA activities in QVH are in place using the Datix systems for reporting purposes.

	QVH staff training programmes for adult and child safeguarding have been reviewed and continue to be updated and clinically focused. Staff provide evaluations which are used to identify areas in which to improve training. Evaluations are reviewed after each training session. We are planning to consider use of an ongoing training audit system to replace this and this will be discussed in QVH training meetings. QVH has an overview of all relevant safeguarding information and documents, which are systematically developed, reviewed and/or updated. One corporate Safeguarding risk and four safeguarding departmental risk assessments are in place. These are discussed at strategic safeguarding group quarterly, monitored monthly and details reviewed at least every 6 months by the Safeguarding Named Nurses.
5.4	QVH has local external regulation undertaken by the CCGs, WSSCP and WSSAB. NHS England ensures QVH are registered with the CQC. A Care Quality Commission (CQC) inspection occurred during February 2019. The report was published on 23rd may 2019 and is on the CQC website.
5.5	Local safeguarding peer review and assurance processes are in place. The Named Nurses for Safeguarding is well supported by the Director of Nursing, Deputy Director of Nursing, Heads of Nursing and the West Sussex Designated Professionals. QVH staff are guided and supported by a team of specialist safeguarding clinicians. This team are supported by Peanut Paediatric ward staff, Minor injuries Unit Staff, Site Practitioners and Heads of Nursing. Consultants now receive level 3 training for all aspects of safeguarding.
5.6	Partnership working with WSSCP and WSSAB is in place.
5.7	Effective contract monitoring is undertaken through audits and regular exception reporting to WSSCP, WSSAB, CCGs and the CQC.

6.	**Involvement & Engagement**
	There is involvement of staff members in safeguarding work streams via Joint Hospital Governance Group, Strategic Safeguarding Group, Safeguarding Steering groups, Nurse Quality Forum, Patient Information group, Volunteers forum and other QVH governance groups, to involve others in: • Identifying safeguarding priorities as part of discussions • Undertaking key areas of safeguarding work/projects • Sharing safeguarding information

	In the coming year we will also start working with council of Governors. Learning Disabilities Strategy will be discussed and developed. A LD peer review is due to be undertaken it has been delayed because of COVID 19.

7.	Safeguarding Learning from Experience
	Safeguarding learning and development is a continuous process; there are a number of key regular routes for this to occur. Experience without reflection does not always result in learning. It is through the reflective process that meaning is created and new insights gained. During the year: Patients' situations and experiences are regularly reviewed at Safeguarding Steering group. Learning is then shared more widely by Safeguarding Link Staff. This approach has been supported by minutes and also the use of the Datix reports for Adult Safeguarding, Safeguarding Children and MCA. Cases are also taken to the Joint Hospital Governance group for review and reflective learning. Feedback back from other agencies, peers, patients and their families either written or verbal is used as part of safeguarding discussions to enable staff to understand the impact of care provided whilst at QVH.

8.	Recommendations
	Recommendations to take forward in the coming year include: • Continue specialist development and succession planning for Adult safeguarding and MCA with the QVH safeguarding team • Continue to strengthen safeguarding supervision and attendance at relevant meetings within QVH e.g. MDTs' and ward meetings. • Continue to review and develop advice and guidance for QVH staff, patients and their families. Obtain funding for the QVH safeguarding prompt APP. • Promote a culture where staff are encouraged to raise concerns and to whistle blow without fear. • Continue to streamline policies and training sessions whilst maintaining clear direction regarding legal requirements and maintain staff knowledge, competence and skills • Incorporate Learning Disability updates into this report next year.

	• Ensure DVA posters and information are available across the hospital.

9.	DELIVERING THE QVH SAFEGUARDING STRATEGY
	QVH Safeguarding strategy was updated during 2019. Delivery of the safeguarding agenda at QVH will continue to include: Ensure all aspects of safeguarding work and practice are considered and incorporated into all QVH services. Service developments take account of the need to safeguard all patients and are informed by service users and quality impact assessments. Processes in place to disseminate, monitor and evaluate outcomes of all case review recommendations and actions. Ensure there are effective arrangements in place to share information when required. Safeguarding training and systems compliance will be monitored by safeguarding leads. QVH will demonstrate it is meeting its statutory requirements via annual reporting and an audit programme in addition to this a Human Rights Framework has be incorporated into the strategy to make transparent protection of vulnerable patients at QVH.

10.	Conclusions and assurance
	Incorporating safeguarding legal frameworks into every day clinical practice is a continuous process. Safeguarding patients and their families is everybody's responsibility. All health care at QVH is patient centred and QVH works closely with partners to ensure effective safeguarding is managed for all vulnerable patients whether they are children, young people, adults or other family members National metrics are reported to CQC and DH including: FGM assessments and PREVENT referrals. QVH continuously strives to develop staff knowledge, competence and support its staff to achieve the best outcomes for patients at risk of harm. QVH promotes a culture where staff are encouraged to raise concerns and to whistle blow without fear, this is evidenced in the staff survey.

	QVH also promotes feedback from patients and encourages them to raise concerns about anything they see and are worried about. There are close working links with the Patient Experience Manager and the Director of Nursing. Safeguarding systems in QVH continue to be strengthened. There is a transparent overview of what is in place and of safeguarding activity occurring in the organisation. Safeguarding team membership and governance arrangements are well embedded. QVH has a range of internal assurance processes in place. QVH staff training programmes for safeguarding have been reviewed and continue to be strengthened. Staff provide feedback which identifies areas in which to improve training. Evaluations are reviewed after each training session. QVH has an overview of all relevant safeguarding information and documents, which are systematically developed, reviewed and/or updated. One corporate risk and four safeguarding departmental risk assessments are in place. These are discussed at strategic safeguarding group quarterly, monitored monthly and reviewed at least every 6 months. QVH has local external regulation undertaken by the CCGs, WSSCP and WSSAB. NHS England ensures QVH are registered with the CQC. A Care Quality Commission (CQC) inspection occurred during 2019. Local safeguarding peer review and assurance processes are in place. The Safeguarding Team are well supported by the Director of Nursing, Deputy Director of Nursing, Heads of Nursing and the West Sussex Designated Professionals. QVH staff are guided and supported by a team of specialist safeguarding clinicians. This team are supported by Peanut Paediatric ward staff and Site Practitioners out of hours. Partnership working with WSSCP and WSSAB is in place. Effective contract monitoring is undertaken through audits and regular exception reporting to WSSCP, WSSAB, CCGs and the CQC. During COVID 19 the safeguarding team have assessed and mitigated risks. They support patients, staff and teams across the hospital by providing flexible working practice and options to access support out of hours. The safeguarding team has approached the CCG's for additional benchmarking standards with which to compare QVH data, however none have been suggested due to the unique nature of the trust and its activity.

11.	Report approval and governance
	The QVH safeguarding team present this report to provide assurance to the Board that the Safeguarding agenda is robustly overseen and managed within the trust and with partners.

APPENDIX A
TITLE: Safeguarding Strategic Group Action Plan

2019-20 work plan for group based on Safeguarding Strategy Objectives, which contribute to achieving key strategic objectives of the trust:
Outstanding patient care

- World class clinical services
- Operational excellence
- Financial stability
- Organizational excellence

Strategic Objective	QVH initial assessment	Rating (RAG)	Action Required	Timescale	Implement-ation Lead	Progress/ comments
1. To provide senior and Board leadership	QVH require: • Lead Board Director • Nominated Non-Executive Board Director • Safeguarding Adults and Children Named Nurses • Safeguarding Named Doctor • MCA & DOLs lead • Prevent lead • WRAP Facilitators • Child Sexual Exploitation Lead	Green	Review allocated specialist resources in coming year	Ongoing	Director of Nursing & Quality	Safeguarding Named Nurses & MCA Lead in post Departmental risks in place KPIs to Board Annual Report to Board
2. Senior leadership responsibility and lines of accountability for safeguarding arrangements are clearly outlined to employees and members of QVH, as well as to external partners.	QVH require: • Safeguarding Accountability and communication document on Website • Safeguarding Strategy on website • Safeguarding QNET page • Safeguarding Policy, standards, protocols, guidance	Green	Sustain systems Annual review and update training program	Ongoing	Director of Nursing a & Quality with Named professionals	Website safeguarding statement updated QNET update ongoing Quality assurance processes in place Policy review and updates ongoing.

	• Information for staff • Information for patients • Safeguarding training strategy and program in place • safeguarding activity data via Datix system. • Patient information via Evolve, paper record, EDN		Use Evolve/EDM safeguarding section as new system rolled out. Use Datix to capture data			Training uptake data and evaluations scrutinized monthly Datix - used to capture safeguarding and MCA data. Now being used permanently Development of new leaflets for patients and their family
3. QVH contribute to the work of West Sussex LSCB and SAB and their strategic Business Plans and priorities, and provide support to ensure that the Boards meet their statutory responsibilities.	QVH require; • Regular representation at WSSCP • Regular representation at WSSAB • Completion of Section 11 self-audit • Bi-monthly reports to LSCB and SAB • Quarterly reports to CCGs • Quarterly reports to NHS England – *prevent* coordinator	Green	Overlap between reporting requirements – manage and sustain effectively Regular representation at WSSCP and WSSAB Regular updates from NHSE		Director of Nursing & Quality with Named professionals	Safeguarding Children Section 11 self-assessment due for update 2020 Director of nursing attending WSSCP Adult Safeguarding Named Nurse attending WSSAB WSSAB self-audit undertaken 2019
4. QVH support their safeguarding leads to contribute to and influence the work of the LSCB and SAB subgroups and other national and local safeguarding	QVH require; • Named professionals involvement in specific subgroups • Supervision from designated professionals for named professionals	Green	Input into NHS professionals groups		Director of Nursing a & Quality with Named professionals	Supervision in place Attendance at Regional and national conferences

implementation networks.	• Attendance at West Sussex networks • Attendance at Regional Networks					

DELIVERING THE STRATEGY

Ensure all aspects of safeguarding work and practice are considered and incorporated into all QVH services.

Service developments take account of the need to safeguard all patients and are informed by service users and quality impact assessments.

Processes in place to disseminate, monitor and evaluate outcomes of all case review recommendations and actions.

Ensure there are effective arrangements in place to share information when required.

Safeguarding training and systems compliance will be monitored by safeguarding leads.

QVH will demonstrate it is meeting its statutory requirements via annual reporting and an audit programme.

APPENDIX B Safeguarding training – evaluations sample

Safeguarding Adults, Children, LAC, MCA and PREVENT Level 2 - Evaluations from a selection of sessions:

Presenters: Pauline Lambert and Katy Fowler

07/08/19

Rate the Session	Poor	Satisfactory	Good	Excellent
Were aims and objectives of the session met?			3	11
How would you rate the quality of the content of the session?			3	11
How would you rate the skills and knowledge of the trainer for the session?			2	12
How well was the event organised?			2	12
Overall how would you rate the event?			2	12

Comments:
Good engaging session. **Informative training session, nice to have it in one session.** **Good use of examples that helped me to understand each point.** **Great to do sessions altogether.** **Much better session all in one.**

A new evaluation form was introduced across the trust during the year

05/02/20

Rate the Session	Strongly Disagree	Disagree	Agree	Strongly Agree
The quality of the training materials were of a high standard				5
The content was appropriate for the session				5
The trainer had the relevant skills and knowledge to deliver the session.				5
The venue was suitable for the session.				5
The session has refreshed/ developed my knowledge and skills				5

Comments:
Good Grouping of child, adult and mental capacity. The best training I have had on this subject in 18 years of NHS employment, thank you. **Practical applications given through examples was very good.** **It has raised my awareness.** **Be more vigilant when seeing patients, relatives and children.**

Adult Safeguarding, MCA and PREVENT Level 3: 24/02/20

Presenters: Pauline Lambert Adult Safeguarding Named Nurse and MCA lead.

Rate the Session Poor to Excellent	1	2	3	4	5
Speaker			1	12	15
Content			1	12	14
How relevant was the session to your role?	2		1	10	14

How well was the event organised?			1	10	15
What was the standard of the venue and facilities?		1	2	13	11

Comments:
A good refresher.
Very useful especially scenarios.
More case scenarios.
Very good and engaging talk well directed for the multi-disciplinary audience.
Mostly not relevant to my role due to working in paeds but interesting.
Very informative and concise.
The main thing was that when I tried to contact the safeguarding team about a domestic violence case was that I was not able to get through and nobody got back to me for a few days.

Safeguarding Children and Looked After Children (LAC) and Prevent update Level 3: 24/02/20

Presenters: Tania Cubison Named Doctor for Safeguarding Adults and Children and Katy Fowler Named Nurse for Safeguarding Children and Looked After Children.

Rate the Session Poor to Excellent	**1**	**2**	**3**	**4**	**5**
Speaker				3	8
Content			1	2	7
How relevant was the session to your role?		1		4	6
How well was the event organised?			1	2	8
What was the standard of the venue and facilities?				6	5

Comments:
Excellent presentations
Excellent presentation, very informative.
Appreciate time restrictions but videos/ time for more in depth case studies would be useful. Thank you very informative.

APPENDIX C SAFEGUARDING AUDIT PROGRAMME 2019-2020, 3 year cycle

QVH rolling safeguarding audit programme

2015 topic/s	Progress	Next steps
Paediatric safeguarding records audit	Completed March 2016	Report to Paediatric Governance

2016 topic/s	Progress	Next steps
NICE PH 50 DVA	Baseline assessment March 2016 Organisation audit August 2016	Completed report to strategic safeguarding group Re-audit 2019
NICE CG89 when to suspect child maltreatment	Baseline assessment March 2016 Organisation audit August 2016	Completed report to strategic safeguarding group Re-audit 2019

2017 topic/s	Progress	Next steps
Referrals audit Adult children	Completed December 2017	Annual audit Reports to strategic safeguarding group
Maxfax safeguarding children and DVASurvey monkey	February 2018 completed	Report and training to Maxfax Report to Safeguarding Steering group
MCA staff knowledge audit	December 2017 completed	Report to strategic safeguarding group Action plan being monitored on risk register
MCA compliance audit	December 2017 completed	Report to strategic safeguarding group Action plan being monitored on risk register

2018 topic/s	Progress	Next steps
Referrals audit Adult children	Completed December 2018	Annual audit Reports to strategic safeguarding group
Safeguarding prompts card audit	Completed January 2019	Report to safeguarding steering group

2019 topic/s	**Progress**	**Next steps**
Adults safeguarding survey in Maxfax	Completed 2019	Report and training to Maxfax Report to Safeguarding Steering group Article drafted
Referrals audit Adult children	Completed December 2019	Annual audit Reports to strategic safeguarding group

NICE MCA standards	Self-audit	Completed and reported to Strategic safeguarding group

2020 topic/s	Progress	Next steps
NICE CG89 when to suspect child maltreatment audit	Underway survey monkey	
NICE DVA (PH50 and QS116)	Underway survey monkey	
Referrals audit Adult children	Due December 2018	
LAC (CIC) ready for records audit	Identify children on DATIX recording system	

PENDING:		
MCA audit	Due December 2020	
Child not brought to appointment audit	Due December 2020	
EDN safeguarding audit	Due December 2020	
Evolve and records safeguarding sections audit Children Adults	Due December 2020	
LAC (CIC) records audit	Liaison with SW and LAC Nurse Valid consent in place Missed appointments correct action taken	

APPENDIX D
Policy, procedures, protocols, guidance and information for QVH, staff and patients

QVH SAFEGUARDING DOCUMENTS AND INFORMATION March 2020
QVH safeguarding Documents

1.	Item	Date	Location	Next Review
1.1	QVH assurance statement	2019	Website	2021
1.2	QVH safeguarding strategy	2019	Website	2021
1.3	QVH Website and QNET	ongoing	Intranet	Ongoing review and update as required by QVH safeguarding leads
1.4	Sussex Child Protection and Safeguarding Procedures	Updated on line	Link via QNET	Ongoing review and update as required by WSSCB
1.5	Sussex adult safeguarding procedures	Updated on line	Link via QNET	Ongoing review and update as required by WSSCB
1.6	QVH safeguarding annual report	2018-19		April 2020
1.7	QVH and BSUH Paediatric SLA			Copy with Deputy Director of Nursing
1.8	QVH Safeguarding Strategic Group terms of reference	October 2019		Due October 2020
1.9	QVH Safeguarding Steering Group terms of reference	October 2019		Due October 2020
1.10	QVH safeguarding prompt cards for staff	June 2017		Review 2020 Create App
1.11	QVH NMC examples of revalidation forms- completion for safeguarding practice	2016		Available for staff on request
1.12	QVH Safeguarding Learning and Development strategy	2018	QNET	Due for review 2021
1.13	QVH safeguarding risk assessments	ongoing	Overseen by strategic safeguarding Group	Dashboard updated quarterly
1.14	CCG exception reports- ASG	Ongoing	Overseen by strategic safeguarding Group	Jan, Apr, Jul, Oct
1.15	CCG exception reports- SGC	Ongoing	Overseen by strategic safeguarding Group	Jan, Apr, Jul, Oct

1.16	National Prevent reports	Ongoing	Overseen by strategic safeguarding Group	Jan, Apr, Jul, Oct
1.17	Combined safeguarding policy	2019	QNET	Review 2022
1.18	QVH *Prevent* Delivery Plan	2019	Q-Net	
1.19	QVH Mental Capacity Act and DOLS Policy & Procedures	2018	Q-Net	Review 2020 change DOLS to LSP
	PROTOCOLS and GUIDANCE			
1.	Safeguarding Record keeping	2020	QNET	Review 2023
2.	Safeguarding Datix guidance	2020	QNET	Review 2023
3.	ASG form guidance	2020	QNET	Review 2023
4.	Child protection Referral form guidance	2020	QNET	Review 2023
5.	Making safeguarding team aware of safeguarding concerns	2020	QNET	Review 2023
6.	Reporting dog bite injuries	2020	QNET	Review 2023
7.	Children not brought to appointments	2020	QNET	Review 2023
8.	MIU transfer of care			
9.	Child tagged on Peanut ward			
10.	QVH Guidance on management of risks posed by sex offenders/sex related crime /potentially dangerous offense whilst at QVH site	2019	QNET	Approved by Strategic safeguarding group
11.	QVH Abduction or suspected Abduction of an Infant/Child Policy	2019	QNET	Being reviewed 2020
12.	Burns MDT risk assessment process	2020	QNET	Review 2023
13.	Circulation of missing alerts	2020	QNET	Review 2023
14.	Safeguarding PAS patient alert	2020	QNET	Review 2023
15.	Adult fire safety checklist			Drafted
16.	QVH DVA procedures for patients	2020	QNET	Review 2023
17.	Modern Slavery Protocol	2020	QNET	Review 2023
18.	Safeguarding supervision guidance			To be drafted

APPENDIX E Safeguarding Activity 2019-2020

QVH Metrics for The Board – Safeguarding, MCA & Prevent (March 2020)

Item	May 2019	June 2018	July 2019	August 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	March 2020	APR 2020
Adult SG Activity	4	3	9	3	7	6	6	5	5	8	7	5
Paediatric safeguarding activity	28	24	44	24	24	15	31	24	29	28	19	26
Allegations against staff	0	1	0	1	0	0	0	0	2	0	0	0
Support for staff possible DVA	0	0	0	0	1	0	0	0	0	0	1	1
DVA cases seen by joint trauma team												Start collec ng da
Modern slavery/exploit ation cases seen by Joint Trauma Team												Start collec ng da
DASH Risk assessments	0	0	0	0	0	0	0	0	0	0	0	0
MARAC referrals	2	0	0	0	0	0	0	0	0	0	0	0
FGM Risk Assessments undertaken	0	0	0	0	0	0	0	0	0	0	0	0
Children SCR	0	0	0	0	0	0	0	0	0	0	0	0
Safeguarding Adult Reviews	0	0	0	0	0	0	0	0	0	0	0	0
Prevent Referrals	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Damage grade 3/4	0	1	0	1	1 place of harm?	0	2	0	0	0	0	0
*MCA assessments *See notes*	6	1	2	2	5	0	0	2	2	5	4	2
MCA BI decisions	6	1	2	1	5	0	0	2	2	3	4	1
MCA DOLS	1	1	0	0	0	0	0	0	1	0	1	0
IMCA				1	1	0	0	1	0	0	0	0
Adult SG Training level 1	98	94	97	97	96	96	95	95	93	93	94	94
Adult SG Training and MCA Level 2	97	96	96	94	93	93	93	92	91	91	92	93

**Permanent Staff*												
Adult SG L3	74	74	73	74	86	83	80	80	81	92	93	93
WRAP Training L3 Prevent ELearning option added April 2018	85	85	85	85	84	85	87	87	87	88	89	89
Paediatric SG and LAC L1	95	95	94	95	94	94	95	95	95	95	97	95
Paediatric SG and LAC L2	94	94	95	95	94	93	95	95	95	95	95	94
Paediatric SG and LAC L3	88	87	87	86	93	94	91	91	92	92	97	95

TRAINING Data:

The information shows an overall compliance as a snap shot - end of each calendar month. It isn't the number of people trained it is the number compliant at that point in time. Adult Training data percentages are running totals

Adults Safeguarding Commentary:

- Adult safeguarding case details taken from DATIX ,
- June 2020 - cases referred to local authority.
- Modern Slavery cases referred to police
- Adult DVA cases
- reported - Adult dog bite cases

Paediatric Safeguarding Commentary:

- Paediatric safeguarding case details taken from Datix
- June 2020 - cases referred to social care by QVH,
- Cases referred/known to social care prior to transfer to QVH.
- Dog bite cases referred to police,
- Home schooled children.
- LAC

MCA data taken from DATIX

We introduced collection of MCA data during 2018.
Currently the system captures case data of those cases the safeguarding team are aware of, it does not provide an overview of all MCA cases for QVH yet. We are reviewing and adjusting data collection as we go forward. Will need support of medical secretaries to fully capture all cases.

- MC assessments undertaken
- BI decisions
- LPA signed consent form
- IMCA
- DOLS

Amendments have been made to Electronic Discharge Summary to include mandatory section for safeguarding concerns and actions.
Child Protection Information System (CP-IS) on care summary record A all unscheduled children checked by MIU. Peanut Ward set up to check this information.

Queen Victoria Hospital
NHS Foundation Trust

Holtve Rd.
East Grinstead
RH19 3DZ

Infection Prevention and Control

Queen Victoria Hospital NHS Foundation Trust Service Annual Report

Report covering the period from
April 2019 to March 2020

Document Control: committees and groups who have approved this report
Executive sponsor: Director of Nursing and DIPC

Authors: Lead Infection Control Nurse

Date: 7/7/20

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1.	Executive Summary

The purpose of this report is to inform and provide assurance to the Trust Board, patients, public and staff of the processes in place at The Queen Victoria NHS Foundation Trust (QVH) to prevent and control healthcare associated infections (HCAI). The Trust has a statutory responsibility to comply with the Health and Social Care Act: Code of Practice for the prevention and control of Healthcare-Associated Infection 2008 (DH 2015). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. This report provides an overview of infection prevention and control activity at QVH for the reporting period from 1st April 2019 to 31st March 2020 and demonstrates compliance with the Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare related guidance.
The key findings of the report are:

- The Trust has maintained compliance with Care Quality Commission regulations relating to Infection Prevention and Control.
- Overall incidence of Healthcare Associated Infection remains low with one case of methicillin Sensitive Staphylococcus (MSSA) bacteraemia, two cases of Escherichia coli (E.coli) bacteraemia and two Clostridium Difficile (CDI) infections. With each of the positive results for reportable infections there was no transmission to other patients.
- Achieving the national target for staff influenza immunisations
- Actions taken by the Infection Control in the preparation and implementation of actions required for ensuring staff and patient safety during the global pandemic of Covid-19

2.	Introduction

The Trust recognises that the effective prevention and control of HCAIs is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. The purpose of this report is to provide the Board with information on trust performance and provide assurance that suitable processes are being employed to prevent and control infections. This paper provides the board with an overview of work completed during the previous year and goals for the continuing programme of infection prevention and control for the upcoming financial year.

The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008, at the heart of this law there are two principles:

- to deliver continuous improvements of care

- it meets the need of the patient

With this in mind, patient safety remains the number one priority for the Trust. Infection prevention strategy and a consistent approach are key elements to ensuring the QVH has a safe environment and practices. Infection prevention and control is the responsibility of everyone in the healthcare and is only truly successful when everyone works together.
The authors would like to acknowledge the contribution of other colleagues to this report, in particular, the sections on environmental cleaning, linen decontamination and antimicrobial prescribing.

2.1 The Infection Prevention and Control Team

The infection control service is delivered and facilitated by an infection control team which consists of:

- Director of Infection Prevention and Control
- Infection Lead Nurse and Decontamination Lead. (full time, 37.5 hours/week)
- Infection Control Nurse. (part time 22 hours/week)
- Administration assistant.
- Antimicrobial pharmacist.
- The microbiology and virology laboratory services are provided by Brighton and Sussex University Hospital (BSUH). As part of this service BSUH provide QVH with a Consultant Microbiologist who is on site once a week. Outside of this there is 24 hour advice and support via telephone or email to support safe provision of infection control services.

2.2 The Director of Infection Prevention and Control (DIPC)

The Infection Control Team reports directly to the DIPC, who is the trust Director of Nursing and Quality. The DIPC is directly accountable to the Chief Executive and has an overarching responsibility for the strategy, policies, implementation and performance relating to infection prevention and control. The DIPC attends the trust board and other meetings as planned or required, including the monthly infection control team meetings and quarterly infection control committees.

3. Service aim, objectives and expected outcomes

All NHS organisations must ensure that they have effective systems in place to control healthcare associated infections (see Table 1). The prevention and control of infection is part of the Trusts overall risk management strategy. Evolving clinical practice presents new challenges in infection prevention and control, which need continuous review.

Table 1: The requirements of the Health and Social Care Act (2008) updated in this report in line with revised guidance issued July 2015.

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed

	premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

The Trust's infection control policies set out a framework of compliance to these criteria and are published in the trust policy section of Qnet. These documents are reviewed and updated by the infection control nurses (ICN's) and relevant clinicians before being ratified by the Infection prevention and Control Group (IPCG).

Internal assurance processes and board accountability.
QVH has an infection prevention and control structure and processes in place which are led and supported by a team of specialist infection prevention and control clinicians. (See Appendix A for QVH infection prevention and control structure chart).

As an organisation QVH is committed to the prevention of health care associated infection (HCAI) for patients, staff and visitors whilst on the premises or in the care of the hospital. This is done through robust infection prevention and control programme which involves:

- Policies and procedures for staff to follow which conform to current best practice guidance,
- An audit programme to ensure compliance against the policies
- Education programme designed to each staff group
- Guidance and advice to all staff and patients on infection control.
- Mandatory surveillance of reportable infections

The Infection Control Group (ICG) is a multidisciplinary trust group which meets quarterly.
The committee is chaired by the DIPC. Membership of the ICG includes representation from key service areas:
Facilities, Estates, Pharmacy, Theatre, Infection Control Nurses, Microbiology Consultants, Heads of Nursing, Occupational Health, Risk and Safety, Representation from Public Health England and the Commissioning Support Unit. Other trust staff may be invited to attend as required.
The QGC receives a quarterly infection control report on each of the key elements of infection control management. In addition, the DIPC also provides updates to the Clinical Governance Group, Hospital Management Team, and Executive Management Team and to the Trust Board. There is also oversight of antimicrobial issues at this group via attendance of the trust antimicrobial pharmacist.

Members of the IPACT share infection control information and learning with a number of groups

and committees which include:

- Quality & Governance Committee
- Health and Safety Group
- Clinical Audit
- Estates and Facilities Group
- Learning & Development Group
- Medicines Management Optimisation Governance Group (MMOGG)
- Patient Led Assessment of the Care Environment (PLACE)
- Pathology Meeting
- Nursing and Quality Forum

IPACT work closely with all clinical teams, Estates and Facilities and Hotel Services to ensure that infection prevention and control is included in the planning stages of every new project and development or refurbishments.

Infection Prevention and Control microbiology activity

All the trust microbiology specimens are processed by locally in accredited laboratories.
The results of all microbiology samples including blood specimens and swabs are checked for positive colonisation or infection that may have the potential to spread and cause harm. A further check for any positive specimens from a daily lab report is undertaken by the infection control team. Although labour intensive this scrutiny provides oversight and assurance that every specimen taken from QVH ensures that information and clinical advice is then given to the relevant ward/clinical staff. This process allows the ICN to monitor patterns in infection rates, identify samples that are multi-drug resistant (MDR) and identify clusters of positive results that are showing a pattern through either department of organism type. Significant or unexpected results are also relayed to the IPACT or the ward via the on-call microbiologist.

Infection prevention & control link persons (ICLP)

Infection prevention and control remains central to the maintenance and promotion of high standards throughout QVH. The ICLP Group aims to meet every quarter. Its purpose is to provide a link between the IPACT and ward/departmental staff in all clinical and non-clinical areas in order to facilitate the dissemination of information and to promote compliance with infection control policies and the Health & Social Care Act (2015). Every meeting includes an educational element. The ICLP members are reviewed on an annual basis. Or more frequently if there has been staff changes. The link staff conduct monthly infection control audits and champion good infection control practices within their teams/departments.

External Meetings

Infection control remains high on the national agenda. The ICN attends local and national conferences to ensure robust links with other infection control teams, utilise the opportunities to share learning and resources, ensure all practices in the Trust are in line with current national guidance and best practice.

Mandatory Surveillance

Mandatory surveillance data is required to be submitted to Public Health England (PHE) for the following alert organisms:

- *Staphylococcus aureus (S. aureus*) bacteraemia – both Meticillin Resistant *Staphylococcus aureus* (MRSA) and Meticillin sensitive *Staphylococcus aureus,* (MSSA)
- *Clostridium difficile* infection (CDI)
- *Escherichia coli* (E. coli) bacteraemia
- *Pseudamonas aeruginosa bacteraemia*

Glycopeptide Resistant *Enterococci* bacteraemia (GRE) and Vancomycin Resistant *Enterococcus* bacteraemia (VRE) are reported to the Commissioners as required and to Public Health England (PHE) on a quarterly basis.
IPACT also monitor Urinary Tract Infection (UTI), *Acinetobacter, Pseudomonas, Klebsiella spp* and any other Multi Drug Resistant (MDR) organisms.

Root Cause Analysis (RCA)
The Trust continues with the protocol for RCA review for all reportable infections and, for all MRSA bacteraemia and the Post Infection Review (PIR) process.

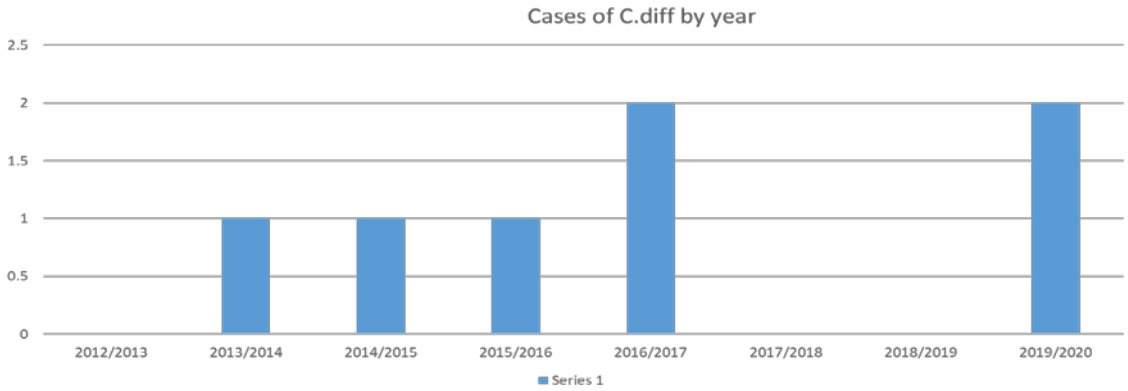
MRSA Bacteraemia

QVH have a target of zero cases of avoidable MRSA bacteraemia every year – the trust achieved this during the 2019/2020. There has not been a revision of this target for 2020/21.

Clostridium difficile infection (CDI)

In 2014/15 NHS England introduced a change in the methodology for calculating organisational CDI objectives and encouraged commissioners to consider sanctions for breach of CDI objectives only where those CDIs were associated with lapses in care. The CDI lapse in care objective target for QVH was set at zero. The Trust had two cases of CDI in 2019/2020. Both cases were investigated using the Root Cause Analysis framework to look at triggering factors and identify learning needs to prevent further cases. The results of these were fed back both to individual teams/departments and through Trust meetings. No sanctions where implemented by the commissioners following review of the cases.
Figure 1 shows previous performance.

Figure 1

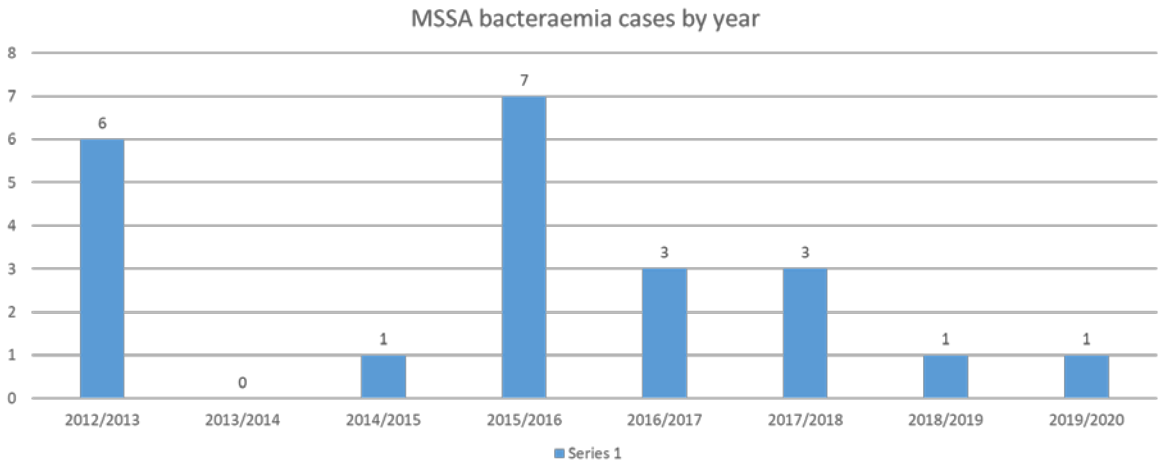


The CDI lapse in care objective target for the Trust remains at zero for 2020/2021.

MSSA bacteraemia
No target has been set for MSSA bacteraemia to date. QVH have had one MSSA bacteraemia case in 2019/20. An investigation was undertaken using the root cause analysis process (RCA) which proved inconclusive to the cause of the bacteraemia.

Figure 2 shows the year on year numbers of trust acquired MSSA bacteraemia.

Figure 2

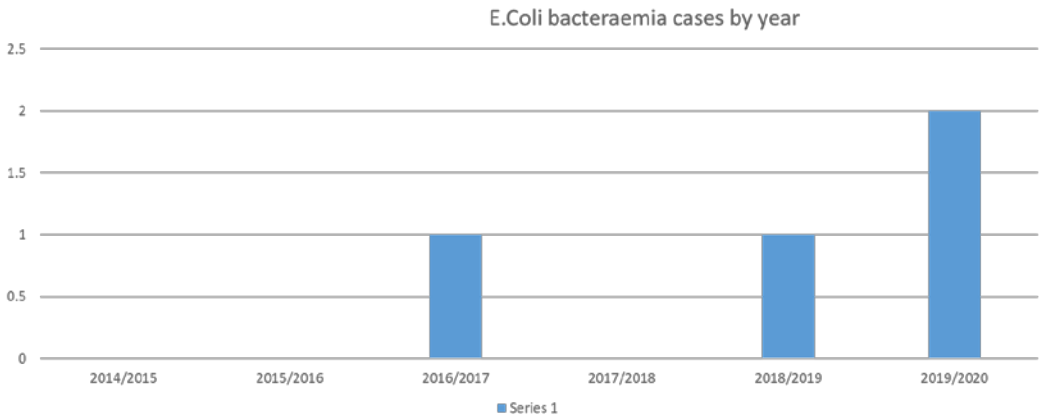


E. Coli bacteraemia

QVH had two reportable *E.coli* bacteraemia in 2019/20, while both were reportable neither was attributable to the Trust as both were resulted within 48 hours of admission classing them as community acquired. An RCA was undertaken for both cases which proved inconclusive to cause of the bacteraemia.

Figure 3 shows the year on year numbers of reportable *E.coli* bacteraemia

Figure 3

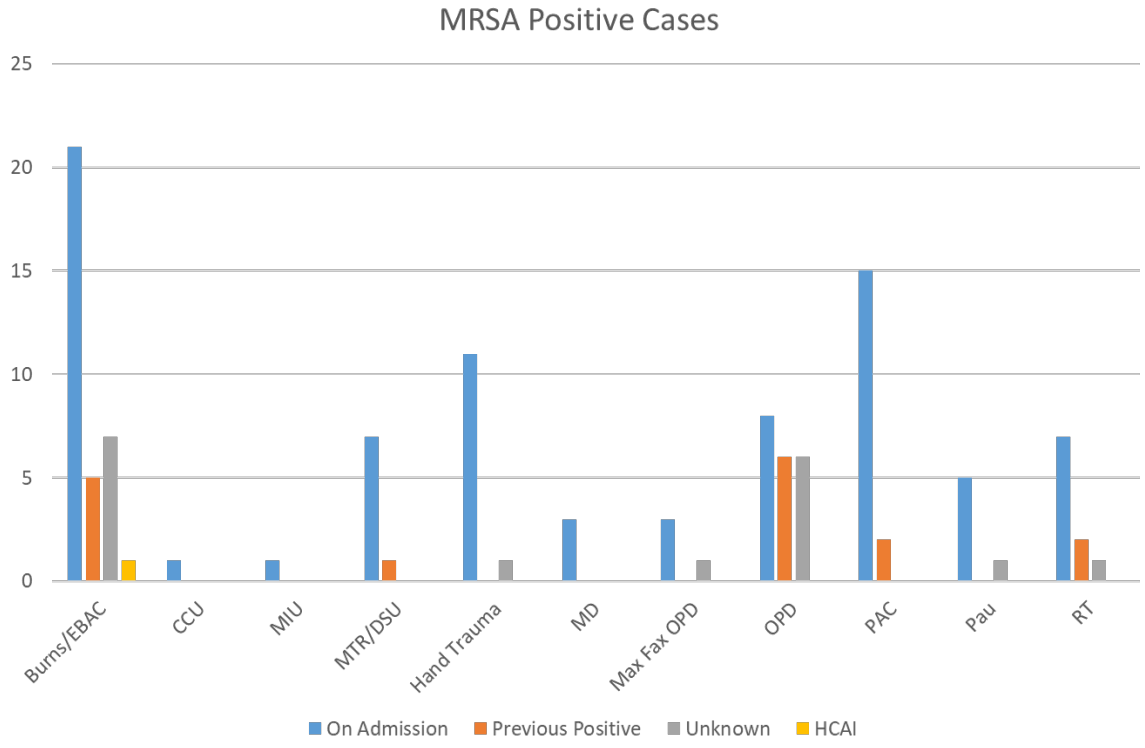


Glycopeptide resistant enterococci bacteraemia (GRE)

No reportable GRE's have been identified at the QVH. No target has been set by DH to date. There have been no Trust acquired GRE infections in the last 10 years.

MRSA positive patients April 2019 to March 2020 (Infected and colonised)

During the period of 2019/2020 there were 117 patients who were confirmed MRSA positive either colonised or infected. None of the positive results were acquired from blood cultures (bacteraemia) but from either surface swabs (such as nose and groin) or from wound swabs. Of these 1 was classed as healthcare associated or hospital acquired (HCAI), 82 were identified from admission or pre-admission swabs (O/A), 17 were from patients known to be previously positive (PP) and 17 patients it was difficult to determine the source of acquisition. This was either because they were not admitted at the time of the result and therefore could have acquired the MRSA during outpatient appointments or whilst at home/in the community. It should be noted that any positive results received from paediatric patients (this group of patients are not routinely screened on admission) or from low risk adult patients (who were not screened on admission as per the change in QVH policy this year) there is no baseline data to determine if the MRSA was acquired in the hospital setting or in the community before admission. RCA's are completed for all HCAI cases to look at any lapses in care or areas of improvement.



4.	**Activity analysis/ achievement**

External regulation and inspection by Care Quality Commission (CQC), NHSI and commissioners

The CQC did not conduct any inspections in between April 2019 to March 2020. The Trust continues to monitor the standards set out in the Health & Social Care Act (2010) via an annual programme of PLACE compliance inspections. Findings are reported to Quality and Governance Committee, Clinical Governance Group and other quality groups.

The Trust Board
The Trust Board has responsibility for overseeing infection control arrangements and has been kept informed by the DIPC providing exception reporting and quarterly reports at the Quality and Governance Committee.

Key Performance Indicators (KPIs)
KPI's set for the IPACT include monitoring hand hygiene compliance, monitoring MRSA screening compliance and monitoring trust acquired reportable infections. Results for these are all included within the document. Ensuring policies are in line with national guidance and within date, a list of all updated policies is included in this document, and that regular audits are completed to monitor compliance against the policies. Completed audits are included in this report in the audit section of this report.
The remaining KPI's are ensuring all members of the IPACT are attending mandatory training and are undertaking an annual appraisal. All members of the IPACT achieved this during the year April 2019 to March 2020

Complaints
If necessary the IPACT will liaise with the Patient Experience Manager to assist with the investigation of complaints associated with infection prevention and control. The outcomes of these are fed back at the monthly IPACT and quarterly committee meetings. There were no complaints or claims made during 2019-2020 relating to infection control.

Infection Prevention and Control Learning and Development
Infection Prevention and Control is part of the Trust's mandatory training programme. Three sessions a month are held, two for clinical staff and one for non-clinical. Induction training days are also held monthly for all categories of staff, with separate sessions for new Doctors' Induction. Training is carried out by the ICN's.

The theme for 2019-2020 was 'Infection Prevention and Control, At the heart of everything we do'. With the emphasis being put on applying infection control practices in every moment and individual responsibility.

- How does infection spread?
- How staff can help prevent the spread of infection (looking after themselves and the environment)
- Hand hygiene and bare below the elbows
- Correct wearing of PPE
- Dress code
- Spillage management
- Sharp safety
- Safe disposal of waste
- Compliance with DH *Pseudomonas* guidance
- Deep cleaning
- What is an HCAI
- CPE
- The rise of anti-microbial resistance
- The Health and Social Care Act (2015)
- Food hygiene
- Flu preparations including FIT testing

Along with clinical, non-clinical and consultant mandatory training IPACT have also given additional teaching to staff on current issues highlighted through audit and surveillance

relating to infection control. Specific departmental training has been delivered to ensure all services and staff have access to infection control support and education.

The ICN was asked by the University of Brighton to deliver Infection control training to student pharmacists at the University. This session followed the format of the Trust induction and was well received by the students and lecturers.

Infection Prevention and Control audit
Clinical audit is a fundamental component of clinical governance and underpins the assurance process for a high-quality service (CQC, 2010). The following audits have been undertaken in the period April 2018 to March 2019. All Ward/Department Matrons are informed of audit results pertinent to their area as they are completed. They are asked to complete any recommendations made within the audit reports.

Saving Lives – Department of Health High Impact Intervention (HII) Audits
The purpose of the Saving Lives programme is to deliver a programme which will reduce HCAIs and allow Trusts to demonstrate compliance with the Health and Social Care Act (DH, 2010), using techniques known as HIIs, of which there are seven. These include:

- Prevention of ventilator associated pneumonia
- Prevention of infections associated with peripheral vascular access devices
- Prevention of infections associated with central venous access devices
- Prevention of surgical site infection
- Prevention of infections in chronic wounds
- Prevention of urinary catheter associated infections
- Promotion of stewardship in antimicrobial prescribing

Data collection for this audit has proved to be problematic with many ways of auditing being tried. The audit programme has been revised and launched in April 2019 as a continuous monthly audit to be conducted by the Infection control link staff.

The data that has been collected has highlighted some areas that require improvement most notably around the insertion and care of peripheral venous cannula, the infection control team are working with the practice educators to devise a plan of education to assist with this. Some areas were not completing the audit forms regularly and this coupled with low numbers of patients with the required HII's has meant that the audit percentages are not an accurate reflection of practice. This has been addressed as a learning opportunity by the Heads of Nursing and individual ward/departmental lead.

Surgical Site Infection (SSI) Audit

The Trust participated in the second GIRFT SSI Survey which was launched in May 2019 covering a period of 6 months. The Survey follows on from a previous SSI survey in 2017. The aims were to:

- Identify the rates off SSI's following 48 selected procedures
- Assess local practice in the prevention of surgical site infection for the specified procedures.

Surgical site infections (SSI's) carry significant impact on morbidity and mortality in surgical patients. Management of SSI's can involve prolonged hospitalisation, protracted antibiotic courses and revision surgeries. The trust has processes in place to monitor SSI activity and take steps to prevent their occurrences. However, it was evident from National trust deep dives conducted Nationally that trusts, and clinicians are often not aware of their own SSI

rates.

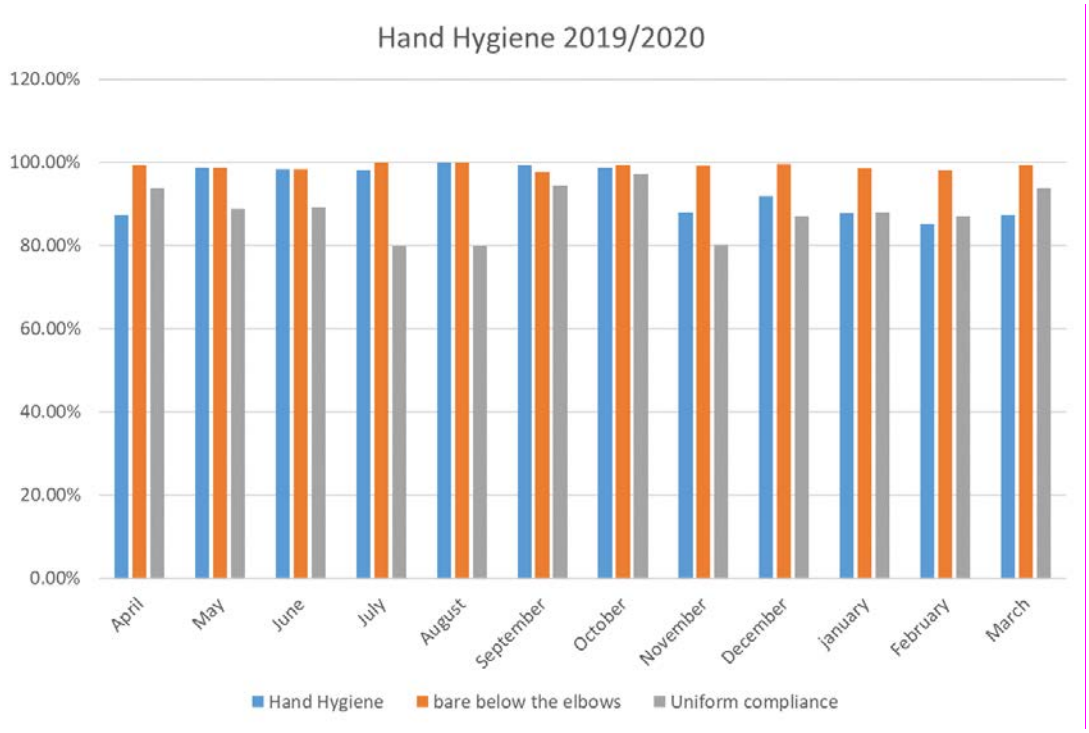
Building on the 2017 GIRFT SSI survey, the second edition of the survey was launched in May 2019 and encompassed 13 surgical specialties: breast surgery, cardiothoracic surgery, cranial neurosurgery, (ENT) ear, nose and throat surgery, general surgery, obstetrics and gynaecology, ophthalmology, oral and maxillofacial surgery, orthopaedic surgery, paediatric general surgery, spinal surgery, urology and vascular surgery.
The survey had been established to:

- Identify the surgical site infection rates of specific procedures within 13 surgical specialties. Procedures selected for inclusion in the survey were identified by GIRFT clinical leads as important procedures in each specialty because of frequency performed or association with SSI's.
- Provide data for participating trusts to benchmark themselves against the national average and to drive better scrutiny and investigation of SSI's and their causes.
- Assess local practice in the prevention of surgical site infection for the specified procedures and spread excellent practice in high performing trusts.

Preliminary data from this audit shows the following SSI rates for the Trust in the specialities applicable:
Breast Surgery 0.3% compared with national average 4.8%
Oral Surgery 1.0% compared with national average 0.3%

It is unclear at the moment why the Oral Surgical SSI rate for the Trust is higher than average, although this may be down to the types of oral surgery conducted at the Trust I.e. referrals for abscesses and traumatic injuries which are classed as 'dirty' wounds and therefore are more likely to become infected. Further data is expected which will look into these figures in more detail at which time learning needs for improvement can be identified and sent out to the relevant parties.

Hand Hygiene Audits



Monthly hand hygiene and bare below the elbows compliance audits have continued, from April 2019 this audit was expanded to include auditing uniform compliance. This audit is conducted by the Infection Control Link staff in their own areas. The audit tool is modelled on the NPSA 5 moments of hand hygiene. Overall compliance in all areas has fluctuated throughout the year. All staff are reminded at mandatory training sessions of the hand hygiene, bare bellows and uniform policy and any staff seen not complying is spoken with by the department lead. Audit results show that the staff group who achieve the lowest compliance each month is the Medical staff. The IPACT ask that staff report the names of those not compliant so that the reasons for this can be discussed on an individual basis and actions agreed for improvement.

Aseptic Technique

- The purpose of the annual audit was to ascertain the level of compliance to the Trusts Aseptic Technique policy. An aseptic technique ensures that only uncontaminated equipment and fluids come into contact with susceptible body sites. It should be used during any clinical procedure that bypasses the body's natural defences. The audit showed 83% of the audits were compliant having all 'yes' or 'N/A' answers which is a decrease on the previous audit which was 88% in 2018. One factor that needs to be taken into account is that the number of audit forms completed and returned to the Infection Control team was lower than normal.
  Five no answers that were given related to staff decontaminating their hands, the infection control team will continue to focus on the importance of basic hand hygiene in all roles and areas. It is noted that the auditor challenged the lack of hand hygiene on two of these occasions which is very positive for the role modelling required to improve practice.

Duty of care visit to Stericycle (SRCL), waste providers.

- Site walkabout completed by Infection control and Hotel Services. No concerns raised nor observed. Assurance provided by SRCL of compliance with all national guidance and requirements. No concerns raised about provision of service.

Duty of Care visit to Steris the sterile service provider

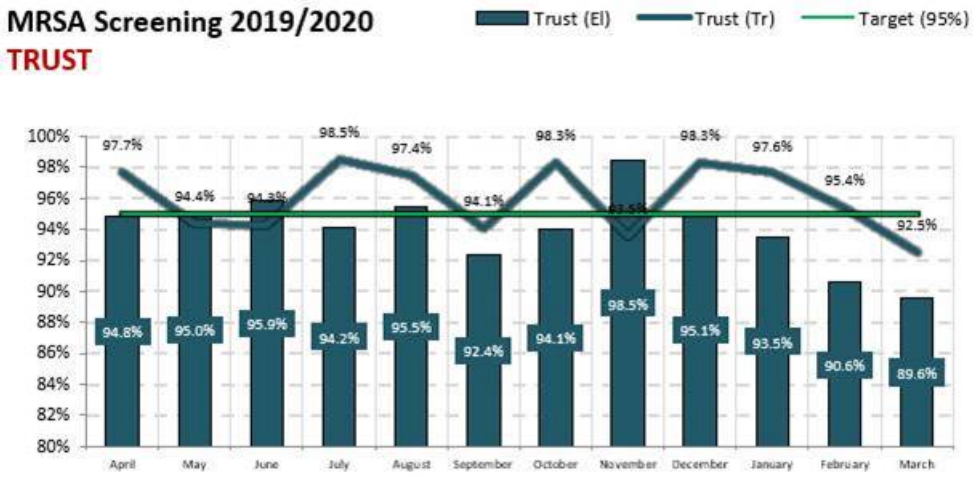
- Attended by the Infection control nurse and all areas inspected. No concerns noted or raised. Site clean and tidy and all safety control measure in place in line with national requirements, supporting data and audit results available to evidence this**.**

Duty of Care visit to Eastbourne Laundry

- Attended the Laundry at EDGH. Infection Control measures appear stringent, quality control and audit measures in place and evidence provided to us to confirm this. Building and equipment appears well maintained, all questions answered. No infection control concerns raised around provision of service.

MRSA screening

Monthly audits are undertaken to ascertain the level of compliance with Trust policy for the mandatory screening of all elective and trauma in-patients.



MRSA Screening Audit of High Risk Patients

This audit is conducted as a one day snap shot looking to see if the patients in on that day have been screened in line with Trust policy The audit has shown that there has been a slight improvement in the management of high risk patients across the hospital, however there is still a long way to go to reach our target of 90% compliance and there are individual areas where compliance is poor total Trust compliance with the screening of High risk patients is 70%. Consistently it is MRSA swabs for wounds and manipulated sites that are being forgotten. Additional ways of reinforcing compliance with MRSA screening is being explored alongside a review of the current MRSA screening guidelines.

Environmental Audits

The infection control team has reinstated multi-disciplinary inspections of all areas within the Trust. All clinical and Non-clinical areas are to be audited twice a year to ensure they are clean, safe and fit for purpose. The audit team will consist of, for clinical areas infection control, hotel services, risk, estates and heads of nursing. Nonclinical areas will be infection control and hotel services. For the period April – June the following clinical areas were audited

- Rehab unit,
- Margaret Duncombe Ward
- Ross Tilley

For Non-clinical areas

- Lower floor Jubilee Building including meeting rooms
- HR,
- Trust offices/upper Jubilee Building,
- Chapel and Multifaith room,
- C Wing Corridor,
- Benjamin Rycroft
- Bed store,
- Appointments,
- SDC,
- Pathology,
- Library,
- A Wing Lecture Theatre Toilet.

Various concerns were noted and raised with leads including repairs and estates work. Equipment not being appropriately cleaned and fire safety concerns.

For the period July - September the following clinical areas were audited

- Photography - Generally clean department, some minor estates work required. Main photographic room very dusty and full of paperwork due to nature of work.
- Public Toilets
- Male toilet on main hospital street blocked (reported on helpdesk),
- Disabled toilet in C Wing -still awaiting refurbishment.
- X-Ray - Clinical equipment dusty, the beds in rooms 1 and 2 are very dusty and the staff/kitchen area requires further cleaning focussing on the fridge and microwave. This was fed back to the department lead following the audit.
- Sleep Studies - One fan in office was dusty/dirty – staff member using the room asked to clean the fan. Kitchen area – still some issues with staff/patient food in same fridge.
- OPD 1 - Some children's books in waiting area damaged and were therefore discarded during audit. Floor very clean.
- Pharmacy - Carpet in staff areas very poor condition. Staff have cleaning rotas for their kitchen. Mostly clean/tidy environment.
- Physiotherapy - Department generally clean, building and fabric of building very old and some areas in need of improvements. Toilets particularly an issue due to one staff toilet having a leak – this and some other minor work reported on estates helpdesk. One pillow discarded during audit as the cover had started to fray and come apart and therefore could not be cleaned properly. Clinical areas audited were – rehabilitation unit.
- Occupational therapy and physiotherapy- Various concerns were noted including repairs and estates work. Equipment not being appropriately cleaned and fire safety concerns

For the period October - December the following areas were audited:
Non-clinical areas audited were:

- Max Fax prosthetic - Labs dusty (to be expected as per their work) they clean regularly and thoroughly on a Friday. Lots of wear and tear to fabric of building – e.g to hand rail on stairs.
- Library - Some chairs in entrance stained, fan in main library, Library staff wipe desks and computers once per week.
- Hotel Services Building - Generally old building. Lots of tape wrapped around pipe entry points in the ceiling rather than having been properly sealed. One chair damaged in sign in room. Some ceilings in the building damaged, possibly by water, looks historic not new but needs to be examined. This is a low risk non-clinical area. Fan in post room to be cleaned. Skirting peeling in staff toilet.
- Nursing and Quality corridor, Jubilee Building- Some general wear and tear of walls/ceilings, some dust present and some floors requiring cleaning, however, domestics have been diverted to higher priority areas so limited time to spend in non clinical areas. One microwave in extremely poor state – requires replacement.
- Trust Offices, Jubilee Building - General wear and tear, one damaged toilet roll holder (reported via helpdesk). Various cracks in walls, damaged window sills, little holes in wall. Staff kitchens remain an issue, namely sink and microwave.
- Trust boardroom and Occupational Health - Some dust on fake plants, cobwebs, some debris in corridor outside but blows in through nearby door. Occupational Health room cluttered with old signs, crack noticed in clinical sink (NC reported via helpdesk). 2 sharps bin's not labelled, lids not on properly, one overfilled, another one with lid not affixed properly on a wheeled trolley. All lids affixed correctly, temp closure put in place on sharps box and datix form completed.

Clinical areas audited were

- Photographic
- Canadian wing following completion of estates work identified during the PLACE inspection earlier in the financial year.

All areas audited requiring improvements were discussed with area/ department lead and actions agreed.

Infection prevention and control policies, procedures and guidance for QVH staff and patients

IPACT have developed guidance for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. All documents are placed on Qnet. All documents have been systematically reviewed and updated in collaboration with relevant services and governance groups (see Appendix C).

IPACT have produced information for patients about the main infection prevention and control issues which are generally raised. These are Pandemic Flu, Norovirus, MRSA, MRAB, Hand Hygiene, Group A Strep, GRE, and CDI. All these leaflets are available for the public and have been updated and approved by the patient information group.

The QVH Infection Prevention and Control team are available to speak to any patients, visitors or staff if they have any concerns about infection.

Local peer review and assurance processes

QVH has a case peer review system in place in the Burns Unit. Meetings to discuss cases occur every Monday (except Bank Holidays). These meetings review injury mechanism and explanation, treatment, risk assess, discuss any Infection Prevention and Control issues and agree actions required.

The purpose of these groups is to strengthen communication and dissemination of infection prevention and control information and practice across the organisation. The meeting is attended by the Consultant Microbiologist.

Influenza arrangements

During 2019/20 support has again been given to the management of influenza (flu), with the ICN's encouraging vaccination of staff within the annual flu vaccination programme. Flu vaccination update is reported through the emergency planning reporting system.

The Infection Control Team co-ordinate the FIT testing programme for clinical staff to ensure safe practice is delivered, update the emergency plan and submit the Trust vaccination data as this is a mandatory requirement.

Untoward Incidents including Outbreaks

This is a summary of events with further details having been included in the Infection Control quarterly reports.

<u>April 2019 to June 2020</u>

- Positive blood culture result showing E.coli from a Burns in-patient. Sample was sent within 48 hours of admission so whilst reportable it is classed as community acquired not hospital acquired.

<u>July 2019 to September 2020</u>

- C.diff positive result received from a patient in Ross Tilley. Result received over 48 hours from admission therefore declared as hospital acquired. RCA completed which highlighted multiple learning needs including the need to ensure staff are aware to send stool samples at the first episode of loose stools (type 5 or above on the Bristol stool chart), staff are aware of the need to inform the receiving ward when transferring patients of any infection control concerns, staff are aware of antibiotic prescribing guidelines. Antibiotics must be prescribed on clinical need with clear documentation of indication, duration, and review. Antibiotics must be discussed with the Consultant Microbiologist for patients with loose stools and their advice followed.
- Patient on Margaret Duncombe ward confirmed to have a Vancomycin resistant enterococcus (VRE) positive wound swab. All infection control precautions implemented and patient monitored. No further cases seen and patients wound healed.
- Patient in Critical Care confirmed to have a Vancomycin resistant enterococcus (VRE) positive wound swab. All infection control precautions implemented and patient monitored. No further cases seen and patients wound healed.
- CPE positive wound swab result received from a patient admitted to CCU from Thailand for Burns care. Full RCA completed which showed patient highlighted as being at high risk of carrying CPE on admission and infection control precautions implemented however there was a delay in sending screens for CPE. Staff educated on how to correctly request CPE screening on the microbiology system. The patient is currently not clinically symptomatic of infection but is being monitored closely. Information given to the patient on the organism and good hygiene practices. The sample was sent to Public health England for typing and confirmation of CPE status.

<u>October 2019 to December 2020</u>

- 1 C.diff positive patient identified. Patient admitted to Ross Tilley for Head and neck surgery. Patient given a single dose of Gentamicin in theatres but no other antibiotic therapy given. There were no other patients or staff at the time with any loose stools or symptoms. RCA completed which showed no obvious cause for the C.diff. Reported as Hospital acquired due to having been admitted for longer than 48 hours before sample sent however no obvious lapses in care seen.
- 2 further patients were identified as being C.diff positive however they were confirmed as colonised but not infected as their samples were toxin negative. Both cases investigated with no obvious cause identified. Some learning noted around communication of patient's symptoms and results between departments with this information fed back through various meetings. Neither case is reportable.
- 1 E.coli bacteraemia identified from a max fac trauma patient admitted to Ross Tilley ward. Sample sent 24 hours after admission therefore reported as community acquired not Trust acquired. Patient transferred to Medway hospital and results of bacteraemia passed to the Infection control team at Medway. On investigation no learning needs were identified as policy was followed.

<u>January 2020 to March 2020</u>

There has been an ongoing global pandemic of Coronavirus (Covid-19) with preparations underway throughout February and March. This has had a significant impact on the working of the hospital and patient/visitor flow. The Infection Control team has prioritised the following actions due to Pandemic;

- Coronavirus Screening Pod running for community testing patients referred via NHS 111
- Screening staff and patients for Covid-19 as directed by PHE or as clinically indicated.
- PPE training, including donning, doffing and disposal of PPE
- Daily site walkabouts to ensure staff feel supported and have access to infection control for concerns and queries
- Attendance at theatre huddles when requested to inform staff of the current situation
- Fit testing staff members to ensure FFP3 masks are fitted and worn correctly to ensure adequate protection, >600 members of clinical staff currently tested.
- Completing SOP's and procedures in line with evolving national guidance provided by PHE.
- Communicating with Infection Control Lead for the McIndoe Centre to ensure cohesive and safe pathway for all NHS patients attending and for QVH staff assisting in this area.
- Attendance at ward meetings
- Reviewing and implementing PHE guidance around PPE and Infection Control
- Working with teams to move patients around the hospital
- Assisted with creation of clinical Covid-19 area in Rycroft
- Review of infection control education delivery for annual updates and induction
- Working closely with Supplies to source appropriate PPE in required quantities within the Trust
- Ensuring PPE required in each department available and staff educated on how to use it to protect themselves and patients
- Working with staff to answer queries as they arise
- Working with estates to review ventilation systems
- Collaborated with other Infection Control colleagues locally
- Supported staff to undertake Coronavirus swabbing

5. Involvement and Engagement

Antimicrobial report
This report is compiled and published by the antimicrobial pharmacist as a separate document.

Decontamination and disinfection report
Routine decontamination of nasendoscopes and specific theatre equipment continues through the Wassenburg (endoscope washer disinfector). Routine water testing and servicing of the wassenburg has been performed which has shown no problems or concerns. The Trust continues to have an external Authorised Engineer who conducts the annual audit and ensures compliance with national guidance.

Steris continue to provide the Trust with sterile services for all reusable equipment that cannot be processed through the wassenburg machine. They are an accredited company licensed to perform sterilisation for healthcare premises in line with national guidance and requirement.

Monthly meetings are held with Steris to ensure compliance with national sterilisation guidance and to monitor the contract.

All decontamination reports and audit results are taken to the Infection Prevention group meeting which has now been incorporated into the quarterly infection control group meeting.

Facilities report

Cleaning audits are undertaken by the Domestic Supervisors weekly, each clinical area is audited every week and non-clinical areas 3 monthly. Where issues or concerns related to cleaning are noted these addressed and resolved within 48 hours with a repeated audit conducted within 7 days.
Deep cleaning programme has continued with all areas deep cleaned in line with the National Standards of Cleanliness with clinical areas done every 6 months and non-clinical areas annually.
The annual Trust PLACE inspection was conducted in November 2019 by Healthwatch, external auditors, patients and QVH staff. Results issued in February 2020
The results are:

	SCORES	2019
Cleanliness	% qvh	99.74 *
Condition Appearance Maintenance	% qvh	96.26*
Food	% qvh	79.03
Privacy, Dignity and Wellbeing	% qvh	85.51
Dementia	% qvh	70.47
Disability	% qvh	75.78*

Estates report – Associate Director of Estates
IPACT continues to work closely with the Estates department and are consulted on infection control issues as well as project works.

Water Safety
The Trust continues to take monthly water sample (Approximately 25 tests per month) for the monitoring of legionella Pneumophila bacteria within the domestic water supplies. This work is undertaken by TSS and their attendance and performance continues to meet expectations. All outlets are inspected for the presence of flexi pipes / dead legs / blind ends. Any defects identified are rectified e.g. flexi pipes removed & replaced with copper hard piping. Dead Legs / blind ends to be removed as far as practically feasible.
All Legionella sampling is monitored by the estates water safety team, with actions taken when required.

Pseudomonas samples taken in during the year have all returned negative.

Infection Control Risks and incidents.
The ICN's receive notification of any suspected Infection Prevention and Control incidents via the Datix reporting system. The ICN's respond to each Datix report. The response may be in the form of advice or it may trigger further investigation. This activity allows the lead ICN to maintain oversight of all Infection Prevention and Control incidences
Each risk identified on the Datix system is investigated by the ICN. Some risks require no input as they are dealt with at the time and entered onto the Datix system as a formal record, for example a case of a hospital acquired infection.
Each risk is reviewed and appropriate action taken if require by the IPACT or through an alternative department.

Contract monitoring -Sussex CCG Infection Prevention and Control Standards
CCG's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective Infection Prevention and Control arrangements in place. A self-assessment tool is completed annually and contributes to providing evidence of assurance in conjunction with assurance site visits and submission of audits as part of an audit programme.

Infection Prevention and Control mandatory training

	Required	Achieved	Compliance %
Quarter 1	1252	1161	92.73%
Quarter 2	1230	1083	88.05%
Quarter 3	1246	1101	88.36%
Quarter 4	1238	1105	89.26%

6.	Learning from Experience
	The end of the 2019/2020 year was particularly challenging with the emerging threat from Covid-19 that was being faced. Much of the infection control team's time and resources was spent preparing for the inevitable outbreak on the UK. Actions for this included mass FIT testing staff, working with procurement to ensure adequate supplies and much more as detailed in the sections above. As a result of the additional pressures on the infection control team, the movement of clinical services and the limitations put in place around visiting other sites some of the audits have not been conducted that were due in the final quarter. These audits will prioritised for the coming audit period. Patients and staff can be put at risk by failure to adhere to good infection control practice. The Trust continues to strive to improve compliance with all aspects of Infection Control in order to safeguard the patients, service users and staff through a robust programme of education, audit and reporting. Whilst the rates of both reportable and non-reportable infections remained low there is still improvement to be made. The areas that have been shown through the auditing process for this year as requiring improvement remain the same as previous years these being: compliance with MRSA screening, compliance with hand hygiene and bare below the elbows and compliance with the dress code policy The infection control team will continue to champion and promote the implementation of infection control to all staff in all departments with the emphasis on 2020/2021 programme being reinforcing compliance with infection control. The infection control team aims to increase departmental based inspections, offer a variety of events for staff to learn more about infection control and ensure that the infection prevention and control team is a visible and constant presence within the Trust.

7.	Recommendations
	This report has evidenced the challenges faced for the trust's Infection Control team through the use of audit, training and engagement with key service providers across the Trust. The results of these have shown that overall, compliance with National guidance, Trust policy and National targets is good although there is still some improvement required. Looking forward, using the experiences and knowledge gained throughout the last financial year, further targeted work could be undertaken to improve the internal structure of key clinical areas. Additional education and training is indicated in the management of patients with specific organisms

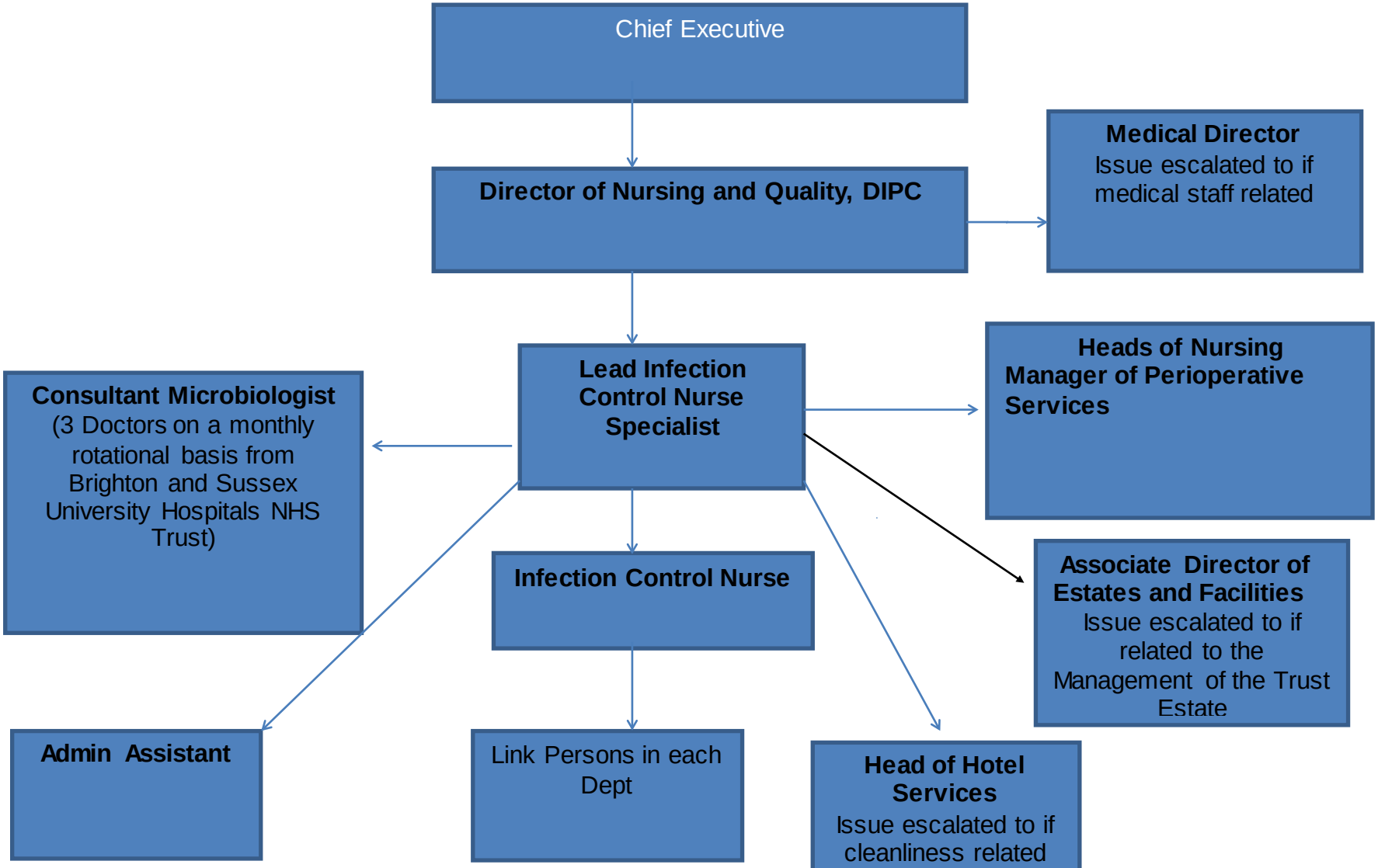
8.	Future Plans and Targets
	There are going to be many challenges to be overcome in the foreseeable future due to the ongoing Pandemic from Covid-19. The Infection Prevention and Control team will continue to be at the forefront of the trusts strategic approach to safely providing new clinical pathways including the cancer hub, urgent procedures and trauma services enabling the earliest possible increase in these services in line with recovery and restoration guidance and public health guidance. The team will continue to work flexibly and responsively to this pandemic contributing to the integrated governance and providing assurance about the fundamental management of infection prevention and control as well as bespoke solutions to evolving issues as the global situation dictates.

9.	Conclusions and assurance
	This report demonstrates the systems and processes in place to ensure that the trust meets the requirements of the Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare related guidance. The completion of the infection control audit programme, teaching and alert organism surveillance is a proven method of achieving high standards across the trust and it is the ICN's implementation of this that ensures assurance processes are focused on patient, visitor and staff safety as a priority. This is done through the writing and implementing of policies in line with best practice guidance, a robust audit process and programme of education and staff engagement which has been detailed in this report. This has assisted in maintaining the Trusts low rate of healthcare associated infections across all departments. QVH also promotes feedback from patients and encourages them to raise concerns about any Infection Prevention and Control issues they see and are worried about. QVH has a range of internal assurance processes in place. An overview of Infection Prevention and Control activities in QVH are in place. The ICN's also works closely with the CCG ICN to provide reassurance on processes and practice within the trust. QVH has an overview of all relevant Infection Prevention and Control information and documents, which are systematically developed, reviewed and/or updated. QVH has local external regulation undertaken by the CCGs. Monitor ensures QVH are registered with the CQC. Local Infection Prevention and Control peer review and assurance processes are in place. IPACT are well supported by the Director of Nursing/ DIPC. QVH staff are guided and supported by the specialist Infection Prevention and Control clinicians. The QVH Infection Prevention and Control team present this report to provide assurance to the Board that the Infection Prevention and Control agenda is robustly overseen and managed within the trust and with partners. To conclude, the Infection Control Team believes this annual report accurately reflects the commitment and achievements of the infection prevention and control service in the trust.

10.	Report approval and governance
	The Board is asked to consider the contents of this report and raise any issues of concern or outline any specific action they request.

11. Appendices

APPENDIX A **Infection Prevention and Control Structure Chart 2017/2018**



Appendix B
Infection Control Annual Programme Objectives for 2020/21

Infection prevention and control continues to be a top priority at both National and local level. The IPACT, under the direction of the DIPC and with the full support of the Board of Directors and Governors, will continue to ensure that the highest possible standards in infection prevention and control are applied and achieved at the QVH.

This action plan contains new areas of activity and a number of on-going areas of particular importance. A large amount of activity is on-going and not included in the action plan.

Department	Section	Action	Frequency
Microbiology	Management	Continued review of pathology provider to ensure safe and efficient service delivered	On-going
Microbiology	Management	Continued review of pathology provider IT systems, e.g., the provision of electronic reporting in a useable, reliable format and request for regular list of blood cultures taken	On-going
Microbiology	Management	Continued review of antimicrobial prescribing	On-going
Microbiology	Management	Maintain input into Clinical Audit Meetings and Consultant mandatory training	Quarterly
Microbiology	Management	Maintain input into the review of any new Estates project from start to finish	On-going
IC	Management	Continue to review the Board Assurance Framework related to the Health and Social Care Act (2010)	Quarterly
IC	Management	Quarterly IPACT report for Board	Quarterly
IC	Management	Decontamination Lead to continue monitoring of decontamination of equipment in conjunction with the decontamination staff within Theatres	Ongoing
IC	Management	Review policies in line with DoH and NICE National guidance and Trust timescale	As required
IC	Management	Continued attendance at external meetings and Infection Prevention Society annual conference	On-going
IC	Surveillance	Continue mandatory surveillance and reporting in line with DH requirements including MRSA, MSSA, *C. difficile* and *E. Coli*	Monthly
IC	Surveillance	Enhanced surveillance (RCA/PIR) of *C. difficile*, MRSA, MSSA and *E. coli* bacteraemia	When new case identified
IC	Surveillance	Continue speciality specific surgical site infection audit	Annual
IC	Audit	Audit sharps policy compliance	Trust wide annual
IC	Audit	Continue hand hygiene audit and compliance	Monthly
IC	Audit	Continue to review external contracts e.g. laundry	As required
IC	Audit	Continue to implement the DH Saving Lives audit programme	On-going
IC	Audit	Continue PLACE inspections	Monthly
IC	Audit	Audit compliance with MRSA policy	Twice

		Audit compliance with MRSA screening	yearly Monthly
IC	Education	Updates for Clinical Practice Educators / Department Managers / departments	As required
IC	Education	Mandatory training: Clinical Non-clinical Induction Junior doctors Consultants	X2 month X1 month X1 month X6 year X2 year
IC	Education	Link person training	quarterly
IC	Education	Infection control awareness week	Annual
IC	Education	Hand hygiene roadshow	Annual
IC	Education	Hand hygiene training	On-going
IC	Education	Deliver training to staff on current issues and attend department meetings on request	As required
IC	Education	Relaunch the infection control team to promote compliance with infection control trust wide	As required
Estates	Management	Involvement in the Capital Programme	As required
Estates	Management	Review of estates policy and new guidance	As required
Estates	Management	Involvement in reviewing water sampling and ventilation results	As required
Estates	Management	Involvement in the prioritising of general refurbishment works within the Trust	As required
Estates	Management	Update for IPG	Quarterly
Estates	Audit	Waste facility	Annual
Decontamin-ation	Management	Review of decontamination and disinfection policy	As required
Decontamin-ation	Management	Update for ICC	Quarterly
Decontamin-ation	Management	Formalise Decontamination structure and roles within the Trust	As required
Decontamin-ation	Management	JAG audit	Twice a year
Decontamin-ation	Audit	Synergy service	Annual

Appendix C

IC Policies Ratified April 2019 – March 2020

IC.7024.9	Infection Control	Management of Outbreaks	Director of Nursing and Quality	Lead Infection Control Nurse	Infection Prevention & Control Group
IC.7016.4	Infection Control	Management of Patients with Tuberculosis	Director of Nursing and Quality	Lead Infection Control Nurse	Clinical Governance Group
IC.7015.5	Infection Control	Management Of Patients with Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSEs)	Director of Nursing and Quality	Lead Infection Control Nurse	Clinical Governance Group
IC.7013.4	Infection Control	Policy for the Insertion and Care of Central Venous Catheters (CVC)	Director of Nursing and Quality	Lead Infection Control Nurse	Clinical Governance Group
IC.7014.5	Infection Control	Policy for the Prevention of Healthcare Associated Infection in Peripheral Venous and Arterial Cannula	Director of Nursing and Quality	Lead Infection Control Nurse	Clinical Governance Group
IC.7008.8	Infection Control	Policy for the Screening of Patients for Meticillin Resistant Staphylococcus Aureus (MRSA) and Treatment and Management of MRSA Positive Patients	Director of Nursing and Quality	Lead Infection Control Nurse	Clinical Governance Group
IC.7023.4	Infection Control	Policy for the Management of Patients with Blood Borne Viruses	Director of Nursing and Quality	Lead Infection Control Nurse	Infection Prevention & Control Group
IC.7030.1	Infection Control	Management of Suspected or Confirmed Cases of Influenza	Director of Infection Prevention and Control	Infection Control Nurse Specialist	Infection Prevention & Control Group
IC.7018.4	Infection Control	Policy for Mandatory Reporting Episodes of Infection	Director of Nursing and Quality	Lead Infection Control Nurse	Infection Prevention & Control Group
IC.7011.5	Infection Control	Taking Blood Cultures Policy	Director of Nursing and Quality	Lead Infection Control Nurse	Infection Prevention & Control Group

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Queen Victoria Hospital
NHS Foundation Trust

Patient Experience Annual Report

Queen Victoria Hospital NHS Foundation Trust

Report covering the period from
April 2019 to March 2020

Document Control: Quality and Governance Committee

Executive sponsor: Jo Thomas, Director of Nursing and Quality

Authors: Nicolle Ferguson, Patient Experience Manager

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1. Executive Summary

We are proud to publish the combined patient expereince, complaints and Patient Advice and Liaison Service (PALS) annual report for Queen Victoria Hospital NHS Foundation Trust during 2019/20.

We are committed to welcoming all forms of feedback, including complaints and using them to improve services, to address complaints in a person-centred way and to respect the rights of everyone involved. The last 12 months has seen Queen Victoria Hospital demonstrate an ongoing commitment to listening and learning from the experience of patients/carers and service users. We have continued to seek feedback using a range of methods.

During 2019/20 we received feedback from patients, from a wide range of sources including Friends and Family Test feedback, national and real-time patient surveys, Patient Advice Liaison Service (PALS) enquiries and complaints. This feedback provides us with a rich picture of patient experience while also offering insight into what matters to patients. We want to be an organisation that truly listens, learns, changes and improves whilst being open and transparent, sharing the learning widely.

This feedback provides us with a rich picture of patient experience while also offering insight into what matters to patients. Importantly, it allows us to develop plans for patient and public engagement and quality improvements.

The Patient Experience Manager and the teams responsible for Risk and Patient Safety are committed to ensuring that all information the Trust received about its care and services is used in a coordinated way to safeguard the quality of care received by our patients and their families. The Trust cares for large numbers of patients locally, the South East Coast as well as nationally, the vast majority have a positive experience. We seek to improve how we listen to and encourage our patients to tell us how they felt about their experiences, so that we can continue to improve the quality of the care and services we provide.

2. Introduction

This annual report demonstrates how the Trust measures progress towards the ambitions set out in the Trust Key Strategic Objectives (KSO), focusing on KSO1 Outstanding Patient Experience. The report includes a summary of patient and carer feedback and actions and initiatives to improve patient experience during 2019-20. The Trust's Patient Experience Group (PEG), a sub-group of the Quality and Governance Committee, provides the direction to deliver the strategy.

The purpose of this report is to provide a review of the Patient Experience data collected through the Friends and Family Test (FFT), the real time survey system, national surveys as well as themes from PALS enquiries and formal complaints received within Queen Victoria Hospital NHS Foundation Trust during 2019/20.

Patient experience monthly reports are provided to operational teams and patient comments are automatically shared with our staff. Leaders of our clinical services use the feedback we receive from patients to shape quality improvement activities at ward level and see whether the improvements we are making improve patient experience over time.

The Trust Board has oversight of patient experience through bi-monthly reports at public Trust Board meetings. The Director of Nursing and Quality is the Executive Lead for patient

experience, who chairs the Patient Experience Group (PEG) within the Trust. Their role is to be assured that action on improving and responding to patient experience concerns are addressed. Membership of PEG includes representation from; Trust staff, Trust Governors, and HealthWatch. This group routinely reviews patient experience improvement programme actions and progress, to ensure areas of poor patient experience are addressed. We know from existing feedback there are many examples of excellent care and experience being delivered by our staff and the overwhelming majority of patient's comments are very positive. Staff are frequently described of as being kind not only towards patients but also towards each other and go above and beyond the expected level of care.

All feedback is shared with the relevant ward or department to enable teams to share positive feedback and consider suggestions for improvements made by patients and carers. Each ward/ department has a 'learning from your experience' poster which is updated monthly to share the actions that have been taken as a result of patient feedback. The Trust

Participates in the national mandatory patient experience surveys co-ordinated by the Care Quality Commission. This feedback is valuable as it enables the Trust to compare performance with other Trusts throughout the country. Last year the Trust received feedback from the national inpatient survey. A summary of results from this survey is included in the report

The Trust adheres to Regulation 18 of the The Local Authority Social Services and National Health Services Complaints (England) Regulations (2009)[1], which came into effect in April 2009. The regualtations require NHS bodies to provide an annual report on complaint handling and consideration, a copy of which must be available to the public.

3. Friends and Family Test

The Friends and Family Test (FFT) is a tool used for providing a simple, headline metric, which when combined with a follow-up question and triangulated with other forms of feedback, can be used across services to drive a culture of change and of recognising and sharing good practice. Each patient is surveyed at discharge or within 48 hours of discharge and the standardised question format must be as follows: 'How likely are you to recommend our ward (or department) to friends and family if they needed similar care or treatment?'

This is a national survey designed to give the public an easy way to express their feedback. Our trust utilises returned tests through a multitude of facets. Initially, FFT results help raise any issues patients may have with our service, often illuminating latent issues which are not raised through the formal complaints process. Negative feedback is swiftly analysed and provides us with an initial step for improvement. Positive and neutral feedback provides a further prospect of quality improvement. Our software Envoy's thematic analysis tool provides a rich source of the most commonly raised themes brought up by patients. .

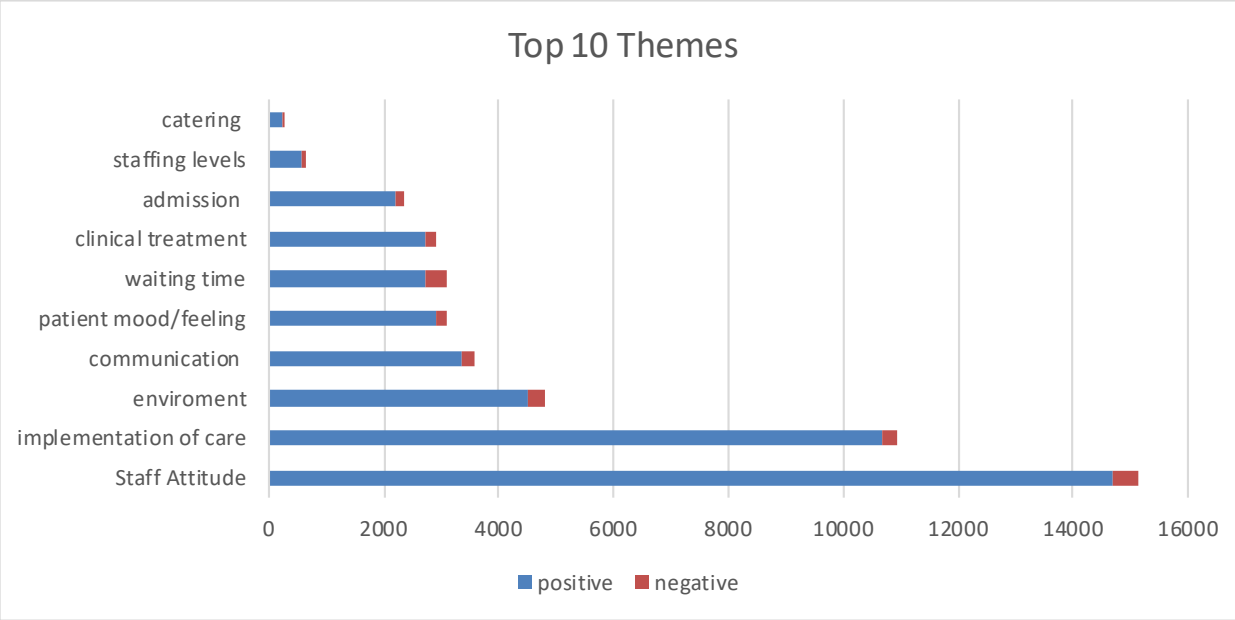
[1] NHS England & Social Care England. The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009)

3.1 How likely are you to recommend our ward/department to family and friends?

Positive and neutral feedback provides a further prospect of quality improvement. Our software Pansensic's thematic analysis tool provides a rich source of the most commonly raised themes brought up by patients. The tables below separate the positive and negative themes for the year, allowing a clear analysis of areas to celebrate and those that require further exploration.
The response rate to the Friends and Family Test question for In-Patients who are 'extremely likely/likely' to recommend us to a friend or family during that period from Margaret Duncombe ward, Ross Tilley ward, Burns ward and Peanut ward is 39% (the national response rate target to achieve is 40% for inpatient returns).

Between April 2019 and March 2020, we received 28,249 responses to the FFT, with over 23,158 comments given. The overall percentage of inpatients recommending (Extremely likely or likely) was 97%.

The table below separate the positive and negative themes for the year.



As with previous years, the vast majority of our patients are more than satisfied with the high standards of care they receive, citing the friendliness, helpfulness, excellence, clinical outcomes, professionalism and overall very positive patient experience.

Where patients felt their visit could have been improved, cited communication and waiting times in clinic as their main concerns. Of the other suggested improvements, the majority concerned issues relating to the, communication and the lack of information on display to indicate if a clinic is running late waiting time in clinic and difficulties in parking. .

The Patient Experience Group will monitor improvements against the issues raised over the coming year.

The following figures show the Friends and Family Test inpatient recommended rate:

FRIENDS & FAMILY TEST DATA BREAKDOWN 2019/20		Target	April	May	June	July	Aug	Sept	Oct	November	December	January	February	March
Inpatients	% patients who would recommend us	90 %	98.0 %	98 %	99 %	99 %	98 %	98 %	98 %	97 %	98 %	98.0 %	97.0 %	98.0 %
	% patients who would not recommend us	0%	0.0%	0%	0%	0%	0%	0%	0%	0%	0%	0.0%	0.0%	0.0%
	Response rate	40 %	41.0 %	35.0 %	37.0 %	43.0 %	31.0 %	32.5 %	44.0 %	40.5 %	40.0 %	47.0 %	38.0 %	41.0 %
	No. of responses	–	233	217	211	250	169	167	254	208	205	219	193	431
	No. of patients eligible	–	566	618	574	585	546	514	580	514	510	470	505	176

3.2 How do we report it?

Patient feedback, both from FFT and real time patient experience surveys are routinely provided directly to ward and department managers on a monthly basis which include individual comments. Key metrics are included in the Quality Scorecard provided to the Trust Board. Each ward displays the FFT score for that ward for patients and staff to see.

4. National Inpatient Survey 2019

The latest national NHS inpatient survey shows that QVH continued to achieve some of the best feedback from patients in the country. This year's survey carried out by the Care Quality Commission surveyed 76,915 people who received care at an NHS hospital in July 2019. The findings help the NHS to continually improve, enabling hospitals to see how they are doing year-on-year and how they compare with others.

Overall, QVH scored better than other trusts across all ten relevant sections of the survey – and we scored significantly better than other trusts for 48 of the 62 questions asked. Areas where QVH scored particularly highly were:

Eligibility and participation:

- Number of QVH participants 550: (England;76,915)

- Response rate: 45 per cent for QVH and 45 per cent for England
- Age range: 16 years and older
- Time period: patients discharged from hospital during July 2019
- Eligibility: patients aged 16 years or older, who had at least one overnight stay
- Exclusion: patients whose treatment related to maternity or, patients admitted for planned termination of pregnancy, day case patients, private patients (non-NHS)

Significant positive improvements for patients at QVH:

- Having confidence and trust in the doctors and nurses treating them
- Being involved with the decisions being made about their care
- Staff working well as a team
- Having enough information about their treatment

There were no significant areas of decline however areas in need of improvement in patient experience were:

- Length of time to wait for discharge
- Rating of hospital food / help from staff to eat food
- Enough notice about when you were being discharged

An action plan will be implemented and this will be monitored by the Patient Experience Group.

Nine acute trusts were classed as 'much better than expected' in 2019 including QVH as shown below:

	Historic results	Overall results				Core service		Overall CQC rating
	2018	2019	Most Positive (%)	Middle (%)[f]	Most Negative (%)	Medical care	Surgical	
			66	18	16			
Liverpool Heart and Chest Hospital NHS Foundation Trust	MB	MB	76	13	11	MB	MB	O
Liverpool Women's NHS Foundation Trust	S	MB	77	12	12	MB	N/A	G
Queen Victoria Hospital NHS Foundation Trust	MB	MB	81	11	9	MB	MB	G
Royal Papworth Hospital NHS Foundation Trust	B	MB	78	12	9	MB	B	O
The Christie NHS Foundation Trust	MB	MB	76	13	10	MB	B	O
The Clatterbridge Cancer Centre NHS Foundation Trust	MB	MB	76	14	9	MB	N/A	G
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	MB	MB	82	10	8	S	MB	G
The Royal Marsden NHS Foundation Trust	MB	MB	78	14	8	MB	MB	O
The Royal Orthopaedic Hospital NHS Foundation Trust	MB	MB	76	15	10	N/A	B	G

Key:

Trust performance	About the same (S)	Better (B)	Much better (MB)	
CQC rating	Inadequate (I)	Requires Improvement (RI)	Good (G)	Outstanding (O)

[f] Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. For example, 'yes, sometimes' is the middle option (scored as 5/10) for the question *'When you had important questions to ask a doctor, did you get answers that you could understand?'*.

5. Analysing the patient experience feedback

Analysis and triangulation of all forms of patient experience feedback, including complaints, results in the production of monthly detailed patient experience reports. These reports are then discussed at clinical governance group and quality and governance committee prior to public board. Exceptions are reviewed and actions taken, an example of this was targeting wards with lower inpatient feedback- discharge nurse and patient experience manager encouraged patients to provide feedback (which can be anonymous or named) and this was successful in improving response rates.

Developing an understanding of the patient experience by identifying and gaining knowledge of what people feel is crucial to the process of enabling the Trust to improve the experience of patients in our care. As a result of analysis, improving communication was chosen as a patient experience initiative in 2018/19. To ensure that all patients/carers receive timely, clear and sufficient information that enables them to understand their condition and care, and make informed choices about proposed future treatment plans The Trust will continue to develop staff guidance on the importance of 'customer care' and excellent communication skills. A comprehensive cultural change programme is being developed and implemented to support our vision, values and behaviours. The principles of the programme will be integrated into existing programmes and incorporated into newly commissioned programmes.

6. Patient Story at Board

Queen Victoria Hospital continues to use the experience of our patients – both positive and negative, to support learning and improvement. These are presented at the Trust's bi-monthly public Board meetings.

An individual story is not in itself representative of all patient experiences; however the story is individual to the patient and is representational of their personal experience at that time. Collectively, stories can help the Trust to build a picture of what it is like as a service user and how the Trust can improve the service it provides.

From April 2019 and March 2020 a total of four stories were presented to the Board and led to service improvements in various service areas. They included:

- Learning from complaints relating to skin grafts. This led to improvement in the provision of the information both verbal and written that is given to patients prior to their surgery.
- Positive patient experience of the treatment that a patient received form our Minor Injuries Unit.
- Learning from complaints relating to the hand trauma pathway and communication. This has resulting in looking at ways that this pathway can be streamlined.

Positive patient experience of the treatment that a patient received from the Burns unit.

7. Patient Experience Group (PEG)

The group meet on a quarterly basis, chaired by the Director of Nursing and Quality, are the key vehicle for patient representation / participation, and the group is a formal, business/assurance group comprised mainly of Trust staff, patient representatives, dementia and learning disabilities leads and Healthwatch representatives. PEG is a sub-Committee of the Board's Quality & Governance Committee.

The role of PEG is to:

- Advise the Trust on issues of concern to patients
- Form patient/representative led working groups to help develop priorities for action and ensure regular feedback on outcomes of actions
- Help develop Trust strategies, appraise information for the public developed by the Trust and help determine priorities for patient engagement
- Consider service changes and participate in a range of schemes to gather patient/ carer intelligence on Trust services including surveys, walkabouts and ward visits
- Monitor trends in complaints and feedback
- Ensure the effective implementation of action plans arising from individual local and national surveys
- Share and promote good practice in connection with patient experience

PEG has continued to receive and comment on reports including complaints, feedback, patient experience reports and national surveys. The committee has received updates on key projects which impact on patient experience, including the outpatient improvement programme. They also undertook their own outpatient survey when they met and spoke with patients within outpatient and looked at ways that they could improve on the following:

- The punctuality with which clinics start
- Ensuring that it is communicated with patients from the outset when clinics are running late
- The comfort of outpatient waiting areas
- The system for the receptionist calling the next patient, so that mistakes or misunderstandings are less likely

The group has also worked on cleaning audits and helped with the PLACE (patient led assessment of the care environment) initiative.

The outputs from PEG are discussed at the Quality and Governance Committee, a sub-committee of the Board. Also feeding the work of PEG are any care reviews or reports from Healthwatch West Sussex.

8. Complaints

This report provides a summary of formal complaints received in 2019-20 in accordance with the NHS Complaints Regulations (2009). The Trust is committed to improving the experience of our patients from their first contact with the Trust. Complaints and concerns provide valuable information to monitor the experience of patients, carers and relatives. Users of the service are encouraged to discuss their concerns with staff at the time the problem arises. However, it may be the case that

patients feel unable to do this, or perhaps staff have tried to resolve the issue but have not achieved this. The Patient Advice and Liaison Service (PALS) provide 'on the spot advice and support' with the aim of timely resolution. In the event that this has not been achieved, PALS will give advice on the formal complaints process. The Trust recognises the value that learning from complaints and concerns brings. It is vital to make the process simple and easily accessible and leaflets and posters are displayed throughout the hospital to help facilitate feedback. The following pages provide an indication of the Trust's position for complaints and concerns.

The Trust uses the following definitions:

- Complaints are expressions of displeasure or dissatisfaction where the complainant wishes a formal investigation to be undertaken;

- Concerns are issues that are of interest or importance affecting the person raising them, including displeasure or dissatisfaction and where the complainant is content for the issue to be dealt with via the PALS route;

- Feedback is information/suggestions about care or services that we provide, which may be complimentary or critical;

- Compliments are expressions of thanks and praise.

The distinction between a 'concern' and a 'complaint' is challenging. Both indicate a level of dissatisfaction and require a response. It is important that concerns and complaints are handled in accordance with the needs of the individual, and investigated with an appropriate level of scrutiny.

In order to ensure that complainants have access to appropriate support, as part of our complaints handling process, complainants are signposted to SEAP (Support Empower Advocate Promote) for help in making their complaint. All complainants are signposted to the Parliamentary and Health Service Ombudsman (PHSO) of the NHS complaints process in case they wish to take their complaint further.

The Trust has an integrated service – Complaints and PALS - to manage complaints, concerns and feedback in accordance with its Complaints Policy. This service is made up of one full time member of staff who manages the complaints, PALS and overall patient experience service. This member of staff also provides guidance, training and support to staff.

Being a single person service has some limitations on the service such as not always being able to meet the Trust standard of closing complaints in 30 working days or continuity of service during periods of leave (cover is provided by the director of nursing's office during these times).

8.1 Standards for Complaints management and escalation

The Chief Executive has corporate responsibility for the quality care and the management and monitoring of complaints but can delegate this responsibility if required.

The Trust's Patient Experience Manager is responsible for ensuring that:

- All complaints are fully investigated in a manner appropriate to the seriousness and complexity of the complaint.
- All formal complaints receive a comprehensive written response from the Chief Executive or nominated deputy.
- Complaints are resolved within the timescale agreed with each complainant at a local level whenever possible; the standard for complaint responses is 30 days, however in some circumstances i.e. complexity of the complaint, an extended time scale maybe negotiated with the complainant.
- Where a timescale cannot be met, an explanation and an extension agreed with the complainant.
- When a complainant requests a review by the PHSO, all enquiries received from the Ombudsman's office are responded to promptly.

8.2 Complaints received

Complaints handling and any trends or themes identified from them are shared and discussed regularly at a number of forums including the Clinical Governance Group which is chaired by the Medical Director and the Quality and Governance Group which is chaired by a Non Executive Director and attended by the Chief Executive and Director of Nursing as well as other members of the board, governors and staff.

All complaints are acknowledged within 3 working days. In this time frame 99% of complaints were acknowledged within 3 working days. The Trust endeavours to respond to all complaints within 30 working days in an honest, open and timely manner. If it is clear on receipt of the complaint or at any point during the investigation that the investigation cannot be completed on time, for example when a complaint is more complex or requires a joint response from services/organisations a new timeframe will be agreed with the complainant.

Again it has been a challenge to respond to complaints within the the 30 working day response timeframe but it has increased slightly to 46% (previous year 45%). However, the complaints that were responded to outside of this timeframe was agreed with the complainant.

As a Trust it is recognised that further improvements are required to achieve an improvement the number of complaints being responded to within the 30 day timeframe. In the coming year we continue to improve complaints handling with an aim of responding to 100% within the agreed time.

The Trust is committed to learning from any complaint received and considerable focus is placed on this aspect of the complaints process. We try to ensure that all complaints

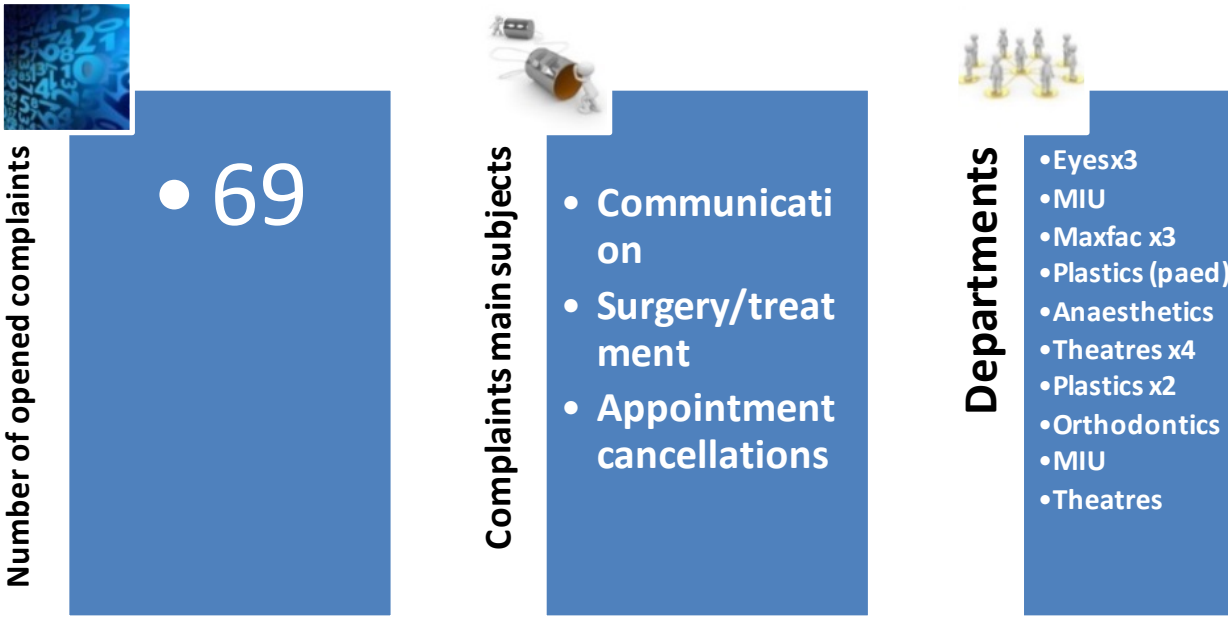
are robustly investigated and that, where action is needed to improve the care or service a patient receives, this is reflected in the complaint response.

The services have systems in place to ensure they learn from complaints and additionally they identify actions in a timely way to improve the experience of future patients Every reasonable effort is made to resolve complaint at a local level; this involves prompt correspondence and meetings with complainants.

Complaints may highlight a need to change a practice or improve a service in an individual area. When identified, a change in practice will be implemented to avoid recurrence. Individual complaints (in an anonymised format) are used in training at all levels and for all staff.

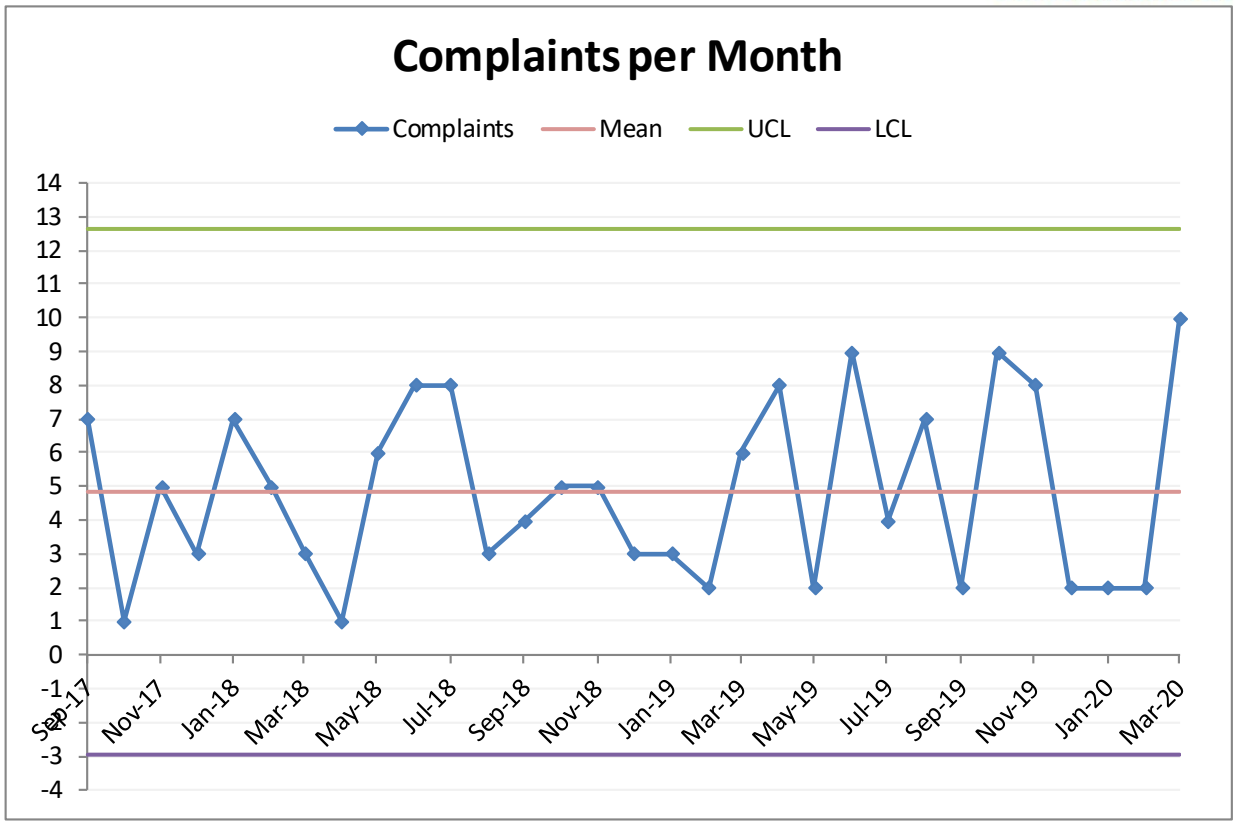
Throughout 2019/20 the Patient Experience Manager have offered training sessions for staff on both handling complaints and concerns on the frontline. All new staff received a session about customer care and handling concerns on the frontline as part of the Corporate Trust induction. Additional bespoke training is also delivered to groups of staff and individuals where indicated and requested.

During 2019/20 we received 69 formal complaints, which is 15 more than the previous year. To provide a context the 69 complaints represent 3.5 complaints per 1000 spells.



We take all negative feedback very seriously and our Chief Executive sees all complaints when they arrive and reviews all responses personally before they are sent. Complaints handling and any trends or themes identified from them are shared and discussed regularly by the Executive Team and the Board of Directors.

The chart below shows 30 points of data from Sept 2017 which reflects a process that is behaving normally and has no obvious indicators of Special Cause Variation.



8.3 Investigation outcomes

Complaints received by subject of complaint 2019/20	Total number of complaints received	Complaints upheld	Complaints upheld in part	Complaints unsupported
Appointments/admission delay/cancellation	13	7	5	1
Treatment (nursing)	5	2	2	1
Admission/transfer/discharge arrangements	1	1	0	0
Communication/information to patients (written & oral)	17	7	9	1
Treatment (medical)	5	1	2	2
Confidentiality	1	0	0	1
Surgery treatment/procedure	15	5	8	2
Attitude of staff	8	6	2	0
Treatment not commissioned by CCG	2	0	1	1
Health records	1	0	1	0
Consent to treatment	1	1	0	0
TOTAL	**69**	**30**	**30**	**9**

On completion of a complaint investigation we state whether a complaint is upheld, upheld in part or not upheld. Establishing if a complaint is upheld/not upheld can be complex, as often there are a number of concerns/allegations within an individual complaint, some of which may prove to be unfounded whilst other elements are.

Complaints received during 2019/20 included the following themes and whether the

complaints was upheld, upheld in part or unsupported:

- The thirty complaints that were graded to be upheld included incidents relating to service failure. This is categorised for example as appointment cancellations and communication.
- The thirty complaints upheld in part were categorised as such because there were clear concerns about a patient's experience being poor. This included poor communication, certain aspects where care could be improved and expectations not being met.
- The nine complaints that were unsupported, as the investigation concluded that care and treatment provided was timely and appropriate.
- The assessment of the outcome of complaints as to status of upheld, not upheld or partially upheld continues to be developed.

8.4	Learning from complaints, concerns or feedback

There is an organisational emphasis on both quality and timeliness of complaint handling which is re-inforced by the Board.

All complaints, together with their respective responses, are quality/accuracy checked and challenge by the Chief Executive and Director of Nursing. This includes recommendations for incident reporting or other independent clinical review where appropriate.
Because complaint reflect a personal experience, it is difficult to be precise about any common themes but most complaints are communication issues and the negative impact this has had. Poor attitude and behaviour is a trigger for a complaint when staff do not display empathy and compassion or are brusque and do not appear to be willing to give the patient the voice to speak. Complaints of this type are more apparent in the outpatient setting. Cancelled elective admissions and the rescheduling of outpatient appointments escalate to a formal complaint when patients cannot be given an early resolution or have ha had multiple poor experiences.

There were sixteen complaints received where attitude was recorded as the primary subject of concern. In relation to staff attitude, staff are encouraged to read the complaint letter and are supported by their line manager to reflect by providing a reflective statement on how they could have responded differently. The reflection is further reviewed with the staff member to ensure learning has taken place. Where indicated, training on values based leadership and effective people management is provided. Customer service training is also provided by Patient Experience Manager for staff teams. For medical staff, staff are required to discuss the complaint with their medical supervisor and agree a corresponding development plan.

Below are examples of actions and learning identified from complaints:

- New streamlined system put in place for the ordering of eye lenses.

- As a direct result of a complaint a clinician has now changed their practice and now mentions a rare complication in the consenting process. In addition we

have reviewed and improving both our written information and consent forms to include this complication.

- A review of eye unit patient pathways being undertaken to improve the patient experience in this area.

- When a foreign object is not located during surgery, a patient must be reviewed the following week.

- Individual member of staff was updated on a specific aspect of the consent process.

8.5 Further analysis of formal complaints

- None of the 69 patients who had raised a formal complaint, approached advocacy services to support them through the complaints process.

- The Trust received no requests for a complaint response in large print or brail.

- As in previous years, all formal complaints were received in the English language with no requests made by a complainant (or enquirer) for the assistance of the Trust's Interpreting Service.

- The Trust received no formal complaints where people stated that they had a learning disability nor did this become evident during any of the investigations.
- Of the 69 complaints, one of the complainants has asked to meet with a senior member of staff on completion of the investigation. At the time of writing, this report this meeting was yet to take place.

- No external review of care was commissioned as part of the Trust investigation during 2019/2020.

- In line with the Duty of Candour (November 2014) the trust investigation responses have been scrutinised to ensure they are open and transparent. Where it has been established that errors occurred this was shared with the complainants and an apology given and lessons identified to enhance learning for the Trust.

8.6 Parliamentary and Health Service Ombudsman (PHSO)

A complainant may refer their complaint to the PHSO if they do not feel that the Trust has responded to all of their concerns or they are unhappy with the way in which we have dealt with their complaint. The PHSO gives the Trust the opportunity to ensure that all local resolution has taken place to try and resolve the issues and will give an independent view on the complaint.

The outcme/final decision of a PHSO investigation can be to fully uphold, partly uphold or not uphold the complaint. If the complaint is fully upheld this could mean that they found that:

- the Trust made mistakes or provided a poor service that amounted to maladministration or service failure and

- this has had a negative impact on an individual which has not yet been put right.

They might partly uphold a complaint if:

- they found that the Trust got some things wrong, but not all the issues that were complained about or

- the mistakes made did not have a negative effect on anyone.

If not upheld this could meant that they found:

- the Trust acted correctly in the first place or

- the Trust made mistakes but we have already done what PHSO would expect to put things right for the person or people affected.

We are pleased to report that no cases were referred to the PHSO in 2019/2020 which is the same as the previous year.

9. Patient Advice and Liaison Service (PALS)

PALS provide advice, information and support to help resolve concerns that a service user or their family/carers may have as well as providing information on Trust services and signposting. The PALS lead works closely with the service leads to resolve problems and concerns quickly and effectively. If it becomes clear that the patient wishes to raise the issue as a complaint, we will ensure that the concern is addressed through the complaints process. It is made clear that concerns received from, or on behalf of patients in no way affects how they are treated, and are seen as valuable information to help improve services for all patients and carers.

PALS continues to work closely with neighbouring Trusts which allows for a seamless transition for the enquirer between Trusts along with regular contact with Advocacy services.

During the period of 1 April 2019 to 31 March 2020, there were 73 PALS enquiries:

- 52 of these were dealt with as concerns
- 21 of these were for advice and information

The following chart shows the main subjects

PALS by subject

	Number
Access to Queen Victoria services	5
Access to QVH information	4
Admission - delayed	3
Appointment - delayed	10
Attitude - non-clinical staff	1
Cancelled appointment	11
Cleanliness	1
Clinical care - medical	13
Communication with patient	10
Cancelled Operation	2
Health Records - access	6
Health Records - inaccurate	1
Communicating results	2
Transport	4
Totals:	73

The majority of these enquiries were related to appointment cancellations and referrals, especially within the eye services. The majority of these enquiries were dealt with satisfactorily, however 3 cases become formal complaints and were dealt with in accordance with the NHS complaints procedure. In addition, 2 cases were reported as a clinical incidents and formally investigated via that process by the Risk Management Team.

Appointments is the most common reason for patients and their families raising a concern or an informal enquiry with our PALS service. Cancellation of appointments is the most common reason for seeking assistance form PALS in relation to the appointment process whilst relation to re-booking of appointment is logged as the 2nd most common cause of dissatisfaction. The service which is linked most often to PALS concerns related to waiting for and cancellation of appointment is our Corneo Plastic Unit. This was identified as an issue last year. It is anticipated that this figure will reduce with capacity planning is ongoing for this area, as follow up appointments continue to be a challenge within this speciality.

We continue to build relationships with external partners and other NHS Trusts. PALS has also continues to ensure that learning is passed on to members of staff and general managers.

The PALS telephone contact line is operated during working hours Monday to Friday. A voice mail service is available during 'out of hours' and calls are returned on the next working day. During out of hours the Site Practitioner is the contact for patients/relatives who have urgent issues that require action.

10. Website feedback

During the year, the Trust has been responding to feedback posted onto social media websites. This is an important source of feedback for us with 36 comments regarding the Trust being posted over the past 12 months on the two main patient feedback websites, NHS Choices and Care Opinion.

We post news stories and information about the hospital on a regular basis via Facebook, Twitter, Instagram and YouTube.

Here are just some of the comments:

"Absolutely fantastic"

Within half an hour of the GP referring me online, the QVH had phoned and offered me an appointment for the following morning! I was seen within 10 minutes of the appointment time and everyone was lovely, friendly and helpful. Really great service.

"Great nurse in recovery team"

I cannot believe how wonderful the nurse was today 22/01/2020 during my 5 hour recovery

She acted with impeccable patience and diligence due to my breathing difficulties and eventually arranging admission into Ross Tilley - She even came to see me when her shift finished I can't praise her enough for her professionalism and care Thank you .

"Fantastic care"

We have visited Queen Victoria on many occasions with sporting injuries - From the Walk in Centre to Peanut ward and Theatres we have been treated so well. We are very lucky to have this hospital by our door step

"Incredible care"

I was such a baby while I was there having never had to stay in hospital before and being quite a distance from home but the nurses and support staff were so lovely and caring and despite having such long shifts nobody ever looks grumpy or tired and were always helpful and kind. Couldn't have asked for a better experience.

"Fantastic treatment"

My daughter had 2 years of orthodontic work and I am so impressed with the treatment. The staff we saw during the 2 years were all so professional and friendly. Fantastic service and so pleased with the end result of my daughter's teeth.

All comments are viewed by all staff via the Trust's intranet website and passed to relevant staff across the Trust for action.

11. Patient Information Leaflets

The Trust's library of clinical patient information leaflets continues to grow, with a current collection of over 1,500 leaflets. These Trust-approved leaflets support our patients and their carers with well-written and clear information, helping to improve their overall hospital and care experience.

Our leaflets help patients and/or their carers to make choices about treatment, including information about safety, risks, benefits and alternatives.

A project was started in 2019 to improve and enhance the review and production process of patient information. Directorates and divisions are looking closely at their leaflets, to prioritise those that need review most promptly.

12. Summary

We have seen many improvements made to the processes within PALS and complaints, these include

We have continued to develop internal relationships across our service to ensure the best possible outcome for our complainants.

We have continued to triangulate data received via complaints, compliments, concerns, incidents, PALS and Friends and Family Test to continue to learn lessons, change practice and improve the experience for our patients.

13. Future developments 2020/21

Overall, the year has been a challenging one. There has been an increase in the number of formal complaints, and there has been a struggle to achieve the performance target. However the quality of the complaints response has been sustained and this is evidenced by the very small number of reopened complaints or complaints accepted for investigation by the Ombudsman.

Further work is required to ensure that the learning from complaints is effectively disseminated, shared, embedded into practice and the impact assessed, to offer the required assurance that improvement has been achieved as a result of complaints.

This continues to pose the greatest present challenge to the Trust in terms of complaints management.

In order to improve the services provided to patients further, additional developments will be implemented.

- Our first aim is to try to ensure that patients/carers concerns are dealt with in the moment, so that they can be resolved. However, if people have had a poor experience it is essential that they are supported to raise their concerns and that these are responded to in a timely manner. Currently this is not the case and we have undertaken a review of our complaints system and put in place processes to ensure smooth and efficient future systems.
- Improve communication so that all patients have access to the information they need. Communication is a key theme, generating significant number of concerns via PALS system and a prime contributing factor across a range of areas of poor experience. Our data also tells us that when we get this right this has a considerable positive impact on people's confidence and overall experience of care.

When experiences do not achieve the required standards we will commit to listening and acting on concerns raised and aspire to resolve concerns and complaints within the timeframes.

We will do this by:

- Continuing to be open and transparent in complaint responses
- Develop ownership with managerial and clinical leads that lessons learned from complaints are embedded into service delivery
- Improve the monitoring of complaint action plans post-investigation
- Improve the response timescales by aiming for 30 working day turnaround
- Review the use of action plans, monitor their quality and continue with the triangulation and sharing of action plans to ensure consistency and shared learning across services.
- Continue to provide Patient Stories at Trust Board
- Continue to advise and support staff with tools and techniques with which to capture feedback, involve patients and carers and act on what they learn
- Continue to refine the patient experience reporting
- Continue to explore and refine our approach to gathering data on themes

Queen Victoria Hospital
NHS Foundation Trust

Emergency Preparedness Resilience and Response and Business Continuity Annual Report

Queen Victoria Hospital NHS Foundation Trust

Report covering the period from
April 2019 to March 2020

Document Control: Quality and Governance Committee
Executive sponsor: Jo Thomas

Author: Nicky Reeves

Date: June 2020

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Circulation: QVH Trust Board

1.	Executive Summary
	The emergency preparedness resilience and response (EPRR) annual report highlights the significant events and activities during 2019/20. It also identifies the rationale behind the duties placed on the trust regarding emergency planning. The 2019 NHS England annual assurance review process undertaken in conjunction with our Clinical Commissioning Group (CCG) assessed our compliance with national standards as **substantial** (appendix 1 for confirmation and appendix 2 for definitions). Following the governance and assurance process of NHSE/I, QVH's compliance was assessed as being **partial** despite the earlier assessment by the CCG. Further detail is contained in section 5. The action plan in appendix 3 identifies the work ongoing to further improve compliance in 2020 onwards

2.	Introduction
	The Civil Contingencies Act 2004 places a number of duties on responding agencies in the event of a Major Incident. QVH is categorised as a Category One responder which include the following responsibilities: • To carry out a risk assessment of our operational areas • To make emergency plans • To make business continuity plans • To warn and inform the public • To cooperate with other responders through a Local Resilience Forum • To share information with other responders During 2019/20, EPRR and Business Continuity delegated executive leadership within QVH was held by the Deputy Director of Nursing and Quality (DDNQ) who represented the organisation at the Local Health Resilience Partnership Executive Group (LHRP). This report provides a summary of the work undertaken in relation to Emergency Planning and Business Continuity within QVH in 2019/20.

3.	Service aim, objectives and expected outcomes
	QVH is expected to deliver the requirements of a category one responder for the purposes of EPRR. The EPRR lead has co-ordinated activities which demonstrate the trust has met its responsibilities as a category one responder the key outcomes being: • Updated EPRR policy • Refreshed and tested plans related to emergency plans • Collaborative working with LHRF • Establishing QVH in the wider EPRR health economy and utilising expertise within this network • Resilience test of business continuity. Maintaining effective continuity of our business is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management (BCM).

4.	Activity analysis/ achievement
	Policy Emergency Preparedness policies are held centrally on the Trust intranet pages accessed via a "tile" within the Policies section; for ease they are divided into sections to reflect specific guidance. Policy review is ongoing; seasonal policies (Cold Weather

	and Heatwave) have been changed in line with national guidance and local action cards for major incident have also been revised. Work is carried out during the year to ensure the policies are up to date and all sections are currently in date. **Incidents** QVH has had a particularly challenging year with regards to managing incidents with a number of significant business continuity and emergency planning issues including Brexit preparation, loss of water to the site, a total IT failure which led to loss of telephones for approximately 20 minutes and all IT for 8 hours, flooding in the main theatre and water leaks around the Trust during the particularly wet winter. **Pandemic** During 2020 QVH has been fully involved and engaged in the national response to COVID 19. Throughout the period and still, the incident room is open as mandated seven days per week. QVH complies with all requests for situation reports (Sitreps) and has robustly managed numerous competing demands during this time. Gold command for this incident has been held by DDN full time, ensuring the provision of consistent senior clinical and managerial decision making. An extensive integrated governance system has been embedded to take forward actions and decisions required from the external incident control as well as the internal ones and monitor progress and outcomes.

5.	**Involvement & Engagement**
	Assurance process *Internally:* Bi-monthly on-call manager meetings continue with all managers and directors who undertake on call duties being invited to the meeting. At these meetings the on-call logs and incidents are reviewed and learning is shared and actioned. As previously, new managers receive an induction session from the EPRR lead and to facilitate the transition into the element of their role. A buddy system for new on-call managers to 'test' decisions is offered for the first couple of on-call periods. There is also a system in place for non-clinic on-call managers without an operational remit to have the contact details of a manager with a clinical background to call for advice as required. EPRR updates have been Quality and Governance Committee and the annual report is presented for information at Board. These updates have been presented by the Director of Nursing and Quality or the DDNQ during 2019/20 *Externally:* All NHS Trusts who are category 1 and 2 responders (Civil Contingencies Act 2004) are required to complete a self-assessment and submit a statement of readiness to NHS England stating compliance against the national requirements of EPRR. We are designated as a Category 1 responder. The Trust reviewed its compliance with the EPRR Core Standards and the Statement of Readiness as part of the LHRP process in September 2019. The Trust undertook a self-assessment against the core standards for emergency planning and this assessment was reviewed with our lead commissioner. Following this assessment and review the Trust compliance rating was recorded as **"Substantial"** (appendix 2). There are 55 core standards applicable to QVH and we can demonstrate full compliance in 48 of these (green). Six standards are rated as partially compliant

(amber), and one is non- compliant (red). This relates to non-compliance with the data protection tool kit specifically regarding information governance training. A summary of the assessment is contained in the table below and QVH was able to demonstrate and overall compliance of **"Substantial".**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	1	1	0
Training and exercising	3	3	0	0
Response	5	4	1	0
Warning and informing	3	3	0	0
Cooperation	4	3	1	0
Business Continuity	9	7	1	1
CBRN	7	5	2	0
Total	55	48	6	1

In addition to the core standards, the Trust was also assessed on a "deep dive" item, this year was the severe weather response and the assessment was carried out in conjunction with the Associate Director of Estates. A summary of the assessment is contained in the table below. It should be noted this does not contribute to the Trusts overall score.

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	10	5	0
Long Term adaptation planning	5	0	5	0
Total	20	10	10	0

Following the CCG review, as per process, NHSE review the QVH assurance self-assessment document and disappointingly the Trusts score was amended from **substantial** to **partial**. Below is the relevant paragraph received via email from the CCG lead (appendix 2). QVH has not received a formal letter from NHSE, simply the email from the CCG.

"Queen Victoria Hospital NHS Foundation Trust's (QVH) stated level of compliance in line with the national letter (gateway 000719) is **partially compliant.** It was noted that:

1. Although QVH has remained partially compliant there has been some progress and improvement with individual core standards. However, without a designated EPRR manager there is still a risk that the Trust will not improve its position going forward. That being said, the Trust lead is now supported by a Business Manager which has meant greater attention is being paid to policies, ensuring they are refreshed and up to date.

2. Further work is required by the organisation to improve its Business Continuity planning. The overarching Trust Business Continuity Plan by its own definition under

	section 4.5 does not meet the necessary requirements. It does not recognise potential impacts that threaten the organisation; or identify the core services for the Trust. It is more aligned to a policy document. 3. The Trust needs to update its Emergency Plan to align with the NHS England EPRR Framework 2015 e.g. include definition of types of incident and reference the concepts of NHS command and control in relation to Strategic and Tactical Coordination Groups and health system coordination. 4. The CBRN plan needs to be updated removing old references such as the PHE's CBRN weblink and Guy's & St Thomas' who no longer provide poisons advice. The Trust needs to ensure that it is aligned to the latest guidance. 5. The Lockdown process is not a plan but a policy document. It does not set out the arrangements for site access and egress for patients, staff and visitors. This needs to be addressed as a matter of priority" These issues have been added to the action plan.

6.	**Learning from Experience**
	Practice Exercises and Live Events During 2019/20 QVH has tested its emergency planning resilience during a number of "live" incidents including IT failures, Brexit preparations and the COVID 19 response. The learning from these incidents is utilised to ensure the emergency plan remains up to date and is reviewed in the light of any recommendations as a result of these scenarios. Any changes to the emergency plans are approved via the Quality and Governance Committee. Other than general review of the plans, no significant changes have been made following incidents. **Winter Planning** **Snow** No adverse weather during the winter of 2019/2020 **Flu** The 2019/20 flu vaccination programme concluded in March 2020 with all data submissions to IMMFORM uploaded successfully. QVH focussed on increasing the frontline uptake of vaccine and utilised a range of incentives to encourage staff to be vaccinated, In addition, reasons for refusal and opt out were reviewed and updates were taken to the Trust Board. Final uptake for staff receiving the vaccination was 63.9%, a small improvement on 61.3% for 2018/19. As in previous years, a CCG locally agreed variance to the CQUIN allowed us to include all staff officially "declining" the vaccination producing a final figure of 84.9 %, exceeding the national target of 80%.

ImmForm Data Submission - Count of Current Vaccinated Staff		% of staff group headcount
All Doctors	**82**	**54.3%** *151*
Qualified nurses	**164**	**72.9%** *225*
All other professional qualified	**100**	**65.8%** *152*
Support to clinical staff	**170**	**60.7%** *280*
ImmForm Total Current Headcount	**516**	**63.9%**

The 2020/21 target for vaccination of the frontline workforce has not yet been confirmed.

Training
Face to face training continues to be delivered at trust induction and also at clinical and non-clinical mandatory update sessions. Mandatory training for Non-clinical staff is delivered every 3 years.

Emergency planning clinical as at 1 July 2020

Staff group	Assignment Count	Required	Achieved	Compliance %
Perm staff	640	640	568	88.75%

Emergency planning non clinical as at 1 July 2020

Staff group	Assignment Count	Required	Achieved	Compliance %
Perm staff	460	460	436	94.78%

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

All business continuity plans can be accessed by the on call managers and site practitioner team via folders on the "N" drive and hard copies of the emergency plan area available in the incident control room in the event of a power or IT failure and all departmental leads have a copy of their individual plans.

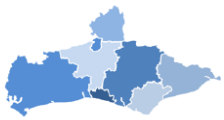
Other activity undertaken over the year:

- Training sessions on Emergency Planning Preparedness were delivered for all new employees on induction and current employees at mandatory training as an ongoing rolling programme.
- Bi monthly meeting for on-call managers, control personnel and bleep holders.
- The Trust maintained its membership with the Sussex Resilience forum
- Attendance at the LHRP executive Group

8.	Future plans and targets
	The EPRR lead has developed an action plan for 2019/20 to ensure the organisation has satisfactory arrangements in place to meet the requirements of the peer review.(appendix 3) A member of the exiting team will start to attend the emergency planning delivery group to increase compliance with this requirement

9.	Conclusions and assurance
	As reported to the Board in December 2019, the Trust currently has effective policy and systems in place for the effective management of expected and unexpected EPRR and business continuity incidents. It meets the requirements of the category one responder and demonstrates **partial** compliance to the national standards. Delivery of the work plan should ensure the organisation achieves **substantial** compliance in the 2020 review however due to the specialist and particular nature of the Trust, full compliance may always be a challenge. The trust should also consider whether a dedicated EPRR officer should be appointed following lessons learned review of COVID-19 pandemic.

Appendices
Appendix 1



Sussex and East Surrey
Clinical Commissioning Groups

NHS

Nicola Reeves
Deputy Director of Nursing
Queen Victoria Hospitals NHS Foundation Trust

Via Email nicola.reeves2@nhs.net

Terry Willows
Executive Director of Corporate Governance
Sussex CCGs

E-mail:Terry.willows@nhs.net

05 November 2019

Dear Nicky,

EPRR Assurance 2019 – Queen Victoria Hospital NHS Foundation Trust

Thank you for meeting with Owen and Michele on 24 July 2019 and 25 September 2019 to discuss the EPRR arrangements for the Trust and its submission against the EPRR core standards.

Further to EPRR Assurance review meeting, and on assessment of the evidence presented, the CCG considers the Trust's overall position to be **Substantially Compliant** with this year's NHS England EPRR core standards, subject to the outcome of our forthcoming review meeting with NHS England and NHS Improvement.

NHS England define substantial compliance as: *The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.*

The rationale for this assessment is contained in the table below for those standards that were assessed to be partially compliant (please note the deep dive standards do not form part of the overall assessment of compliance):

Ref	Standard	Rating	Commentary
25	Command and Control: Trained on-call staff		QVH on-call managers receive 1:1 training from EPRR lead. Training analysis to be undertaken and identify on call staff requiring Strategic Leadership in a Crisis training
33	Response: Loggist		QVH to secure local training for loggists and recruit loggists
41	Cooperation: LRF and BRF attendance		QVH designated staff to attend on regular basis
49	Business Continuity: Business Impact Analysis		QVH BIAs to be reviewed and updated over the next six months.

Ref	Standard	Rating	Commentary
50.	Business Continuity: Data Protection and Security Toolkit		QVH did not meet the standard in 2018/19 due to not meeting the 95% IG training compliance. Information Governance lead taking forward for 2019/20
66.	CBRN: Training Programme		QVH to source and provide external training for CBRN.
68	CBRN: Staff training - decontamination		QVH to source and provide external training for CBRN.
Deep Dive			
DD9	Severe Weather response: flood response		QVH to review its arrangements with reference to its roles and responsibilities in relation to the Multi Agency Flood plan and ensure on call/response staff are clear how to obtain the plan.
DD11	Severe Weather response: flood response		QVH to review and regularly risk assess its site against flood risk.
DD12	Severe Weather response: risk assess		QVH to risk assess and regularly review severe weather
DD14	Severe Weather response: Exercising		QVH estates team to lead on testing severe weather arrangements and document any learning from the exercises.
DD16	Long Term adaption planning: Risk Assess		QVH estates team to risk assess and regularly review risks in relation to climate change
DD17	Long Term adaption planning: Overheating risk		QVH estates team to risk assess and regularly review areas of the estate exceeding 27 degrees.
DD18	Long Term adaption planning: Building adaptations		QVH estates team to develop an adaptation plan that includes building modifications or infrastructure changes in the future.
DD19	Long Term adaption planning: Flooding		QVH estates team to identify areas in the organisation that might benefit drainage surfaces.
DD20	Long Term adaption planning: New build		QVH estates team to document it is including adaptation plans for all new builds.

I will be meeting with NHS England and Improvement to discuss assessments on 7 November 2019. Following that meeting we will confirm if they have identified any areas where they would like further assurance. The Local Health Resilience Partnership will then meet on 12 November 2019 for the final assurance meeting.

If you have any questions around our assessment, or have any points requiring clarification, please contact the EPRR team (owen.floodgate@nhs.net or michele.newman@nhs.net).

I would like to thank you and your team for the hard work and commitment that you have made to this process.

Yours sincerely,

Terry Willows,
Executive Director of Corporate Governance
(Accountable Emergency Officer – Sussex CCGs)
On behalf of the Sussex and East Surrey Clinical Commissioning Groups

Appendix 2

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Appendix 3

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisation Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Job description of EPO. Risk Register	Partially compliant	Review of staffing resources. Paper to EMT to identify support	EPRR Lead	Dec-20	Although QVH has remained partially compliant there has been some progress and improvement with individual core standards. However, without a designated EPRR manager there is still a risk that the Trust will not improve its position going forward. That being said, the Trust lead is now supported by a Business Manager which has meant greater attention is being paid to policies, ensuring they
21	Duty to maintain pla	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	EPRR policy section 6 and 6a	Partially compliant	Review of policy by LSMS and reworking of process as required.	Asociate Dirctor of Estates and Facilities	Oct-20	The Lockdown process is not a plan but a policy document. It does not set out the arrangements for site access and egress for patients, staff and visitors. This needs to be addressed as a matter of priority"
25	Command and contr	Trained on-call staff	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed	• Process explicitly described within the EPRR policy st	On call rota and Training records	Partially compliant	On call managers to be encouraged to access trainign as required.	EPRR lead	Deember 2020	

33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	• Documented processes for accessing and utilising loggists • Training records	EPRR policy. Additional traingin required for this role. Local for a local solution	Partially compliant	Interim arrangement provided by Executive Administrative team. To send individiual on loggist training as avaialble	Executive Assitant Team Lead	Oct-20	
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • Governance agreement if the organisation is represented		Partially compliant	Attendance at SHRG and LHRP already, to invstigate requirement to attend LRF	EPRR Lead	Aug-20	Currnetly do not appear to be invited.
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Section 11	Partially compliant	Subject matter expert to be consulted regarding requirement for QVH	EPRR initially	Aug-20	Further work is required by the organisation to improve its Business Continuity planning. The overarching Trust Business Continuity Plan by its own definition under section 4.5 does not meet the necessary requirements. It does not recognise potential impacts that threaten the organisation; or identify the core services for the Trust. It is more aligned to a policy document.
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Being reviewed	Partially compliant	All require update	Heads of Department	Sep-20	
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Statement of compliance	standard not met 18/19. 99/100 mandatory assetions met, failed to meet 95% IG traingin compliance	Non compliant	To achive increased compliance	IG Lead	Sep-20	
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	EPRR Policy section 7,7a,7b,7c	Partially compliant	Review policy and re write as appropr	MIU Clinical Services Manager	Oct-20	The CBRN plan needs to be updated removing old references such as the PHE's CBRN weblink and Guy's & St Thomas' who no longer provide poisons advice. The Trust needs to ensure that it is aligned to the latest guidance.
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Training programme to be developed	Partially compliant	Review training requirement	MIU Clinical Services Manager	Oct-20	

68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Training programme to be developed	Partially compliant	Review training requirement	MIU Clinical Services Manager	Oct-20	

Queen Victoria Hospital
NHS Foundation Trust

Holtye Rd
East Grinstead
RH19 3DZ

Queen Victoria Hospital NHS Foundation Trust
Research & Development Annual Report

Report covering the period from
April 2019 to March 2020

Document Control: Q&G Committee, R&D Governance Group
Executive sponsor: Keith Altman

Authors: Sarah Dawe

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1.	Executive Summary

- QVH has increased its research activity for the fifth successive year in a row.
- More and more of our patients have been offered the chance to take part in research. In 2019-20 we recruited 772 participants, of which **709** were to National Portfolio studies. This represents a **10%** increase in Portfolio recruits over the previous year.
- As a result of this excellent performance, our NIHR funding was increased by nearly **24%**.
- The Trust also had a major grant-funded study ongoing, to develop a new device to assist with the rehabilitation of facial palsy patients. This project was funded by the National Institute for Health Research (NIHR) Invention for Innovation (i4i), and Charles Nduka was the lead applicant. This was a collaborative effort with the University of Nottingham Trent and a commercial partner (Emteq).
- We are proud that four of our clinicians acted as Chief Investigators on National Portfolio studies (Charles Nduka, Raman Malhotra, Simon Booth, Emma Worrell). This is a significant achievement for a small Trust.
- We have also expanded work on commercial studies, and this year we undertook 5 such studies.
- QVH achieved the national target for time to first recruit on 100% of its non-commercial studies. We also achieved the national target time for study set up on 84% of our studies.

2. Introduction

It gives me great pleasure to introduce the annual Research and Development Report for 2019/2020. Research activity has continued to grow for the fifth consecutive year at the Trust. We recruited our largest number of patients ever into research studies. Our successes have been recognised by the National Institute of Health Research, which increased our core funding. This allowed us to expand the number of research staff employed at the Trust.

We have continued to forge successful alliances with a variety of partner organisations including Universities, NHS Hospitals and the private sector. Examples of these include the University of Oxford for the NINJA and Dupytren's studies, and our commercial work with Emteq and Smith & Nephew. This has allowed us to critically evaluate many of the innovative treatments we deliver to our patients.

QVH clinicians are both developing in-house research projects and ensuring the QVH is an active partner in appropriate multi-centres studies. I am particularly glad that this is not solely driven by doctors. Simon Booth, a Burns Nurse, and Emma Worrell, a Principal Prosthetist, are both Chief Investigators delivering nationally important research projects.

The Charitable Funds have been generous in their support of research at the Trust, and for the past two years have funded Jag Dhanda (Consultant Maxillofacial Surgeon) to work on maxillofacial research projects. This funding has now come to an end. We are very grateful to the Charitable Funds for the commitment they have shown.

I am also tremendously grateful for all the hard work put in by the research nurses, and by Sarah Dawe and Emma Foulds who oversee the managerial and governance arrangements.

I hope that we will be able to build on the successes of 2019/20. However, the COVID pandemic will prove a challenge for research at the QVH. The NIHR initially asked that Trusts focus solely on COVID research. The QVH's primary focus has been to provide cancer and trauma services for the surrounding Trusts whilst endeavouring to remain COVID free. Thus far this has made it impossible for the Trust to participate in the large scale COVID studies. Things are now gradually returning to normal. We are trying to concentrate on studies that allow us to explore how to deliver care to patients at home rather than in the hospital environment. As the lockdown eases we are aiming to collaborate with Public Health England on a COVID prevalence study.

Historically wars and natural disasters have precipitated major innovations in technology and health care. I hope the same will happen as a result of the ongoing pandemic.

	Dr Julian Giles

3.	Service aim, objectives and expected outcomes
	Research & Development improves outcomes for patients both at QVH and in the wider NHS. This is achieved through a research programme which focuses on quality, transparency and value for money. R&D at QVH is performance-monitored by our local CRN. They track our research activity on a daily basis via an interactive online system (Edge), as well as via regular meetings and written reports. The key objective by which the CRN measures our performance is a 'Value For Money' (VFM) measure. QVH has consistently delivered one of the most cost-efficient R&D programmes in Kent/Surrey/Sussex, with a cost-per-weighted-recruit of around £62. The NIHR CRN also sets objectives for: total recruitment; time to first recruit; time to local approval; and recruitment to time and target. QVH has performed well on all these targets.

4.	Activity analysis/ achievement

Research Activity

The number of patients receiving NHS services provided or sub-contracted by the Queen Victoria Hospital NHS Foundation Trust in 2019-20 that were recruited during that period to participate in research approved by the Health Research Authority was **772**, of which **709** were recruits to National Portfolio studies. This represents an **11%** increase in National Portfolio activity over the previous year.

Participation in clinical research demonstrates QVH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

QVH was involved in conducting **34** clinical research studies in 2019-20, as per the tables below.

Study ref in appendix	Study title	Start date	Principle Investigator	National Portfolio study	Recruitment in 2019-20

1	Clinical Characterisation protocol for Severe Emerging infection	03/02/20	N/A	Yes	0
2	Breastfeeding and anaesthesia	10/03/20	External	No	0
3	MET-REPAIR v1.0	06/01/20	Fiona Ramsden	Yes	5
4	MET-REPAIR-FRAILTY v1.0	06/01/20	Fiona Ramsden	Yes	5
5	SPaCE Pilot	23/08/19	Simon Booth	Yes	7
6	Organisational resilience questionnaire development and validation	06/06/19	External	Yes	
7	JaWPrinT	27/03/2019	Jag Dhanda	Yes	12
8	FFFAP Falls Audit Evaluation	18/10/2018	N/A	Yes	0
9	Allotex - IntraStromal - (PRO10)	08/02/2019	Samer Hamada	Yes	10
10	Single Use PICO NPWT Post-Market Safety and Efficacy Study	21/01/2019	Simon Booth	Yes	2
11	TEARS Grading scale: grading the clinical severity of epiphora	12/11/2018	Raman Malhotra	Yes	114
12	XEN45 in Angle Closure Glaucoma	22/10/2018	Gok Ratnarajan	Yes	1
13	Nail bed INJury Analysis (NINJA)	23/05/2018	Rob Pearl	Yes	17
14	DEFeND	11/12/2018	Jag Dhanda	Yes	5
15	Objective dynamic description of facial co-contractions and facial dominance in the general population	13/08/2018	Charles Nduka	Yes	0
16	Haemostatic markers in ECMO (HAE) study	25/01/2018	N/A	Yes	0

17	Smartmatrix SMA0217	10/09/2018	Baljit Dheansa	Yes	6
18	Patient experiences of adapting to life following orthognathic treatment for facial asymmetry	25/09/2018	Lindsay Winchester	Yes	4
19	Ambulatory measurement of facial expressions in health and disease - FRAME	12/11/2018	Charles Nduka	Yes	110
20	Improving perioperative care through the use of quality data: Patient Study of the Perioperative Quality Improvement Programme (PQIP)	03/05/2017	Julian Giles	Yes	194
21	Ciclosporin 1mg/ml eye drop emulsion (Ikervis) for the treatment of severe keratitis in adult patients with dry eye disease, which has not improved despite treatment with tear substitutes	28/09/2017	Samer Hamada	Yes	0
22	Validation of the MIRROR facial expression tracking application in healthy subjects and facial paralysis patients	11/03/20	Charles Nduka	Yes	0
23	Lock & Key	08/06/2017	N/A	No	0
24	Lugol's Iodine in Surgical Treatment of Epithelial Dysplasia in the Oral Cavity and Oropharynx - LISTER	07/12/17	Paul Norris	No	0
25	A nationwide survey of prosthetic eye users: a collaborative study with all NHS ocular prosthetic service providers.	01/03/2017	Raman Malhotra / Emma Worrell	No	8
26	Antibiotic Levels in Burn wound Infection (ABLE)	30/08/2016	Simon Booth	Yes	6
27	EuPatch	01/07/2016	Samer Hamada	Yes	0
28	Investigation of Potential Biomarkers in the Role of Scar Formation	16/03/2016	Baljit Dheansa	No	63
29	SUBMIT	21/09/2016	Asit Khandwala	Yes	2
30	A study to refine the CAR burns scales	03/11/2015	Simon Booth	Yes	101
31	Molecular mechanisms and pathways of chronic inflammatory and degenerative diseases. (Dupuytrens patients)	30/11/2015	Loz Harry	Yes	100

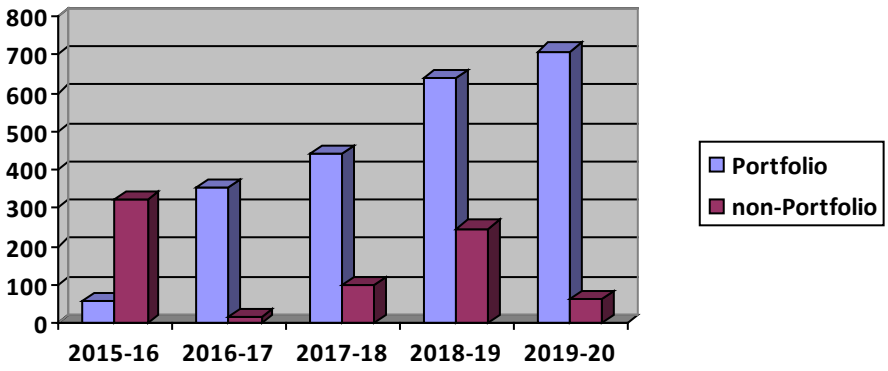
32	Molecular Genetics of Adverse Drug Reactions	31/01/2012	Baljit Dheansa	Yes	0
33	Leadership styles and their effectiveness in the NHS	04/06/19	External	No	0
34	The anatomy of flexor tendon repair	01/10/18	Rob Pearl	No	0

Involvement in NIHR Portfolio studies

Accruals for NIHR Portfolio studies are recorded and monitored via a national database, and the level of CRN funding received by the Trust is partly determined by these accrual figures. In the past four years, the number of Portfolio participants recruited has greatly exceeded the number of non-Portfolio recruits, reflecting a strategic push to increase the proportion of Portfolio studies we undertake.

QVH recruited **709** Portfolio participants in 2019-20. This represents an **11%** increase over the previous year.

Research Participant Recruitment 2015-2020



Maxillofacial research funded by QVH Charitable Funds

Jag Dhanda was very generously funded by the QVH Charitable Funds for 3PA/week to focus on research. Two new studies were ongoing in 2019-20: DeFEND (Determining the Effectiveness of Fibrin Sealants in Reducing Complications in Patients Undergoing Lateral Neck Dissection - 4 patients recruited in 2019-20), and JaWPrinT (Jaw reconstruction with printed or flexed titanium and free tissue transfer – 12 patients recruited in 2019-20).

A third, SAVER (Sodium Valproate for Epigenetic Reprogramming in the Management of High Risk Oral Epithelial Dysplasia), is planned for 2020-21.

External Funding

Grant funding

The Trust held one grant in 2019-20, a prestigious NIHR i4i award, for which Charles Nduka was the lead applicant. This was a collaborative effort with the University of Nottingham Trent and a commercial partner (Emteq), to develop a new device to assist with the rehabilitation of facial palsy patients. The grant was worth a total of **£846,000** across all three partners.

Core funding

The CRN awarded the Trust **£172,308** core funding in 2019-20, plus £11,700 contingency funding and £3000 Specialty Lead Funding. The CRN determines its level of funding using an algorithm based on the number of patients recruited to Portfolio studies over the previous two years. This activity-based funding formula is a key driver for how research work is prioritized at QVH.

Funding was allocated according to CRN guidelines in the following way:

Resource	Staff	Name	Allocation
Lead Research Nurse	Gail	Pottinger	26,457
Research Nurse	Simon	Booth	25,697
Research Practitioner	Debbie	Weller	7,039
Research Nurse	Tracey	Shewan	41,900
Research Nurse	Cassie	Honeywell	27,286
Clinical Lead for R&D	Julian	Giles	5352
Clinical Trials Pharmacist	Judy	Busby	2094
Specialty Lead	Jagtar	Dhanda	3000
Head of Research	Sarah	Dawe	24,580
Research Governance Officer	Emma	Foulds	10,042
Training			0
Travel			1,564
Overheads			11,997

The Trust also received **£2,250** from the Brighton and Sussex Medical School to support the IRP students who undertake fourth-year research projects at the hospital.

Charitable Funding

The QVH Charitable Funds very generously supported a Maxillofacial Consultant to undertake research for 3PA/week. This is reported on under 'Research Activity' above.

The Scar Study has been kindly supported by the League of Friends and the QVH Charitable Funds, which between them funded 3 day/wk of a research technician. This study is investigating potential biomarkers in the role of scar formation. 63 participants were recruited in 2019-20.

5.	Involvement & Engagement

Patient and Public Involvement and Engagement

QVH continues to work to find meaningful ways to involve patients and members of the public in its research activity. We are fortunate to have on our R&D Governance Group two very involved patient representatives, who take an active role in advising on and monitoring the research activities of the Trust, and this year we also appointed a new Patient Research Ambassador. Patients are also often involved in the early stages of research projects via focus groups, who feed into protocol development. We have set up a Research Panel which has been established to suggest as well as review new research ideas for the QVH as they are being formulated.

In 2019/20 we continued to raise patient awareness of QVH as a research active organisation. A short video featuring both research patients talking about their own experiences and clinicians explaining about research benefits is now completed and running in outpatient waiting rooms on a timed loop. Leaflets and pull up banners are also in use throughout the organisation to advertise research opportunities.

Participant Research Experience Survey (PRES)
QVH takes part in the national anonymous PRES questionnaire. In 2019/20 we increased research participant engagement with PRES and extended invitations to patients in a broader range of clinical specialities to fully represent the diverse nature of the QVH clinical trials portfolio. 96 PRES responses were received in total.

Data from PRES is reviewed regularly throughout the year and helps us better understand the experience of research participants and how we might improve their experience. The results are shared both internally and with our CRN. Action plans are in place to address the main PRES findings.

The findings show that there is a widespread recognition of research staff being friendly, professional and answering questions in an understandable manner, with 100% of respondents agreeing with this. 93% felt valued as a research participant, and 98% agreed that they had been given all the information they needed in relation to study. 90% reported having had a good experience of taking part in research.

Some 43% of participants were unaware that QVH was a research active Trust prior to joining their study. This is down from 67% the previous year, and shows that publicity we have put in place is starting to have a positive effect.

A new finding this year showed that 25% of patients were unsure of what to expect at follow up. Research Nurses are now providing more verbal instructions to supplement written leaflets; contact cards are also in process giving generic research e-mail and contact numbers for trial participants to use for any questions regarding their appointments. This intervention will be monitored over the coming year for effectiveness.

Comprehensive Research Network (CRN)

The Trust is a member of the Kent, Surrey, and Sussex Comprehensive Research Network (CRN). We work with the CRN to maximize opportunities for Portfolio studies, identify new studies the Trust may participate in, and implement new national systems and structures. The CRN distributes R&D resources amongst its members according to an activity-based algorithm. The CEO sits on the CRN Partnership Board, and the Head of Research and the

Clinical Lead for Research regularly attend CRN finance and performance meetings, working closely with the CRN Link Manager and her team. Meeting CRN targets is a priority area for the Trust.

Our people

Clinical Research Staff

We are proud that four of our clinicians acted as Chief Investigators on National Portfolio research studies (Charles Nduka, Raman Malhotra, Simon Booth, Emma Worrell). This is a significant achievement for a small Trust.

In 2019-20, the Trust supported one Lead Research Nurse (0.6WTE), one Burns Research Nurse (1WTE), one Research Practitioner (1WTE), two Research Nurses (1.89WTE), and one Research Assistant (0.2WTE).

We have been fortunate to have the support of the QVH Charitable Funds, who have funded 3PA/year of a maxillofacial consultant's time for research (Jag Dhanda).

The Scar Study has been generously supported by the League of Friends and the QVH Charitable Funds, which funded 3 day/wk of a Research Technician.

Some clinical departments also each have their own arrangements for Research Fellows. These are funded by the departments themselves and are not managed by the R&D Department. In addition, we have identified nurses within different clinical areas who have been trained up to support research in their own department.

Research Management and Governance

The R&D Department presently consists of one Clinical Lead for R&D, one Head of Research (0.66WTE) one Research Governance Officer (13.8h/wk), and one Research Assistant (0.2WTE).

Funding was received from the Comprehensive Research Network (CRN) to support the research management and governance. Other income to support the R&D infrastructure comes from commercial studies, which in addition to paying general Trust overheads, contribute a fee for R&D Department services in processing applications, setting up contracts, and implementing and monitoring studies.

Intellectual property and Innovation

The Trust has engaged the services of NHS Innovations South East to assist with commercializing and developing its intellectual property, and this year they have been managing royalties for a tracheostomy dressing device originally developed at QVH.

Training and Development

Local Training
Individual support tailored to the individual is provided by the R&D Department to all new researchers who require guidance developing their protocols, navigating the approvals

process and setting up their studies.

It is a legal requirement that all staff involved in clinical trials complete Good Clinical Practice (GCP) training, and the Trust has facilitated this for staff – either by providing an onsite trainer, enabling access to off-site courses at other Trusts, or by paying for staff to do an individual online course. One member of staff is a qualified GCP trainer, and also runs courses outside the Trust on behalf of the CRN. Commercial companies also regularly run refresher GCP courses for staff involved in the clinical trials they run at the Trust.

Our research staff also attended external courses on Project Management, Finance, Change Management, Influencing and Negotiating, Report Writing, Group Facilitation, as well as conferences on Head & Neck Cancer and at the British Burns Association.

CRN training
The Trust also has access to training provided by the CRN for any studies which are accepted onto the National Portfolio. A wide range of courses are offered, including GCP training.

Research Design Service
The NIHR Research Design Service South East provides a very good service in supporting staff making grant applications. They provide us with invaluable advice on study design and methodology.

Governance Structure

R&D at the Trust is overseen by a Research & Development Governance Group. Its members include: Clinical Lead for R&D, Chief Pharmacist/Clinical Trials Pharmacist, Anaesthetics Lead, Burns Lead, Corneoplastics Lead, Hand Surgery Lead, Maxillofacial Lead, Deputy Director of Nursing, Oncoplastics Lead, Healthcare Science Lead, Orthodontics Lead, Head of Research, Finance Department Representative, Designated Individual with responsibility for Human Tissue Authority license, and External Academic Advisors from the University of Brighton. The Group also has two very active patient representatives who play a valuable role in advising on new projects.

The R&D Governance Group reports to the Quality and Risk Committee.

The Director of Nursing acts as the Trust's Nominated Consultee for research participants unable to consent.

***Trust policies which cover R&D*:** Adverse Event Reporting Policy, Research Fraud Policy, Code of Practice for Researchers, Pharmacy policy for Clinical Trials, Intellectual Property Policy.

R&D approvals and targets

QVH has effective, streamlined systems for managing R&D approvals in proportion to risk, and our turnaround times are swift. The R&D Dept provides guidance with using the national IRAS applications system, and works with the Health Research Authority (HRA) to approve studies and ensure they meet national guidelines. We use the Edge online system to manage and monitor research here at the Trust.

There are national targets for the processing of R&D applications and for time to first recruit. QVH approval times for clinical trials and for commercial studies are also reported quarterly to the NIHR, and published on the QVH website.

The proportion of new studies at QVH meeting the national HL04 target for site set up within

	40 days was **84%** in 2019-20. This compares to 71% nationally (2018-19 figures). For non-commercial studies, QVH achieved the HL05b target of 30 days to first recruit in **100%** of studies. This compares with 46% of non-commercial studies nationally (2018/19 figures). For commercial studies, QVH achieved the HL05a target first recruit within 30 days on **0%** studies (only one eligible study). This compares with 33% of commercial studies nationally (2018/19 figures). **Sponsorship status** Some research carried out at QVH is investigator-led ie designed and conducted by our own staff, and these require the Trust to provide structures to support pre-protocol work and peer-review, as well as the subsequent management of active projects. We currently have four Chief Investigators at the Trust who have initiated QVH-Sponsored National Portfolio studies, as well as one Chief Investigator for a non-Portfolio studies. No research study may begin in the NHS without a Sponsor being identified. The Trust continues to offer its researchers the benefits of providing Sponsor status for the studies they initiate. QVH believes that it is right to support its researchers in developing new projects, and to encourage the spirit of intellectual enquiry, and so continues to provide Sponsorship status for all single-site non-CTIMPs plus phase IV CTIMPs. The Trust's capacity for R&D, and its commitment to research, is clearly stated in its official RDOCS (R&D Operating Capability Statement), which is a publically available document endorsed by the Board and published on the QVH website, according to national guidelines.

6.	Learning from Experience
	QVH has made excellent progress in growing its National Portfolio research activity over a sustained 5-year period, and this has been recognised by extra funding from our CRN. Prioritizing CRN targets ahead of other research objectives has resulted in R&D finances now being on a more secure footing. This has given research at QVH more stable foundation to build on in 2020-21.

7.	Recommendations
	Research activity at QVH has had five successive years of growth. In order to sustain this, consultant engagement needs to be developed.

8.	Future plans and targets

	Specific targets for 2020-21: • Support the national focus on COVID19 studies • Where required, redeploy staff to frontline care • Continue to recruit to non-COVID19 studies where possible Progress towards these targets will be monitored by the CRN and by the R&D Governance Group.

9.	**Conclusions and assurance**
	Research at QVH has benefitted from five successive years of growth, due to a sustained focus on meeting CRN targets. As a result of this activity, the CRN and NIHR have awarded us more core funding. This has put R&D finances on a stable footing. We expect a significant fall in activity in 2020-21 due to the COVID19 pandemic.

10.	Appendices

Registered research projects (with HRA Approval) ongoing in 2019-20

1 Clinical Characterisation Protocol for Severe Emerging Infection

This is a standardized protocol for the rapid, coordinated clinical investigation of severe or potentially severe acute infections by pathogens of public health interest. Patients with a spectrum of emerging and unknown pathogens will be enrolled. This protocol has been designed to maximize the likelihood that data and biological samples are prospectively and systematically collected and shared rapidly in a format that can be easily aggregated, tabulated and analysed across many different settings globally. The protocol is designed to have some level of flexibility in order to ensure the broadest acceptance and has been initiated in response to the recent cases of novel coronavirus (nCoV) in 2012-2013, Influenza H7N9 in 2013 and viral haemorrhagic fever (Ebolavirus) in 2014. Information will be circulated by the Investigators and disseminated by the NIHR Clinical Research Network to clarify the eligibility criteria in the event of the emergence of a pathogen of public health interest. The study is now recognised by the NIHR as being an Urgent Public Health Research study

2 Breastfeeding and anaesthesia

Very few drugs make breastfeeding absolutely contraindicated (3). An evolving knowledge of pharmacology and breast milk physiology has led experts to suggest that mothers can resume breastfeeding following anaesthesia as soon as they feel able (4,5).

There is currently no national guidance on breastfeeding and anaesthesia. Supporting breastfeeding peri-operatively is essential to provide infant nutrition, maintain lactation and prevent breast engorgement & mastitis. Anaesthetist give a range of advice to breastfeeding mothers, which may cause distress to mother and infant and result in the premature end to their breastfeeding journey, depriving mother and baby of the health benefits. It is difficult to justify anaesthesia being a reason for women ceasing to breastfeed.

This project seeks determine current practice nationally through the use of a short online survey of currently practicing anaesthetists. The survey has been piloted in North Bristol NHS Trust, yielding 51 responses with grade of anaesthetist proportionally representing the department.

3 MET_REPAIR v1.0

This study seeks to investigate the prognostic value of estimation of a patient's exercise capacity prior to major noncardiac surgery. Current guidance from the European Society of Anaesthesia and European Society of Cardiology, American College of Cardiology and American Heart Association recommends that patients' exercise capacity should be estimated in terms of metabolic equivalents (METs). The number of METs reflects the increase in oxygen consumption during an activity compared to when at rest. For example, if 1 MET equates to a patient at rest and 4 METs is walking up two flights of stairs, the latter activity requires four times as much oxygen consumption. The primary objective is to determine whether the number of METs a patient can achieve, as estimated using a questionnaire, is associated with major adverse cardiovascular events or cardiovascular mortality around the time of surgery, and if so, what is the value for METs that can best predict whether a patient will suffer these complications?

In a substudy, the patient's NTproBNP (N-Terminal prohormone of Brain Natriuretic Peptide) level will be measured to determine whether NTproBNP improves prediction of perioperative cardiovascular events and cardiovascular mortality when added to clinical data and estimated

METs. If such associations exist, they will add to the methods available for establishing patients' risk of morbidity or mortality when they undergo major surgery.

4 MET-REPAIR-FRAILTY v1.0

See above

5 SPaCE pilot

The objective of this pilot study is to evaluate the technology that is intended to be incorporated into a SPaCE-swab sensor kit. The kit is intended to be a low cost, fast, near-to-patient method of assessing the infection state of a wound. It would rapidly indicate wound colonisation (onset of infection) by the four principal microbial wound pathogens: Staphylococcus aureus, Pseudomonas aeruginosa, Candida species, and Enterococcus faecalis.

6 Organisational resilience questionnaire development and validation

This research involves exploratory testing of a widely used, but poorly tested concept of organisational resilience in a healthcare context. Resilience refers to the ability of an organisation to 'bounce back' or recover from an unexpected event. Unexpected events, such as infection outbreaks have a significant adverse impact on many hospitals. Understanding what constructs constitute resilient approaches at organisational level will help improve hospitals' preparedness and response to unexpected events.

A questionnaire designed to ascertain the constructs comprising organisational resilience will be developed from the literature and a case study and then validated across a sample of hospital staff from England. The results from the questionnaire will be collated and statistically analysed. The analysis will attempt to validate the questionnaire as a tool to test organisational resilience in a hospital context. The research aims to provide an improved understanding of organisational resilience in healthcare with the aim of developing practical strategies that can be adopted by hospitals to become more resilient.

7 JaWPrinT

JaW PrinT is a 'real-world' prospective observational pilot study, evaluating the clinical effectiveness, usability and economics of two approaches to mandibular reconstruction surgery (figure 1). Patient participants will be recruited prospectively over a minimum period of 18 months (with observation of at least 10 participants in each treatment pathway). The figures are based upon the historical clinical practice of the research site, with both techniques in equal use; choice depending on resources, surgical training requirements and surgeon's clinical preference.

As a purely observational study, treatment choice will be made in the normal clinical manner and will in no way be influenced by the study itself. Participants will be followed up at their routine outpatient clinics (6 weeks, 6 months and 1 year postoperatively) with prospective outcomes data collection

8 FFFAP Falls Audit Evaluation

Audit and feedback is widely used within quality improvement initiatives as a strategy to improve professional practice. However, the use in practice of these tools needs to be carefully designed and adapted to the specific local context to be effective. Falls are the most frequent patient safety issue experienced by old patients during an acute hospital episode, resulting in over 2,000 hip fractures annually as well as considerably other injury, distress, and anxiety, plus increased healthcare expense.

This research will explore current use and opportunities of improvement of the National Audit of Inpatient Falls (NAIF), one of the work-streams of the Falls and Fragility Fracture Audit Programme (FFFAP), which is a national programme of quality improvement managed by the

Royal College of Physicians (RCP) in the Clinical Effectiveness and Evaluation Unit (CEEU).

The purpose of this project is to provide a scientific evaluation to better understand the barriers and enablers to the use of the NAIF data by clinical services in their quality improvement work to reduce the incidence of inpatients falls. In particular in this research we aim to investigate technical, social and contextual factors, related to the audit and feedback process of the NAIF programme in order to explore how the audit data and reports from 2017 are perceived, received, and acted upon. The results of this research will be used to make recommendations as to how to improve the audit and wider programme 2018-2021 and more in general to inform future National Clinical Audits.

9 Allotex - IntraStromal - (PRO10)

The objective of this clinical study is to evaluate the safety and effectiveness of intrastromal implantation of the Allotex TransForm corneal allograft (TCA) for improving near vision in presbyopic subjects.

The Allotex TCA is a piece of acellular cornea, sterilized with electron beam radiation and shaped to a particular shape using a laser. The availability of precise laser shaping systems and sterile corneas are the key factors that make the use of allogenic implants possible. One size of the TCA is available which has a +2.50 D power with a diameter of 2-3.5 mm and a central thickness of 15-25 microns. The TCA is applied to the surface of the cornea at the layer known as Bowman's membrane, which is just underneath the epithelium.
The goal is to enhance the visual performance of the patient with a material that is 100% biocompatible and precisely shaped for the individual's needs.

10 Single Use PICO NPWT Post-Market Safety and Efficacy Study

There is a significant amount of clinical evidence to show that NPWT may reduce oedema, increase healing and reduce chance of infection, through maintenance of pressure therapy, in closed incisions, but limited clinical evidence on skin grafts and flaps. In order to meet MDR regulation this study is being complete to assess performance efficacy and safety in skin grafts. In addition, a minor modification has been made to the pump to reduce noise level. Evidence on a small number of abdominal and knee incisions are also being collected to assess that the pump works in the same way as previously on these indications. Subjects with abdominal incisions, skin grafts and knee incisions following knee surgery will be recruited to the study and receive NPWT for 7 days. Functional performance of the system will be assessed through the use of pressure data loggers and acceptability of the device as assessed by patient and clinician. Safety will be assessed with a 30 day follow up to assess complications and device related events.

11 TEARS Grading scale: grading the clinical severity of epiphora

Epiphora (watery eye) is a common presentation to the ophthalmology clinic, with most patients being amenable to surgical (61-69%) or non-surgical treatment. Surgically-amenable epiphora affects an estimated 16/100 000 persons rising to 100/100 000 in 75-84 year olds. While in some, the epiphora represents no more than a tolerable nuisance, in others it significantly affects their quality of life. At the more severe end of the spectrum, some cases require repeat medical attendances and hospital admissions for systemic infection. With ever-increasing financial constraints on healthcare providers, there is a need for clinicians and healthcare commissioners to better prioritise patients for surgical intervention.

The 'TEARS scale' was developed through extensive literature review, patient focus groups and consultation with an expert panel of consultant ophthalmologists. Disease severity is graded based on 4 subscales: symptom frequency, the effects on patients and healthcare providers, patients' functional status, and the compounding effect of ocular surface disease. This prospective study aims to validate the TEARS scale by recruiting adult patients presenting to oculoplastic clinics with epiphora. Two clinicians will complete the TEARS grading scale at the study entry point. Patients will complete two questionnaires: The Watery

Eye Quality of Life score (WEQOL) and The Lacrimal Symptom Questionnaire (Lac-Q). In a subset of patients who have previously agreed with their clinician to undergo either surgical or non-surgical intervention, the TEARS scale will again be completed at their clinical review by two clinicians between 3 and 6 months after their initial visit. Patients will again complete the WEQOL and Lac-Q, as well as the Glasgow Benefit Inventory (a measure of change in quality of life).

The scale's reliability will be evaluated through statistical testing of inter-rater agreement. Construct validity will be assessed by the scale's correlation with patient-reported outcome measures and by evaluating its responsiveness to surgical intervention.

12 XEN45 in Angle Closure Glaucoma

Glaucoma is an eye condition where the optic nerve is damaged by the high pressure of the fluid in the eye (aqueous humour). Aqueous humour is produced by a ring of eye tissue called the ciliary body, located behind the iris (coloured part of the eye). It flows through the pupil and drains out through a spongy network of holes called the trabecular meshwork (which sits in the angle formed where the iris meets the cornea). In Angle Closure Glaucoma (ACG), the outer edge of the iris and cornea come in contact, closing the drainage angle. This prevents the aqueous humour from draining and causes the pressure in the eye to build up. Currently available treatment for ACG consists of procedures to reduce eye pressure, including laser treatment, lens extraction, eye pressure-lowering medications, and incisional surgeries. There are no minimally invasive glaucoma surgery options available for ACG. XEN45 Glaucoma Treatment System (referred to as XEN) potentially alleviates this unmet need. XEN comprises of the Gel Implant and the Injector. The Gel implant is a soft gelatinous implant, approximately 6 mm long and as wide as a human hair. After implantation in the eye, it acts as a conduit for the drainage of aqueous humour in the eye.

The current study, sponsored by Allergan, is a prospective, multicentre, single arm, open-label (the participants and study team will know which treatment the participant is assigned to) clinical trial in patients with ACG. Approximately 65 patients will be implanted with XEN in one eye and followed for 12 months to evaluate its safety and effectiveness. Participants will be enrolled at approximately 15 research sites in the Asia-Pacific and European regions.

13 Nail bed INJury Analysis (NINJA)

Nail bed injuries are the most common hand injury in children in the UK. Treatment usually involves surgical repair of a laceration located underneath the fingernail. To do this the fingernail is removed, the laceration repaired, and the fingernail can be replaced or discarded. Historically the nail was replaced routinely but recent evidence indicates not replacing the nail may reduce the incidence of infection and post operative complications. The NINJA trial is a multicentre, parallel group, randomised controlled trial comparing replacing the nail to the alternative practice of discarding (not-replacing) the nail as part of the surgical nail bed repair for the treatment of nail bed injuries. This study will be undertaken at multiple UK sites, identified through the Reconstructive Surgery Trials Network (RSTN) over a 3 year period. Each patient will be followed up for 4 months.

14 DEFeND

A neck dissection is an operation to remove the glands in the neck either because they have cancer in them or they are at risk of cancer spreading to them. Complications after neck dissection are a significant problem for patients and may affect their quality of life. Research on understanding the feelings of patients who have had head and neck cancer, has shown that avoiding complications is very important to them.

We have found evidence that by giving patients a substance that copies the blood clotting process called Fibrin Sealant, we may be able to protect them from complications. This is because this substance can seal areas of bleeding and stick the raw surfaces of the wound together. Unfortunately, there is no high quality research that has been able to answer whether Fibrin Sealants can prevent complications after neck dissection. Therefore we have

designed a clinical trial to help us answer this important question. However, before this can be started we need to conduct a miniature version of the trial to make sure it has been designed in the best possible way.

15 Objective dynamic description of facial co-contractions and facial dominance in the general population

In the context of lack of research describing normal patterns of facial co-contractions, this project aims to elucidate this research question by measuring objective patterns in healthy subjects. This will allow a baseline to be defined for assessing patients with facial nerve pathology and subsequent treatments.

16 Haemostatic markers in ECMO (HAE) study

Multicentre, prospective cohort study of haemostatic activation markers and correlation with bleeding and thrombotic complications in patients receiving extracorporeal membrane

17 Smartmatrix SMA0217

This is a multi-centre, non-comparative, prospective study to demonstrate that the Smart Matrix dermal replacement scaffold has an acceptable safety profile and enables healing in full-thickness surgical wounds. Approximately 40 patients scheduled for elective surgical excision of suspected or histologically proven BCC or SCC lesions who meet the inclusion and exclusion criteria and provide written informed consent will be enrolled in the study.
The study will be conducted in 2 stages, with the first 12 patients (the safety cohort) reviewed by the Data Monitoring Committee (DMC) to assess the safety and performance of Smart Matrix.

When the safety cohort reaches the Week 6 post-operative time point, safety and the requirement for rescue therapy, in the opinion of the Investigator, will be assessed to decide if the study should continue to full enrolment.

18 Patient experiences of adapting to life following orthognathic treatment for facial asymmetry

The aims of this study are to understand patient experiences of undergoing orthognathic surgery for facial asymmetry and adapting to everyday life after treatment. Orthognathic treatment involves the use of orthodontic appliances (braces) and jaw surgery to correct major skeletal discrepancies in a person's jaw. Facial asymmetry is a notable discrepancy between the left and right sides of the face which affects a person's facial appearance. Symmetrical and asymmetrical faces have particular social meanings. There is a need to better understand patient experiences of facial asymmetry and adapting to facial change post-treatment.

The research will use interviews and photos to explore patient experiences before, during and after treatment. Patients of different ages and genders who have undergone orthognathic treatment for facial asymmetry will be recruited to the project. Participants will be encouraged to talk about their experiences of facial asymmetry, undergoing orthognathic treatment and their experiences of adapting to life since surgery. They will be encouraged to provide photos to illustrate their experiences and talk about these in their interviews. This project will allow us to develop recommendations for orthodontists and jaw surgeons on meeting the needs of their patients with facial asymmetry.

19 Ambulatory measurement of facial expressions in health and disease – FRAME

Spontaneous facial expressions are part of daily interactions, but can be affected by a number of health conditions. The aim of this project is to develop a sensor enabled glasses, that can detect facial expressions of the wearer to provide pervasive monitoring of treatment effects outside the clinic. Potential beneficiaries of this technology include service users with conditions that affect facial expressions such as those living with facial palsy, Parkinson's disease and depression. FRAME is being developed as a NIHR-funded project in partnership

between the host, Queen Victoria Hospital NHS Foundation Trust, and Emteq Ltd, a technology company co-founded by the study PI, Charles Nduka.

In order to assess facial expressions in specific conditions, we need to understand the patterns of data created by non-clinical volunteers as well as service users. The pilot study consists of 2 parts. First, we will investigate facial expression of service users living with these conditions and of healthy participants in response to standardised video clips designed to provoke emotional responses (Samson, Kreibig, Soderstrom, Wade, & Gross, 2016). Whilst participants are watching these videos, we will assess facial muscle activity using (i) electromyography (EMG), (ii) the non-invasive sensor technology, FRAME, embedded in a pair of glasses and (iii) video recording. This will enable us to establish a baseline and highlight markers which can help enable the technology to distinguish between emotional facial expression responses. We will also ask participants to complete a series of self-assessments. The second part of the study will investigate the recruitment usability, and retention rates of participants wearing FRAME over an extended period of time. This study will enable us to evaluate how well we can monitor facial expressions "in the wild" by having service users use the glasses at home. Participants will be asked to wear the FRAME glasses, during weekdays for up to 4 weeks at home. In addition to these measures, participants will be asked to complete short condition-specific questionnaire 3 times a day.

The eventual outcome of this pilot project will be a technology that will enable objective, remote measurement of facial expression responses.

20 Improving perioperative care through the use of quality data: Patient Study of the Perioperative Quality Improvement Programme (PQIP)

Over ten million operations take place in the UK NHS every year. The number of patients which are at high risk of adverse postoperative outcomes has grown substantially in recent years: this is attributable to a combination of an ageing population, the increased numbers of surgical options available for previously untreatable conditions, and the increasing numbers of patient presenting for surgery with multiple comorbidities. Estimates of inpatient mortality after non-cardiac surgery range between 1.5 and 3.6% depending on the type of surgery and patient related risks. Major or prolonged postoperative morbidity (for example, significant infections, respiratory or renal impairment) occur in up to 15% of patients, and is associated with reduced long-term survival and worse health-related quality of life; this signal has been consistently demonstrated across different types of surgery, patient and healthcare system.

Data from the US demonstrate wide variation in risk-adjusted mortality & morbidity rates between healthcare providers, suggesting that at least some complications after surgery could be avoidable if standards of care were improved. It is likely that the same is true in the UK; however, there is currently no unified national system for measuring complications or patient reported outcomes across different types of major surgery in the NHS. In order to address this gap, the National Institute for Academic Anaesthesia's Health Services Research Centre (NIAA-HSRC) has launched the Perioperative Quality Improvement Programme (PQIP) for the UK. PQIP will measure risk-adjusted morbidity and mortality, as well as process and patient-reported outcome data in adult patients undergoing major surgery (eg lower GI resection, upper GI resection, liver resection, cystectomy, major head and neck reconstructive surgery, thoracic resection).

21 Ciclosporin 1mg/ml eye drop emulsion (Ikervis) for the treatment of severe keratitis in adult patients with dry eye disease, which has not improved despite treatment with tear substitutes

Dry eye disease (DED), also known as keratoconjunctivitis sicca, is a multifactorial, chronic and progressive ophthalmic disease causing inflammation and damage to the ocular surface, caused in part by increased osmolarity of the tear film.

Treatment depends on disease severity. Currently available medical options include artificial tear products, lubricants, topical steroids and ciclosporin A (CsA). Lubricants are classified as 'health products', proof of their efficacy is not required by Health Authorities [15], and many are

available over-the-counter. Mild to moderate DED can usually be treated symptomatically with tear substitutes, but few effective treatments exist for moderate to severe DED. Artificial tears provide short-term relief at best, and require frequent dosing.

The efficacy of Ikervis has been explored in trials however there is a lack of evidence from the real-world, observational setting. This non-interventional prospective study will evaluate the effectiveness, tolerability and safety of Ikervis in routine clinical practice. As such, the study will recruit a substantially more heterogeneous patient population than would be seen in a clinical trial.

22 Validation of the MIRROR facial expression tracking application in healthy subjects and facial paralysis patients

Facial paralysis (FP) presents from either a peripheral nervous abnormality (most commonly Bell's Palsy) or a central nervous lesion (usually a cerebro-vascular accident (CVA)). Bell's Palsy accounts for 60% of cases of facial palsy, causing up to 24,800 new UK cases annually, leaving upwards of 100,000 people living with permanent disability. Of the 152,000 CVAs per year in the UK, many patients suffer resultant chronic facial movement problems. Current methods for tracking facial expression recovery include subjective measures, e.g. doctor-delivered grading systems, and objective measures, e.g. 2D / 3D imaging (photography and/or stereophotogrammetry) or videos of dynamic facial function. However, a consensus method for objectively measuring initial paralysis and monitoring progress towards normal facial expressions remains elusive. Gold standard treatment for FP includes daily rehabilitative exercises, but patients often fail to perform these regularly due to lack of feedback on exercise efficacy leading to demotivation and non-compliance with the prescribed physiotherapy. This in turn reduces patients' likelihood of recovery of normal facial function.

A new iPad-based non-invasive physiotherapeutic software application (MIRROR) has been developed, allowing FP patients to objectively track their paralysis / facial expressions in real-time via MIRROR's immediate feedback on exercise performance. To validate MIRROR, a study has been designed to analyse the facial movements of healthy and FP patients pre- and post-administration of Botulinum toxin (BT). Each subject's response to BT over the period of action of the injected BT will be assessed. Subjects will have their facial expressions quantitatively analysed via subjective grading scales validated for use in FP analysis, 2D / 3D imaging, via surface-electromyography (sEMG) and using MIRROR.

23 Lock & Key

At any time, around 10% of people carry meningococcal bacteria in the nose and throat, which can cause meningitis, blood poisoning and other serious illnesses. Most people carry these bacteria and never become ill, yet a very small proportion go on to develop these illnesses which can result in life long disabilities or death. The mechanism by which this happens is poorly understood and has been studied in various ways, usually focussing on the bacteria or on the individual, but none has given a definitive answer. This study will be the first of its kind and will assess the interaction between the host and the bacteria at the genetic level, through genetic mapping, helping us to understand what makes some people susceptible to this infection.

The study will have minimal impact on individuals as we hope to use residual samples from those collected whilst they were in hospital or convalescing, though we will have the mechanism for collection of a new sample in the few cases where no residual is available. The study will include all cases recorded within a five year period regardless of age, and whether or not they survived. This is essential in gaining a breadth of information. The study will not affect the care pathway, which is explained in the information leaflet, but could contribute to the development of new treatments and vaccines, which it is anticipated would be of interest to anyone who has experienced this infection as those being invited to participate will either personally have done, or as the family of a case.

24 Lugol's Iodine in Surgical Treatment of Epithelial Dysplasia in the Oral Cavity

and Oropharynx

When patients are referred with abnormal lining tissue (mucosa) in the mouth or throat which has been present for more than two weeks a sample of this tissue (a biopsy) is taken to assess the surface cells under the microscope. In these abnormal areas, there can be changes to the cells: this is called dysplasia. The cells can be slightly abnormal or very severely abnormal. If they are very severely abnormal, a cancer is more likely to develop from them in the future. This is why these changes are also referred to as precancerous changes. We know that removing these cells can reduce the risk of cancer developing. However it is often difficult for surgeons to see clearly where the abnormal tissue ends and normal tissue starts.

Lugol's iodine stain, which has been used as an antiseptic for many years, is used in some other parts of the body to help identify these precancerous cells. We think that this stain might help us to be more sure of removing all of the precancerous/abnormal cells and leaving behind the normal areas. There is evidence which suggests that if we do this, fewer patients will develop cancer after surgery and so more will be successfully treated.

25 A nationwide survey of prosthetic eye users: a collaborative study with all NHS ocular prosthetic service providers.

Patients who wear an ocular prosthesis often suffer with dry eye symptoms. Up to 90% will also complain of socket discharge, many on a daily basis. No literature exists on their quality of life post eye loss or adapting to monocular vision. Psychometric questions from the National Eye Institute Visual Functioning Questionnaire, investigate the patient's quality of life and how the loss of an eye has impacted on patients' well-being.

Participants receive a questionnaire covering aetiology, length of prosthetic eye use, length of eye wear, age of prosthesis, cleaning regime, lubricant use, inflammation, comfort and discharge. Lower scores relate to a better-tolerated prosthesis. Is there an association between deposit build up, frequency of ocular polish, to socket discharge and dry eye symptoms? A series of quality of life questions probe the effects of monocular vision on day-to-day activities, hobbies, driving and how each patient regards their own general health after the loss of an eye.

26 Antibiotic Levels in Burn wound Infection (ABLE)

Burn wounds have a high risk of developing infections. Oral or intravenous antibiotics are routinely given to manage such infection; however, the appropriate use of antibiotic therapy as a means of treating infection has become a topic of international debate due to rise in antimicrobial resistance (AMR). Several issues within the management of burn wound infection have led to the question of therapeutic levels being found in the burn wound. The most common antibiotic used, Flucloxacillin, belongs to a family of antibiotic known as Beta-Lactam antibiotics. Unfortunately this group of antibiotics is known to bind to serum proteins in the blood, meaning a fraction of the original dose is available and active at treating infection. Secondly, the antibiotic needs to be transported to the area which needs treating. The body does this by transporting the drug through the blood; however, burn wounds have an impaired blood supply which would lead to the supposition that very low levels enter the wound. Furthermore, the wound environment may have an altered pH which may further prevent effective utilisation of the antibiotic as antimicrobials such as Flucloxacillin have a narrow band of acid/alkali that they can be effective in.

The main question that the study will answer will be whether we can find therapeutic levels of antibiotics in patients wounds, which are sufficient to treat the infection.
Participants will give consent to participate and then give a wound exudate swab and blood test to measure their levels of antibiotic. At each subsequent dressing change the wound swab and blood samples will be repeated until the participant finishes their course of antibiotics. This is likely to be up to a maximum of 4 blood samples and 4 additional wound swabs

The study population will be adults with burn injuries over and including 1% total body surface

area who are being treated with antibiotics for suspected or confirmed infection.

27 EuPatch

Amblyopia (also called lazy eye) is the most common disease affecting vision in childhood. It affects between 2 to 5% of the population and 90% of visits to children's' eye clinics are for the purpose of treating amblyopia. Currently 30% of children treated for amblyopia do not reach normal vision after a year or more of treatment. Amblyopia is usually treated with glasses wearing and by patching the better eye.

There is controversy whether a long period of glasses wearing before patching, called refractive adaptation, helps in treating children with amblyopia. Refractive adaptation has not been tested in a randomised controlled trial, and currently we do not know how long children wear glasses each day.

The purpose of this study is to perform the first randomised controlled trial to test whether refractive adaptation before patching improves the number of successfully treated children with amblyopia. We will use electronic monitors to measure how much children wear their glasses and patches each day and will determine how this relates to their improvement in vision. We will also investigate whether different types of amblyopia respond better to different treatments.

28 Investigation of Potential Biomarkers in the Role of Scar Formation

The reason for the development of a scar is not clearly understood and the causes are multi-factorial. In simple terms, scarring may be a direct consequence of evolutionary changes that have lead to a rapid healing of the wound site in order to prevent infection. As a consequence of this speed of wound epidermal closure, the cells in the dermis of the skin are prone to produce inappropriate amounts of extracellular matrix molecules. It is this over production that leads to the formation of a scar.

The only example of scar-free healing is in utero. Surgery performed on a foetus in the third trimester (and these often save lives of unborn children) do not leave any traces of surgical intervention. A child is born without a scar. This amazing ability is lost shortly after birth and for the rest of adulthood, any post-traumatic event to the skin results in the production of a scar. The Queen Victoria Hospital (QVH) is a regional centre for burns and plastic surgery. The hospital treats patients with acute wounds and those undergoing surgical reconstruction or scar revision. As part of this treatment scar tissue will often be removed and disposed of as clinical waste. This redundant scar tissue offers the possibility of developing a clearer understanding of the mechanisms of scar formation.

29 SUBMIT

Metacarpal fractures are common, accounting for 40% of all hand injuries and many can be treated non-operatively. However, surgery is reserved for cases in which an adequate reduction of both angular and rotational deformity cannot be maintained or where an adjacent ray is damaged.
A variety of surgical strategies exist, including percutaneous kirschner wiring, intramedullary fixation, and fixation with plate and screw construction. A plate secured along the dorsal midline of the metacarpal has been shown to be the best biomechanical method of fixation, and allows early aggressive hand therapy post-operatively.

Traditionally, bicortical fixation is the standard practice, where both dorsal and palmar cortices of the metacarpal are drilled though. However, such practice is not without risk. In this method, the flexor tendons and neurovascular bundles at risk from over-zealous drilling through the palmar cortice. Correct screw size selection is also critical as overly long screws can irritate and cause rupture of flexor tendon. More recently, with the advent of a new generation of locking plates, unicortical fixation, where only the near cortex is drilled, has been used to treat fractures. Unicortical fixation is a surgically less complex operation, can theoretically cause less damage to surrounding soft tissues and avoids the complications associated with

incorrectly sized screws.

This trial aims to compares the functional outcomes and complications of patients having unicortical versus bicortical fixation for diaphyseal metacarpal fractures.

30 A study to refine the CAR burns scales

A burn injury can greatly impact upon a person's quality of life. In order to provide the most useful support it is vital for health workers such as doctors, nurses, psychologists and physiotherapists to know what are the most important issues to patients affected by burns. Therefore in collaboration with burn patients themselves, a survey has been developed which explores adult's experiences of living with a burn injury. The plan is for all adults that are seen in hospital for a burn injury to complete this survey, so health professionals can identify their support needs and their treatment progress.

We are asking adults living with a burn to complete this survey to test out the questions. The results of this study will help us shorten and refine the survey, so it can be used in burn units throughout the UK to provide the best possible care and support for patients and their families.

31 Molecular mechanisms and pathways of chronic inflammatory and degenerative diseases

Using synovial tissue in explant cultures obtained from rheumatoid arthritic patients undergoing joint replacement surgery, the Kennedy Institute was the first research laboratory in the world to identify the pathogenic role of the inflammatory cytokine tumour necrosis factor alpha (TNF) in Rheumatoid Arthritis (RA). Biological therapies that block the function of TNF are now clinically proven and over one million people worldwide have been treated successfully with this drug. However, this is not a cure for RA, so current research activities at the Kennedy are aimed at understanding those events that trigger RA, and developing better therapies for this disease.

Patients scheduled to undergo a surgical procedure as a result of arthritis or other inflammatory diseases, will be given the option to take part in our study. In addition, waste tissue will be obtained from an amputation as a result of a traumatic injury and adipose as a result of an abdominoplasty. A qualified clinician / GCP trained team member will take written, informed consent prior to surgery. Waste tissue from surgery is collected in a sample pot and couriered to the Kennedy Institute. This waste tissue includes joints (cartilage and bone), periarticular tissue, connective tissue (muscle and fascia) and other soft tissue such as skin.

The tissue will be processed ex vivo to liberate single cell suspensions, which will then be cultured for up to 5 days or long term lines will be derived. Cell supernatants will be analysed for cytokine, MMP and other inflammatory mediators by ELISA and cell phenotype determined by Flow cytometry. In addition, mRNA will be harvested and gene expression determined by TaqMan PCR. The histopathology of the tissue will also be looked at.

32 Molecular genetics of adverse drug reactions

Adverse drug reactions (ADR's) are a common cause of drug-related morbidity and may account for about 6.5% of all hospital admissions. A meta-analysis of studies performed in the USA has shown that ADRs may be the fourth commonest cause of death. ADRs are also a significant impediment to drug development, and a significant cause of drug withdrawal. The purpose of this research is to (a) identify patients with different types of adverse drug reactions; (b) using DNA obtained from blood or Saliva samples from these patients, identify genetic factors which predispose to adverse reactions. The net effect of our research will be the development of genetic tests which can help in predicting individual susceptibility to adverse reactions prior to the medication's administration. Patients with a pre-disposition to reacting adversely can be prescribed alternative medication of monitored more closely during their treatment. This will reduce the harm for patients and save valuable resources for the NHS.

We aim to recruit 250 cases for each reaction for a period of eight years throughout multiple sites in the UK. Specific adverse drug reactions we are looking at include:

- Statin induced myotoxicity, characterised by high CK
- Severe hypersensitivity reactions including Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis
- Anaphylaxis induced by NMBA anaesthetics
- ACE inhibitor or ARB induced angioedema
- Taxane hypersensitivity
- Chemotherapy induced peripheral neuropathy
- Bleomycin induced lung toxicity
- Clozipine induced agranulocytosis or neutropenia
- Bisphosphonate-related osteonecrosis of the jaw
- Tenofovir associated renal injury
- Serious bleeds induced by warfarin or other anticoagulants

33 **Leadership styles and their effectiveness in the NHS**

There is an absence of empirical research comparing the leadership qualities and styles of NHS chief executives who have been recruited from the private sector and those recruited within the NHS.

The aim of this PhD research study is to explore and contrast the leadership attributes and styles of current NHS chief executives within the acute trust environment to bring new knowledge to this area of study.

34 The anatomy of flexor tendon repair

This study will be a joint project with the Department of Anatomy and Queen Victoria Hospital and look at different methods of tendon repair in cadaveric hands.

Specifically, the volume of the knot and suture material as a proportion of the cross sectional area of the tendon, the circumference of the tendon repair site and the degree of shortening will be measured in cadaveric hands for different types of tendon repair.

New projects which are expected to start in 2020-21

- Facial muscle responses with reported pain scores
- SAVER
- NEON – flexor tendon repair
- Burn-code: multicentre review of burns patients
- IDose
- LOOC – lymphatic mapping of oropharyngeal cancer
- GENOMICC

11.	Report approval and governance
	This annual report has been reviewed by our R&D Governance Group, as well as by the Quality and Governance Committee.

Queen Victoria Hospital
NHS Foundation Trust

A Framework of Quality Assurance for Responsible Officers and Revalidation
Queen Victoria Hospital NHS Foundation Trust Annual Board Report and Annual Statement of Compliance

Covering reporting period
1st April 2019 to 31 March 2020

Document Control: Quality and Governance Committee

Executive Sponsor: Mr Keith Altman, Medical Director

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A Framework of Quality Assurance for Responsible Officers and Revalidation – Queen Victoria Hospital NHS Foundation Trust Annual Board Report 1st April 2019 to 31 March 2020 and Annual Statement of Compliance

1 Executive Summary

The medical revalidation and appraisal process is used to provide assurance to the General Medical Council (GMC) that a doctor has fulfilled the necessary criteria to continue their licence, to practice based on the Good Medical Practice Framework published by the GMC.

All doctors are required to have a prescribed connection to a Designated Body. Designated Bodies include NHS Trusts, Local Education and Training Boards, (LETB), Locum Agencies and other organisations. Each Designated Body has a Responsible Officer (RO), usually the Medical Director who is responsible for the appraisal and revalidation process.

Doctors on training rotations are connected to the Local Education and Training Board (LETB) with the relevant Dean as their Responsible Officer. All other doctors who perform the majority of their practice at Queen Victoria Hospital (QVH) are connected directly to the Trust. Doctors connected to Queen Victoria Hospital fall under the responsibility of Mr Keith Altman, Medical Director, as the Trust's Responsible Officer (RO) appointed on 1 October 2019.

On 19 March 2020, QVH followed the recommendation of Professor Stephen Powis, National Medical Director, NHS England and NHS Improvement to suspend all medical appraisals until further notice due to COVID 19 to free up capacity to maintain essential care. (Appx 1)

As of 31 March 2020, 105 doctors had a prescribed connection with QVH.

2 Purpose of the Paper

The purpose of this report is to provide assurance to the Board that arrangements for Medical Appraisal and Revalidation have been operating effectively during the calendar year (1 April 2019 - 31 March 2020). This report forms part of the Medical Director's duties as Responsible Officer (RO).

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

- The appraisal element, which is the process by which a doctor is supported in their continuing professional development
- The revalidation element, whereby a doctor demonstrates that they remain up to date and fit to practice over a 5 year cycle.

3 Background

Medical Revalidation was launched in 2012 to strengthen the way doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Trusts have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that Trusts will oversee compliance by:

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

The Trust submits quarterly confirmation of appraisal rates to South East and South West Regions Team (NHS England and NHS Improvement). This year's Quarter 4's return, the Annual Organisational Audit (AOA) was cancelled due to COVID 19, this report however maintains the format and includes the qualitative questions contained in the AOA and is offered to support QVH in reviewing its progress in the following key areas over time and combines the Statement of Compliance for efficiency and simplicity:

- Audit of Appraisals 2019-2020
- Effective Appraisal
- Recommendations to the GMC
- Medical Governance
- Employment Checks
- Summary and overall conclusion
- Statement of Compliance

The report is based on appraisal rates for those with a prescribed connection to the Trust as at 31 March 2020.

This report is to provide assurance to the Quality & Governance Committee that the appropriate processes are in place within Queen Victoria Hospital for the management of medical appraisals and revalidation, as well as providing an update on the recommendations for further improving processes.

4 General Qualitative questions/statements

4.1 A summary of completed appraisals as at 31 March 2020

	Number of Prescribed Connections	Completed Appraisals	Approved Incomplete or Missed	Unapproved Incomplete or Missed
Consultants	67	63 (94%)	0	4 (6%)
SAS Doctors	7	7 (100%)	0	0
Doctors on Performers List	0	0	0	0
Doctors with practising privileges	0	0	0	0
Temporary or short-term contract holders	30	28 (93%)	0	2 (7%)
Other doctors with a prescribed connection	1	0	0	1 (100%)
Total	105	98 (93%)	0	7 (7%)

Comments; this was the initial year all medical appraisals were expected to be conducted during April to December. Progress was satisfactory and the reduced timescale from 12 to 9 months raised no concerns from doctors or appraisers.

The 7 unapproved incomplete or missed appraisals were largely due to doctors' time management and or availability of appraisers. Lack of visibility of Medical & Dental Bank doctors through normal reporting processes resulted in 1 missed appraisal.

Action for next year; continued with 9 months' window for completion of appraisals and improve visibility of medical & dental bank doctors with a QVH prescribed connection.

4.2 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer

Mr Keith Altman was appointed Medical Director and RO on 1 October 2019 and Lt Col Tania Cubison, Consultant Plastic Surgery was appointed as Deputy Medical Director and Appraisal Lead responsibility with effect from 1 December 2019. Both maintain competencies and attend regional RO and Appraisal Lead network sessions to ensure compliance and knowledge.

Action for next year; continue to attend regional RO and Appraisal Lead network training sessions.

4.3 The designated body provides sufficient funds, capacity and other resources for the RO to carry out the responsibilities of the role.

Mr Keith Altman acknowledges sufficient funds, capacity and resources are available to carry out the responsibilities of this role. Administration support continues to be provided from within the Workforce Team for both RO and doctors.

Action for next year; discuss and agree continued support from within the Workforce Team with new Deputy Director of Workforce.

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

The GMC Connect portal is utilised to ensure an accurate record of all doctors with prescribed connection is maintained. This is regularly monitored by the RO and Medical Workforce Manager. A new doctor is added to the list and when a doctor leaves the Trust the doctor is removed.

Comments: Some newly appointed oversea doctors are not always fully aware of UK practices, the GMC's Connect process plus their responsibility to connect to their new designated body.

Action for next year; continue with existing good practice plus ensure new overseas doctors attend Welcome to UK practice, a GMC workshop within 3 months of start date; this will provide practical guidance about ethical scenarios and the chance to connect with other doctors coming from abroad.

4.5 All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The Trust has a published Medical Appraisal, Revalidation and Remediation Policy which aims to ensure doctors within its employment receive high quality appraisals which support their practice with a view to identifying development opportunities, provide greater assurance to patients and drive continuous improvement. It is expected that by engaging in the appraisal process, this will enable the RO to make a recommendation to the GMC that the doctor can continue to practice. All Trust policies are reviewed every 3 years

The policy was reviewed and ratified by the Local Negotiation Committee in September 2019. Renewal date is September 2022.

Action for next year; policy to be monitored in line with monitoring schedule.

4.6 A peer review has been undertaken of this organisation's appraisal and revalidation processes.

An annual screening review was conducted in August 2018 by the Higher Level RO (HLRO) (South).

Comments; a follow up meeting with the HLRO was due to take place during mid 2019, this was pushed to late 2019 to coincide with appointment of Mr Keith Altman as new RO. No dates yet confirmed and have since been pushed back due to COVID 19.

Any actions for next year; will be identified post follow up meeting with HLRO.

4.7 A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

During the year, personalised communications were reintroduced notifying doctors at 3, 2 and 1 month internals prior to appraisal expiry dates. Alongside personalised revalidation readiness reports which were introduced to support doctors with continuing professional development, appraisal, revalidation, and governance requirements.

Action for next year; continue with personalised notifications, revalidation readiness reports and annual appraisal data packs.

5 Effective Appraisal

5.1 All doctors in this organisation have an annual appraisal that covers a doctor's whole scope practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

During the course of the year the requirement of Medical Practice Information Transfer (MPITs) as evidence of whole scope of practice as an appraisal input was incorporated into the appraisal update sessions. These were held in September and

February. Guidance was improved and added to Qnet. The requirement of a joint appraisal under the Follet Principles for those individuals who also hold academic roles was also highlighted and guidance provided. The requests for appraisal data packs increased, these packs share with the doctor any complaints and incidents together with information relating to their statutory and mandatory training compliance. These support reflective practice; improve ways of working and engagement in the process of continuous learning and development.

Action for next year; improve guidance available on requirement for joint appraisal under Follet Princples for additional academic roles.

5.2 Where in 5.1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

During the year; there were 7 unapproved incomplete or missed appraisals due to doctors and appraisers factors. All reasons given for delays are recorded and used to identify any barriers and improvements.

Action for next year; early escalation to Appraisal Lead identifying barriers and necessary improvements for late or missed appraisals.

5.3 There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

During late 2019 the policy was ratified by the Local Negotiation Committee.

Comments; there were no significant changes introduced with the exception of moving all appraisal dates to fall within 1 April to 31 December. The objective being to complete all medical appraisals within a nine month period, thus striving to improve the completed appraisal rate by 31 March 2020.

Action for next year; monitor policy in line with policy's annual monitoring schedule.

5.4 The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

There are currently 19 trained appraisers.

Specialty	No. of Appraisers
Anaesthetics	6
Corneo Plastics	3
Oral & Maxillofacial Surgery	1
Orthodontics	3
Plastic Surgery	6
Total	19

During the year; 3 appraisers relinquished the role and 2 were reinstated.

Action for next year; recruit a further 1 appraiser from Oral & Maxillofacial Surgery.

5.5 Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

We collaborate with East Sussex and Healthcare NHS Trust and Brighton & Sussex University Hospital Trusts to provide quality assured training for new appraisers to ensure quality and consistency.

Each appraiser is required to attend the Trust's appraiser training sessions which covers annual updates and participation in peer network sessions. These sessions have been incorporated into the Consultants' Statutory and Mandatory Update Sessions which take place in February and September annually. During this reporting period 89.5% of appraisers attended these sessions.

Action for year; to increase attendance rate to 90%+

5.6 The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

The Trust has identified the NHS England's Appraisal Summary and PDP Audit Tool (ASPAT)1 as its preferred system. Data will be anonymised and shared with appraisers to identify future training needs. No audits have been conducted during this reporting period due to change in post and delay in appointing an new Appraisal Lead.

Action for the upcoming year; the appraisal outputs of 2 appraisers will be audited each month by the Appraisal Lead using ASPAT generic tool together with appraisal feedback questionnaires provided by doctors. Results will be shared with appraisers to be reviewed for continued personal development.

[1] [1] http://www.england.nhs.uk/revalidation/ro/app-syst/

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

6 Recommendations to the GMC

6.1 Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

During the year; 29 recommendations were made on time with 1 late or missed recommendation, of which 9 were deferred due to insufficient evidence.

As a result of COVID 19 revalidation recommendations have been deferred by the GMC since mid March 2020 to March 2021.

Action for next year; 2 recommendations due in year up to 31 March 2021. In the following year, 50 recommendations will become due and an appropriate plan will be put in place to manage this increased number.

6.2 Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All upcoming recommendations are reviewed and discussed by the Appraisal & Revalidation Recommendation Panel (A&RRP) during its quarterly meetings. Any issues relating to the doctors' revalidation portfolio are communicated to the doctor in a timely fashion by either the RO or Workforce support.

Action for next year; to maintain current practices.

7 Medical Governance

7.1 This organisation creates an environment which delivers effective clinical governance for doctors.

All doctors work within the clinical governance framework of the Trust, fulfils all CQC patient safety, risk and quality improvement requirements. Clinical incident reporting is monitored by the medical director and Quality and Governance committee to ensure any conduct and capability concerns are reported and acted on promptly. The introduction of data packs collates this information in a reportable format suitable for appraisal.

7.2 Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Conduct and performance concerns are reported via direct reports to the Medical Director, through patient and staff complaints, clinical governance, including audit and outcome measurement and incident reporting. The response monitored through annual appraisal and direct intervention by the RO where needed.

7.3 There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

The Trust utilises a policy based on the national 'Maintaining High Professional Standards (MHPS)' and GMC guidance. Last revised and ratified at Local Negotiating Committee in 2019.

7.4 The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

Responding to concerns is undertaken by the Medical Director, supported by the Director of Workforce, and discussed with the GMC Liaison Officer and NCAS / NHS Resolution as required. Any investigation conducted is overseen by a non-executive board member. Numbers and type of complaints are reported annually through this report.

In 2019/20, there were formal conduct cases against two doctors relating to behaviour. Both resulted in sanctions.

7.5 There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

This is managed by the Responsible Officer and the Workforce support. Timely transfer of information from other organisations can be challenging at times due to volume of requests.

A generic email address has been adopted and published on the GMC website for all requests to be received by the dedicated administration support, enabling swift responsiveness to requests from other organisations. Information from within the QVH risk and complaints teams is readily available to support responses.

7.6 Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

The Disciplinary policy for medical and dental staff has been revised in 2019, and continues to adhere to national MHPS and GMC / NHSE guidance on managing concerns. Concerns are managed by the RO and Medical Director, supported by The Director of Workforce and OD, and the HR team as required.

8.0 Employment Checks

8.1 A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

All medical and dental positions including the medical and dental Bank are now processed via the Trac recruitment system ensuring visibility and consistency with substantive recruitment. Full checks are carried out and evidence of revalidation and appraisal are sought. The use of a Confirmation of Employment form has helped validate information and is confirmed by the doctors' substantive employing Trust where full records are kept. Along with this is a local memorandum of understanding between Trusts within the same STP where doctors are able to move more freely with the confirmation of checks in place to avoid duplication and unnecessary checks being carried out.

All applicants are asked questions based on the Trust's values, in addition to the standard clinically based questions at interview. The purpose of this is to assess organisational fitness and ensure that they are able to converse and understand medical

terminology at an appropriate level in English. References follow a set format and must include past employer and most recent Responsible Officer declaration.

A similar although more extensive assessment process using Stakeholder Panels is part of the recruitment process for consultants.

Action of the next year; continue with current good practice.

9.0 Summary and overall conclusion

9.1 General review of last year's actions.

There was steady and continued progress in the medical appraisal rate during this reporting period. Conducting appraisals during the months April to December was well received as too was the appraisal data packs. These packs provided the doctor and appraiser with the data to support reflective practice discussions. Early and improved communication to newly appointed doctors improved engagement and understanding in the medical appraisal process at QVH.

9.2 Actions still outstanding

The onset of COVID 19 cancelled medical appraisals (Appx 1) from mid-March 2020. This delayed the implementation of the early escalation to the Appraisal Lead for late or missed appraisals and the audit of appraiser outputs. These actions are to be carried forward into next year.

9.3 Current Issues

From 17 March 2020 all doctors who were due to revalidate before the end of September 2020 will have their revalidation date deferred for one year. The GMC will keep this under review and make further deferrals as necessary.

The GMC has recently stated that in future all doctors whose recommendations have been deferred will be under notice for an entire year as opposed to 4 months. Four rather than five appraisals in this revalidation cycle will suffice to make a positive recommendation as long as the appropriate supporting information has been presented and discussed at appraisal.

This means that a large number of doctors will come under notice towards the end of this year and we will be able to make a positive recommendation to the GMC if the appraisal criteria above are met. Plans will be put in place so that recommendations will be done in strict date order over the 2020/21 cycle so as not to burden the appraisal office or appraisers.

9.4 New Actions

Corrective Action	Timescale
Early escalation to Appraisal Lead for late or missed appraisals process to be implemented	31 March 2021
Agree continued administration support with Deputy Director of Workforce	31 March 2021
All new overseas doctors to attend Welcome to UK practice within 3 months of start date	31 March 2021
Carry out annual monitoring of policy	31 March 2021
Improve guidance available on requirement for joint appraisal under Follet Principles for additional academic roles	31 March 2021
Recruit further 1 appraiser from Oral & Maxillofacial Surgery	31 March 2021
Increase attendance rate of appraiser training/peer sessions to 90%+	31 March 2021
Recommence ASPAT undertaking 2 per month once medical appraisals are reinstated	31 March 2021
Implement plan for increase number of recommendations due in 2021/2022	31 March 2021

9.5 Overall Conclusion

The processes for effective appraisal and revalidation are embedded and function well, and the QVH is compliant with all regulations pertaining to revalidation.

Areas for further development include qualitative improvement in appraisal content ensuring to an annual appraisal cycle and strengthening reflective practice.

10 Statement of Compliance

The Board of Directors of Queen Victoria Hospital NHS Foundation Trust has reviewed the content of this report and confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: QVH NHS FT Board of Directors

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

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

Appendix 1:

To: All Responsible Officers and Medical Directors in England

Professor Stephen Powis
National Medical Director
Skipton House
80 London Road
SE1 6LH

19 March 2020

Dear Colleague

Covid-19 and professional standards activities (including appraisal and revalidation)

I am writing about changes to professional standards activities in light of the latest Government advice on managing the Covid-19 outbreak. Professional standards activities safeguard patient safety and quality of care, support professional development and ensure that action is taken when concerns arise. However, in the current situation it is entirely appropriate to free up capacity to maintain essential care and minimise spread.

Medical Appraisal

As National Responsible Officer for NHS England and Improvement and the person who delegates the Senior Responsible Owner function for The Medical Profession (Responsible Officers) Regulations 2010 (amended 2013) in England I strongly recommend that appraisals are suspended from the date of this letter until further notice, unless there are exceptional circumstances agreed by both the appraisee and appraiser. This should immediately increase capacity in our workforce by allowing appraisers to return to clinical practice.

Until reinstated, Responsible Officers (ROs) should classify appraisals which are affected as 'approved missed' appraisals. For clarity, affected appraisals will be regarded as cancelled, not postponed.

Revalidation decisions

The GMC has now issued guidance that doctors who are due to revalidate before the end of September 2020 will have their revalidation date deferred for one year. This will be kept under review the GMC will make further deferrals as necessary.

This decision has been made to give doctors more time to reschedule and complete appraisals, and to avoid the need for ROs to make revalidation recommendations during this time.

The GMC has started making changes to its systems so that notifications about

revalidation dates aren't issued. They will continue to send notifications when doctors move on and off GMC connect lists so ROs can keep track of prescribed connections.

Framework for Quality Assurance for Responsible Officers and Revalidation
In keeping with the need to minimise non-direct quality improvement activities, we have decided to cancel the 2019/2020 Annual Organisation Audit, which we had planned to launch on 6 April.

Mandatory training and other activities
Other measures to release clinical capacity and allow focus on the current priority include amending local requirements for mandatory training and other CPD and quality improvement activities not directly relevant to the current outbreak. I encourage ROs to work within their organisations to make sensible changes in these areas.

Responding to concerns about a doctor's practice
Oversight of professional concerns must continue, but as the situation evolves, our priority will be those concerns that are assessed as high risk.

I know that you and your teams are working hard to prepare for the challenge of the coming weeks and months and hope that these measures will help you and your clinicians to focus on best possible care for patients for the duration of this outbreak.

Yours sincerely,

Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**3 September 2020**		**Agenda reference:**	**138-20**	
Report title:	**National inpatient survey results 2019**				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Authors:	Jo Thomas, Director of Nursing and Quality Care Quality Commission				
Appendices:	Full CQC 2019 inpatient survey report				
Executive summary					
Purpose of report:	To provide assurance about the quality of patient experience at QVH, comparing trust performance with previous year and national benchmarks.				
Summary of key issues	The survey shows QVH has sustained the patient experience with 49 of the comparable 60 questions responded to were better than the national average and no responses were worse than the national average. There are no statistical difference in the comparison with QVH 2018 and 2019 data where 57 of the questioned showed the same, very high levels of satisfaction.				
Recommendation:	The Board is asked to **NOTE** the results of the National Inpatient Survey 2019				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience* √	KSO2: *World-class clinical services* √	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	This report links primarily to KSO1 which has been reviewed and amended following publication of the full report				
Corporate risk register:	There are several corporate risk which relate directly to patient experience this has been reviewed following publication of this report				
Regulation:	None: It is part of the Trust's regulatory requirement to undertake the annual CQC inpatient survey				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	EMT				
	Date:	22/06/20	Decision	**Noted**	
Next steps:	Action plan will be completed and will be overseen and monitored by the patient experience manager at the patient experience group with feedback to Q&GC.				

Report to:	Board Directors
Agenda item:	138-20
Date of meeting:	3 September 2020
Report from:	Jo Thomas, Director of Nursing and Quality
Report author:	Care Quality Commission
Date of report:	2 July 2020
Appendices:	A: CQC Patient survey report 2019

National inpatient survey results 2019

Introduction

The 2019 survey of adult inpatient's experiences involved 143 NHS acute trusts in England. The CQC received responses from 76,915 patients, a response rate of 45%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital during July 2019. The questionnaires were sent out and returned took place between September and December 2019.

The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQC's Insight, which provides inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS England and Improvement will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health and Social Care will hold them to account for the outcomes they achieve.

Executive summary for QVH 2019 impatient survey

Respondents and response rate

- 550 Queen Victoria Hospital NHS Foundation Trust inpatients responded to the survey
- The response rate for Queen Victoria Hospital NHS Foundation Trust was 44.72%

Banding

- The trust's results were better than most trusts for **49** questions.
- Your trust's results were worse than most trusts for **0** questions.
- Your trust's results were about the same as other trusts for **11** questions.

Comparisons with last year's survey

Your trust's results were significantly higher ↑ this year for **1** questions.
7. Was your admission date changed by the hospital?

Your trust's results were significantly lower ↓ this year for **0** questions.

There were no statistically significant differences between last year's and this year's results for **57** questions.

Key areas where there was improvement and performed better than national benchmark QVH:

- Patients received answers that they could understand when they had an important question to ask the doctor
- Confidence in the doctors and nurses

- Length of time on the waiting list (area for improvement last year)
- Was your admission date changed by the hospital (area for improvement last year)
- Doctors or nurses gave family friends or carers all the information they needed to help care for the patient
- cleanliness of wards

There were no significant areas of decline or responses below the national benchmark; however areas to review to further improve patient experience were:

- Patients felt they got enough emotional support from hospital staff during the admission (last year was an improved area)
- Rating of hospital food (same as last year, though choice of food improved)
- Offer of help from social services on discharge
- Enough help to wash
- Information on how they could expect to feel after surgery

Recommendation

The Board is asked to **NOTE**:

- The results of the National Inpatient Survey 2019.
- That this report was embargoed until publication by CQC on 2 July.
- That this report forms part of our assurance that patient experience is being sustained and improved which is notable given the challenges in our workforce, as well as demonstrating that patient experience as a whole is not compromised due to operational and financial challenges that emerged during 2019.

Appendix 1
The full 2019 QVH inpatient survey

2019 Adult Inpatient Survey: Early release of CQC benchmark results

This report provides benchmark results for Queen Victoria Hospital NHS Foundation Trust, in advance of national publication of the 2019 Adult Inpatient Survey in June 2020. It contains the same scoring and 'banding' (how your trust performed compared to other trusts across England), but does not include national scores. These national results can only be shared at official publication of the survey results in June.

By sharing results now, you will be able to see how your trust performed on individual questions in advance of the national publication.

Information on how to interpret this information is similar to that provided within the published benchmark reports and is detailed below. If you require any assistance, have any queries, or would like to provide feedback on the format of this report, please contact the CQC Surveys Team at: patient.survey@cqc.org.uk.

2019 Adult Inpatient Survey

The 2019 survey of adult inpatient's experiences involved 143 NHS acute trusts in England. We received responses from 76,915 patients, a response rate of 45%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital during July 2019[1] and were not admitted to maternity or psychiatric units. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between September and December 2019.

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQC's Insight, which provides inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS England and Improvement will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health and Social Care will hold them to account for the outcomes they achieve.

Making fair comparisons between trusts

People's characteristics, such as age and gender can influence their experience of care and the way they report it. For example, men tend to report more positive experiences than women and older people than younger ones. Since trusts have differing profiles of people who use their services, this could potentially affect their results and make trust comparisons difficult. A trust's results could appear better or worse than if they had a slightly different profile of people.

[1] 31/143 (22%) trusts also sampled additional months because of small patient throughputs.

To account for this, we 'standardise' the data, i.e. we apply a weight to individual responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by age, gender and method of admission (emergency or elective) of respondents to reflect the 'national' age-gender-admission type distribution (based on all respondents to the survey). This helps to ensure that no trust will appear better or worse than another because of its respondent profile.

Scoring

For each question in the survey that can be scored, individual responses are converted into scores on a scale of 0 to 10. For each question, a score of 10 is assigned to the most positive response and a score of 0 to the least positive. The higher the score, the better the trust's results.

It is not appropriate to score all questions because some of them do not assess a trust's performance. For example, the primary purpose of some questions is to filter out ineligible respondents. For full details of the scoring please see the technical document, which has been provided to trust survey leads alongside this report.

Interpreting your data

The 'better' and 'worse' categories, displayed in the column with the header '2019 Band' in the tables below, are based on an analysis technique called the 'expected range'. It determines the range within which your trust's score could fall without differing significantly from the average score of all trusts taking part in the survey. If the trust's performance is outside of this range, its performance is significantly above or below what would be expected. If it is within this range, we say that its performance is 'about the same'.

Where a trust's survey results have been identified as 'better' or 'worse' than the majority of trusts, it is very unlikely that these results have occurred by chance. If your trust's results are 'about the same', this column will be empty.

If fewer than 30 respondents have answered a question, a score will not be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great.

Scores from last year's survey are also displayed where available. In the column with the header 'Change from 2018' arrows indicate whether the score for this year has increased significantly (up arrow), decreased significantly (down arrow) or has not significantly changed from 2018 (no arrow). A statistically significant difference means that the change in the result is unlikely to be due to chance. Significance is tested using a two-sample t-test. Please note that historical comparisons are not provided for section scores as the questions contained in each section can change.

Where a result for 2018 is not shown, this is either because the trust's score for that year's survey were suppressed due to insufficient respondent numbers, the question was new this year, or the question wording and/or the response categories have considerably changed. For information on question changes in the 2019 questionnaire, please see the next section ('notes on specific questions'). Comparisons are also not shown if a trust has merged with other trusts since the 2018 survey, or if a trust committed a sampling error in 2018.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases

only to some trusts.

All trusts

- Q50 and Q51: The information collected by Q50 “On the day you left hospital, was your discharge delayed for any reason?” and Q51 “What was the main reason for the delay?” are presented together to show whether a patient’s discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q51 and is worded as: “Discharge delayed due to wait for medicines/to see doctor/for hospital transport.”
- Q52: Information from Q50 and Q51 has been used to score Q52 “How long was the delay?”. This assesses the length of a delay to discharge for reasons attributable to the hospital.
- Q53 and Q56: Respondents who answered Q53 “Where did you go after leaving hospital?” with “I was transferred to another hospital” were excluded from the scoring of Q56 (“Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?”).

Trusts with female patients only

- Q11: If your trust offers services to women only, the score for Q11 “While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?” is not shown.

Trusts with no A&E Department

- Q3 and Q4: The results of these questions are not shown for trusts that do not have an A&E department.

Notes on question comparability

The following questions were amended for 2019, and it is therefore not possible to compare with previous years:

- Q51: One response option was changed from “I had to wait for an ambulance” to “I had to wait for hospital transport”.
- Q66: Question wording was amended from “Was the care and support you expected available when you needed it?” to “After being discharged, was the care and support you expected available when you needed it?”.

Further information

The full national results will be available on the CQC website in June, together with an A to Z list to view the results for each trust and the technical document which outlines the survey methodology and the scoring applied to each question: www.cqc.org.uk/inpatientsurvey

Results for Queen Victoria Hospital NHS Foundation Trust: Executive Summary

Respondents and response rate

- 550 Queen Victoria Hospital NHS Foundation Trust inpatients responded to the survey
- The response rate for Queen Victoria Hospital NHS Foundation Trust was 44.72%

Banding

Your trust's results were better than most trusts for **49** questions.

Your trust's results were worse than most trusts for **0** questions.

Your trust's results were about the same as other trusts for **11** questions.

Comparisons with last year's survey

Your trust's results were significantly higher ↑ this year for **1** questions.

7. Was your admission date changed by the hospital?

Your trust's results were significantly lower ↓ this year for **0** questions.

The were no statistically significant differences between last year's and this year's results for **57** questions.

Tables of results

Section 1. The Accident and Emergency Department

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
3. While you were in the A&E Department, how much information about your condition or treatment was given to you?					
4. Were you given enough privacy when being examined or treated in the A&E Department?					

Section 2. Waiting list or planned admission

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?	437	9.2	Better	8.9	
7. Was your admission date changed by the hospital?	439	9.6	Better	9.4	↑
8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	439	9.2		9.0	

Section 3. Waiting to get to a bed on a ward

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	538	9.2	Better	9.2	

Section 4. The hospital and ward

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
11. While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?	544	9.8	Better	9.7	
13. Did the hospital staff explain the reasons for being moved in a way you could understand?					
14. Were you ever bothered by noise at night from other patients?	532	8.5	Better	8.5	
15. Were you ever bothered by noise at night from hospital staff?	542	9.1	Better	9.3	
16. In your opinion, how clean was the hospital room or ward that you were in?	543	9.5	Better	9.5	
17. Did you get enough help from staff to wash or keep yourself clean?	261	8.4		8.7	
18. If you brought your own medication with you to hospital, were you able to take it when you needed to?	314	8.6	Better	8.8	
19. How would you rate the hospital food?	405	6.0		6.4	
20. Were you offered a choice of food?	490	8.3		7.9	
21. Did you get enough help from staff to eat your meals?	107	7.8		7.9	
22. During your time in hospital, did you get enough to drink?	519	9.8	Better	9.7	
72. Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?	393	9.4		9.5	

Section 5. Doctors

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
23. When you had important questions to ask a doctor, did you get answers that you could understand?	461	9.4	Better	9.4	
24. Did you have confidence and trust in the doctors treating you?	531	9.6	Better	9.6	
25. Did doctors talk in front of you as if you weren't there?	529	9.4	Better	9.3	

Section 6. Nurses

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
26. When you had important questions to ask a nurse, did you get answers that you could understand?	460	9.2	Better	9.4	
27. Did you have confidence and trust in the nurses treating you?	541	9.6	Better	9.6	
28. Did nurses talk in front of you as if you weren't there?	539	9.5	Better	9.5	
29. In your opinion, were there enough nurses on duty to care for you in hospital?	534	9.0	Better	9.1	
30. Did you know which nurse was in charge of looking after you (this would have been a different person after each shift change)?	532	8.0	Better	8.0	

Section 7. Care and treatment

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
31. Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?	291	9.3	Better	9.3	
32. In your opinion, did the members of staff caring for you work well together?	505	9.6	Better	9.6	
33. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	540	9.1	Better	9.3	
34. Were you involved as much as you wanted to be in decisions about your care and treatment?	535	8.8	Better	8.6	
35. Did you have confidence in the decisions made about your condition or treatment?	537	9.3	Better	9.4	
36. How much information about your condition or treatment was given to you?	526	9.7	Better	9.7	
37. Did you find someone on the hospital staff to talk to about your worries and fears?	243	7.0	Better	7.7	
38. Do you feel you got enough emotional support from hospital staff during your stay?	287	8.2	Better	8.9	
39. Were you given enough privacy when discussing your condition or treatment?	536	9.2	Better	9.5	
40. Were you given enough privacy when being examined or treated?	534	9.7	Better	9.8	
42. Do you think the hospital staff did everything they could to help control your pain?	250	9.2	Better	9.3	

Section 7. Care and treatment *(continued)*

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
43. If you needed attention, were you able to get a member of staff to help you within a reasonable time?	433	8.9	Better	9.2	

Section 8. Operations and procedures

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
45. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	402	9.3	Better	9.5	
46. Beforehand, were you told how you could expect to feel after you had the operation or procedure?	415	8.1		8.4	
47. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	413	8.7	Better	9.2	

Section 9. Leaving hospital

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
48. Did you feel you were involved in decisions about your discharge from hospital?	503	8.4	Better	8.3	
49. Were you given enough notice about when you were going to be discharged?	536	8.7	Better	8.3	
51. Discharge delayed due to wait for medicines/to see doctor/for hospital transport	520	8.3	Better		
52. How long was the delay?	518	9.1	Better	9.1	
54. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	246	8.2	Better	7.9	
55. When you left hospital, did you know what would happen next with your care?	490	8.3	Better	8.4	
56. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	520	8.2	Better	7.8	
57. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	312	9.4	Better	9.4	
58. Did a member of staff tell you about medication side effects to watch for when you went home?	242	7.3	Better	7.4	
59. Were you given clear written or printed information about your medicines?	271	8.6	Better	8.9	
60. Did a member of staff tell you about any danger signals you should watch for after you went home?	357	7.9	Better	7.4	

Section 9. Leaving hospital *(continued)*

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
61. Did hospital staff take your family or home situation into account when planning your discharge?	257	8.2	Better	7.6	
62. Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	258	7.7	Better	8.0	
63. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	502	9.3	Better	9.3	
64. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?	99	7.7		8.9	
65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?	190	8.8		9.5	
66. After being discharged, was the care and support you expected available when you needed it?	331	9.1	Better		

Section 10. Feedback on care and research participation

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
69. During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?	417	1.7		1.7	
70. During your hospital stay, were you ever asked to give your views on the quality of your care?	424	2.4	Better	1.8	
71. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	345	2.7		3.2	

Section 11. Respect and dignity

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	535	9.7	Better	9.7	

Section 12. Overall experience

Question	Respondents	2019 Score	2019 Band	2018 Score	Change from 2018
68. Overall... I had a very good experience	527	9.1	Better	9.1	

Section scores

	Section Scores	
Section	2019 Score	Band
1. The accident and emergency department		
2. Waiting list or planned admission	9.3	Better
3. Waiting to get to a bed on a ward	9.2	Better
4. The hospital and ward		
5. Doctors	9.5	Better
6. Nurses	9.1	Better
7. Your care and treatment	9.0	Better
8. Operations and procedures	8.7	Better
9. Leaving hospital	8.4	Better
10. Feedback on care and research participation	2.3	Better
11. Respect and dignity	9.7	Better
12. Overall experience	9.1	Better

Demographic information

Demographic Information

Characteristic	%
Total respondents	550
Response rate	44.7
Gender	
Male	45.1
Female	54.9
Age	
16-35	11.5
36-50	13.1
51-65	32.1
66+	43.2
Ethnicity	
White	95.4
Multiple ethnic groups	0.2
Asian or Asian British	0.7
Black or Black British	0.7
Arab or other ethnic group	0.2
Not known	2.7

Demographic Information (Continued)

Characteristic	%
Religion	
No religion	27.2
Buddhist	0.4
Christian	66.5
Hindu	0.4
Jewish	0.2
Muslim	0.4
Sikh	0.2
Other religion	1.7
Prefer not to say	3.1
Sexuality	
Heterosexual	94.2
Gay/lesbian	1.2
Bisexual	0.6
Other	1.0
Prefer not to say	3.1

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03 September 2020**		**Agenda reference:**	**139-20**	
Report title:	**Review of QVH COVID19 Business continuity ToRs for Board and Committees**				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Author:	Clare Pirie, Director of communications and corporate affairs				
Appendices:	NA				
Executive summary					
Purpose of report:	The Board is asked to review measures approved in March 2020 which enabled the Trust to focus on immediate needs related to the pandemic.				
Summary of key issues	Measures brought in to allow the Trust to focus on the immediate needs related to the pandemic and to continue to make decisions if key people were off sick are not currently needed and this paper proposes that these exceptional measures can now be brought to an end.				
Recommendation:	The Board is asked to **APPROVE** the recommendation.				
Action required *[highlight **one** only]*	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	**KSO1:** *Outstanding patient experience*	**KSO2:** *World-class clinical services*	**KSO3:** *Operational excellence*	**KSO4:** *Financial sustainability*	**KSO5:** *Organisational excellence*
Implications					
Board assurance framework:	The BAF reflects specific pandemic related issues, and continues to be reviewed with the usual frequency and strong governance				
Corporate risk register:	N/A				
Regulation:	N/A				
Legal:	N/A				
Resources:	Return to normal governance processes is based on sufficient staff resources remaining available				
Assurance route					
Previously considered by:					
Next steps:	Assuming approval the business continuity approach will end with immediate effect from 03 September.				

QVH COVID 19 Business continuity Terms of Reference for Board and Committees

The purpose of this document, approved in March 2020, was to ensure we could still make decisions at Board level even if key individuals were off sick.

The review of each element below suggests that the Trust no longer needs specific business continuity terms of reference. Virtual meetings will continue and are permitted under the normal terms of reference.

Recommendation: Remove the Covi-19 business continuity terms of reference, noting that the Board has the ability to reinstate through Board decision made by email outside of formal meeting if required in case of second wave.

Original version March 2020	Current position
1) The Terms of Reference and Membership, including quorum arrangements, for the Board and its Committees will be temporarily suspended as of 23 March 2020, until further notice.	The purpose of this document was to ensure we could still make decisions at Board level even if key individuals were off sick. Propose this temporary suspension is removed.
2) The Covid 19 business continuity arrangements set out in this document will be reviewed after four months (23 July 2020).	Reviewed at QVH BoD 02 July 2020 and agreed further review at Board on 3 Sept. Propose end to use of business continuity ToR so no further review date set.
3) During this period, where possible meetings will use telephone / digital technology and members of the public will not be invited to the Board meetings. The lead governor will be invited to join relevant Board meetings as usual.	Board and sub-committee meetings are being held using technology to connect members virtually. Governors and members of the public are invited to public Board meetings as observers. The relevant lead governors are invited to join Board and sub-committee meetings as usual. We do not currently have sufficient experience and technical support to record and publish video record of Board meetings but will continue to learn from trusts which have begun to pilot this. QVH Board meeting is well recorded through publicly available minutes.
4) The primary focus of communication with the Board will be the organisation's response to covid 19, including the safety of patients and the wellbeing of staff.	Deleted in July, in the context of capacity to cover the full range of the Board's responsibilities.
5) While every effort will be made to maintain the current level of Board member engagement in decision making, matters may be approved or decisions made with a quorum of 1 Executive Director and 2 Non-Executive Directors.	Deleted in July. Normal quoracy requirements in place.

6) Matters for approval or decision based upon the existing Board and subcommittee work programmes which are not directly related to patient safety or staff wellbeing will be managed as follows: • deferred if not urgent or • circulated to Board / Committee members via email for approval, allowing sufficient time for review / response and the decision will be recorded or • discussed via telephone / digital technology with the decision minuted or • discussed by the chief executive or relevant executive director with the Board / Committee chair for Chair's Action	Deleted in July. Board and subcommittees covering the full work programme.
7) It is possible that those responsible for preparing assurance papers for committees and the Board may not be in a position to do so, therefore all matters for information or assurance which are not focussed on the safety of patients or the wellbeing of staff may be: • put on hold until further notice or • circulated via email	Deleted in July. Board and subcommittees covering the full work programme.
8) Board and subcommittee secretaries will ensure an accurate record of items considered, approved or deferred is maintained.	This is business as usual and will continue

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**3 September 2020**		**Agenda reference:**	**140-20**	
Report title:	**Audit Committee Assurance update**				
Sponsor:	Kevin Gould, Audit Committee Chair				
Author:	Kevin Gould, Audit Committee Chair				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide assurance to the board in relation to matters discussed at the Audit Committee meeting on 29 July 2020				
Summary of key issues	The Committee received updated assurance on KSO1 & KSO2. It received an update from KPMG on future audit arrangements, and updates on Internal Audit and Counter Fraud from RSM.				
Recommendation:	The Board is asked to **NOTE** the contents of this report.				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience* √	KSO2: *World-class clinical services* √	KSO3: *Operational excellence* √	KSO4: *Financial sustainability* √	KSO5: *Organisational excellence* √
Implications					
Board assurance framework:	Framework for KSOs 1 & 2 was reviewed				
Corporate risk register:	Linkage to CRR for KSOs 1 & 2 was considered				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	None				

Report to:	Board of Directors
Meeting date:	3 September 2020
Report from:	Kevin Gould, Chair
Author:	Kevin Gould, Chair
Appendices:	N/A
Report date:	25 August 2020

Audit Committee report
Meeting held on 29 July 2020

1. The Committee received an assurance update on KSO1 and KSO2 from the Director of Nursing and Medical Director. Although risks have clearly changed this year, the committee was assured by the mitigation in place to address key risks and the processes in place to support the board assurance framework. This was reinforced by a verbal report from the Chair of Quality & Governance, in particular focussing on the assurance received from its sub-committees.

2. KPMG provided a brief update. Both the Director and Manager responsible for KPMG's work will be moving from our account as part of an internal restructure. The Committee Chair and Director of Finance will meet with the outgoing and incoming Directors from KPMG to discuss how disruption will be minimised.

3. The Committee received an update on progress against the internal audit plan. Some changes have been made to reflect changed priorities as a result of the pandemic. Original timescales for management actions had been reviewed by the Executive Management Team in May and revised as appropriate; this will remain a focus of the Committee to ensure risk levels are not materially affected.

4. RSM advised that three internal audit reports had been issued since the March meeting as follows:
    - Financial Control during COVID (Substantial Assurance)
    - Estates (limited assurance, one high priority recommendation)
    - Procurement (Substantial Assurance)

5. The Committee received a report on the progress of Counter Fraud activity.

There were no other items requiring the attention of the Board.