Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 04 March 2021

Session in public
11:00 – 12:30

(via video conference)

MEMBERSHIP: MEETINGS OF THE BOARD OF DIRECTORS March 2021

Members (voting):

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

In full attendance (non-voting):

Director of Operations	-	Abigail Jago
Director of Workforce & OD	-	Geraldine Opreshko
Director of Communications and Corporate Affairs	-	Clare Pirie
Deputy Company Secretary (minutes)	-	Hilary Saunders
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 • Trustee, Centre for Alternative Technology	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
Nicky Reeves 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
Nicky Reeves 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

Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 07 March 2020
11:00 – 12:30
via MS Teams

Agenda: session held in public			
Welcome			
33-21	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
34-21	**Patient Story**	*Assurance*	-
35-21	**Draft minutes of the meeting held on 07 January 2021** *Beryl Hobson, Chair*	*approval*	1
36-21	**Matters arising and actions pending** *Beryl Hobson, Chair*	*review*	7
37-21	**Chair's report** *Beryl Hobson, Chair*	*to note*	8
38-21	**Chief executive's report** *Steve Jenkin, Chief executive*	*assurance*	11
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
39-21	**Board Assurance Framework** *Nicky Reeves, interim Director of nursing, and* *Keith Altman, Medical director*	*assurance*	23
40-21	**Quality and governance assurance** *Karen Norman, Non-executive director*	*assurance*	25
41-21	**Corporate risk register (CRR)** *Nicky Reeves, interim Director of nursing*	*review*	30
42-21	**Quality and safety report** *Nicky Reeves, interim Director of nursing, and* *Keith Altman, Medical director*	*assurance*	36
43-21	**Guardian of safe working** *Keith Altman, Medical director*	*assurance*	82
44-21	**Health Care Worker Flu Vaccination Information** *Nicky Reeves, interim Director of nursing*	*information*	96
Key strategic objectives 3 and 4: operational excellence and financial sustainability			

45-21	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*assurance*	100
46-21	**Financial, operational and workforce performance assurance** *Paul Dillon-Robinson, Committee chair*	*assurance*	102
47-21	**Operational performance** *Abigail Jago, Director of operations*	*assurance*	105
48-21	**Financial performance** *Michelle Miles, Director of finance*	*assurance*	121
Key strategic objective 5: organisational excellence			
49-21	**Board assurance framework** *Geraldine Opreshko, Director of Workforce and OD*	*assurance*	129
50-21	**Workforce monthly report** *Geraldine Opreshko, Director of Workforce and OD*	*assurance*	130
Governance			
51-21	**Board effectiveness review** *Clare Pirie, Director of communications and corporate affairs*	*assurance*	144
Any other business (by application to the Chair)			
52-21	*Beryl Hobson, Chair*	*discussion*	-
Questions from members of the public			
53-21	*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*	-

`	**Minutes (Draft & Unconfirmed)** **For accuracy, it should be noted that item 16-21 was taken ahead of 13-21**	
Meeting:	**Board of Directors (session in public)** **Thursday 4 January 2021, 11:00 – 13:00 via videoconference**	
Present:	Beryl Hobson (BH)	Trust Chair (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)
	Karen Norman (KN)	Non-executive director (voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
	Nicky Reeves (NR)	Interim Director of nursing (voting)
	Gary Needle (GN)	Non-executive director (voting)
	Geraldine Opreshko (GO)	Director of workforce and OD (non-voting)
Apologies:	Keith Altman, (KA)	Medical Director
In attendance:	Hilary Saunders (HS)	Deputy company secretary (minutes)
	Ian Francis (IF)	Associate medical director
	Peter Shore (PS)	Lead governor
	Aneela Arshad (AA)	BAME Network Lead Co-Chair [item: 03-21]
	Kokila Ramalingam (KR)	BAME Network Lead Co-Chair [item: 03-21]

Welcome	
01-21	**Welcome, apologies and declarations of interest** The Chair opened the meeting and began by thanking all staff for their support in 2020 throughout extraordinary circumstances; particular thanks were extended to the CEO and the executive team. Today's meeting had been extended due to the length of the agenda, and to better manage the time available board members had submitted questions in advance. No questions had been raised by members of the public in advance but there would be an opportunity to do so at the end of this meeting. BH went on to welcome NR to her first meeting as interim Director of Nursing, and IF who was deputising for KA today. BH also welcomed AA and KR, co-chairs to the QVH BAME network, who were attending to present item 03-21. The virtual public gallery included four governors, 2 members of staff and one member of the public. Apologies were noted as above; there were no new declarations of interest.
Standing items	
02-21	**Patient story** A recording of an interview with a burns patient had been prepared for today's meeting; unfortunately due to issues with sound quality, it was decided that the video link would be circulated to board members after today's meeting. BH summarised the story, noting the patient's positivity and humour; she would write to the patient personally to thank her for taking the time to provide this helpful feedback. **[Action: BH]**
03-21	**QVH Black, Asian and Minority Ethnic (BAME) network** KR and AA recently appointed co-chairs of the new QVH BAME staff network had joined today's meeting to provide a progress update. The network had been established to support BAME staff in improving the working environment and addressing barriers in career development and highlights of the update included: • The new vision statement which aimed to empower BAME staff to achieve their potential through creating positive change.

	• A description of the development opportunities, programme of wellbeing, resilience and education for all staff to enable meaningful conversations which would recognise where changes were needed. • A description of the regional support provided by Cavita Chapman and Olivia King from NHSEI; further links with other trusts would be established to improve the network. • Details of the BAME staff survey and how feedback would be used to improve understanding of the issues. • Workshops, not exclusive to BAME staff, would be set up and include an 'ally' network. The Board considered the update, seeking assurance as follows: • BAME staff had felt pressure to be on the front line and had genuine concerns about the risks during the pandemic. A podcast had been produced, intended to alleviate fears but the Board also reiterated the importance of staff voicing concerns so that these could be addressed. • Whilst feedback should highlight areas of concern, it would also be important to highlight the success stories. • There was a recognition within Sussex, that opportunities for senior development didn't present themselves very often for BAME staff; however, the system was now taking this very seriously. The Chair and several members of the Board expressed an interest in joining the network of allies. The Chair agreed to follow up after today's meeting to agree how the board skills and experience might best be used to support this. **[Action: BH]** Regular updates would continue to be published via Qnet, the Trust's intranet, and Connect, and the Board would be apprised of the network's objectives once finalised. On behalf of the Board, the Chair thanked KR and AA for their time today.
04-21	**Draft minutes of the meeting held on 05 November 2020** The minutes were approved as a correct record with the following amendments: • The document template was corrected to show the session was in public not private. • That in November, the Board had received assurance regarding allegations of unacceptable behaviour as described in the report.
05-21	**Matters arising and actions pending** The board received the latest Matters Arising update.
06-21	**Chair's report** The Board received the Chair's report.
07-21	**CEO report** SJ presented his report, highlighting in particular: • The current significant and rapid increase in COVID infections; the Sussex resilience forum had taken the collective decision to declare a major incident to ensure we were prepared for this challenging and difficult period. • The impact on how this would affect QVH, and a thank you to staff for their rapid response to the ever changing situation. • An update on the roll out of the vaccine programme, with QVH expected to go live on 18 January. The Board considered the report and update, and sought additional clarification as follows: • That the Trust had received a number of mutual aid requests from across KSS to bring back breast cancer work, with the first list from BSUH due this week. Dates with BSUH and Western had been agreed, with further dates being finalised with colleagues in Kent and Surrey. • QVH was seen as a positive contributor to the overall system, including what we had already achieved in the first wave. Feedback from the KSS cancer alliance, and the CEO of Royal Surrey, which emphasised the strategic importance of QVH should not be underestimated. First wave cancer outcomes showed that the South East had been the best performer and there was a clear understanding of our regional role as a cancer hub, with recognition that we were agile and quick to respond. • Returning to our cancer hub role would make it difficult to maintain our Phase 3 recovery plan. This is also recognised at ICS level. Other concerns, such as independent sector capacity,

	workforce challenges and spoke site challenges would also impact on our plans. Patients with the lowest clinical priorities will inevitably form a large proportion of long-wait patients and impact on our waiting lists. The Board was reminded that this latest spike in COVID will be challenging for all providers, inevitably requiring a step down of elective work. There were no further comments and the Board **noted** the contents of the update.
Governance	
08-21	**Securing long term future of QVH** SJ presented a paper which set out the process and timetable to support decision making on the proposed merger with the new organisation formed by the merger of Western Hospitals NHS Foundation Trust (WSHFT) and Brighton and Sussex University Hospitals NHS Trust (BSUH). He reminded the Board that at its previous meeting, it had received a paper setting out the governor role and timetable; this latest update included additional detail around: • How the Trust would help to equip governors with the knowledge and skills required to engage in this process; this included sessions designed to update governors on the national perspective and legal requirements for governors in the merger process. • An update on the current governor election and induction process. • The governance structure for Board, Council and merger evaluation working groups. • The continued programme of stakeholder engagement. • Drafting of the strategic case which was underway and is currently expected to be considered by the Boards of both organisations in April. If approved this would lead to development of the full business case with an outline timeline for review by the Boards of both organisations in August The Board considered the contents of the update, seeking additional clarification as follows: • Whilst acknowledging that everyone shared in the ambition to preserve and protect what was good about QVH, the Board was concerned that the Trust's logo had been used as part of a campaign to challenge the proposed merger; it was agreed that whilst the campaign was not legally entitled to use the Trust's logo, no further action would be taken at this stage unless there was demonstrable evidence that this was causing confusion. • It was noted that campaign material included misinformation claiming that staff felt unable to speak up and had been threatened with dismissal. There was in fact clear evidence that staff have been engaged and responsive in the current process and the Board emphasised the importance of enabling honest and transparent debate, without distortion of the facts. • Confirmation that the proposed working group of governors, would include a NED (the Trust Chair) as an observer and likely be chaired by a lead governor. • The process by which the Board will develop and assess the criteria to establish whether this merger would address identified challenges will be carried out through the February seminar, with a formal review of the strategic case work in progress at the March private board meeting. • The current timeline is based on assumption that WSHFT and BSUH will merge on 1 April 2021 but plans would be reviewed if this were not the case. There were no further questions and the Board **noted** the contents of the report and update.
09-21	**Review of Trust Constitution** The Board reviewed proposed amendments to the Constitution, one of which would permit the Board to ask Council to consider a delay to an election for a period of 12 months, where there was good reason for doing so. Other minor amendments included clarification around processing of memberships, and updating of pronouns. After due consideration, the Board **approved** the revised Constitution; it also **approved** a proposal to ask Council formally to agree to a 12 month delay to this year's elections for 4 public governor vacancies which will exist from June 2020. These proposals would now be presented to Council at its meeting on 11 January 2021; if approved the revised Constitution would take immediate effect.

10-21	**Review of Trust Reservation of Powers/Scheme of Delegation** The Board **approved** a minor update to the Trust's current Reservation of powers/Scheme of delegation.
11-21	**Nomination and remuneration committee** The Board **noted** the Chair's report on the most recent nomination and remuneration committee meeting.
12-21	**Audit committee** The Board **noted** an update on the December audit committee meeting.
Key strategic objective 5: organisational excellence	
13-21	**Board assurance framework** The Board received the latest KSO5 BAF. In response to a query GO noted that there had been significant changes to the risk column which now better aligned to KSO1.
14-21	**Workforce monthly report** GO presented the latest workforce report, drawing the Board's attention to the fact that whilst the report showed only a small number of staff had been off sick with COVID, (as opposed to COVID related reasons), this data was from last November; figures had changed significantly since that time, with approximately 8% of workforce currently impacted by COVID. In response to question, GO advised that the increase in bank and agency staffing was as a result of COVID, and was set to continue for the time being. The Board noted that long service awards process was currently underway, and the roll out of virtual staff awards imminent. The Chair noted the importance of recognising what all staff have done over the last year. 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	
15-21	**Board assurance framework** The Board noted that the current version of the KSO3 BAF had been circulated following distribution of the main board reports. Focusing on KSO4, the Board asked whether the £4.6m top-up was still guaranteed. MM confirmed that this was the included in the financial guidance from the Department of Health and Social Security, and currently remains within the financial plans of both QVH and the ICS. Any change to this could result in a larger deficit than currently planned and a £4.6m cash issue due to the deficit.
16-21	**Financial, operational and workforce performance assurance** PD-R presented a report following the recent meetings of the Finance and performance committee. Key points included: • That whilst financial results were forecasting break-even for this year, the caveat remained that this was entirely due to the national funding calculation. Pressures were mounting in expenditure and the Phase 3 plan would not be achieved. • To date, operational performance had generally outperformed plan, but was heavily reliant on a wide range of key dependencies and an understanding in terms of finance and activity was important. • Workforce indicators remained very positive. There were no questions and the Board **noted** the contents of the update.
17-21	**Operational performance** AJ presented the operational performance report, highlighting in particular a focus on RTT (referral to treatment) challenges, and the overriding challenge of the current climate with its impact on operational delivery. The Board considered the report, seeking additional clarification as follows:

	• As an organisation we are expected to deliver a suite of constitutional standards. Whilst COVID has had a significant impact, we are still delivering a number of standards. • Whilst faster diagnosis (FDS) and the cancer 62-days target were being delivered in some months, performance was less consistent. • Areas of challenge remain the RTT18 and RTT52 week targets, however, these and the 31-day cancer target were improving ahead of plan. • As previously reported, risks to achieving the Phase 3 plan targets were around capacity. Whilst making reasonable headway with the QVH activity plan, we were constrained primarily by operating capacity. Patient cancellations and workforce challenges are also a risk and had an impact. • Elective work will be significantly affected by the proposed resuming of cancer surgery for Kent, Surrey and Sussex. • A number of changes had been implemented to keep patients and staff safe, including pre-surgery isolation guidance. There was also increased asymptomatic testing of the workforce including the roll out of lateral flow testing for those who cannot access Optigene. There were no further questions and the Board **noted** the contents of the update.
18-21	**Financial performance** MM presented the latest finance report, highlighting her top concerns as: • Cash implications should the Trust overspend against plan; there had been a significant increase in spend as a result of COVID. • The financial planning process was subject to continual update, which increased pressure on the small and already stretched team. • Guidance on COVID capital funding was still outstanding. Whilst QVH was not an outlier in this, uncertainty remained as to whether we would still be expected to achieve our capital plan. The Board sought and received the following clarification regarding capital planning: • The impact on performance if suggested capital expenditure funding shortfall has to be met from our contingency fund: at present we could broadly still achieve plan as a result of delays in projects. • In mitigation, work was underway to review which 2021/22 projects might be achieved in 2020/21; also an assessment of whether high priority medical and IT equipment could be purchased before year end once further guidance is received. • EMT has undertaken a review to ensure that all equipment assigned to the COVID funding stream had been appropriately allocated. • The ICS was continuing to push for a regional response to this issue. There were no further questions and the Board **noted** the contents of the update.
Key strategic objectives 1 and 2: outstanding patient experience and world class clinical services	
19-21	**Board Assurance Framework** BAFs for KSO1 and KSO2 were received by the Board. NR reiterated that recent changes to KSO1 would ensure better alignment with the KSO5 BAF. In response to a concern raised regarding residual gaps in theatre staffing, NR assured the Board that an advert was currently running for recovery staff, with flexible working options. At the same time, the Trust was continuing to develop its own staff and whilst this would result in increased backfill costs, these would be offset by the increase in qualified staff.
20-21	**Quality and governance assurance** The Board received the quality and governance assurance report, seeking confirmation that the first virtual ward/departmental visits were scheduled to take place in January. NEDs were already invited to attend the weekly matron meetings and plans were underway to introduce an abridged form of Compliance in Practice inspection. Following on from discussions around clinical harm reviews at the last meeting, NR confirmed that whilst the team have developed a tool to assess psychological harm, given the numbers involved, further work was required around how this would be resourced.

	Concerns were raised by the Board regarding the report's reference to the corporate risk register. Whilst recognising that COVID challenges had been significant for the whole of the NHS, it was noted that histopathology cover should not have been highlighted as a top risk. There were no further comments and the Board **noted** the contents of the report and verbal update.
21-21	**Corporate risk register (CRR)** The Board **noted** the contents of the latest corporate risk register.
22-21	**Quality and safety report** The Board received a report which provided assurance as to how the organisation was maintaining quality and safety standards at this time. In response to a question raised by the Chair, NR noted a general anxiety around the risk of a COVID outbreak at QVH, but had no specific concerns about the way in which we continued to care for our patients. IF noted the recent change in vaccination strategy; to protect more people second doses would now be given after 12 weeks. It was noted that Jeremy Collyer would be leaving the Trust and the Board commended his years of service to the Trust as Consultant Oral & Maxillofacial Surgeon, Chief Clinical Information Officer and latterly, Deputy Medical Director. His contribution to QVH was enormous both as a surgeon and in his managerial roles and he would be sorely missed. The Chair indicated that she had written to Mr Collyer to thank him for his service to QVH. There were no further comments and the Board **noted** the contents of the update.
23-21	**BAF, QVH Risk Appetite Statement and CRR review** The Board received an update on steps being taken to manage corporate risk during the pandemic, and also throughout the exploration of potential partnership arrangements. It agreed this was a pragmatic approach, noting that additional work would follow in due course. There were no further questions and the Board **noted** the actions outlined in the report.
24-21	**EPRR core standards & statement of readiness - update** NR reminded Board that at this stage of the year, the peer reviewed EPRR core standards and statement of readiness would usually be presented for sign off. However, as a result of COVID this process remained outstanding whilst feedback from NHSE and CCG was still pending.
Any other business	
25-21	There was none.
Questions from members of the public	
26-21	There were 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	Jan 2021	02-21	Patient story	Standing items	Chair to write to patient to thank her for taking time to record her experience	**BH**	**ASAP**	Completed	**Closed**
2	Jan 2021	03-21	QVH BAME network	Standing items	Chair to liaise with BAME co-chairs to agree how board member skills and experience might be used to support development of 'network of allies'	**BH**	**ASAP**	Chair has met with both co-chairs and is supporting process of NED ally link up	**Closed**
3	Nov 2020	155-20	Patient story	Standing items	Chair to write to Breast Care nurses to thank them for their significant care and support, as highlighted during this month's patient story	**BH**	**ASAP**	Confirmation that this has now been actioned	**Closed**
4	Nov 2020	160-20	CEO update	Standing items	Recently appointed co-chairs of QVH BAME staff network to be invited to attend next public meeting in January.	**CP**	**BoD Jan 2021**	On January agenda	**Closed**
5	Nov 2020	176-20	Guardian of Safe Working	KSO2	If required, the GSW (Joy Curran), will be invited to attend board to present next report.	**KA**	**BoD March 2021**	On March agenda	**Closed**
6	Nov 2020	179-20	Annual workforce diversity report 2019/20	KSO5	Discrepancy in recording BAME staff access to training to be rectified.	**GO**	**April 2021**	This update will be included in the action plan when it returns to F&P in April.	**Closed**
7	Nov 2020	179-10	Annual workforce diversity report 2019/20	KSO5	All mandatory requirements to be collated under one single document, to include KPIs and deadline dates. Also confirmation whether this would be returned to BoD for review, in addition to F&PC	**GO**	**April 2021**	This update will be included in the action plan when it returns to F&P in April.	**Closed**

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/03/21**		**Agenda reference:**	**37-21**	
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 Chair, NED and governor 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:	4 March 2021
Agenda item reference no:	37-21
Report from:	Beryl Hobson, Chair
Date of report:	23 February 2021

Chairs Report

1. Chair and NED activity

a. Board Seminar

Since the last public board meeting, the board held one seminar in February. At this session we received and discussed an update on Sussex Acute collaborative working, we also discussed the evidence we would want to see to support a strategic outline case.

Following the November seminar, there have been further discussions between NEDs and Executive colleagues on how to allocate corporate risks between the Finance and Performance committee and the Quality and Governance committee. This was trialled at the February committee meetings and will be refined in the light of experience.

b. QVH Black, Asian and Minority Ethnic (BAME) network

At the last board meeting we welcomed Kokila Ramalingam and Aneela Arsha, our recently appointed BAME staff network leads. It was helpful and challenging for the board to hear their first impressions in the role. In response to their request for the board to provide allies for BAME colleagues, several board members volunteered to work with Kokila and Aneela. Since then I have met with them both together and individually – they asked if I would mentor them and we agreed that in doing so I would welcome 'reverse mentoring' where they could help me understand the issues they face. As a direct result of these conversations I have asked that all hospital consultant recruitment panels that I chair should have a diverse interview panel and Kokila and Aneela are joining us as observers at one of the panels in the near future. We have agreed that I will work with them to match board members and colleagues who require mentoring or allyship.

c. NED assurance

Over the last year the NEDs (along with all NEDS across the country) have been trying to develop the best way to ensure scrutiny and challenge in the current environment. It is well recognised that some of our established ways of 'triangulating' the information we receive at board have not been possible - we do not wish to create additional burden on our QVH colleagues or to create infection control risks by visiting staff in person.

We have developed several ways of doing this in addition to our usual chairing of committees and attending hospital meetings such as the Joint Hospital Governance Meeting (which is attended by many clinical colleagues). We also receive the papers for all board sub-committees including those where we are we are not members of the committee (and all board members have open invitations to attend any board sub-committee as observers).

In addition to this, NEDs have attended several of the briefing meetings between the CEO and staff, where we have been able to hear any concerns that staff members may have.

NED colleagues have also attended the Head of Nursing forum, held a meeting with the Freedom to Speak up Guardian and volunteered on the main reception desk. We have also had more regular meetings with the executive directors and networked with NEDs in other trusts to identify any other learning on how they are obtaining assurance. These have all given us valuable insights into the issues facing QVH at this time.

d. Nominations and Remuneration (N&R) committee

Since our previous meeting, the N&R committee (comprised solely of NEDs) received and accepted the guidance from NHSI on the remuneration review for Very Senior Managers (VSM). We also accepted a proposal relating to the interim director of nursing role having taken into account benchmarking material from other trusts.

e. Kent NHS Provider Chairs

I continue to attend the fortnightly meeting of the Chairs of Provider Trusts in Kent (which reflects the fact that many of our patients are based in Kent). In addition to the current covid situation, their discussions have included development of the Kent ICS. It is planned that all STPs should become ICSs by 1st April 2021 and Kent Chairs believe that they should be in a position to achieve this.

f. Good Governance Institute

This company provides governance support for NHS trusts and non-executive directors. In recent weeks I have attended two of their events – one about the white paper (referred to in the CEO report) and the other session was about the proliferating number of requests for NEDs to serve as champions/ guardians for various NHS services.

This latter point has been an issue for some time, with some DHSC Departments asking for NEDs to be involved in issues which would take them beyond their independent scrutiny role. Our membership organisation, NHS Providers, has now convened a working group including NHSE/I and some Chairs, and they are planning to identify a series of recommendations during the spring. (Current arrangements at QVH are included in the appendix to the Board effectiveness review paper later in this meeting).

2. Governors

On 1st February we welcomed 17 newly elected governors to the Council of Governors – 3 new staff governors and 14 public governors (including two who had been re-elected). We also said farewell to two members of the previous Council of Governors who were not re-elected. We have held two induction events and a further event is planned for 16th March. The NEDs and I look forward to working with the Council.

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 meeting 24/02/2021. KSO1 and 2 were also reviewed at the Quality and Governance Committee, 22/02/2021. KSO 3, 4 and 5 were reviewed at the Finance and Performance Committee 22/02/2021. The trust finances are break even due the national requirement and we await further national /regional instruction regarding the financial flows. 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 will be referenced in the respective director reports to the March trust board .

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/03/2021**		**Agenda reference:**		
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	1) Integrated dashboard 2) 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	• Thank you to staff introducing Staff Awards • Covid-19 Vaccination hub – our role to date • Key risks as we move towards 2021/22 • Government White Paper – 'Integration and Innovation: working together to improve health and social care for all' – collaboration and integrated care systems				
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:	BAF reviewed at EMT				
	Date:	22/02/21	Decision:	More detail review of BAF	
Next steps:					

CHIEF EXECUTIVE'S REPORT
MARCH 2021

TRUST ISSUES
Thank you
As I write my last report for this financial year, I can only reflect on what a remarkable twelve months the country has endured. The Covid-19 pandemic has brought the very best out of the NHS; here at QVH we too can be proud of our achievements in particular stepping up to being a regional cancer hub and more recently our work as a vaccination hospital hub and supporting the Crawley hub.

All of our accomplishments have been through our talented and committed staff and volunteers, which is why we want to recognise and celebrate the roles individuals and teams played in enabling is to continue to supporting our patients against the backdrop of a global pandemic, with our Staff Awards.

With over 300 nominations made, all of them singing the praises of much valued individuals and teams, this is not a year for judging. So instead we have put together an amazing selection of prizes and everybody nominated will go into a random draw for these delights.

- Making a difference award - recognising a team(s)
- Care and compassion award - recognising an individual(s)
- Hidden hero award - recognising an individual(s)
- Leading and inspiring award - recognising an individual(s)
- Best newcomer award - recognising an individual(s) who joined QVH substantively in 2020
- Outstanding Bank staff award - - recognising the vital contribution of our temporary workforce when teams are challenged with unplanned absences, vacancies or urgent work needing to be covered.

We received about 50 nominations from patients recognising some exceptional contributions from our staff to the experience of patients.

Farewell

I wanted to thank Jeremy Collyer, Deputy Medical Director & Consultant Maxillofacial Surgeon, who leaves QVH on 6 April 2021 after many years of outstanding service. Jeremy has been an exceptional clinical leader and was the first individual winner of the Chair's Cup back in 2018, for being instrumental in supporting and implementing the challenging and complex IM&T strategy. He has devoted his own time, out of hours, to ensure systems were clinically assessed, whilst enshrining patient safety within the systems and processes. We wish Jeremy well for the future.

Long-service awards

Thank you to those staff who have recently received their NHS long service certificates. Once again, in the absence of a formal staff awards ceremony, Board colleagues have been visiting those in receipt of long-service awards in their areas to thank them for their ongoing work. One of our longest serving is pictured left, Jennifer Francis, ward clerk in our Rehab Team celebrating 45 years' service in QVH. Jennifer has worked in many areas of the trust and embodies everything that is outstanding about QVH.

Covid Vaccination hub

During 2 weeks in January QVH rolled out the Covid-19 vaccine programme to our staff and other local health and social care workers. We vaccinated 1895 people in total, of which 961 were QVH staff, 934 were staff from other organisations. In addition 139 QVH staff accessed a vaccination elsewhere.

We were able to access both Pfizer and Astra Zeneca vaccine and are making arrangements to administer the second doses in late March as per national guidance. Although we have paused our programme until second doses, we are now providing staffing support to the Crawley hub as part of Sussex Integrated Care System (ICS) programme.

The feedback for this process has been really positive and staff have been overwhelmingly enthusiastic:

> *"We have received amazing feedback today from the Horder staff that have been over and had their vaccinations with you. They have fed back how well organised the process was and how friendly and reassuring the staff were – so once again, thank you."*

> *"Just wanted to say thank you for arranging the vaccine for me. I've been and had it done…. so far so good! Much easier to have it done at QVH too. The reserve list was a brilliant process."*

> *"I just want to let you know that I thought the layout, the process through the doors and the treatment of the team was amazing. Please can you thank everyone for reassuring us and*

making us feel relaxed and calm during the vaccine roll out. Everything seemed to run smoothly and a credit to all the team. Well done to the QVH team."

Thank you to Captain Sir Tom Moore

Following the sad news that Captain Sir Tom Moore had passed away last month, we joined many other NHS organisations in lowering our flag to half-mast as a sign of respect. Captain Tom raised over £32 million for NHS Charities Together and we are fortunate to have been granted some of this money to use at QVH. This included funding the meals for staff onsite in the first wave of the pandemic, and a grant recently received which will allow us to bring in additional psychological support for cancer patients right through their treatment journey. Thank you to Chris Dann and our estates team for arranging for our Union Jack to be flown, and to Barry Waite for this lovely photo.

Two-way text reminders are now live

As an organisation we have sent patient appointment reminders by text message for a number of years, but it was a system designed, set up and managed internally by our staff. To give patients the ability to respond to the messages for outpatient appointments, we have purchased a managed and supported system which officially went live at the beginning of January. Patients can reply to their text message with the words CONFIRM, REBOOK, CANCEL or STOP (to opt out of future messages). In the first week we had a response rate of 72% with most of these being to confirm patients will be attending their appointment. A huge number of people from across the Trust have worked hard behind the scenes to enable this system to go live so thank you to everyone involved.

New website helps our patients attend appointments virtually

Since early in the pandemic, we have been working hard to develop alternative ways to continue treating and supporting patients virtually, where clinically appropriate to do so, without them needing to come to hospital. Online consultations via a computer, smartphone or tablet have become a popular method and around 1,000 of our appointments a month are currently carried out that way, in addition to telephone consults.

To support our patients to navigate this potentially new territory of seeing their clinician online rather than in the flesh, we have launched a dedicated mini-website just for them. Housed within our main hospital website, it is a one-stop shop, allowing patients to enter a virtual waiting room before being called through to their consultation. It also provides a secure, end-to-end encrypted way to send their clinical photos to help with their diagnosis or treatment. Patients can watch videos explaining the process, including one we have made ourselves showing how to take photos for their consultations https://youtu.be/AvODX0uEeCU

Partnership working

Soon after our last Board meeting, Civica Election Services, formerly (Electoral Reform Services) forwarded details of those people successfully elected as public and staff governors. Two induction sessions were held on 21 and 28 January to welcome new governors and to inform them of the work of the Trust including securing the long-term future of the hospital.

Ongoing engagement with staff colleagues around this is vitally important and includes frequent sessions open to all staff, weekly meetings with the clinical directors and a new monthly staff ambassador's group including staff from various areas across the trust to discuss issues and seek views of future needs. All these forums are a useful barometer to understand the thinking and seek opinions of staff.

Integrated Performance Dashboard Summary
Our Integrated Performance Dashboard summary (Appendix 1) highlights at a glance the key indicators from all areas within the Trust including safety and quality, finance and operational performance, and workforce, against each Key Strategic Objective. From 1 August 2020, in line with Phase 3 expectations, QVH has an ambitious recovery plan to reduce patient waiting times. During January 2021 we stepped up once again as a cancer hub providing 29 theatre lists a week for our breast cancer surgeons from trusts across Kent, Surrey and Sussex.

The Trust continues to report a breakeven position at M10, which remains in line with the financial framework guidance issued from NHSE/I for the interim period. A new funding framework came into place on 1st Oct 2020. The Trust will be operating within a funding envelope and additional costs relating to COVID-19 will become prospective and at an Integrated Care System (ICS) level rather than retrospective and organisational.

Board Assurance Framework (BAF)
The entire BAF was reviewed at executive management meeting (24/02/2021) alongside the corporate risk register. KSO 1 and 2 were reviewed at the Quality and Governance Committee, 22/02/2021. KSO 3, 4 and 5 were reviewed 22/02/21 at the Finance and Performance Committee. Changes since the last report are shown in underlined type on the individual KSO sheets.

Media
Appendix 2 shows a summary of QVH media activity during December 2020 and January 2021; reflecting interest about the future of the trust, our staff awards, and our role as a cancer hub together with vaccination hub.

2021/22
In considering the key risks to our work in the months ahead, we will need to continue to focus on:

- Maintaining patient and staff safety through pandemic
- Securing a sustainable future for QVH
- Keeping our staff engaged, motivated, supported through a time of great change

These issues are at the forefront of our decision making around actions and resources. I am proud of how QVH staff have risen to the challenges of the past year and confident that our teams will face the year ahead with resilience and care for colleagues, enabling QVH to continue to deliver the excellent patient experience and outcomes for which we are rightly known.

SUSSEX ICS ISSUES
Covid-19 Vaccination
At the time of writing, Sussex had surpassed the half million mark of vaccinations to protect those in the most vulnerable groups. This reflects the huge amount of working taking place across the system to give those who are eligible the vaccination as quickly as possible. After two weeks as a hospital hub, staff from QVH have supported the vaccination hub at Crawley Hospital run by Sussex Community NHS Foundation Trust.

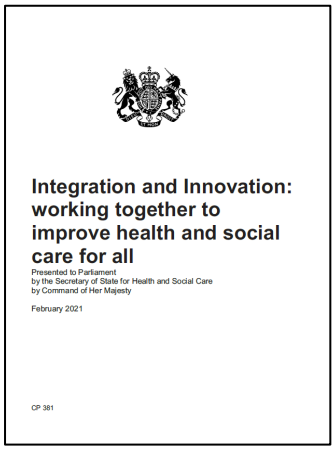
The milestone comes as the NHS sets out an accelerated national timetable for the vaccination programme. The commitment aims to ensure that the most vulnerable are vaccinated as quickly as possible, and protection is provided for the whole adult population by the summer.

The NHS in Sussex met the national target for all those in the first four priority groups to have been offered the vaccine by 15 February. Official figures of vaccinations given are published nationally on a weekly basis every Thursday and reflect figures up to the previous week.

NATIONAL ISSUES

Government White Paper - Integration and Innovation: working together to improve health and social care for all

The NHS in England is to be reformed so health and care services can work more closely together, the government says. Health Secretary Matt Hancock said the planned restructure will mean a focus "on the health of the population, not just the health of patients". A full White Paper was published on 11 February 2021, setting out the proposed future legislation.


Integration and Innovation: working together to improve health and social care for all

Presented to Parliament
by the Secretary of State for Health and Social Care
by Command of Her Majesty

February 2021

CP 381

Announcing the changes to MPs, Mr Hancock said the new system would see the NHS and local councils take decisions about local health together.

"The new approach is based on the concept of population health," he said.

Organisations called "integrated care systems" - which already exist in some parts of the country - will be set up in each part of England and be responsible for funding to support that area's health.

"They will provide not just for the treatments that are needed but support people to stay healthy in the first place," said Mr Hancock.

Responding to criticism over the timing, Mr Hancock said the pandemic had "brought home the importance of preventing ill health in the first place."

The government's white paper on health and social care is in essence a staging post in the development of integrated care. At its core are proposals to establish integrated care systems as statutory bodies, introduce a duty to collaborate across the health and care system, and dismantle rules on competition and procurement, building on work underway across England.

One of the most significant gains will see the shift from competition to collaboration and removing some of the barriers to progress. Equally important will be the investment of time and resources in building collaborative relationships which have been undermined by decades of market-oriented NHS reforms. This includes recognising that organisational autonomy like that of foundation trusts such as QVH needs to give way to partnership working, both within the NHS, and between the NHS and other bodies.

It is worth noting that many of the benefits of integrated care occur when teams focus on joining up care. The NHS has seen many examples of this during the pandemic including our role as a cancer

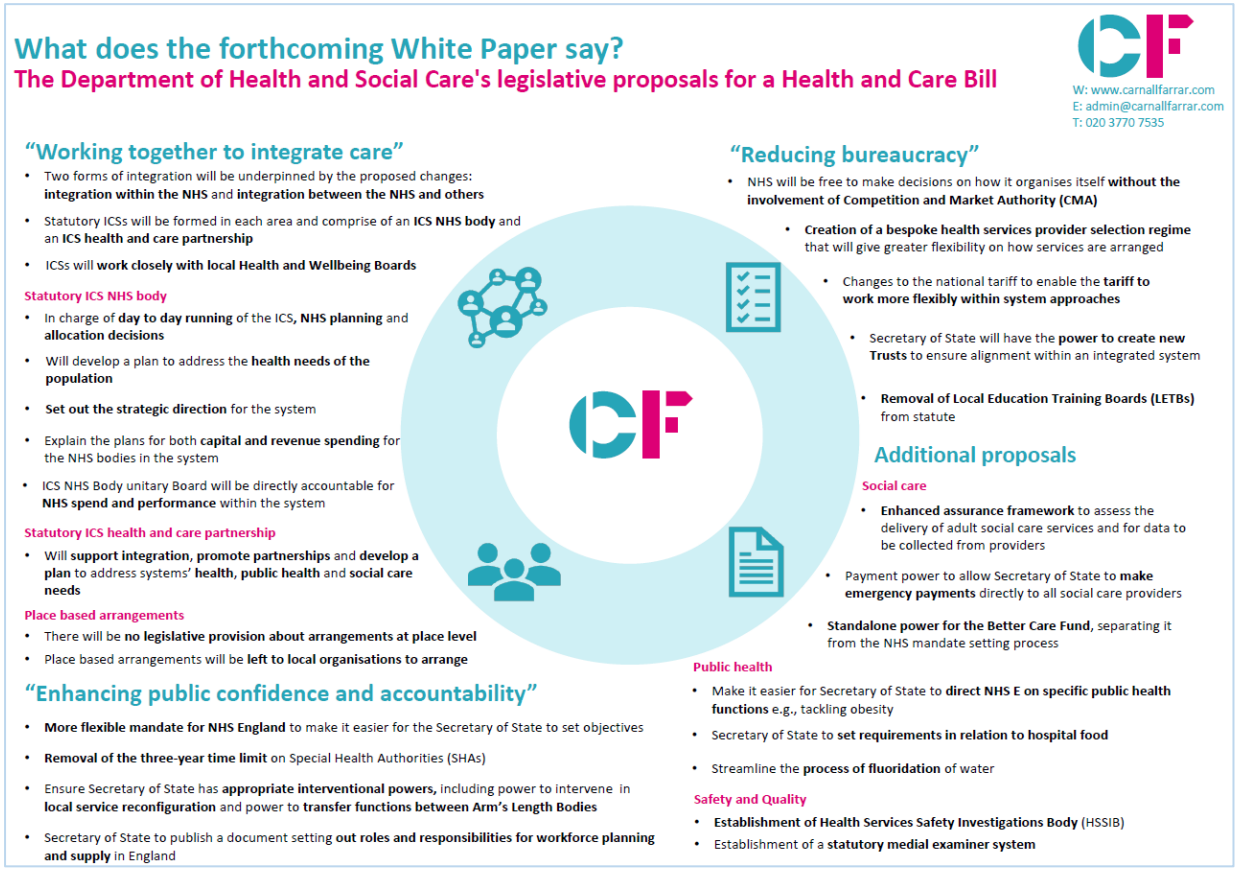
hub serving patients from across Kent, Surrey and Sussex. Team working across organisations and services is the foundation of integrated care.

Sussex became an integrated care system last year. Last year the Sussex ICS held the Big Conversation aimed at ensuring that the voices of patients, service users, and carers are in the room when decisions are made and using the expertise of voluntary and community sector organisations to enhance the support offered to people in need. The expectation of the white paper will be encouraging local NHS healthcare providers and local authorities to work together to provide joined-up solutions to prevent ill health and enable people to be active agents of change.

Through closer collaboration and stronger working relationships, local organisations can take on greater responsibility for managing pooled budgets and resources. They can also take on the challenge of delivering shared performance targets for the benefit of patients.

The NHS is focusing on improving overall health and proactively preventing illness, as well as meeting standards for healthcare provision. Furthermore, the plan is to eliminate variation and gaps in care, so that each patient in each area can access seamless services.

Ultimately, the NHS wants to encourage collective local ownership and responsibility for healthcare across the country. The new way of working will be all about partnerships, with all local NHS trusts working as part of a formal, place-based provider collaborative.



Snapshot: White Paper summary (Carnall Farrar)

Integrated Dashboard Summary
Key indictators at a glance - March 2021 (reporting M10)

Queen Victoria Hospital
NHS Foundation Trust

KSO1 Outstanding Patient Experience & KSO2 World Class Clinical Services

C-Diff	0
MRSA	0
E-coli	0
Gram-negative BS	0
Serious Incidents	0
Never Events	0
No of QVH deaths	0
No of off-site deaths (within 30 days)	0
Complaints	3
Closed <30 days	3

FFT

In patients	100%
Outpatients	97%
MIU	97%
Day surgery	95%
Hand trauma	100%

KSO 3 Operational Excellence

MIU <4hrs	100.00%
RTT 18 weeks	71.10%
Cancer 2ww	98.90%
Cancer 62 day	85.70%
Diagnsotics <6weeks	98.80%
52ww	740

Phase 3 activity

Day case	67.00%
Elective inpatient	55.00%
Outpatient (new)	57.00%
Outpatient (follow up	81.00%
First O/P virtual	43.00%

QVH continues to provide additional capacity for surgical cancer treatments on behalf of organisations from Kent, Surrey and Sussex impacting capacity for non urgent activity until the end of March

Key	Improved Performance	Deteriorating Performance	Remains the same

KSO4 Financial Sustainability

Income	65,389k
Pay expenditure	43,396k
Non-pay expenditure	16,943k
Surplus/Deficit	84k

Year to date at month 10 the Trust is reporting £533k favorable variance against the submitted plan. £199k clawed back top up related to first half of the financial year to achieve breakeven months 1-6 position.

A new Funding Framework came into place on 1st Oct 2020. The Trust will be operating within a funding envelope and additional costs relating to COVID-19 will become prospective and at an Integrated Care System (ICS) level rather than retrospective and organisational.

KSO5 Organisational Excellence

Vacancy rate	10.44%
Turnover rate	10.54%
Sickness rate	3.20%
Appraisal rate	82.03%
MAST	92.30%
Q4 Staff FFT (work at QVH)	74.71%
Q2 Staff FFT (care at QVH)	95.35%

QVH media update – December 2020

Securing the future of QVH

Consideration of possible merger with Brighton and Sussex University Hospitals (BSUH) and Western Sussex Hospitals to help secure the future of QVH continued to receive coverage in December with mentions in outlets across Sussex, Kent and Surrey. This included HSJ, the InYourArea website, the Crawley Observer and West Sussex County Times, the GetSurrey website, Susy Radio. These pieces featured campaigners' claims that access to specialist services could be denied for patients from Kent and Surrey, with stories from patients who have benefitted from QVH services expressing fear that they, or patients in similar circumstances, might have to go elsewhere for treatment.

A statement issued to media who approached QVH for comment included: "Queen Victoria Hospital plans to continue to provide services to patients from Kent and Surrey as well as the rest of the wide area we cover currently."

Providing treatment to cancer patients during a pandemic

NHS Providers published a blog by Steve Jenkin our chief executive which talked about how we have been driven to find new ways of working by the belief that our patients with high-risk cancer need and deserve to continue receiving a high level of care. It discusses how we became as a specialist surgical cancer hub early in the pandemic and how our restoration and recovery plans have not only required us to responsive but would not have been possible without the can do attitude of our staff who were willing to work differently to provide the best care for our patients.

Emily's candle warning after sustaining significant burns

In the lead-up to the festive season, one of our patients, Emily Fairbrass, helped us remind people to be burns aware. Emily suffered significant burns last December when her hair caught alight whilst blowing out a candle at home. Emily had leaned over to put out the flame when her hair caught fire, spreading to her head, face and neck. Emily is still receiving physiotherapy and treatment at QVH to reduce her scarring, and she wants to not only make people more burns aware, but to support those who have sustained burns by encouraging them not to let their injuries define them.

Emily's story was featured in the West Sussex County Times, the Crawley Observer and the RH Uncovered website – both in the East Grinstead section and as its lead story.

Promoting the QVH Charity

RH Uncovered magazine ran an article in its December East Grinstead edition about QVH Charity. The full-page piece thanked QVH Charity supporters for enabling it to make a meaningful contribution to the hospital, despite it being a challenging year for charities. This included funding free meals, outdoor seating, and additional psychological support for staff at the hospital.

Sleep myths solved

Peter Venn, clinical lead of our sleep disorder centre, was interviewed by BBC Radio Kent on 11 December. Peter spoke about ways to try and improve your sleep, how he and the team support our patients and answered some questions posed by listeners.

Healthcare assistant's poppy painting

Kirsty Chapman, a healthcare assistant from our burns unit, was featured on the Mid Sussex Times website, talking about the poignant tribute she is creating to our serving forces. Kirsty who is the third generation of her family to work at our hospital, is hoping to get hundreds of soldiers involved in her project, adding fingerprint poppies to her painting.

Press releases
Emily's candle warning after sustaining significant burns

Information published on our website
- Visiting patients on our wards during the COVID-19 pandemic – updated
- Coronavirus information and advice for our patients and visitors – updated standing item

QVH media update – January 2021

SpiderMan style wound dressing
Baljit Dheansa, our consultant plastic surgeon, was quoted in an article in The Guardian about a medical gun that spins out a protective web to cover burns and wounds. It is hoped that the product called SpinCare, which provides a breathable "skin substitute", will help patients recover without the need for painful bandage changes. Our burns team have been trialling the wound covering on some of our patients with the intention of evaluating is efficacy and publishing their research.

A version of the interview was also featured in The Times of Israel and the Inceptive Mind website.

Supporting patients with cancer
The HSJ ran an article focusing on how we have freed up 29 theatre sessions a week so cancer surgery from nearby providers can continue during the pandemic. It talks about how surgeons from six other trusts across the South East are working with our teams to provide cancer patients breast, head and neck, and maxillofacial surgery.

Surgery for patients with head and neck cancer
The January edition of The Operating Theatre Journal ran an article about a report from the COVIDSurg Collaborative, which reveals, "head and neck cancer surgery is safe for patients, amid earlier infection fears". Brian Bisase, clinical lead for head and neck cancer, is quoted in the piece.

Search for outstanding staff
This month we gave patients who have accessed our services during 2020 the opportunity to nominate outstanding members of our staff. As part of our staff awards, we want to recognise and celebrate how staff across the hospital continued to support, treat and care for patients against the backdrop of a global pandemic.

The request for nominations was featured on the RH Uncovered website; InYourArea website; West Sussex County Times; Crawley Observer; and the Mid Sussex Times.

Securing the future of QVH
The petition set up by the action group Save Our Specialist Services related to the possible merger of QVH with Brighton and Sussex University Hospitals (BSUH) and Western Sussex Hospitals was covered by the Mid Sussex Times and the West Sussex County Times.

COVID-19 vaccinations
There has been much regional media interest around vaccination centres and where people can receive their COVID-19 jab. Whilst QVH only operated for a short period of time offering the vaccination to QVH staff and other health and care staff, it was mentioned in some local press as a hospital hub. This included the Hastings Observer; the Eastbourne Herald; and the Crawley

Observer. We were referenced as the “hospital hub in East Grinstead” on the InYourArea website and St Victoria Hospital by the Chichester Observer.

Hospital parking charges
The Argus ran an article looking at how much money hospital trust across Sussex made from parking charges and penalty fines in 2019/20. Using data from NHS Digital, it looked at money generated from visitor and staff parking in the year to March 2020. QVH was listed in the review of all Sussex hospitals, the piece saying, "figures reveal that the trust's patients and visitors paid an average hourly rate of £1, while staff dug out 50p per hour."

Healthy eyes
Gok Ratnarajan, consultant ophthalmic and glaucoma surgeon, wrote an article for the Crawley and East Grinstead print versions and website of RH Uncovered magazine about how to achieve 2020 vision in 2021. It features some advice and tips to keep your eyes healthy.

Healthcare assistant’s poppy painting
Kirsty Chapman, a healthcare assistant from our burns unit, was featured in the Crawley and East Grinstead print versions and website of RH Uncovered magazine, talking about the poignant tribute she is creating to our serving forces.

Press releases
Your chance to nominate outstanding hospital staff

Information published on our website
- Visiting patients on our wards during the COVID-19 pandemic – updated standing item
- Coronavirus information and advice for our patients and visitors – updated standing item
- Donating to us during the pandemic

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality &Governance
Date last reviewed 10th February 2021

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 or retain a workforce with the right skills and experience due to uncertainty of the potential merger
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.
3) The on site paediatric support has been temporarily reduced whilst RACH are experiencing significant Covid-19 pressures. Risk 834 rescored

Risk Appetite The Trust has a **low 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

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

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

Future risks
- Additional-patients with longer waiting times and additional52 week breaches , due to COVID-19 , new CHR process under development
- 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
- Availability of dressing and some medications post Brexit

Future Opportunities
- Developing new healthcare roles – will change skill mix
- Potential merger could offer significant opportunities for development of the workforce

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 ,
- 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. Inpatient paeds on exception basis
- 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
- Reviewing 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 clinical 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.
- Outcome of KPMG work unknown at this time

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Date last reviewed: 19th February 2021

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
~~Assurance regarding clinical governance, research & innovation. Safe & effective clinical services evidenced by excellent world-class outcomes.~~

1. Potential for harm to patients due to long waits for surgery
2. Maintaining safe & effective clinical services evidenced by excellent outcomes & clinical governance
3. Developing a robust research & innovation strategy along with potential collaboration with BSMS if there is a future merger

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.

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.
- Consultant medical staffing of Sleep Disorder Centre, Histopathology and Radiology
- Non-compliant RTT 18 week and increasing 52 week breaches due to COVID-19
- Commissioning and ICS reconfiguration of head and neck services
- Restoration & recovery: risk stratification and prioritisiation of patients for surgery and loss of routine activity
- Sussex Clinical Strategy Review
- Breast surgery & head and neck surgery from other trusts being undertaken again at QVH with visiting surgeons
- Recruitment to orthoplastics consultant post

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

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
- 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
- Possible merger with Western/BSUH

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
- 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:

- Link between internal data systems & external audit requirements & programs
- Creation of QVH clinical research strategy
- Limited data from spokes/lack of service specifications
- Achieving sustainable research investment
- Sleep disorder centre sustainable medical staffing model & network
- Inadequate Consultant radiologist cover (CRR 1163)
- Significantly reduced Consultant Histopathologist cover (CRR 1168)
- Maxillofacial trauma service (CRR 1209)

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	04 March 2021		**Agenda reference:**	**40-20**	
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 arising since the last Board meeting.				
Summary of key issues	This report updates the board on assurance issues arising from the Covid-19 pandemic and confirmation of assurance received. It notes continued concern with regard to the rise in waiting lists and the changes to Clinical Harm Review processes. QVH is now compliant with the National Data Guardian's data security standard and this item will be removed from the CRR.				
Recommendation:	The Board is asked to **NOTE** 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:	Committee received updates on relevant BAF summaries and 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:	As above				
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:	As documented in paper.				

Assurance route				
Previously considered by:	N/A			
	Date:		Decision:	
Previously considered by:				
	Date:		Decision:	
Next steps:	For presentation to board on 07.05.2020			

Report to:	Board Directors
Agenda item:	**40-20**
Date of meeting:	
Report from:	Karen Norman / Gary Needle
Report author:	Karen Norman
Date of report:	24 February 2021
Appendices:	None

Quality and governance assurance
The Q&GC wish to bring the following matters from those considered at our meeting to the attention of the Board.

Covid-19 Update
Q&GC discussed this comprehensive report on the current issues and risks to the trust, staff and patients faced by the Covid-19 pandemic. The committee reviewed Version 5 of the NHSE Infection prevention and control board assurance framework, which is also submitted, in full, to the board for consideration. Assurance was taken from evidence cited against most of the standards and also from the actions taken to mitigate gaps noted in existing assurance in the document. Further assurance was sought and given with respect to mitigating actions for areas where gaps in assurance were noted.
The uptake of the vaccines by QVH staff and QVH BAME staff were reported as comparatively high.

Patient Safety Summary Exception Report: Data Dec/Jan–2020/21
No serious incidents were reported in this period. Q&GC welcomed the introduction of a Statistical Process Control chart for the total numbers of incidents in this report and looked forward to these being extended to the categories of incidents which occur with the highest frequency in future..

There had been an increase in the incidence of Patient Falls. A Trust Falls group has been established to undertake a more detailed review. Further information was requested for assurance with respect to inoculation injuries. Q&GC noted the recommendation from the Ockenden Report (Dec 2020): Maternity Services Shrewsbury & Telford NHS Trust that ‘staff who work together must train together.’ The Executive agreed to explore this further with respect to existing training in QVH.

Clinical Harm Reviews (CHR)
Q&GC have previously advised the board of their concerns with respect the rise patient waiting lists and consequent rise in the length of time patients wait for surgery. This is a national problem,

which has been exacerbated by the Covid pandemic. Clinical harm reviews are a process by which patients who breech standard waiting times are assessed to identify whether harm as occurred (or is likely to occur) as a consequence any delays to their treatment. It noted that an additional post has been funded that will facilitate oversight of the process, collation of the breached patients and forwarding to the clinical leads in each specialty for CHR. The committee ratified the revised Clinical Harm Review Policy. Concerns were raised about the sensitivity and efficacy of the harm review tool, the high numbers of harm reviews still due for completion and the impact on the workload of the clinicians undertaking these reviews. Further updates will be bought to future meetings for assurance by the Medical Director.

Corporate Risk Register (CRR), Risk Management Strategy and Board Assurance Framework (BAF).

Following recommendations arising from the recent board seminar on corporate risk and the CRR, the risks identified in the QVH CRR have now been allocated between Q&GC (for quality & patient safety risks) and F&P (for performance and activity risks). This is work in progress and will be reviewed by the Chairs of both committees in future months, to ensure this strengthens scrutiny and governance with respect to the ongoing management of CRM. Progress will be reported to the Board via their respective board reports.

Infection Control

Q&GC noted and commended the work of the department in their detailed report. This gave assurance that actions relating to the ongoing Covid-19 pandemic have been reviewed, discussed and undertaken by the IPAC Team. Compliance with MRSA screening for both trauma and elective has fluctuated throughout the quarter, with Quarter 3 showing 91% and trauma at 99%. There has been an increase in compliance since the policy changed, however improvement is still required. Further assurance was sought with respect to medical and dental staff being able to attend IPAC training. Work on improving compliance with hand hygiene and uniform policies remains a priority for the nursing quality forum.

Patient Experience Report

Q&GC took assurance from the positive indicators in this report, which confirmed high levels of satisfaction from our patients for the care and treatment they received.

Quality & Safety Board Report

The Q&S board report was reviewed. The ward level data metrics are a work in progress and are under review by the Interim Director of Nursing and Heads of Nursing. Further assurance on nursing recruitment was sought and given.

WHO Surgical Safety Checklist Compliance

Good progress has been made in many areas of this important work particularly with regard to team briefing, sign-in and ‘time-out’ in theatres. ‘Sign-out’ from theatres has yet to be fully embedded in practice. Q&GC sought and received further information on actions to be taken. Progress on this item will be subject to further review.

Quality Account Q3 Update / Priorities 2021/2
Q&G were advised that partial compliance on the Clinical Effectiveness Quality Priority had been met, due to the impact of COVID on expected progress and patient numbers. The Patient Experience Quality Priority on the Mental Capacity Act was partially achieved.

Compliance in Practice
Consideration had been given to the possibility of undertaking these virtually to address the loss of this form of assurance due to the pandemic. It was recommended that this could best be undertaken by clinical staff as an observational audit, with the results presented via the governance structure as before. In the interim, NED's have been invited to the Nursing Quality Forum for further assurance.

Information Governance Group summary Report
The only outstanding action on QVH compliance with the data security and protections standards for health and care, as set out in the National Data Guardian's data security standard, has now been met. At least 95% of staff have completed data security training in the previous 12 months.

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**04 March 2021**		**Agenda reference:**	**41-21**	
Report title:	**Corporate Risk Register**				
Sponsor:	Nicky Reeves, Interim Director of Nursing				
Author:	Karen Carter-Woods, Head of Risk, Clinical Quality & 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	The Board is asked to:
	• Agree that the risk appetite document will be reviewed in the November 2021 board meeting.
	• Note changes to the process of Corporate Risk Review at the committee level
	• Note key changes to the CRR this period:
	  • Three corporate risks added
	  • One corporate risk closed
	  • No corporate risks rescored				

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 by Q&G and F&P				
	Date:	22/02/21	Decision:	Agreed	
Previously considered by:	The Corporate Risk Register is also reviewed by EMT				
	Date:	24/02/21	Decision:	Agreed	

Corporate Risk Register Report
December 2020 and January 2021 Data

Key updates

Following the December Board Seminar, the Corporate Risk Register is now divided and reviewed in two subcommittees of the Board, Quality & Governance and Finance & Performance. The full corporate risk register is bought to board for review and discussion and is copied below for reference.

In addition during the seminar the Trusts risk appetite document was reviewed. Given the significant changes and challenges linked to covid, it was been agreed to defer further review until November 2021 Board meeting.

Corporate Risks added between 01/12/2020 and 31/01/2021: 3

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x5=15	1189	Workforce succession planning: radiology	RPC meeting
3x5=15	1199	Inability to deploy a flexible CCU workforce across the green and amber pathways which are split across two areas in QVH	DoN
3x4=12	1209	Maxillofacial trauma service	MD

Corporate Risks closed this period: 1

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x4=12	1139	Risk to patients with complex open lower limb fractures	Risk reviewed at Plastics BU Meeting CD & GM Service has been working well due to commitment and efforts of consultant body covering on-calls etc

No Corporate Risks were rescored this period

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 71 risks currently on the Trust Risk Register as at 3rd February 2021, of which 16 are corporate, with the following modifications occurring during this reporting period (December 2020 to January 2021 incl):

- Twelve new risks added: 3 Corporate, 9 Local (IT re: unsupported Microsoft systems)
- One risk closed: Corporate
- No risks rescored

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 71 risks open on the trust risk registers: risks that score 12 or more are managed via the Corporate Risk Register.
Five of the 16 corporate risks are within the higher grading category:

	No harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2		1	7	4	10
Possible 3		3	27	2 ID: 968, 1192	0
Likely 4		2	6 ID: 1040, 1077, 1136, 1148, 1168, 1209	4 ID: 1125, 1163, 1167, 1179	0
Certain 5		1	3 ID1140, 1189, 1199	1 ID: 877	0

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 Trust Board is asked to **note** the contents of the report and to **agree** the Trusts risk appetite document will be reviewed in the November 2021 board meeting

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1209	16/01/2021	Maxillofacial trauma service	Patients with cervico-dental infections and trauma are unable to be accepted at the QVH due to lack of beds and CCU. CCU beds may be required if a dental abscess has airway compromise. Also increased risk of a patient being unknowingly Covid-19 positive.□ Potential for reduced consultant cover at QVH out of hours	Communication between doctors at peripheral EDs and QVH maxillofacial surgeons to assess the patient's risk of airway compromise and that our surgeons may have to travel to the patient to operate.□ Testing for Covid-19 at peripheral hospital.	Keith Altman	Mr Kenneth Sneddon	Patient Safety	12	9		KSO1 KSO2 KSO3
1199	09/12/2020	Inability to deploy a flexible CCU workforce across the green and amber pathways which are split across two areas in QVH.	* Potential for there being insufficient trained staff to care for a critical care patient□ * potential for cases to be cancelled * Possible reputational damage due to being unable to cover amber pathway and patients being refused. * Stress to workforce endeavoring to cover at very short notice. * Staff reluctance to cover □	Refusal of admissions when staffing unsafe	Nicola Reeves	David Johnson	Patient Safety	15	9		KSO1
1192	09/10/2020	Inability to provide full pharmacy services due to vacancies, sickness and covid vulnerable pharmacist	Delays to indirect clinical services (e.g. updating policies / guidelines / audit/ training)□ Unable to move forward with non-clinical initiatives e.g compliance with falsified medicines directive, EPMA introduction□ □ Delays in projects e.g. EPMA and supporting new services□ Pharmacist vacancy rate increasing and inability to recruit□ □ Loss of long established staf	1. All technical staff in post apart from 0.2WTE band 2 assistant. Vacancy money used for bank staff.□ 2. Pharmacy clerk new to post but is progressing well.□ 3. Pharmacist assistants have completed apprenticeship and could dispense if needed to help reduce pharmacist to cover technicians.□ 4. Long term locum in post along with part-time bank pharmacists□ 5. Chief Pharmacist working addition bank hours.□ 6 Retired bank technician helping cover some vacancies and leave. Medicines management technician working on wards supporting pharmacist when possible.□ 7. Recruited new bank pharmacist who can work 1 day a week□ 8. Direct clinical work a priority.□ 9 Second locum pharmacist in place and working well covering wards and dispensary □	Abigail Jago	Judy Busby	Patient Safety	12	8	25/12/20 Awaiting start of band 7 to cover fixed term band 8a maternity. MSO post offered but in discussion about hours - unlikely to appoint.□ 24/11/20 Advert for MSO reopened, closes today. Shortlisted for band 7 fixed term post, interviewing 1 applicant on 26/11/20. To start recruitment again for other vacant pharmacist posts this week. Allocating some project work to agency staff to try to catch up on outstanding indirect clinical work. □ 11/11/20 Adverts out for MSO post and fixed term B7 post to cover BBa maternity leave.	KSO1 KSO2 KSO3 KSO4 KSO5
1189	08/12/2020	Workforce succession planning: radiology	- 50% of the workforce at / approaching retirement age□ - difficulties recruiting: Lack of ultrasound / radiographer/Radiologist workforce nationally□ - multiple failed recruitment drives previously and currently	-Bank staff/ agency □ □	Abigail Jago	Sarah Solanki	Compliance (Targets / Assessments / Standards)	15	9	**28-01-2021** - Recruitment premium not yet approved but we have had an experienced CT/MRI radiographer apply to join the bank - very good appointment - recruitment paperwork going through. Have been working with Katherine Bond about developing an apprenticeship role BC to train RDA to become radiographer. Regional paper submitted to trusts about a possible funded overseas recruitment drive. Awaiting further information re this.□ □ 21-12-2020 - applied for recruitment premium to be added to MRI/CT vacancies. Awaiting confirmation. Have a person interested in bank work (MRI experienced) - added to trac - currently awaiting approval from workforce team etc. Also developing BC re radiography apprenticeship - starting Sept 2021.□ We have had a band 5 job out since last year. Only just recruited into. Band 6 radiographer jobs also since end of last year. Only recruited 0.4WTE out of 2.0WTE. Ultrasound vacancy - we trained someone in the time the vacancy was unfilled. Consultant posts vacant since December 2019. Still vacant.□ □ 1.0WTE (2 part time) of US team can retire at any point.1.6WTE (3 staff) of Radiographer workforce can retire at anytime. □	KSO1 KSO2 KSO3 KSO5
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	August 2020: site reconfiguration work completed, SOP's continue to be updated in line with National Guidance. Optigene testing of staff and patients supporting Covid-light status.□ 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	**January 2021**: Arrangements in place with outsourcing to cover retire and return. Temporary staffing support in place and turnaround time standards are being met. □ October: Oversees appointment has withdrawn due to Covid situation. Workload being successfully covered with specialist expertise from bank consultant. Post will go back out to advert. There is another interested pathologist in Scotland who plans to visit the lab pending covid movement restrictions.□ August: nil update □ 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
1107	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	**January 2021** update: out to advert□ January 2021: awaiting approval on Trac then will go out to advert □ Dec 2020: approved at AfC Panel and going out to advert stat; fixed term, 1wte Band 4□ Nov 2020: Job advert written. Next AfC panel 15/12/20. Request made for job evaluation team to sense check to enable advert to go live prior to next panel. No staff identified for secondment to date.□ Oct 2020: 1.0wte Band 4 Failsafe Officer fixed term for 1 year approved at EMT (part funded from current Corneo budget). Job Description to go to AfC panel and job to be advertised. Also trying to identify any secondment opportunities to fill the post temporarily.□ Sep 2020: Review of admin structure - vacant posts identified with associated budget. JD needed for AfC banding to ascertain WTE that could be funded within budget.□ Aug 2020: No further update. Options still to be reviewed and on hold due to COVID□ 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□ 2020: 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	**28-01-2021** - on-call provision to change to outsource model for CT. Medica have been chosen to move forward. This should enable more meaningful leave ability for consultant. Cover in post 1 day per week. 1 bank H&N consultant 3 days per week. 1 agency consultant covering general/MSK vacancy. Global fellowship discussions ongoing but no progress due to pandemic. 21-12-2020 - have engaged with NHSSC for outsource delivery model for on-call and have had some initial response. Discussions held with global fellowship program and on-going support from Bank 23-11-2020 - on call provision paper submitted to EMT and approved - meaning that on-call provision will change to an outsourced model for radiologist cover. This will involve a procurement process but ultimately will de-risk on-call service as there will always be cover. 30-10-2020 - substantive post 1 day per week as H&N consultant - approved at EMT. Start date 13th November. 21st Sept 2020 - 6 month fixed term locum covering general/neuro/msk vacancy to add resilience of team. Paper submitted to manager around on-going on-call radiology cover. August 2020 - Jobs back out to advert, initial interest from agency only. Bank consultants delivering on-call with home reporting functionality. Substantive consultant on leave during August. Global fellowship program initial plans to reinvigorate in October 2020 but very much dependent on pandemic. 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
1148	24/07/2019	Clinical coding backlog	Coding backlog now at signficant level □ Potential to impact income recovery□ Clinical indicator data unavailable	-overtime approved□ -agency approved: restraints obtaining agency workers□ -monitoring reports 3x weekly□ -Coding team have been supported by external outsourcing company to reduce the backlog and develop in house processes□ -Internal staff are gaining confidence and experience and their output is increasing□ -Activity has been low due to COVID so the backlog is reduced□ -Operational issues regarding availability of notes remain□ -Proposal for blended onsite and remote coding support strategy has been drawn up and sent on for approval (?EMT ?F&P).□ □	Michelle Miles	Banu Thiagaraj	Finance	12	6	**February 2021**□ Two new starters as agreed in the business case have been appointed and started. Training has already commenced. Work on procuring the encoder system is underway□ October 2020□ Update as at August. In addition the business case for the coding department has been approved.□ August 2020□ The outsource provider is still supporting the backlog in coding. This backlog is mainly due to notes being unavailable for coding. Work is ongoing with the services, medical records and the operations team to ensure that notes are available for coding.□ □ 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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
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	15	4	**28-01-2021** - VNA risk comms this week indicated the risk issue has now been sorted but needs to be end to end tested by each trust. If successful - possibility for QVH to start migration in February. RIS BC approved at QVH & ASPH - awaiting approval from other boards. Project to progress. PACS - we have 3 vendors after the 2 sets of questions were sent to the providers by the framework. approx. 6 scored themselves as non-compliant for on those filtering questions so we have Sectra, GE and Agfa moving forward to the main procurement. OBS document being shared by framework to providers. Clinical staff to be available in March to score the documentation. Dates asked for ASAP so we can block out clinical time for evaluators.□ □	KSO1 KSO2 KSO3 KSO4
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 the log on times to system being reduced by the use of single sign on in "kiosk mode" plus the roll out of faster pc to clinical areas and the upgrade of operating system to windows 10.□ -Eform instability: It is possible for a user to finalise the living form at the end of a treatment episode. The Trust has worked closely with Kainos the provider of the EDM software to develop fixes for the Eform instability. The fixes have been tested and have been uploaded to the live environment. Testing being completed to verify instability issues have been addressed	Michelle Miles	James Cooper	Patient Safety	12	6	**February 2021**□ Therapies now has a set go live date. The business case for the scanning options has now been approved via HMT.□ October 2020□: The BAU for evolve is now transferring over to the Operations team with support from the implementation team.□ August 2020□: The completion of the roll out of evolve is due to be October of 2020. BAU for evolve is now developing with the structure being reviewed between DoO & DoF with support from both the CIO and CCIO.□ □ 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□ Update 27 Nov 20□: Discussions underway with Kent, Surrey and Sussex ICS with agreed provisional commitment to support ICS access for Q1/Q2 of 2021.□ The increase in the number of patients over 52wk is starting to decrease, with October reporting a rise of 53 patients, compared to 94 in Aug-Sept and 141 in Jul-Aug. Plastic surgery remains overall the most challenged specialty. Theatre improvement programme is ongoing. Out of hours additional resource to support scheduling and enable increased forward booking.□	Abigail Jago	Victoria Worrell	Compliance (Targets / Assessments / Standards)	16	9	August 2020: routine elective activity stood down in line with NHSE direction due to C-19 response. Significant impact on RTT with an average 10% reduction in performance per month, since Apr. 52WW reporting over 300 in July, PS and CP main challenged areas. R&R continuing, in line with the third phase NHS response. Clinical senate and capacity hub in place and embedded. □ 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 cornea 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.□ 27/11/20: Update 27 Nov 20:□ Discussions underway with Kent, Surrey and Sussex ICS with agreed provisional commitment to support ICS access for Q1/Q2 of 2021.□ The increase in the number of patients over 52wk is starting to decrease, with October reporting a rise of 53 patients, compared to 94 in Aug-Sept and 141 in Jul-Aug. Plastic surgery remains overall the most challenged specialty. Theatre improvement programme is ongoing. Out of hours additional resource to support scheduling and enable increased forward booking.□	KSO1 KSO2 KSO3 KSO4 KSO5
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	07/12/20: Risk reviewed by SA/HN; Delay in international recruits starting, issue in recovery staffing levels due to leavers over a 3 month period. Unable to recruit into the positions-backfilling where possible to mitigate risk as much as possible. Lead for recovery returning to work in February. Using bank/agency to cover gaps in theatres. Currently able to run all elective activity, monitored daily.□ □ □ 06/11/20: Delay in international recruits starting, continuing to recruit and internal promotion as appropriate, exploring recruitment & retention initiatives. Reduced availability of agency staff during pandemic.□ 18th August 2020: 4 international recruits: On hold. 4 staff leavers during July/Aug/Sep. On going recruitment. 2 Band 6 staff-internal promotion. Shortfall being managed with Bank and agency as required to ensure cover to open all ten main elective theatres. 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□	KSO1 KSO2
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/Flouro 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	Sarah Solanki	Patient Safety	12	2	**28-01-2021** - Brief MES meeting held this week with commercial solutions framework lead - Phil Spicer. Project stages and timelines talked through. MM identified the need for a projrct manager - to be scoped. Next steps are for Phil Spicer to share Slide deck. asset register template to be shared by commercial solutions to SS, and for Estates to have plans of the building etc. ready to move forward. NHSEI - loaned QVH 2 mobile xray machines. Emailed at the end of Nov to notify SS that these assets may be transferred to the trust. SS chased and informed that formal outcome to be expected in the next 2 weeks for central NHS re the assets.□ □ Jan 21: Business case for MES approved at EMT. To be taken forward with DOF as executive lead.□ 21-12-2020 - Delay to Fluoro room finish date due to broken fuse in PDP box - issue caused by contractor we believe. Fix completed by estates electrician. NHSEI may hand over ownership of loaned portable equipment. Awaiting confirmation. □ □ 23-11-2020 - New funded US on site, commissioned and working. MES paper submitted to AJ and due to be discussed at EMT in coming weeks. Still large risk around multiple pieces of old equipment and general lack of on-going capital replacement. Fluoro room is due for completion the week before Christmas.□ 02-11-2020 - some delays to building works in fluoro room due to more reinforcement needed in the floor (set back 1 week). The lead screen manufacturer has had to temporarily shut their factory due to COVID outbreak. Soonest they can open is 9th November. This may impact timeline but is outside of our control. I will keep in contact with manufacturer for updates.□ MES BC now has financials back so need to add this into document and send to execs for them to assess prior to resubmission to EMT. □ 22nd Sept - NHS England have loaned QVH a new digital portable which is being commissioned this week. The fluoroscopy project is due to begin with removal of kit on the 28th Sept and turnkey due to start on the 12th Oct.□ 14th August-TMC supportive of us using the C arm for urgent swallows if required and for salivary work. We have a provisional process around this with involvement of SaLT and Radiologists. We have agreed to staff the services. This reduces the risk to in-patient swallow cohort.□ 5th August 2020 - Fluoro room has had terminal failure of the fluoroscopy functionality. I have escalated to Canon but project cannot move forward due to manufacturing time required. I have approached TMC to ask if we can use their C arm to do some salivary work. SALT team have been informed. They are differing non urgent patients to PRH referral route. Am developing a pathway with PRH for urgentin patient cases but am awaiting their Superintendent to come back to me. □ 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 2021. 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.□	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 scalled 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	Nicola Reeves	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	20	16	**February 2021**: Month 9 achieved plan and the Trust is forecasting to hit plan as a minimum. Work is still underway at the center to understand if the Covid Capital will be paid and also the loss of Non NHS Income. December 2020: Month 7 achieved plan, however the plan includes £5.2m of ICS topup to achieve break even plan.□ October: Due to current NHS financing arrangements the position for the organisation has improved - rescored to 20. However due to the underlying financial deficit that the Trust is facing this is still a significant risk to the Trust.□ August 2020□: The current financial regime of block contract has remained in place. At present due to the significant reduction in spend on both pay and non pay the Trust is in a breakeven position in line with national guidance. Work is being undertaken in conjunction with the ICS on the phase 3 funding streams into the Trust. In addition, further work is underway to highlight vacant and non backfilled posts.□ □ 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.□ □	KSO4

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/03/2021**		**Agenda reference:**	**42-21**	
Report title:	Quality & Safety Report				
Sponsor:	Nicky Reeves, Director of Nursing and Quality				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	1. Covid update 2. Infection Control Covid 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	The Board's attention should be drawn to the following key areas detailed in the reports: • Progress with Clinical Harm Reviews waiting over 52 weeks and cancer patients waiting over 104 days as per the national guidance *Delivering Cancer Waiting Times* • Continued response to Covid-19 pandemic, including vaccination of staff • Infection Control Covid BAF – updated to v1.6 post Q&G to encompass national guidance changes				
Recommendation:	The Committee is asked to be assured 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: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: *Financial sustainability*	KSO5: ***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:	The Quality and Safety Report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	22/02/2021	Decision:	Noted	
Next steps:	Nil				

Executive Summary - Quality and Safety Report, March 2021

Domain	Highlights
Director of Nursing and Quality	Safety of our patients and staff continues to be the primary focus for the trust whilst also maintaining a positive patient experience. The safe delivery of services continues with the restoration and recovery clinical governance weekly meeting being fully utilised to agree and accelerate clinical governance requirements. QVH continues with LAMP (optigene) testing of staff to identify asymptomatic Covid positive people and has also utilised Lateral Flow testing for those unable to access LAMP. Work continues to recruit staff to the newly established Head and neck unit. In addition to the ward establishments, QVH continues to provide resources to swab elective patients prior to admission as per guidelines. The Trust has completed the winter flu vaccination campaign, and to date 622 of the 822 (75.7%) frontline workforce has been vaccinated. Covid-19 vaccine programme was successfully rolled out during January. Paediatric on site medical support has been reduced during January and moving forwards due to covid-19 operational pressures at RACH. 24 telephone advice is still available and transfer arrangements are still in place. The situation is being reviewed on a monthly basis. To date, there have been no incidents identified due to the reduction

Medical Director	**Clinical Directors** Martin Jones, Consultant Plastic Surgeon is stepping down as Clinical Director for Plastics after three years in the role where he has been very successful and shown strong leadership for the directorate. An advert for his replacement is currently out and one candidate has applied. Jeremy Collyer (past Deputy Medical Director & Consultant Maxillofacial Surgeon) leaves QVH 6th April 2021. His post will be replaced by an Associate Medical Director role, specifically for governance, and this will be advertised shortly. Ian Francis, current Associate Medical Director, will become Deputy Medical Director and maintain his focus on the clinical strategy. Furthermore, the post of CD for Anaesthetics & CSS is about to be re-advertised. **Clinical Harm Reviews** Prospective clinical harm reviews continue to be undertaken for maxillofacial, plastics, Corneo-plastics, orthodontics, sleep, cardiology, rheumatology and paediatrics. This is a continual process, which was implemented 18/9/2020. As of 28/01/2021there are 1682 52-week breaches of which 777 reviews have been completed to date. There has been no harm reported in this cohort of 777 breaches. **Medical Appraisal & Revalidation** On 3 September 2020 Steve Powis, NHS Medical Director, agreed that further appraisal suspensions may be necessary in the face of local outbreaks or a more generalised further wave of the pandemic as we are now experiencing. He recommended decisions about any further suspensions or pauses be made locally. He also recommended that ROs adopt a flexible approach and that understanding be shown to individual doctors by postponing or approving the missing of appraisals as necessary. If current pressures meant a suspension of appraisal activity for doctors, the advice from NHSE is that this decision was made locally. The need for flexibility on a case by case basis was reiterated so to be mindful that individual doctors may greatly value the opportunity at this very difficult time for a supportive appraisal conversation with a peer. At QVH we are continuing with appraisals but will be flexible about this in line with the advice above.

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 2021. Due to the Covid-19 pandemic the 52 week breaches have increased and the trust 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'. The majority of cases were Maxfac (Dental) and Plastics and any that cannot be confirmed at the time of review as 'no harm' were followed up until point of treatment to ascertain if any harm has been caused: there have been nil harms identified so far. The total number of reviews completed under that process were 766. The clinical harm review process was reviewed in 2020 and 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. From mid-Sept to end of January there have been 1682 52 week breach patients identified, the majority being plastics and Corneo, of which 844 have had CHR's with a small proportion being expedited for clinical review; no levels of harm have been identified or confirmed to date.
Responsive: Coronavirus pandemic	Minimise infection risk to staff and patients: Quality risk added to CRR	Work continues to maintain the safe delivery of elective and non elective care within the trust. There is a robust in house governance process for this and there is additional external monitoring on the access and performance of recovery plans. Weekend provision of Optigene testing has commenced. In addition Lateral Flow testing kits have been rolled out to a number of staff to assist with diagnosis of asymptomatic Covid positive staff. Covid -19 vaccination programme rolled out at QVH. 1895 people vaccinated over the course of 2 weeks in January 2021. QVH supporting vaccine roll out in the Crawley hub.

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	Q4 2019/20			Q1 2020/21			Q2 2020/21			Q3 2020/21			Q4 2020/21	12 month total/ rolling average
		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	
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
Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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%	91%	90%	99%	90%	98%	81%	83%	90%	83%	99%	93%	99%	91%
MRSA screening - trauma	95%	98%	95%	95%	89%	61%	84%	94%	99%	98%	99%	100%	99%	95%	92%
Incidents															
Never Events	0	0	1	0	0	0	1	0	0	0	0	0	0	0	2
Serious Incidents	0	2	0	0	0	0	1	0	0	0	0	0	0	0	1
Theatre metrics															
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	3	4	1	3	2	3	4	3	3	2	3	3	4	35
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		98%	99%	99%	99%	99%	99%	98%	99%	99%	99%	99%	99%	99%	99%
Non-clinical cancellations on the day		19	5	8	5	1	1	0	6	4	5	7	8	0	50
Needlestick injuries	0	1	1	0	1	0	0	0	0	3	0	0	3	4	12
Pressure ulcers (all grades)(Theatre metric)		1	7	2	0	1	1	1	0	0	0	0	0	0	12
Paediatric transfers out (<18 years)		1	0	1	1	1	1	0	1	0	2	0	0	0	7
Medication errors															
Total number of incidents involving drug / prescribing errors		33	12	7	7	11	10	5	1	7	16	7	6	6	95
No & Low harm incidents involving drug / prescribing errors		30	11	6	6	9	9	4	1	6	12	7	5	6	82
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		1.8	0.6	0.8	1.5	2.1	0.9	0.8	0.0	0.6	2.2	0.0	0.6	0.0	0.8
Pressure Ulcers Hospital acquired - category 2 or above		1	1	0	0	1	0	2	0	0	0	1	2	0	7
VTE initial assessment (Safety Thermometer)	95%	100%	100%	96%	nc	nc	91%	100%	100%	100%	94%	100%	100%	100%	98%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	95%	95%	100%	91%	nc	nc	100%	100%	100%	100%	100%	97%	97%	100%	99%
Patient Falls resulting in no or low harm (inpatients)		1	2	3	2	0	2	4	3	3	2	5	4	4	34
Patient Falls resulting in moderate or severe harm or death (inpatients)		1	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient falls per 1000 bed days		0.8	4.6	3.6	2.8	1.9	1.8	3.6	4.7	0.0	5.3	8.4	4.0	3.7	3.7

*MRSA April 20 - the revised score following a meeting between QVH & MCIndoe and screening process reviewed.

nc = not collected or not reported

Nursing Workforce - Performance Indicators, Safe staffing data

Peanut ward - In December there were 3 overnight cases on 3 occasions and there was only one night when the ward was “closed”. In January there were 6 patients overnight on 5 occasions, there were 3 nights when the ward was “closed.”

December safe staffing data demonstrates compliance across all the bands with staffing levels above 95% of the required template. Care hours were 126 hours less than template across the month. Staffing levels are reviewed on a regular basis and as a minimum three times a day. Use of the Safe Care Live module is also supporting the team to make real time staffing decisions.

Combined Staffing exc. Site — *Target 95%*

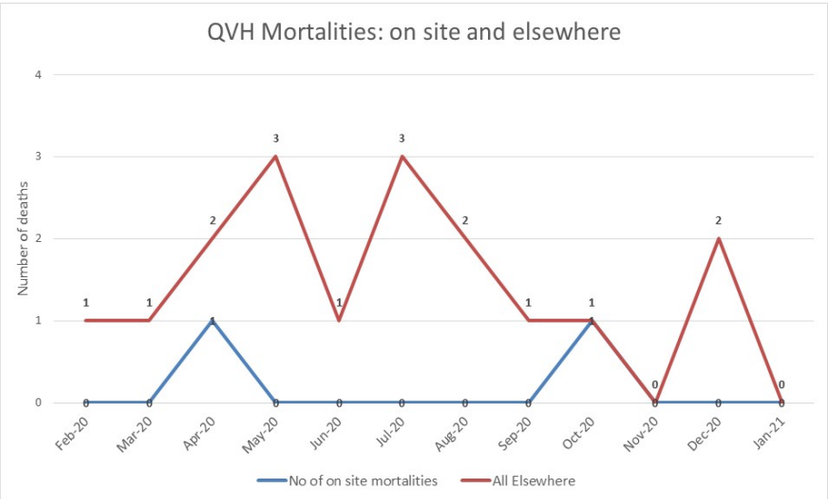
	Planned staff			Actual staff			Dec-20	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA		RN	NA	HCA	RN	NA	HCA
DAY	5359	241.5	2473	5313	241.5	2415	*Total Hrs Planned and Actual*	NIGHT 4428	276	897	4416	276	885.5
				99.1%	100.0%	98%	*% Planned Hrs Met*				99.7%	100.0%	98.7%
			8073			7970	*Total Hrs Planned & Actual - Combined reg & support*			5601			5578
						98.7%	*% Planned Hrs Met - Combined reg & support*						99.6%

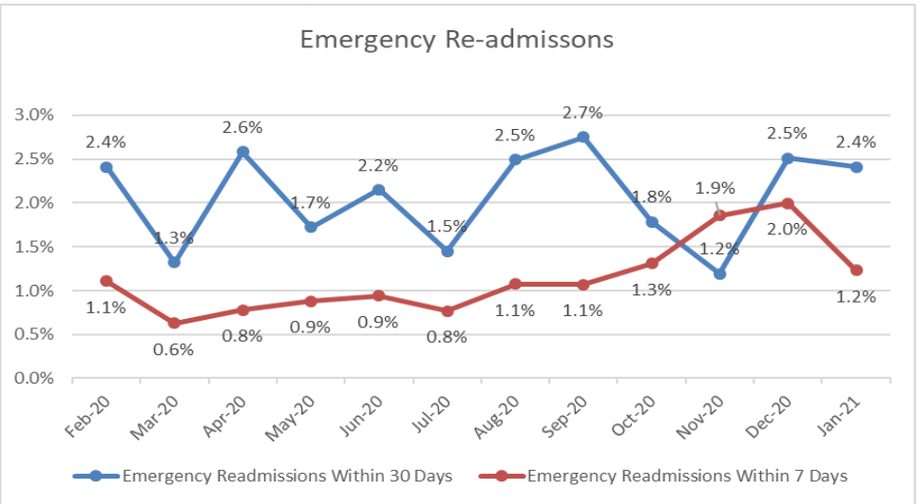
January safe staffing data demonstrates compliance across all the bands with staffing levels above 95% of the required template. Care hours were 92.5 hours less than templated across the month. Staffing levels are reviewed on a regular basis and as a minimum three times a day. Use of the Safe Care Live module is also supporting the team to make real time staffing decisions. The head and neck unit has remained incorporated within Margaret Duncombe ward whilst QVH ensured there were sufficient critical care beds available to expand the service if required during the Covid surge.

Combined Staffing exc. Site — *Target 95%*

	Planned staff			Actual staff			Jan-21	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA		RN	NA	HCA	RN	NA	HCA
DAY	5474	207	2277	5405	207	2265.5	*Total Hrs Planned and Actual*	NIGHT 4163	195.5	713	4152	195.5	713
				98.7%	100.0%	99%	*% Planned Hrs Met*				99.7%	100.0%	100.0%
			7958			7877.5	*Total Hrs Planned & Actual - Combined reg & support*			5072			5060
						99.0%	*% Planned Hrs Met - Combined reg & support*						99.8%

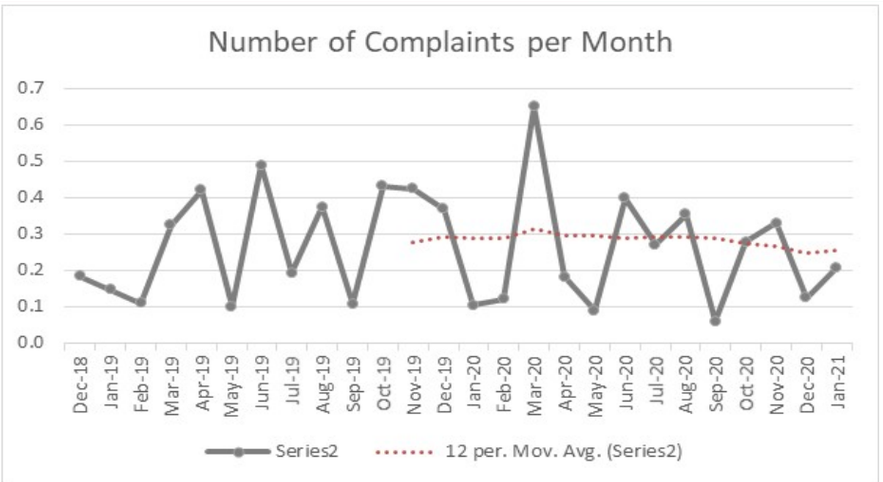
Effective - Performance Indicators

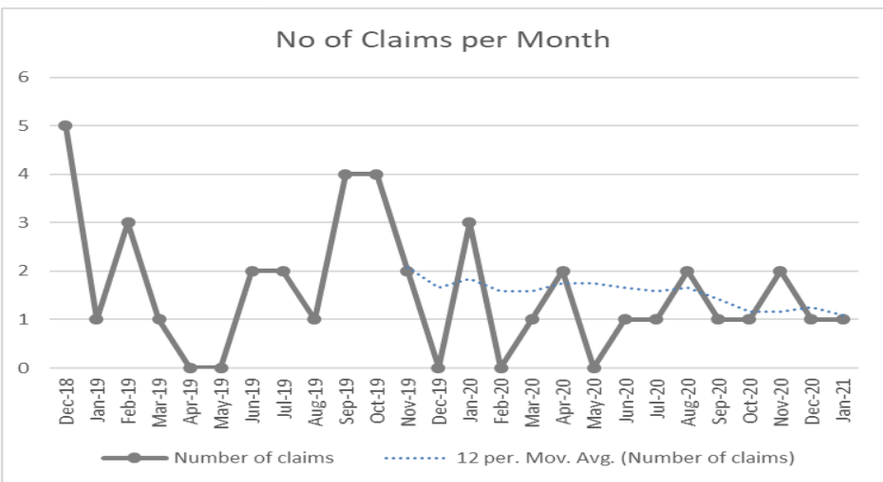




			Q4 2019/20		Q1 2020/21			Q2 2020/21			Q3 2020/21			Q4 2020/21
			Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Mortalities within 30 days of an inpatient episode or outpatient procedure	Inpatient	No of on site mortalities	0	0	1	0	0	0	0	0	1	0	0	0
		No of mortalities elsewhere	0	1	2	3	0	2	2	1	1	0	1	0
	Outpatient		1	0	0	0	1	1	0	0	0	0	1	0
	All Elsewhere		1	1	2	3	1	3	2	1	1	0	2	0
Reviews		Completed Preliminary Reviews	1	1	3	3	1	3	2	1	2	0	2	0
		No of deaths subject to SJR	0	0	1	0	0	0	0	0	1	0	0	0
No of mortalities in patients with learning difficulties (inpatients only)			0	0	0	0	0	0	0	0	0	0	0	0

Caring - Current Compliance - Complaints and Claims





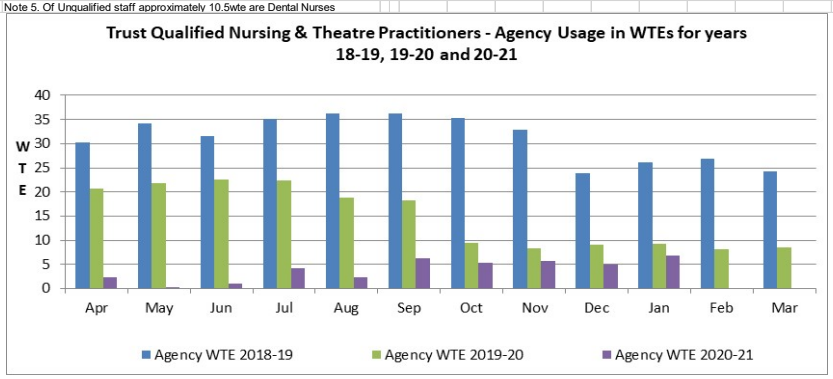
	Q3 2019/20		Q4 2019/20			Q1 2020/21			Q2 2020/21			Q3 2020/21	
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Number of complaints	2	2	10	2	1	5	4	5	1	5	6	2	3
Complaints per 1000 spells	0.10	0.12	0.65	0.18	0.09	0.40	0.27	0.35	0.06	0.28	0.33	0.12	0.21
Number of claims	3	0	1	2	0	1	1	2	1	1	2	1	1
Claims per 1000 spells	0.16	0.00	0.07	0.18	0.00	0.08	0.07	0.14	0.06	0.06	0.11	0.06	0.07
Number of cases referred to PHSO	0	0	0	0	0	0	0	0	0	0	3	0	0

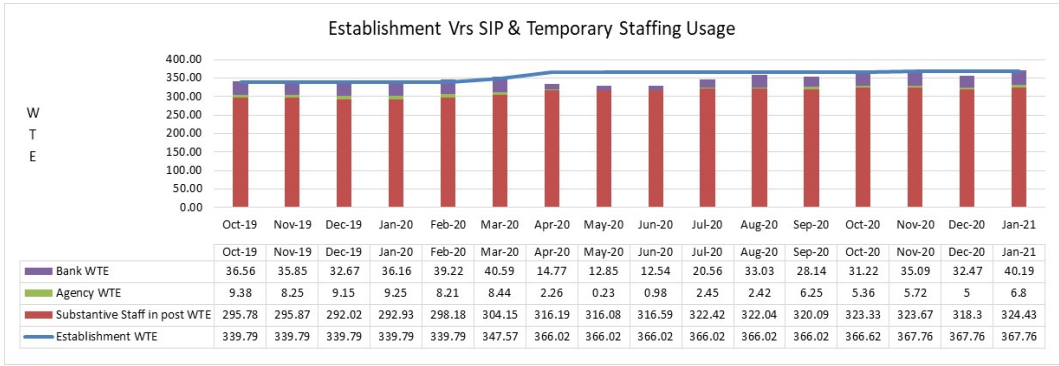
Nursing Workforce - Performance Indicators

ALL QUALIFIED & UQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020-21			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	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)				339.79	339.79	347.57	366.02	366.02	366.02	366.02	366.02	366.02	366.62	367.76	367.76	**367.76**	▲
Staff In Post WTE				292.93	298.18	304.15	316.19	316.08	322.52	322.42	322.04	320.09	323.33	323.79	318.30	**324.43**	▲
Vacancies WTE				46.86	41.61	43.42	49.83	49.94	43.50	43.60	43.98	45.93	43.29	43.97	49.46	**43.33**	▼
Vacancies %	>18%	12%<>18%	<12%	13.79%	12.25%	12.49%	13.61%	13.64%	11.88%	11.91%	12.02%	12.55%	11.81%	11.96%	13.45%	**11.78%**	▼
STARTERS WTE (Excluding rotational doctors)				1.00	5.43	4.41	0.51	2.23	5.01	0.61	2.00	2.00	3.63	3.00	0.00	**11.56**	▲
LEAVERS WTE (Excluding rotational doctors)				6.00	0.00	1.02	3.91	3.00	0.00	2.32	2.75	1.00	1.00	4.61	4.36	**4.18**	▼
Starters & Leavers balance				-5.00	5.43	3.39	-3.40	-0.77	5.01	-1.71	-0.75	1.00	2.63	-1.61	-4.36	**7.38**	
Agency WTE (Data From Healthroster)				9.25	8.21	8.44	2.26	0.23	0.98	2.45	2.42	6.25	5.36	5.72	5.00	**6.80**	▲
Bank WTE (Data From Healthroster)				36.16	39.22	40.59	14.77	12.85	12.54	20.56	33.03	28.14	31.22	35.09	32.47	**40.19**	▲
Trust rolling Annual Turnover %	>=12%	10%<>12%	<10%	10.50%	9.94%	9.71%	9.95%	10.27%	8.67%	8.48%	8.23%	7.79%	7.44%	8.35%	9.21%	**8.90%**	▼
Monthly Turnover				1.44%	1.42%	0.00%	1.31%	1.01%	0.00%	0.77%	0.91%	0.33%	0.33%	1.51%	1.10%	**1.14%**	▲
Sickness Absence %	>=4%	4%<>3%	<3%	3.63%	2.67%	6.30%	3.64%	2.21%	1.67%	3.30%	2.54%	2.94%	3.82%	3.87%	**4.50%**	***TBC***	

Note 1. 2020/21 budget updated September 20 backdated to April 20 to show most current position. March 20 Establishment updated as queries resolved. Both 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 Maxilliofacial Nurses and 23.5wte are ODP Theatre Practioners
Note 5. Of Unqualified staff approximately 10.5wte are Dental Nurses





	Oct-19	Nov-19	Dec-19	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
Bank WTE	36.56	35.85	32.67	36.16	39.22	40.59	14.77	12.85	12.54	20.56	33.03	28.14	31.22	35.09	32.47	40.19
Agency WTE	9.38	8.25	9.15	9.25	8.21	8.44	2.26	0.23	0.98	2.45	2.42	6.25	5.36	5.72	5	6.8
Substantive Staff in post WTE	295.78	295.87	292.02	292.93	298.18	304.15	316.19	316.08	316.59	322.42	322.04	320.09	323.33	323.67	318.3	324.43
Establishment WTE	339.79	339.79	339.79	339.79	339.79	347.57	366.02	366.02	366.02	366.02	366.02	366.02	366.62	367.76	367.76	367.76

Medical Workforce - Performance Indicators

Metrics	Target	Quarter 4 2019/20		Quarter 1 2020/21			Quarter 2			Quarter 3			Quarter 4	12 month rolling
		Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	
Medical Workforce														
Turnover rate in month, excluding trainees	<1%	0.00%	2.93%	0.00%	0.28%	1.12%	0.00%	3.28%	1.01%	1.06%	0.87%	1.08%	1.08%	12.75%
Turnover in month including trainees 9%		9.57%	2.82%	0.70%	0.17%	1.42%	0.71%	15.26%	4.07%	5.98%	0.55%	2.07%	0.69%	42.73%
Management cases monthly	**0**	0	0	0	0	0	0	0	0	0	0	TBC	TBC	0
Sickness rate monthly on total medical/dental headcount		1.55%	1.99%	1.63%	1.52%	0.65%	0.31%	0.55%	1.56%	2.42%	2.03%	1.71%	N/A	1.35%
Appraisal rate monthly (including deanery trainees)		88.44%	91.36%	81.40%	74.85%	62.05%	57.74%	74.51%	77.27%	75.25%	85.88%	76.14%	76.83%	N/A
Mandatory training monthly	**95%**	88.50%	86%	87%	87%	86%	86%	86%	81%	80%	82%	85%	85%	N/A
Exception Reporting – Education and Training		5	0	0	0	0	1	0	1	0	1	0	0	8
Exception Reporting – Hours		1	0	0	0	0	5	0	4	0	1	0	2	13

Medical & Dental Staffing

The first doctors' induction of 2021 took place on 3rd February and we welcomed new anaesthetics and core surgical trainees. The London rotation was delayed for a month which means that not all anaesthetics trainees will be starting in February as planned, and therefore we will also be running an additional induction on 3 March for that group. The Med Ed team are working closely with HR Advice and Resourcing to make sure that everything comes together as planned, and we are also starting to plan for April doctors' induction.

There are a number of surgeons coming to QVH from around the region to perform their urgent breast surgery operations, and they all require access to the QVH IT systems, so Helen Moore has been working closely with Kathy Brasier to ensure that they can access everything that they need while at QVH.

Education	All specialties are continuing to deliver teaching, making use of the available technology and larger rooms to allow for social distancing. At this time restrictions are still in place on external parties coming on site so plans for external courses and medical student electives are on hold, with hopes to restart them some time later in 2021. A library of mandatory training videos is currently being developed which should help to improve mandatory training rates and we are also planning an online consultants mandatory training day for the end of February. The Education Centre was used to deliver the first phase of the vaccination programme, and will be used again in March for the second phase.

COVID-19 UPDATE FEBRUARY 2021

The impact of the second wave of the Covid-19 pandemic has caused significant challenges to the way we are delivering services in our organisation, across Kent, Surrey and Sussex and nationally.

We continue to utilise the redesigned surgical pathways to ensure QVH is able to deliver the speciality care required. Throughout we have provided “green” elective care to our planned patients utilising pre-operative covid-19 testing and PHE isolation recommendations. The non elective cohort of patients, unable to isolate pre admission have been managed with an “amber” pathway and Optigene rapid testing.

The NHS response remains Level 4 with national command and control during the second wave. There is a clear expectation however that elective care should be continued whilst managing the increasing numbers of Covid cases. As before utilising the above pathways has supported QVH in continuing to deliver the plan. The oversight of decisions regarding pathway changes is continued through the restoration and recovery clinical governance weekly meeting. This group focuses on ensuring the clinical governance requirements, quality and sustained positive patient experience are maintained.

As previously, QVH screens front line staff weekly utilising Optigene and we have also utilised the national roll out of lateral flow testing for staff home testing.

QVH is also participating in the national SIREN research project investigating Covid-19 prevalence in the workforce and now also looking at the impact of the vaccination roll out. To date approximately 174 staff have been enrolled in the study.

QVH has seen the impact of Coivid-19 more significantly in the recent months with two confirmed small outbreaks in non clinical areas. Both have been well managed and contained within individual departments. Deep dives in to both these have been carried out.

The anxiety and impacts of working through the pandemic in terms of staff wellbeing are being monitored and managed with input from psychological therapy as needed. The organisation is committed to ensuring the mental and physical health of the workforce is supported as far as possible.

Covid-19 Vaccination Roll out

During 2 weeks in January QVH rolled out the Covid-19 vaccine programme to our staff and other local health and social care workers. We vaccinated 1895 people in total, of which 961 were QVH staff, 934 were staff from other organisations. In addition 139 QVH staff accessed a vaccination elsewhere.

We were able to access both Pfizer and Astra Zeneca vaccine and are making arrangements to administer the second doses in late March as per national guidance.

Although we have paused our programme until second doses, we are now providing staffing support to the Crawley hub.

The feedback for this process has been really positive and staff have been overwhelmingly enthusiastic.

Infection Prevention and Control Board Assurance Framework COVID-19 (IPC BAF).
An updated version of the IPC BAF document is included below.

Appendix 1

Infection Prevention and Control board assurance framework February 2021 V1.6

Initial version completed May/June 2020 monthly updates for EMT for Q&GC and Board V1.6

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 • there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative • that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are	• All elective admissions are assessed as to whether they are urgent i.e. 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. • 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		**Oct /Nov update** New stocks of FFP3 sourced and in stock. Additional FIT training continues, sufficient supplies of hoods in theatres Temperature screening checkpoint removed from the main car park due to the thermometers becoming ineffective in the colder weather and the risk to staff from standing outside in the colder, wetter months. All departments to check patients and visitors for symptoms and temperature and ask Covid risk questions. Change in National guidance

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
cleaned as per guidance. • monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice ○ staff adherence to hand hygiene? ○ staff social distancing across the workplace ○ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a) clinical b) non-clinical setting • monitoring of staff compliance with wearing appropriate PPE, within the clinical setting consider implementing the role of PPE guardians/safety champions to embed and encourage best practice • implementation of twice weekly	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 3 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		implemented in relation to Covid screening. All patients whether day case or inpatient are now screened for Covid with PCR swabs either 72 hours pre-admission for elective cases or on admission for trauma patients. In patients are then screened 3 days post admission and every 3 days thereafter for the duration of their admission. MRSA screening policy changed to bring it in line with current national recommendations. Hand Hygiene audit tool modified to provide more focused auditing **January 2021 update** Pre-admission isolation guidance changed from 72 hours pre-admission to 10 days. This was done in response to rising cases in the local area as well as nationally and to the increase in restrictions being put in place by the government. Additional FFP3 masks sourced and FIT testing re-commenced

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace • additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team. • training in IPC standard infection control and transmission-based precautions are provided to all staff • IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training • all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the			Screening process for on the day trauma patients changed so they are screened through the drive through screening POD and results received before entering the Hospital. Elective screening also expanded to include all elective paediatric admissions. **February 2021 update** All patient admission pathways are planned to reduce transfer between areas. With the introduction of Sars Cov 2 (optigene) swabbing through the screening POD day case trauma admissions are no longer admitted to the ward but go straight to MTR. Transfers between departments are done only when necessary and follow IPC guidance e.g. amber areas cannot transfer to green areas. Cohorting patients is only done when imperative, and following discussion with infection control. Covid screening for all patients pre-admission reduces the risk of Covid

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
PPE that protects them for the appropriate setting and context as per national guidance • there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace • national IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to national 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			cases patients being admitted. Where patients are admitted out of hours and no screen is available an SOP is in place to guide on isolation requirements. Monthly hand hygiene audit continues with results fed back to the relevant teams and actions identified for improvement. All staff are aware of the requirements to wear a FRSM in both clinical and non-clinical spaces. Compliance with masks added to monthly hand hygiene audit tool. Supplies are delivered to all areas and monitored daily. PPE adherence is monitored by department leads and the infection control team, individuals are challenged where non-adherence is identified. Lateral flow testing has been implemented to all staff that would like to participate, this has not been rolled out to all staff as prevalence is monitored through optigene screening on site. With the

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
			expectation for all clinical staff to be screened weekly and non-clinical staff every two weeks. Where lateral flow is done staff flow the process for reporting results and required actions if a positive is identified. Where an increase in cases is identified in staff groups screening requirements through optigene are increased to twice a week. Posters and guidance are displayed in key areas of the Trust emphasising the importance of compliance with national requirements. The IC BAF is updated regularly and taken through the board for assurance. Senior teams maintain a visible presence in all departments to provide assurance and guidance for all staff. If non-compliance is witnessed challenges are made.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens • that Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner. • This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board • ensure Trust Board has oversight of ongoing outbreaks and action plans • there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• 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 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 No changes to processes and practice for Non COVID-19 IPC. Regularly audits and screening and reporting has continued throughout.	Potential that all staff may not read briefing Impact of delay on patient outcome	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • designated teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas • Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance • Assurance processes are in place for monitoring and sign off terminal cleans as part of	• There are no designated COVID-19 wards due to cancer hub/corona 'lite' hospital status , however anaesthetic staff, CCU staff and ODP's have been running SIM training to care for the unwell COVID-19 patient with a designated area set up that could be used to safely isolate and care for a patient with COVID-19 • Decontamination will be done in the COVID-19 ward area by the nursing staff designated cleaners allocated to minimise risk of spread • Decontamination and terminal cleans are done in line with the national standards of cleanliness and PHE guidance. Utilising the Hydrogen peroxide mist system alongside robust cleaning with detergent and chlorine based	Separate off duty not operational 24/7 due to hospital status	**October/November update** No changes made, decontamination and cleaning remains the same as laid out in the national standards of cleanliness with increased cleaning on high touch areas such as door handles and taps **January 2021 update** No changes made **February 2021 update** Auditing completed by the Domestic supervisors to monitor environmental cleanliness in both clinical and non-clinical areas. Where improvement is identified actions sent to the department leads with auditing increased. Cleaning charts in place in all departments to monitor cleaning of the environment and equipment. Audits completed in line with national guidance of patient equipment to ensure compliance.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
outbreak management • increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per	cleaning products. • Cleaning has been increased in key areas of the Trust by the in-house domestic team, such as main corridors, focusing on high touch areas such as public bathrooms, taps and door handles. • All waste and linen is disposed of in line with PHE guidance and with full discussion with our waste and linen providers. • Where possible single use equipment is used, is not possible all equipment is cleaned following the terminal clean process. • Reusable sterile equipment is decontaminated and sterilised by Steris		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
national guidance • 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily • rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to single use policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance • ensure cleaning standards and frequencies are monitored in non- clinical areas with actions in place to resolve issues in maintaining a clean environment • ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air • monitor adherence environmental decontamination with actions in			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
place to mitigate any identified risk • monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk			

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.	There has been no onsite Consultant Microbiology cover since February 2020	Telephone advice is provided by the Consultant Microbiologists from BSUH as required. Drug charts reviewed daily by pharmacy team and infection control available for advice as required Mandatory reporting and monitoring continues by the infection control team in line with national guidance **February 2021 update** No changes

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	**October/November update** No changes made to visitor guidance with the Trust adhering to the national guidance around reduced visiting except in exceptional circumstances. Where this has been required the designated visitor has undergone isolation and swabbing before being permitted increased visitation. **January 2021 update** Restrictions increased due to significant rise of Covid in the local community. No visiting is permitted except for carers, parents of children and end of life care. All visitors are to be screened using Sars Cov-2 optigene screening **February 2021 update** No changes

• 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 • there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	• 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: • screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 cases to minimise the risk of cross-infection as per national guidance • staff are aware of agreed template for triage questions to ask	• 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 patients 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	**January 2021 update** No changes **February 2021 update** Robust SOP in place to detail patient admission routes, with all elective admissions being screened for Covid pre-admission using a variety of methods including PCR screening through the drive through onsite swabbing POD, home testing through the national home testing system and where neither of these methods are available optigene screening on admission with a clear theatre pathway identified. For patients admitted through the trauma route when swabbing is not available isolation requirements and theatre guidance available. All patients and visitors are asked to wear a face covering whilst on site and medically safe to do so. Masks are available in all departments for anyone who requires one. All patients are screened for Covid

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible • face coverings are used by all outpatients and visitors • face masks are available for all patients and they are always advised to wear them • provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care • monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	• All in patient's elective or trauma are swabbed. All patients returning to care home are screened 48 hours in advance		19 in line with current national requirements and this is documented in the patients notes.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. • to ensure 2 metre social & physical distancing in all patient care areas • for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly • there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document • patients that attend for routine			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
appointments who display symptoms of COVID-19 are managed appropriately			

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: • separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe • all staff providing patient care and working within the clinical environment are trained in the	• 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 • Re-use of PPE is in place following PHE guidance with clear	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 **January 2021 update** No changes **February 2021 update** All staff are trained on which masks should be worn for which procedure, guidance on PPE requirements is detailed in theatre and ward pathways, donning and doffing training delivered in all clinical areas and available for any staff who require it. Adherence with mask wearing has been added to the monthly hand hygiene audit for monitoring and assurance Regular communications are sent out to all staff to remind them of the importance of compliance with national guidance relating to social distancing and mask wearing whilst at work and out. Guidance is displayed in key areas relating to mask wearing and social

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
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 • adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk • hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ○ hand hygiene facilities including instructional posters ○ good respiratory hygiene measures ○ staff maintain physical	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 • 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		distancing.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care ○ staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace ○ frequent decontamination of equipment and environment in both clinical and non-clinical areas ○ clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • staff regularly undertake hand hygiene and observe standard infection control precautions	• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance • guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas • 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 (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
the symptoms a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals) • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported. • robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings			

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: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas • 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	• 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		Due to the relocation of the paediatric ward there is no longer a designated Covid area within the Trust. However guidance has been written for each department showing where potential or confirmed Covid cases should be managed. An 'amber' isolation facility has been created with the CCU to enable CCU staff to care for unscreened and un-isolated patients that require CCU level care **February 2021 update** No changes

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			

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 • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data) • screening for other potential infections takes place • that all emergency patients are tested for COVID-19 on	• 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.		**October/November update** Trust participating in the national postal swabbing service for elective patients who cannot get to site due to ill health, disability or distance for the Covid swab 72 hours pre-admission. Screening and swabbing guidance updated to reflect changes. **January 2021 update** No changes **February 2021 update** Clear SOP's and ward and theatre pathways in place detailing screening requirements for all patients. All elective patients screened 72 hours pre-admission and isolated and then every 3 days throughout the admission period. All trauma patients are optigene screened on admission for assurance and PCR screened for compliance with national guidance, all patients then screened every 3 days for duration of admission. Clear guidance in place on isolation

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
admission. • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. • • that sites with high nosocomial rates should consider testing COVID negative patients daily • That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge • that those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they			and re-screening guidance if a patient develops symptoms. Any patient being discharged to a care home, prison, alternative healthcare facility or communal living facility is to be screened 48 hours pre-discharge and result sent to admitting area. If Covid cases were identified in an inpatient setting then screening of patients within the department would increase to monitor the situation.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
should complete their remaining isolation. • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.			

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.		**October/November update** IPC remains on-call out of normal working hours to provide support for staff **January 2021 update** No changes **February 2021 update** No changes

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 using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported • that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally • staff who carry out fit test training	• 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		**October/November update** Staff screening implemented for staff displaying symptoms due to problems accessing the national screening hubs. Swabs sent by the IPACT to the laboratory at BSUH staff member isolated until results know. Number of swabs sent per week reported. Trust FIT test registered set up and made available on the shared file. FIT test drop in sessions and departmental specific sessions held. **January 2021 update** No changes **February 2021 update** No changes

are trained and competent to do so • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation • for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods • for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of	national guidance and this is confirmed with IPC Team or EPRR lead if any queries re this		

employment record including Occupational health • following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance • all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask			

and in non-clinical areas • health and care settings are COVID- 19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone • staff are aware of the need to wear facemask when moving through COVID-19 secure areas • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff who test positive have adequate information and support to aid their recovery and return to work			

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04 March 2021		**Agenda reference:**	**43-21**	
Report title:	Guardian of Safe Working				
Sponsor:	Mr Keith Altman				
Author:	Dr Joy Curran, Guardian of Safe Working and Kathleen Ally, Workforce projects officer				
Appendices:	Nil				
Executive summary					
Purpose of report:	Summary of data relating to junior doctor hours and education reported to the GOSW.				
Summary of key issues	Data is triangulated from exception reporting by junior doctors, HR information on gaps and locum rates and feedback from Junior Doctor Forums (Held 2 monthly)				
Recommendation:	I would like the Board to note the safe rota and working hours within the Trust. Also the use of bank staff use rather than agency and the remaining need for bank hours within plastics directorate. The main issues rest around poor exception reporting, especially in maxillofacial and junior doctors' rest facilities, which is being addressed. There has been an increase in Guardian fines.				
Action required *[highlight **one** only]*	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs): *[Highlight 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:	Implications for Operational excellence as the activities within the plastics department seems to exceed the number of staff (including Consultants, Trust Grade etc).				
Corporate risk register:	None				
Regulation:	Fatigue and Facilities funding for junior doctors given nationally with guidelines for spend.				
Legal:	None				
Resources:	Potentially within the plastics division for daytime activity.				
Assurance route					
Previously considered by:	Q 3 at LNC				
	Date:		Decision:		
Next steps:					

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING; Q 3 July, August, September 2020

Written by the GOSW with data from the HR dept.

Executive summary

This report covers the data from exception reporting via the Allocate system and cross-referenced with data from HR on locum hours and unfilled posts.

Exception reporting covers the day to day reporting by a junior doctor when their hours or education alters from their agreed work schedule. These reports go to their educational supervisor (ES), the GOSW and DME.

During this quarter, we have slowly returned to more normal operating, rota and education. The core trainees, anaesthetists and some of the higher surgical trainees rotated in August.

Introduction

High-level data for [Lead Employer Trust]

Number of doctors / dentists in training (total):	65
Number of doctors / dentists in training on 2016 TCS (total):	43
Trust grade doctors	22
Amount of time available in job plan for guardian to do the role:	0.75 / 3 hours per week
Admin support provided to the guardian (if any):	ad hoc
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

a) Exception reports (with regard to working hours)

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Anaesthetics	0	0	0	0
Maxillofacial	0	0	0	0
Orthodontic	0	0	0	0
Plastics	3	11	9	5
Radiology	0	0	0	0
Total	3	11	9	5

Exception Reports for Hours breached

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics		
Maxillofacial		
Orthodontic		
Plastics	9	5
Radiology		
Total		

Exception reports for missed Education and Training

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics	0	0
Maxillofacial	0	0
Orthodontic	0	0
Plastics	2	0
Radiology	0	0
Total	0	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1				
F2				
CT1-2 / ST1-2	0	2	2	0
ST3 +	3	7	5	5
Total	3	9	7	5

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Anaesthetics	0	0	0	0
Maxillofacial junior	0	0	0	0
Maxillofacial senior	0	0	0	0
Orthodontics	0	0	0	0
Plastics Junior	0	2	2	0
Plastics Senior	3	7	5	5
Radiology	0	0	0	0
Total	3	9	7	5

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0			
F2	0			
CT1-2 / ST1-2	0		2	
ST3-8	0		5	5
Total	0		7	5

b) Work schedule reviews

We have had no formal work schedule reviews triggered by exception reports. However due to Covid 19 we have had to alter rota. Please see below for further details.

c) Locum bookings and Bank bookings

Locum bookings (bank) by department					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Anaesthetics	5	5	0	54.00	54.00
Maxillofacial	26	26	0	331.25	331.25
Orthodontics	0	0	0	0	0
Plastics	71	71	0	777.65	777.65
Radiology	0	0	0	0	0
Total	102	102	0	1162.90	1162.90

Locum bookings (bank) by grade					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
CT1-2*	24	24	0	286.50	286.50
ST3 +*	42	42	0	506.97	506.97
ST5 +*	36	36	0	369.43	369.43
Total *	102	102	0	1162.90	1162.90

*Trust grades included – Health Roster is not configured to identify separately.

Locum bookings (bank) by reason*					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	51	51	0	583.92	583.92
Sickness*	5	5	0	49.00	49.00
Other**	46	46	0	529.98	529.98
Total	102	102	0	1162.90	1162.90

**Includes Covid*

***Additional Clinic/lists, Additional Dependency – Covid, Annual Leave, Bank Induction Attendance, On-Call, Other, Training*

i) Agency

Nil booked

d) Vacancies

This section should list all vacancies among the medical training grades (including trust doctors) during the previous quarter. This is reported for each month separately; split by specialty / rota and grade.

Vacancies by month						
Specialty	Grade*	Month 4	Month 5	Month 6	Total gaps (average)	Number of shifts uncovered
Anaesthetics	ST5+	0	0	0	0	0
Maxillofacial Core	DCT	0	0	0	0	0
Maxillofacial higher	ST4+	0	0	0	0	0
Plastic surgery core	CT2	0	0	0	0	0
Plastic surgery higher	ST4+	0	0	0	0	0
Orthodontics	ST3+	1	1	1	1	0
Radiology	ST3+	0	0	0	0	0
Total		1	1	1	1	0

e) **Fines**

This section should list all fines levied during the previous quarter, and the departments against which they have been levied. Additionally, the report should indicate the total amount of money levied in fines to date, the total amount disbursed and the balance in the guardian of safe working hours' account. A list of items against which the fines have been disbursed should be attached as an appendix[1].

For example:

Fines by department		
Department	Number of fines levied	Value of fines levied*
Plastics	7	6508.13 Doctors 2479.45 GOSW 4028.64

*HealthRoster is not currently configured to identify exception reporting fines, this has been identified as an area of improvement going forward.

[1] This information will be used to inform the organisation's annual report, which mist include clear detail on how the money has been spent (Schedule 5, para. 15).

General information

In Q3 we have been reverting back to the normal shift patterns. The virtual nest rota stopped in September, the Anaesthetists are back to normal from the August rotation and the senior plastic rota is a newly designed 1 in 19 24 hour nonresident rota with approx. 1 in 10 day weekend cover from their rotation in October. It was negotiated in discussion with the trainees, service managers, clinical tutor and BMA.

A review of pay and hours because of the COVID rota was conducted with our local BMA rep and reviewed at LNC. This was agreed with the trainees and no extra payments ended up being due because of rota changes. However there were extra shifts to cover due to extra sickness, shielding and inability to be fit tested with mask availability. The Trust now has a number of hoods, to be used by staff who have not been able to be fit tested.

Exception reporting has begun to pick up back to normal and to encourage this we are having an exception reporting drive over the last two weeks of September.

Since April we have had monthly GOSW JDF catch ups on Webex that have been good to keep in touch and answer queries as they came up. We are now reverting to three monthly regular meetings. Should further changes occur, of course I will review this.

A new exception reporting policy has been written and finalized; it is due for sign off at this week's LNC.

I have also had monthly KSS on line GOSW meetings since April.

Issues arising

Annual leave. Some trainees found it very difficult to take all their allocated leave due to changes in their shift patterns. For example, the Anaesthetists increased the number of trainees on a weekend day shift and long day shift from one to two. In addition, some plastics trainees found it difficult in the nest to take blocks of leave. After discussion at the local negotiating committee (LNC) it has been agreed that exceptionally this will be given as pay when the trainee rotated in August and a week can be carried over by those who are not rotating.

Increase in Guardian fines. This is the first Q when fines have become due. In the 2019 reset of the 2016 JD contract, the rules on overnight breaches of the rest requirement made this a new Guardian fine. The value is mandated nationally and split between the doctor involved and the Junior Doctor Forum.

We have not yet received any of this money but will be providing the board with detail on spend in due course. There are guidelines regarding its use, which is for training, education and facilities (it should not be used for items that are expected to be provided by the Trust or Deanery).

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

QUARTER 4 OCT – DEC 2020

Executive summary

This is the report from the Guardian of Safe Working (GOSW), Dr Joy Curran. The GOSW is a post created nationally for each NHS Trust with the new Junior Doctor Contract in 2016.

The role oversees the exception reporting data from the trainee doctors relating to breaches in both hours worked above those in the work schedule and education provision that is part of their education agreement. Nationally it relates to those doctors on an appointed training programme. In this Trust we have extended this to all doctors covering the same on call rota although their educational programme differs.

The data presented is in a standard recommended format and broken down by specialty and grade of doctor. The source is Allocate software for the exception reports and HR workforce data who also put hard work into this document.

There is qualitative data from myself as Guardian and chair of the Junior Doctor Forum after the tables.

High-level data for The QVH as at 31 December 2020

Number of doctors / dentists in training (total):	57
Number of doctors / dentists in training on 2016 TCS (total):	39
Amount of time available in job plan for guardian to do the role:	7.5 PAs / y hours per week
Admin support provided to the guardian (if any):	Ad hoc
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

a) Exception reports (with regard to working hours)

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Anaesthetics	0	0	0	0
Maxillofacial	0	1	1	0
Orthodontic	0			
Plastics	5	13	8	5
Radiology	0			
Total	5	14	9	5

Exception Reports for Hours breached

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics		
Maxillofacial	1	0
Orthodontic		
Plastics	11	5
Radiology		
Total	11	5

Exception reports for missed Education and Training

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics		
Maxillofacial		
Orthodontic		
Plastics	2	2
Radiology		
Total	2	2

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1				
F2				
CT1-2 / ST1-2	0	5	4	1
Total				

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Anaesthetics				
Maxillofacial junior		1	1	0
Maxillofacial senior				
Orthodontics				
Plastics Junior	0	4	3	1
Plastics Senior	5	9	5	4
Radiology	0	0	0	0
Total	5	14	8	5

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0			
F2	0			
CT1-2 / ST1-2	1		3	1
ST3-8	0	2	3	4
Total	0			

Although we do still have Trust doctors employed on old T and C of service and a very few Deanery trainees still on the old contract with pay protection; they are given an allocate log in and encouraged to exception report. We have therefore not conducted any monitoring exercises this year.

Hours monitoring exercises (for doctors on 2002 TCS only)					
Specialty	Grade	Rostered hours	Monitored hours	Banding	WTR compliant (Y/N)

b) Work schedule reviews

There have been no work schedule reviews this quarter.

c) Locum bookings

i) Bank

Locum bookings (bank) by department					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Anaesthetics	31.00	31.00	14.00	376.75	376.75
Maxillofacial	29.00	29.00	0.00	442.50	442.50
Orthodontics	0.00	0.00	0.00	0.00	0.00
Plastics	60.00	60.00	0.00	620.48	620.48
Total	120.00	120.00	0.00	1439.73	1439.73

Locum bookings (bank) by grade					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
CT1-2*	4.00	4.00	0.0	44.00	44.00
ST3 +*	28.00	28.00	0.0	332.48	332.48
ST5+*	88.00	88.00	0.00	1063.25	1063.25
Total	120.00	120.00	0.00	1439.73	1439.73

*Trust grades included – Health Roster not configured to identify separately

Locum bookings (bank) by reason*					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	51.00	51.00	0.00	534.00	534.00
Sickness*	9.00	9.00	0.00	91.00	91.00
Other**	60.00	60.00	0.00	814.73	814.73
Total	120.00	120.00	0.00	1439.73	1439.73

**Includes Covid*
***Additional Clinic/lists, Additional Dependency – Covid, Annual Leave, Bank Induction Attendance, Maternity, On-Call, Other, Training and Waiting list Initiatives*

ii) Agency

This section should start by presenting a cost summation (in cash terms) of agency usage across the quarter. Depending on volume, it might be sensible to break this down by department and/or grade. It may also be sensible to highlight areas where the agency-capped rates have been breached.

This section should then list, in aggregated fashion, all the locum work requested and worked via an agency during the last quarter. This data should be presented by department, by grade and by reason. Where a trust has a large amount of bank usage, it may be more appropriate to list the top ten users only, and to include the full data set in an appendix.

In general, most bookings are filled either by current trainees, or ex trainees who have remained on our bank. This is the most effective (and cheapest) way of covering our specialized service. This relies on the department administrators a great deal.

Locum bookings (agency) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Anaesthetics		14		156.75
Maxillofacial				
Orthodontic				
Plastics				
Radiology				
Total		14		156.75

**It might also be useful to include a narrative explaining how the work left uncovered by unfilled requests was delivered. For example: Were clinics cancelled? Were teams left to cope with fewer staff? Did consultants pick up the slack? Did non-resident on-call staff have to come in and so breach rest requirements?*

Locum bookings (agency) by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-2				
ST3-8		14	156.75	156.75
Total		14	156.75	156.75

Locum bookings (agency) by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy		14		156.75
Sickness				
Total		14		156.75

***It might also be useful to include information about the length of advance notice of the booking request; in particular, highlighting "last minute" bookings for any reason other than short term sickness.*

This data does not specify whether gaps were filled by Consultants acting down to the registrar role. It has occurred in Anaesthetics over the few weeks of the year for a few shifts, due to Covid related absence and agency locum unavailability. I think it may also have happened in Maxillofacial too. HR are looking at how to log this data for the next quarters.

d) Locum work carried out by trainees

I do not think that our HR team has found individual data easy to source. Each department administrator is aware of the hours restriction as are the Doctors and we rely on them to work together to safely cover gaps.

This section should identify, in an anonymised fashion (perhaps referencing specialty and grade), doctors who have been carrying out work as a locum for the trust via the staff bank (as per the TCS), outside of the contract of employment (via an agency) or for another NHS 5rganization (via another staff bank, again, as per the TCS). This should be aggregated in a similar fashion to the locum usage above, aggregating the number of shifts worked, the total hours worked, and the overall total hours worked once contracted hours have been considered.

Once again, if there are a large number of trainees undertaking such work, it may be appropriate only to list here the trainee(s) whose patterns of work might give cause for concern (i.e. those working the most hours)

e) Vacancies

This section should list all vacancies among the medical training grades (including trust doctors) during the previous quarter. These should be reported for each month separately, split by specialty / rota and grade.

Vacancies by month						
Specialty	Grade	October	November	December	Total gaps (average)	Number of shifts uncovered
Anaesthetics	St5+	0	0	1	0.33	
Maxillofacial Core	DCT	0	0	0	0	0
Maxillofacial higher	St4+	1	0	0	0.33	

Plastic surgery core	CT1/2	0	0	0	0	0
Plastic surgery higher	St3+	0	0	0	0	0
Orthodontics	St3+	0	0	0	0	0
Radiology	St1+	0	0	0	0	0
Total		1	0	0	0.66	0

f) **Fines**

This section should list all fines levied during the previous quarter, and the departments against which they have been levied. Additionally, the report should indicate the total amount of money levied in fines to date, the total amount disbursed and the balance in the guardian of safe working hours' account. A list of items against which the fines have been disbursed should be attached as an appendix[1].

Fines by department		
Department	Number of fines levied	Value of fines levied
0	0	0

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
4028.64		0	4028.64

Qualitative information

This quarter covers the gradual resumption of more normal work in the Trust as COVID prevalence was low. Trainees rotated as normal in October and the HEE gave directives to attempt to focus on training and catching up on training missed.

The senior plastics rota was reviewed and agreed in August; this started in October. It was very similar to the previous rota and remained a non-resident on call rota (NROC) The extra virtual doctor was removed and trauma cover returned to pre covid levels.

The maxillofacial senior rota was down one in October and the Anaesthetic rota one in December. This accounts for their extra hours. The plastics rota had no gaps but they remain with some unmet clinical sessional needs, discussed at the Local Academic Board looking how this can be solved. I am not sure of the outcome of this, but the high number of locum hours requested has continued this quarter.

Issues arising

[1] This information will be used to inform the organisation's annual report, which mist include clear detail on how the money has been spent (Schedule 5, para. 15).

I remain concerned for two issues in particular which could impact on safeworking hours;

1. **The senior maxillofacial NROC rota is at best only 8 strong and consists of doctors from other Trusts that we have partnerships working with us at weekends. It remains a vulnerable rota as there is little room for extra hours for these doctors. An increase in their out of hours work impacts on daytime clinical work. However, this group of doctors have never exception reported breaches. This is a concern; reasons are multifactorial and cultural. It needs further discussion with the LFG.**
2. **The high level of plastics locum hours required for a rota that has no gaps. As mentioned above this has been flagged up at meetings and solutions sought. There has not been a high level of exception reporting to explain this. At the JDF plastics senior trainees express that they are frequently moved at short notice. During the first wave of COVID there was a national drop off in exception reporting as trainees recognized that the profession needed to pull together and training regrettably but unavoidably came second.**

Actions taken to resolve issues

To encourage exception reporting we held an exception reporting fortnight in September and there was a slight increase for this time. It has disappointingly not persisted.

To ensure that trainees were paid promptly and without further bureaucracy I have undertaken to complete an Exception reporting tracker at the end of each month which is then shared with HR and payroll. This started in August and is now working well.

We had issues receiving the fine money from fines issued in the previous quarter due to accounting technicalities, these are addressed.

Hence, the Fine balance at the end of this quarter is the same. The fund is spent on direction of the trainees and discussed at the JDF. We have plans to buy two sets of surgical microscopy instruments for the micro lab (£3000) and possibly some consumables for the SIM center.

<u>Junior Doctor Rest and Relaxation Areas</u>

This item has not come up so far and does not affect working hours but is having a big impact on morale in what is a tired and stressed workforce already. Part of the surgeons mess has been used to store PPE since last March. Happily at the last LNC meeting it has been agreed that if humanly possible the remaining PPE will be moved and the space able to be refurbished for all doctors to use.

The maxillofacial trainee office / relax room was taken over by another COVID need last March. They have only just been given a temporary room in the Blond McIndoe Centre (for which they are very grateful) and we have spent some monies from the F and F fund on this room.

All staff have used the Medical Education Centre but the bay that was planned to be a small doctors room for the on call teams has not been possible to go ahead as the space would be too small for social distancing. The new sofas in this area are all also from the F and F fund.

Coffee has been supplied to the whole hospital from the kitchen in Medical Education, however we feel now that the cost to keep on with this would be excessive and have placed the coffee pods in a locker to decrease general use.

An outdoor table football has been purchased for the courtyard and there are plans to add planting and more outdoor furniture in the spring.

Summary

Evidence from exception reports suggests that the Trust junior doctor rota are safe and running well.

Triangulating evidence from the locum data above and verbal feedback from the trainees suggests that there are still areas of concern within the maxillofacial senior NROC rota and the plastics daytime shortage of people for clinical activity.

Rest facilities are still being impacted negatively by COVID requirements that is something that should be looked at urgently as all staff are in need of them now.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/03/2021**		**Agenda reference:**	**44-21**	
Report title:	**Review of Healthcare worker Seasonal flu vaccination programme 2020/21**				
Sponsor:	Nicky Reeves, Interim Director of Nursing				
Author:	Nicky Reeves, Interim Director of Nursing				
Appendices:	None				
Executive summary					
Purpose of report:	To **update** the Board on the 2020/21 flu campaign				
Summary of key issues	The report updates the Board on the successful Seasonal Flu vaccination programme. The paper highlights the increased uptake of vaccine in both the "frontline" workforce and the Trust as a whole.				
Recommendation:	The Board is asked to **note** the contents of 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:	Reviewed when writing paper.				
Corporate risk register:	Reviewed no additions made				
Regulation:	Requirement to comply with the expanded Heath and Social Care and Public Heath England National Flu Immunisation Programme 2020-21				
Legal:	NA				
Resources:	Nil now campaign is complete				
Assurance route					
Previously considered by:	Roll out plan reviewed at Board November 2020				
	Date:	05/11/20	Decision:	Noted	
Next steps:	Learning will be incorporated in to the 2021/22 campaign				

Queen Victoria Hospital
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	04 March 2021
Reference number:	44-21
Report from:	Nicky Reeves. Interim Director of Nursing
Author:	Nicky Reeves, Interim Director of Nursing
Appendices:	None
Report date:	19 February 2021

Healthcare Worker Seasonal Flu Vaccination programme: 2020/21

1. Purpose

To **inform** the Board of the evaluation of the QVH 2020/21 flu campaign.

2. Introduction

Prior to starting the 2020/21 seasonal flu campaign there was a detailed review of the effectiveness of last year's plan which also analysed staff comments and feedback. Changes aimed at improving access to the vaccination in the workplace and incentivising the vaccination were successful in increasing the uptake of the vaccine in previous years. In addition the Covid-19 pandemic does appear to have had a positive impact in vaccine uptake both in numbers vaccinated and also in the timeliness of vaccination.

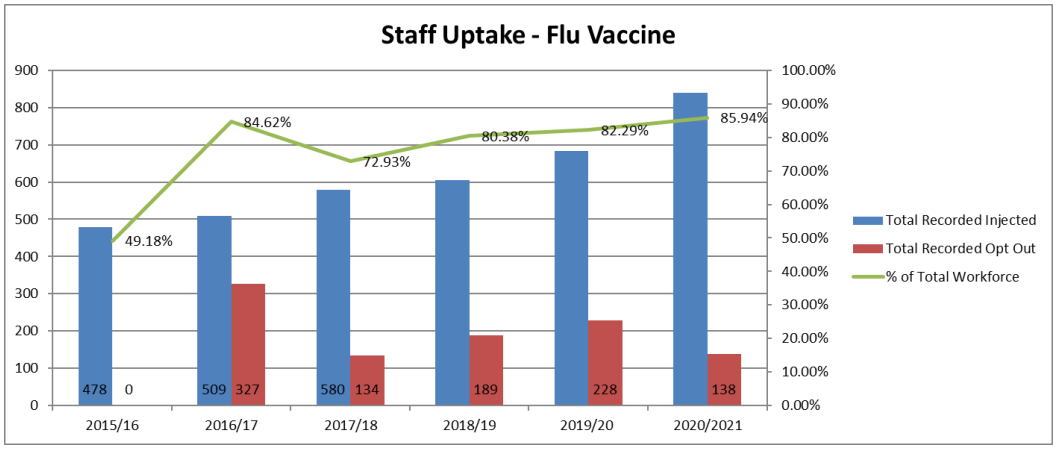
This year, the trust received 900 vaccines and the aspiration was to vaccinate at least 800 members of staff. At the end of January, when the programme closed, 840 staff had been vaccinated against seasonal flu, of which 631 were defined as "frontline staff".

With the ongoing Covid 19 pandemic, early vaccination of the workforce was encouraged to ensure there is sufficient time after the seasonal flu vaccine before any Covid 19 vaccine was administered.

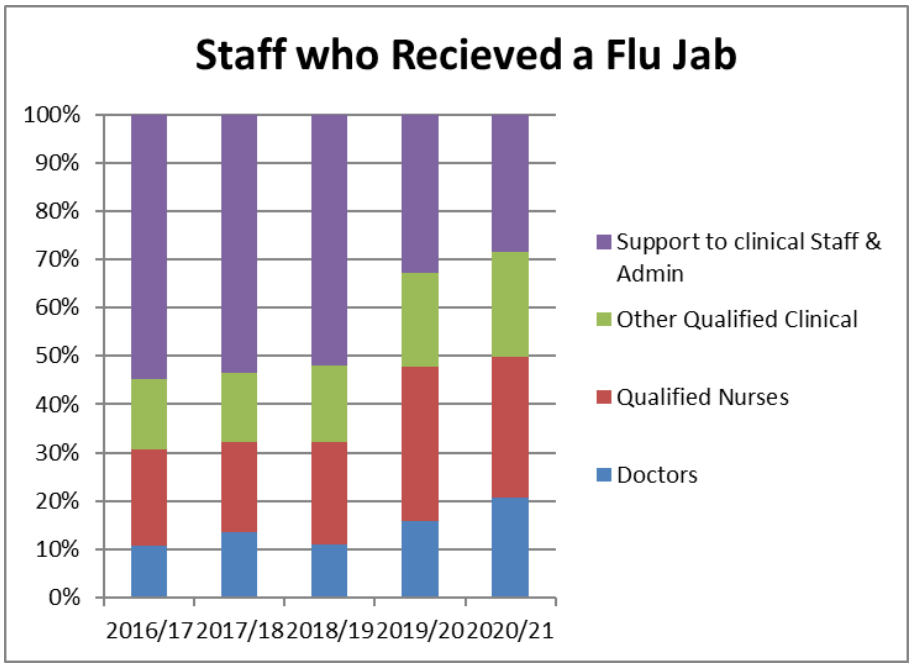
As in previous years, analysis of the "opt out" reasons were reviewed in "real time" to ensure we were able to target relevant information and communications appropriately to support staff to make an informed decision.

3. Data

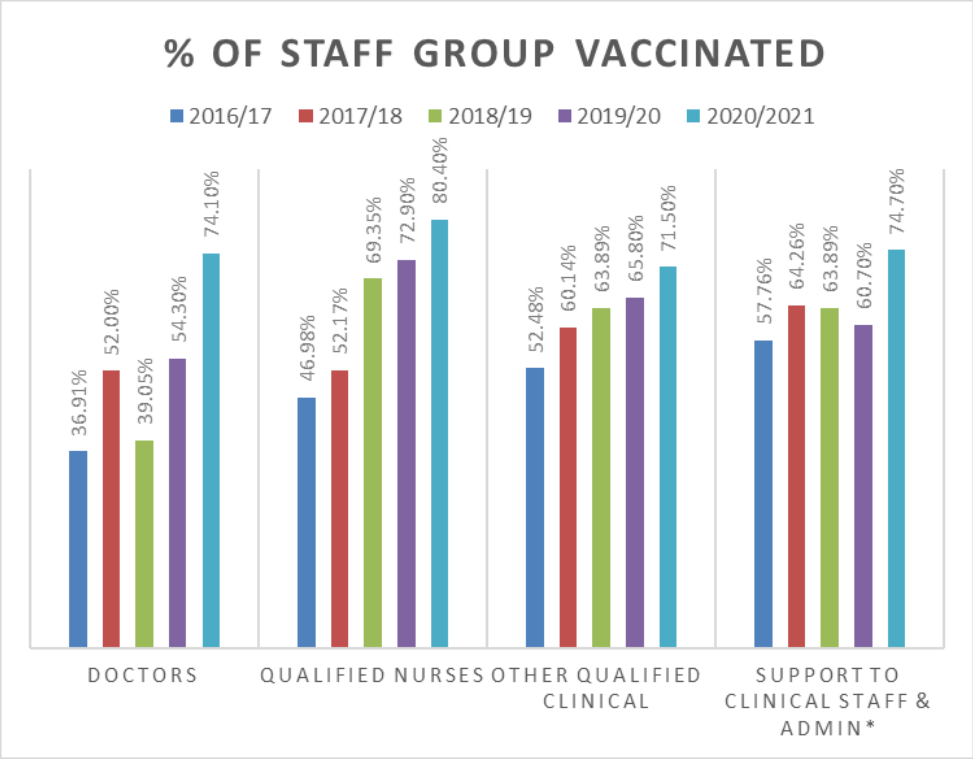
The graph below demonstrates the uptake rates for the past 6 years.



The graph below identifies the distribution of staff groups receiving the vaccine.



The following graph represents the percentages by staff group



4. Recommendation

The Board is asked to **note** the contents of this report and the improvement in uptake in "frontline staff"

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed : 18 February 2021

Strategic Objective
We provide healthcare 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, mode
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

- Increase of RTT waiting list and patients waiting >52 weeks due to COVID-19 pandemic and cancer hub role
- Increased cancer demand due to cancer hub role
- Reduced capacity due to reconfiguration of services to support green and amber elective pathways and infection prevention control requirements
- Reduced capacity due to Rowntree theatre closure
- Covid-19 non urgent activity step down
- Step down of spoke activity due to COVID-19 system pressures
- Anaesthetic workforce gaps due to maternity leave at Consultant and SpR level
- Theatre and pre assessment staffing gaps
- Risk of gaps in staff due to COVID-19 isolation requirements
- Isolation requirement impact - patient take up, timescales to book and ability to utilise capacity following cancellations
- Vacancy levels in sleep [CRR 1116]
- Specialist nature / complexity of some activity
- Vacancies in non consultant level medical staff 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 & vola
- Reputation as a consequence of reco
- Workforce morale and potential rete impact due to merger considerations
- System service review recommendat and potential risks to services

Future Opportunities

- Closer ICS working
- Closer working between providers in opportunities with Kent & Surrey
- Partnership with BSUH/WSHFT

Controls / Assurance

- Mobilising of virtual outpatient opportunities to support activity during COVID-19
- Planned relaunch of outpatient improvement programme
- Additional reporting to monitor COVID-19 impact
- Recovery planning 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
- Additional funding for scheduling support identified
- Planned relaunch of theatre productivity work programme
- Adapt and adopt and system recovery initiatives

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
- 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 COVID-19 on patient willingness
- Uncertainty regarding Independent Sector contract post April 2021
- Challenges in available administrative bank staff to support scheduling teams
- Theatre capacity due to Rowntree theatre closure

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance | **Committee: Finance & Performance** | **Date last reviewed 24th February 2021**

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 5 (L)= 20, High
Target Risk Rating 4 (C) x 3 (L) = 12, moderate

Rationale for current score (at Month 10)

- Favourable variance of £533k against the revised plan YTD, with a forecast of plan at year end. This is due to improved income positon and lower levels of spend
- The plan is based on a £4.6m system top up for months 7-12 to cover the Trusts significant underlying deficit. Two returns in September at the ICS level with a Trust specific return in late October. Returns based on returning activity levels to 19/20 levels for some areas with a slight reduction in other such as elective. Significant risk to the Trust to deliver these activity levels, penalties and incentives will be achieved on an ICS basis.
- 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 and non attendance by patients
- Commissioner challenge and scrutiny post Block arrangement
- Potential changes to commissioning agendas
- Significant activity drop due to Covid and activity issues due to second wave
- Unknown costs of redesigned pathways

Future Risks

NHS Sector financial landscape Regulatory Intervention

- National guidance is developing to understand how the financial regime will impact Trusts over the coming months and further into next FY. Guidance not anticipated in calendar year, business planning will need to continue based on assumptions of current cost base.
- 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
- Unknown Brexit risks for increased costs for such items as drugs and procurement
- Significant work to develop the LTP in line with potential merger
- Lack of relevant resource to deliver BAU, develop required efficiencies and Business Case
- Development of compatible IT systems (clinical and non clinical) & back office functions will be part of the longer term plan to ensure in medium term efficiencies may be achieved.

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
- Decision in principal to move ahead with due diligence with BSUH & WSHT
- Development of increased partnership working through the merger to include greater economies of scale and efficiencies for work load and also potential cash savings in the longer term

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 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) 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 and revised trajectories in line with the phase 3 guidance.
- 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
- 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:	**4 March 2021**		**Agenda reference:**	**46-21**	
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 22 February.				
Summary of key issues	Operational performance has been severely impacted by the response to the Covid pandemic; the surge impact, cancer hub, breast sessions, patient cancellations and changes in national approach. This is, amongst other things, building up our 52ww list going into the new year. Workforce indicators remain, generally, stable and there was positive reporting on the first wave of vaccinations. Covid-related absences, whilst not significant, are a factor to manage. Financial results are forecasting a potential surplus, but this is entirely due to the national funding calculation. Most of our Covid capital funding has been received, but the delay means that committing the balance of capital funds will not be achieved in this financial year.				
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 – strong indicators of successful management, but aware of critical dependencies KS04 – Financial Sustainability – short-term break-even is the result of national funding, longer-term is not resolved KS03 – Operational Excellence – risk remains high as growth in waiting lists and times, given changes in environment				
Corporate risk register:	Reflected in BAF scores. Committee will look in detail at allocated corporate risks from March meeting				
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: 4 March 2021
Reference no: 46-21
Report from: Paul Dillon-Robinson, Committee Chair
Report date: 23 February 2021

Financial, operational and workforce performance assurance

Introduction

The finance and performance committee met on 22nd February, and welcomed Kathy Brasier (Head of Operational Service Improvement), as observer, and noted apologies from Andrew Lane (governor representative) who had emailed his comments on the papers to the Chair.

The committee recognises the significant (short-term) changes that the Trust is handling, along with a lack of clarity on the medium-term planning, but is focused on supporting the efficient delivery of restoration and recovery.

1. Operational performance

The winter surge response to the Covid pandemic has had an impact on the Trust's restoration and recovery plans, within its ongoing role as a cancer hub, through the provision of theatre capacity for breast cancer work for other providers, reduction in spoke site activity and changes in the terms of use of the independent sector. This reduces the capacity available for reducing the Trust's waiting lists and times as quickly as desired or originally planned.

The above is seen, inter alia, in the deteriorating position of the 52ww (and 78ww), directly linked to the above.

The committee discussed theatre capacity and utilisation, noting the analysis of reasons for cancellations (including patient cancellations) and actions to drive improvement in utilisation. It also considered the drive to encourage virtual outpatient appointments, where appropriate.

Going forward, there is uncertainty in a number of areas, such as date for the return to other trusts of breast cancer work and the future arrangements with the independent sector, which make planning difficult.

2. Workforce performance

The Trust's workforce performance indicators remain positive, and the committee drilled into a few areas to confirm this (e.g. on turnover, sickness, etc.) and sought assurance on remedial action (e.g. on low levels of appraisals and training).

The committee discussed the monitoring of Covid-related absences and took assurance that this is being managed appropriately and not having a significant impact (albeit there will be some). It was encouraged by the vaccination uptake, albeit that analysis was not available below the headline figures. It is anticipating the Staff Survey results and analysis coming to a future meeting.

3. Financial performance

The Trust is forecasting a favourable position at year-end but, as must be emphasised, this is due to the funding regime – at the moment - being based on the levels of prior year expenditure run rates. Whilst this might roll into Q1 and 2 of next financial year, this is still not confirmed, and is not a long-term solution.

The committee took assurance on the cash position and encouraged the work on resolving old debtor and creditor balances.

The Trust has, eventually, received confirmation of receipt of most of its Covid capital and, whilst efforts are being made to expedite capital projects and bring forward equipment purchases, there is likely to be an underspend this year.

The committee were keen that, despite delays in central guidance, the Trust should set a budget and business plan for 2021/22, albeit on the understanding that this would flex, but would ensure that the necessary financial controls were established.

4. Other

The committee received updates on:

- the Corneo Plastics Directorate service review (further work focussing on Follow Up Outpatients, admissions from Non-Elective work, and balance of Inpatient and Day Case elective work)
- Estates and Facilities (noting issues with boilers in theatres and air handling, progress of projects and staffing matters)
- EDM programme (noting the move to business as usual, agreement of scanning option and future upgrade).

In line with the Q&G committee, the F&P committee had a first look at those corporate risks allocated to it. They agreed that some of these were directly covered by the current papers (RTT risk, financial sustainability, etc.), but that future meetings would deep dive on any new risks that emerged and then 2 or 3 of the ongoing risks, to monitor remedial actions.

Three workforce policies were approved.

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Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/03/2021**		**Agenda reference:**	**47-21**	
Report title:	**Operational Performance Report**				
Sponsor:	Abigail Jago, Director of Operations				
Author:	Operations Team				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide an update regarding operational performance and phase 3 delivery				
Summary of key issues	Key items to note in the operational report are: • Updated performance of constitutional standards • Covid-19 surge and cancer hub impact				
Recommendation:	The committee is asked to **note** the contents of 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:	BAF 3				
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:					
Assurance route					
Previously considered by:	Finance & Performance committee				
	Date:	22/02/2021	Decision:	Noted	
Previously considered by:					
	Date:		Decision:		
Next steps:					

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Operational Performance Report

Abigail Jago, Director of Operations

February 2021

Trust Board

Final

Contents

Queen Victoria Hospital NHS Foundation Trust

Headlines

Reported month performance

- Performance **meeting national / local set standards** for MIU 4 hour standard, 2ww cancer, 62 day cancer, faster diagnosis and imaging reporting
- Performance **meeting recovery trajectory** for patients waiting > 52 weeks however a deteriorating position due to covid-19 surge
- Performance **behind plan** for 31 day cancer standard, 104 day cancer waits and histology reporting

Forward look

- QVH continues to provide additional capacity for surgical cancer treatments on behalf of organisations from Kent, Surrey and Sussex impacting capacity for non urgent activity until the end of March
- Outpatients to continue as virtual to reduce footfall due to COVID-19 prevalence
- Changes to Independent Sector (IS) contract are ongoing and impact capacity
- Anticipated fall in performance in February for RTT, cancer 2WW and phase 3 delivery due primarily to surge pressures
- Histopathology cover is temporarily challenged due to retire and return within the department. Mitigation plans in place however February and March may remain challenged

Issues of concern / risks to performance delivery

- Surge response impact on recovery
- Theatre capacity on site
- Changes to independent sector provision

Performance Summary

Queen Victoria Hospital NHS Foundation Trust

KPI	TARGET / METRIC	TARGET SOURCE	FEB20	MAR20	APR20	MAY20	JUN20	JUL20	AUG20	SEP20	OCT20	NOV20	DEC20	JAN21
RTT – % patients <18 week	National	National	81.37%	78.5%	69.5%	59.22%	50.48%	42.16%	48.0%	55.6%	64.2%	69.6%	71.4%	71.1%
RTT52	Phase 3	ICS	16	18	38	100	185	320	461	555	608	563	623	740
Cancer 2WW	93%	National	97.7%	90.8%	83.8%	89.5%	77.1%	84.5%	98.4%	99.7%	98.7%	99.4%	98.9%	
Cancer 62 day	85%	National	82.1%	87.8%	90.9%	95.9%	88.2%	77.5%	91.3%	85.3%	81.2%	86.6%	85.7%	
Cancer 31 day	96%	National	89.5%	94.6%	98.2%	98.5%	93.1%	89%	93.9%	89.7%	92.2%	93.3%	92.8%	
Faster Diagnosis	75%	National	88.1%	84.5%	67.4%	79.9%	77.1%	82.5%	75.3%	67.8%	82.2%	75.1%	77.1%	
Cancer 104	Internal trajectory	Local	4	3	4	12	39	15	9	5	6	9	12	20
Cancer 62D backlog	N/A	Local	35	37	53	75	64	42	42	40	45	37	51	41
DMO1 Diagnostic waits	99% < 6 weeks	National	99.20%	90.07%	72.4%	28.09%	73.3%	84.9%	86.8%	92.0%	94.9%	98.1%	96.3%	98.80%
Histology TAT	90% < 10 days	Local	94%	94%	93%	96%	95%	99%	92%	95.0%	95.0%	98.0%	96.0%	88.0%
Imaging reporting	% < 7 days	N/A	98.8%	98.18%	99.0%	98.6%	99.4%	98.5%	98.6%	98.2%	98.6%	98.5%	98.5%	97.9%
MIU- % pt treated/ discharge in 4 hrs	95%	National	100%	100%	100%	100%	100%	100%	99.8%	98.5%	100%	100%	99.6%	100%

Phase 3 Activity KPI	TARGET / METRIC	TARGET SOURCE	SEP20	OCT20	NOV20	DEC20	JAN21
Day Case	Phase 3	ICS	72%	78%	77%	86%	67%
Elective inpatient	Phase 3	ICS	71%	81%	80%	80%	55%
Outpatient (new)	Phase 3	ICS	79%	74%	79%	75%	57%
Outpatient (follow up)	Phase 3	ICS	99%	92%	100%	103%	81%
First OP Virtual	Phase 3	ICS	42%	43%	35%	27%	43%
Follow up OP Virtual	Phase 3	ICS	39%	36%	34%	33%	46%

RAG	
	Deteriorating position or plans not on track/ cause for concern
	Improving position or plans / local trajectories on track
	Delivery of national / local standard

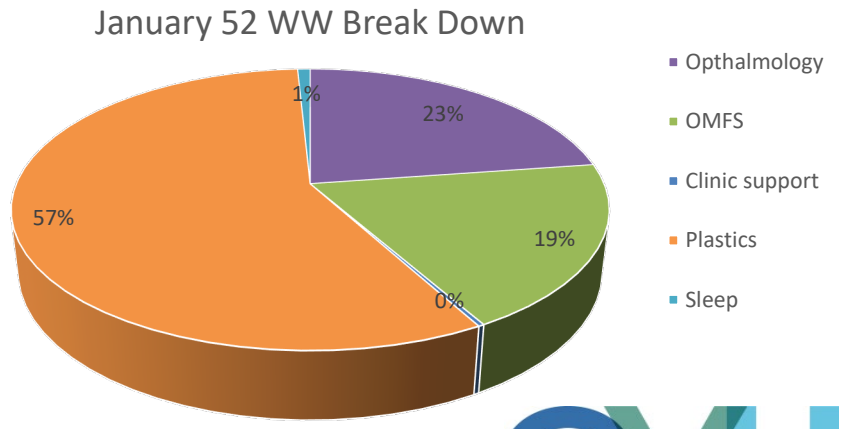
Referral to Treat

52 week wait delivery

Queen Victoria Hospital NHS Foundation Trust

		Q1			Q2			Q3			Q4		
		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
52 weeks	Actual	38	100	185	320	461	555	608	563	623	740		
52 weeks	Plan				320	460	750	886	998	1116	1186	1251	1350
Total Incomplete	Actual 20/21	9,604	8,445	9,854	10,059	10,186	10,282	10,360	9,907	10,069	10,124		
Total Incomplete	Plan				10,059	10,250	10,441	10,497	10,684	11,246	11,507	12,070	12,860
52 weeks as % of WL	Actual				3%	5%	5%	6%	6%	6%	7%		
52 weeks as % of WL	Plan				3%	4%	7%	8%	9%	10%	10%	10%	10%
78 weeks	Actual	1	3	3	4	8	10	16	29	32	43		

PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
• Increased number of patients > 52 weeks in January although remain ahead of plan. • Plastic surgery continues to be the most challenged specialty.	• Increased levels of patients waiting > 52 weeks expected for February due to continued standing down of significant levels of non urgent activity driven by covid-19 surge, ongoing cancer hub role and management of clinically vulnerable patients



78 Week Waits

Queen Victoria Hospital
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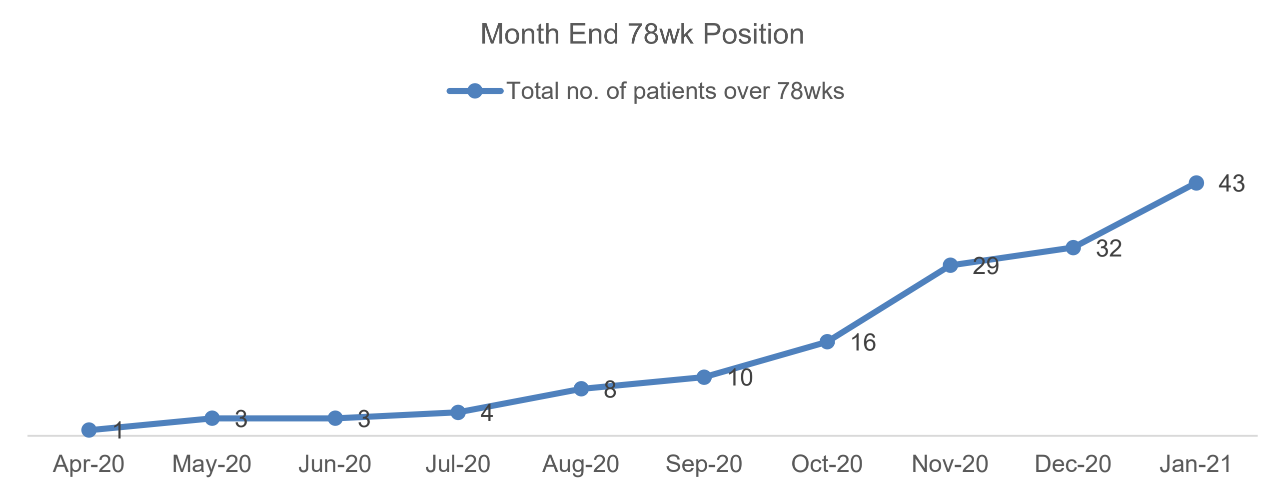
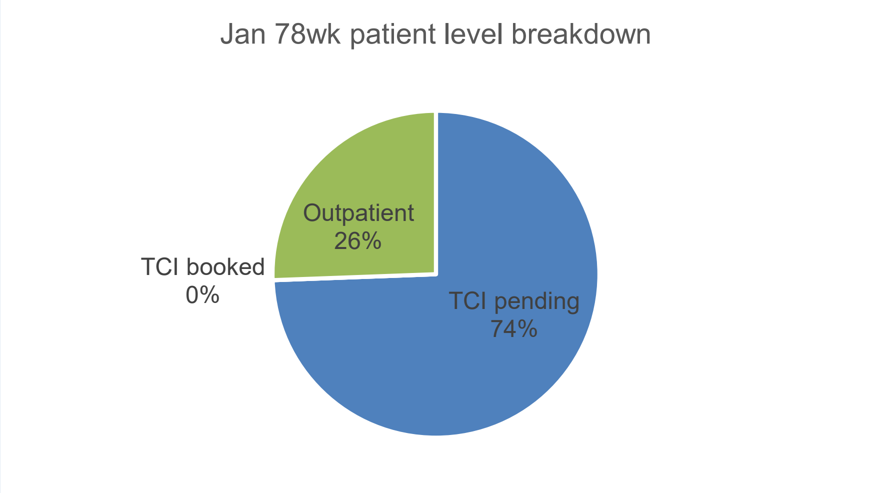
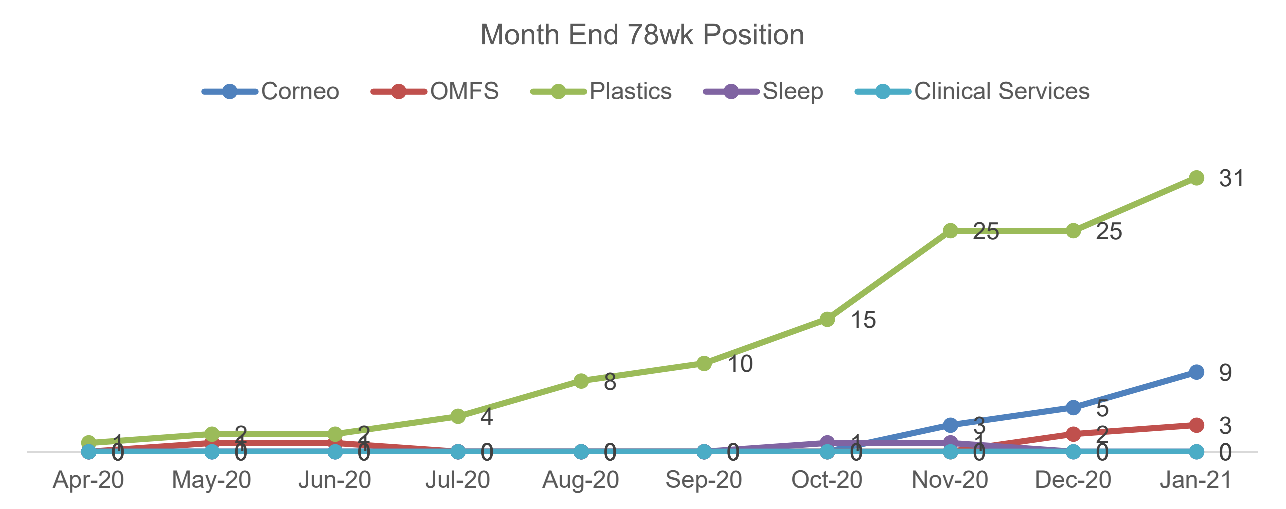






PERFORMANCE COMMENTARY

- Rise in the number of TCI pending's (patients awaiting a date for surgery) due to the reduced routine activity and the trust providing breast cancer hub capacity.
- Of the 43 patients over 78wks 25% are patients that have deferred care.

FORWARD LOOK / PERFORMANCE RISKS

- With the stand down of routine operating activity the number of patients waiting over 78wks is likely to increase in the coming months.
- Patient wanting to delay their treatment until after Covid-19 or after they have received both vaccine jabs is a further risk

Referral to Treat

Waiting list distribution (Trust Level)

Queen Victoria Hospital NHS Foundation Trust

Weeks wait	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Change from last month	Performance change
0-17 (<18)	6682	5565	4974	4241	4858	5718	6652	6895	7185	7194	⇧	9
18-26	1625	1903	2236	2544	1480	455	578	692	901	1089	⇧	188
27-33	702	997	1215	1234	1561	1490	517	216	237	340	⇧	103
34-40	347	480	740	954	886	981	1113	688	184	154	⇩	-30
41-51	210	352	504	766	940	1083	892	853	939	607	⇩	-332
>52	38	100	185	320	461	555	608	563	623	740	⇧	117
>78	1	3	3	4	8	10	16	29	32	43	⇧	11
Total Pathways	9604	9397	9854	10059	10186	10282	10360	9907	10069	10124	⇧	55
Breaches	2622	3832	4880	5818	5328	4564	3708	3012	2884	2930	⇧	46
Performance	69.6%	59.2%	50.4%	42.1%	47.7%	55.6%	64.2%	69.6%	71.36%	71.06%	⇩	-0.003
Clock starts	1163	1353	1957	2133	2131	2404	2499	2504	2248	2322	⇧	74
Clock stops	1205	1033	1254	1429	1643	2104	2540	2680	2226	1991	⇩	-235

PERFORMANCE COMMENTARY

- Consistent open pathway position
- Increased level of patients waiting over 78 weeks
- Reduction in 41-51 week waits in month, due to decreased referrals in during first Covid phase

FORWARD LOOK / PERFORMANCE RISKS

- Anticipate an increase in the number of patients waiting >52 weeks and >78 weeks in the coming months with the stand down of activity

Referral to Treat

Waiting list distribution - Speciality Level

Queen Victoria Hospital NHS Foundation Trust

PLASTICS										
Open Pathways	202004	202005	202006	202007	202008	202009	202010	202011	202012	202101
0-17 weeks	2381	2246	2231	1926	2000	2146	2408	2406	2482	2417
18-26 weeks	492	624	723	829	489	189	245	297	406	458
27-33 weeks	252	324	384	407	534	490	194	114	125	171
34-40 weeks	118	175	233	313	317	359	406	285	100	91
41-51 weeks	85	125	171	272	351	435	380	392	437	297
52+ weeks	30	58	100	137	197	237	300	323	361	423
Total Open Pathways	3358	3552	3842	3884	3888	3856	3933	3817	3911	3857
Total 18 week breaches	977	1306	1611	1958	1888	1710	1525	1411	1429	1440
Clock starts in month	622	746	983	983	850	929	905	821	771	785
Admitted Clock Stops	199	246	381	386	482	535	563	516	465	484
Non admitted Clock Stops	153	135	183	244	241	353	338	340	286	292
Total Stops in month	352	381	564	630	723	888	901	856	751	776

OMFS										
Open Pathways	202004	202005	202006	202007	202008	202009	202010	202011	202012	202101
0-17 weeks	1788	1277	906	828	1133	1399	1783	1949	2028	2106
18-26 weeks	500	549	617	647	347	93	120	153	254	345
27-33 weeks	183	272	351	383	482	425	121	42	39	76
34-40 weeks	102	115	197	266	257	298	331	195	30	23
41-51 weeks	47	92	134	193	248	302	246	222	260	160
52+ weeks	7	19	40	71	112	128	118	91	107	141
Total Open Pathways	2627	2324	2245	2388	2579	2645	2719	2652	2718	2851
Total 18 week breaches	839	1047	1339	1560	1446	1246	936	703	690	745
Clock starts in month	225	245	347	537	605	663	767	805	668	655
Admitted Clock Stops	31	17	27	25	87	115	214	195	124	91
Non admitted Clock Stops	519	127	300	334	310	440	492	631	512	404
Total Stops in month	550	144	327	359	397	555	706	826	636	495

Corneo										
Open Pathways	202004	202005	202006	202007	202008	202009	202010	202011	202012	202101
0-17 weeks	1347	1100	972	621	897	1166	1437	1505	1612	1709
18-26 weeks	540	570	597	641	368	83	108	146	167	208
27-33 weeks	249	364	428	382	407	352	126	41	51	68
34-40 weeks	117	178	295	348	281	267	291	168	43	30
41-51 weeks	75	128	185	284	322	322	251	221	225	148
52+ weeks	1	22	44	109	145	177	175	142	147	168
Total Open Pathways	2329	2362	2521	2385	2420	2367	2388	2223	2245	2331
Total 18 week breaches	982	1262	1549	1764	1523	1201	951	718	633	622
Clock starts in month	142	186	294	225	379	449	432	461	385	534
Admitted Clock Stops	22	19	23	73	178	204	257	277	233	175
Non admitted Clock Stops	68	40	69	69	65	138	153	173	84	87
Total Stops in month	90	59	92	142	243	342	410	450	317	262

Weeks	0-17	18-26	27-33	34-40	41-51	52+
Admitted clock stops						
Corneo	46%	18%	4%	1%	13%	18%
OMFS	44%	12%	2%	1%	16%	24%
Plastics	70%	8%	3%	1%	7%	10%
Non-admitted clock stops						
Corneo	57%	14%	3%	2%	10%	13%
OMFS	72%	12%	2%	2%	8%	3%
Plastics	50%	14%	4%	4%	8%	20%
Sleep	89%	10%	0%	0%	0%	0%

Cancer Performance Dashboard

Queen Victoria Hospital NHS Foundation Trust

Trust Level	Q1 2020-21			Q2 2020-21			Q3 2020-21			Change from last month
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20	
Two Week Wait	83.8%	89.5%	77.1%	84.5%	98.4%	99.7%	98.7%	99.4%	98.9%	↓
62 Day Referral to Tx	90.9%	95.9%	88.2%	77.5%	91.3%	85.3%	81.2%	86.6%	85.7%	↓
Faster Diagnosis	67.4%	79.9%	77.1%	82.5%	75.3%	67.8%	82.2%	75.1%	77.1%	↑
62 Day Con Upgrade	100.0%	57.1%	100%	89.7%	77.8%	88.2%	100%	85.7%	100%	↑
31Day Decision to Tx	98.2%	98.5%	93.1%	89%	93.9%	89.7%	92.2%	93.3%	92.8%	↓
31 Day Sub Treat	100.0%	100.0%	85.7%	75%	92%	100%	100%	90.5%	95.2%	↑

2020-21	Q1	Q2	Q3	Q4	YTD 20-21
Two Week Wait	82.8%	93.7%	99.0%		93.3%
62 Day Referral	91.3%	84.9%	84.3%		86.5%
31 Day Decision to Treat	96.4%	90.9%	92.8%		93.1%

PERFORMANCE COMMENTARY

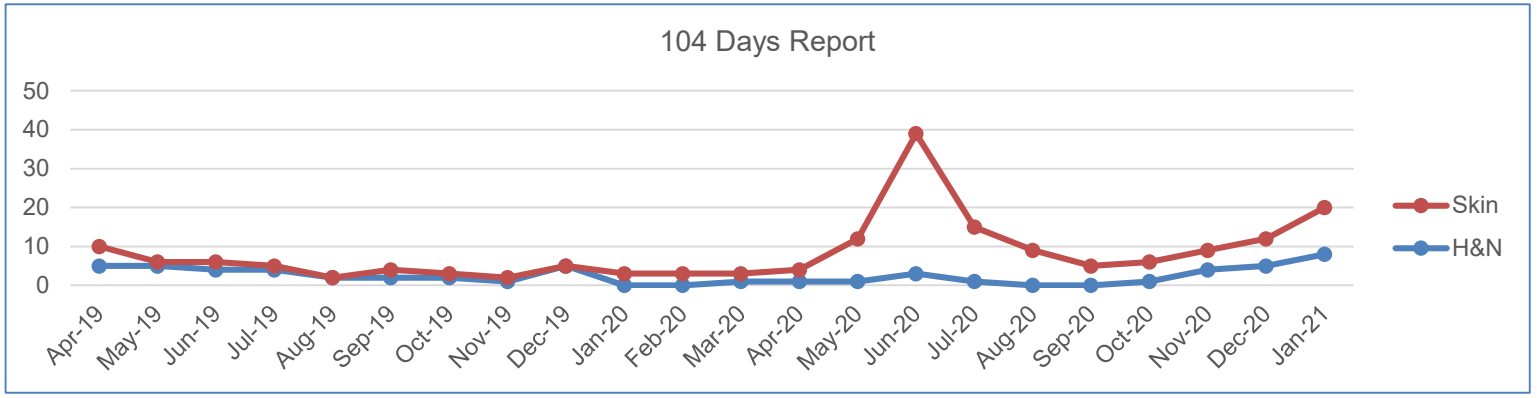
- **2WW** - QVH achieved the target for December, reporting 3 breaches.
- **62 day** - QVH achieved the target for December, reporting 6.5 breaches, 2 in head & neck and 4.5 in skin.
- **31 day** - QVH continues to experience challenges in achieving the target. Skin remains the challenged speciality but achieved their planned trajectory for December.
- **FDS** - QVH achieved the target for December.
- **Consultant upgrade** - The target was achieved in December.
- **31 day subsequent** - QVH achieved the target for December.

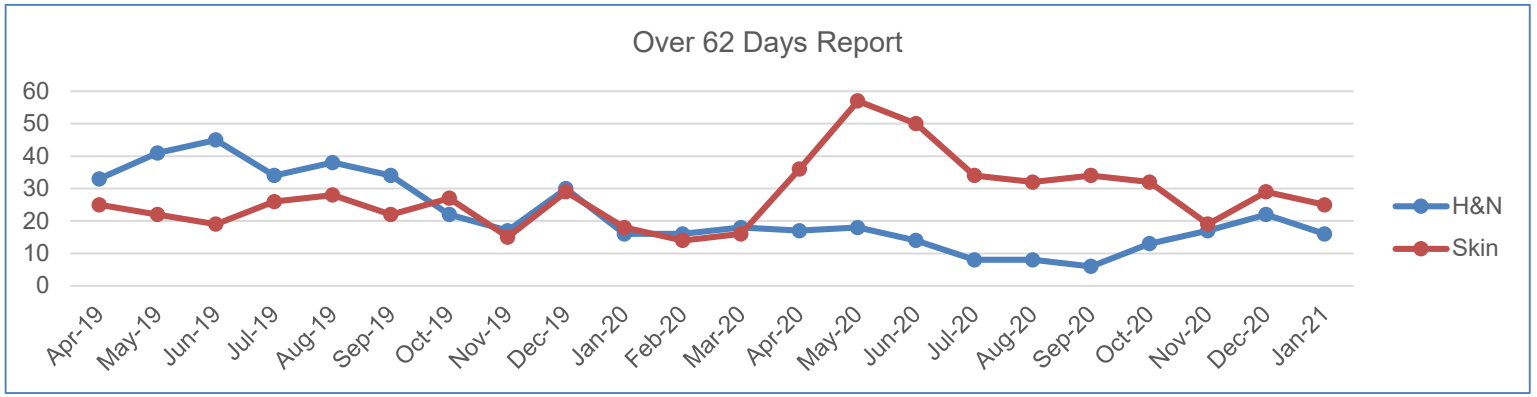
FORWARD LOOK / PERFORMANCE RISKS

- Predicting to be below plan for the **2WW** target for January due to the capacity challenges within head & neck over the Christmas/New Year period. February performance currently on track.
- The unvalidated **62 day** performance for January is below the target at 83%, with challenges for both head & neck and skin due to delays resulting from COVID-19 impact including patient illness and isolation. The new SSCA funded Plastics Coordinator post commences in February which will enhance pathway management.
- The significant performance risk for the trust is the **31 day** target which is driven by skin. The locum skin consultant post is out to advert with a job plan agreed and interviews in February. The trust is predicting to be below plan for February.
- The unvalidated **FDS** performance for January is below plan with challenges in follow-up appointments and outpatient diagnostic biopsies.

Over 104 Days and 62D Backlog

Queen Victoria Hospital NHS Foundation Trust





PERFORMANCE COMMENTARY

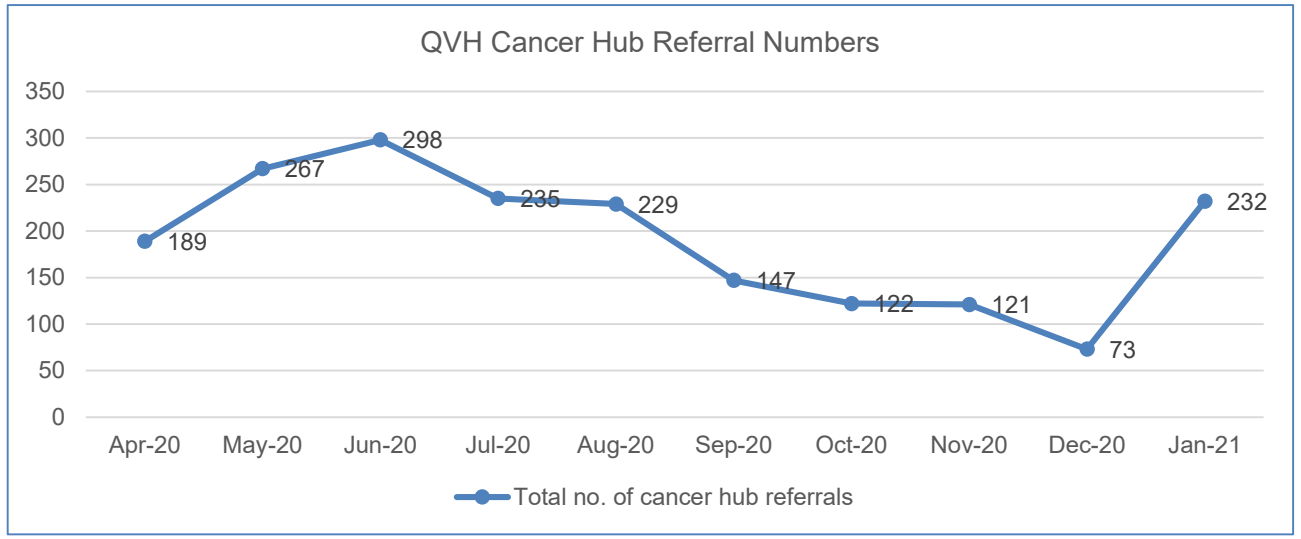
- Continuing to see a rise in the number of patients waiting over 104 days, across both specialties primarily due to covid-19 related delays
- The head & neck benign template letter has been implemented which is starting to impact 62 day performance.
- Increase in more complex cases requiring multiple diagnostics or additional pre-assessment work up which creates additional steps in the pathways.
- Late referrals from other trusts remain a risk. 15% of patients over 62 days are late referrals and 14% over 104 days are also late referrals.

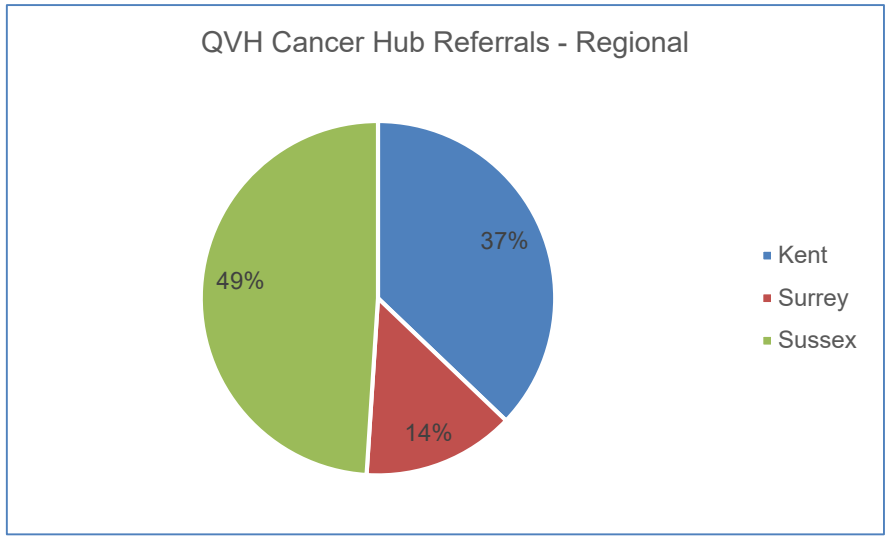
FORWARD LOOK / PERFORMANCE RISKS

- Forecasting a decrease in the number over 104 days in February, mainly within head & neck, predicting to fall to 15.
- The current 104 day trajectory was agreed following the first wave as a result a revised 104 day has been completed and due to be signed off at the March Cancer Board.

104 Day Trajectory												
QVH Trust Level	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual 104 Days	4	12	39	15	9	5	6	9	12	20		
Plan 104 Days						5	5	3	2	1	0	0
Actual PTL Total	246	319	370	380	538	400	475	450	435	398		
Service Level – H&N	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual 104 Days	1	1	3	1	0	0	1	4	5	8		
Plan 104 Days						0	1	0	0	0	0	0
Service Level Skin	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual 104 Days	3	11	36	14	9	5	5	5	7	12		
Plan 104 Days						5	4	3	2	1	0	0

Cancer Hub Referral Activity





Cancer Hub Commentary

- QVH continues to offer capacity for breast, skin and head & neck
- Clear processes and documentation is being completed by the referring trusts for any mutual aid requests
- c30 sessions per week (3 theatres) being utilised plus further sessional capacity for additional head & neck and skin work
- The utilisation of the external breast theatre lists is being monitored closely to ensure full utilisation
- January saw a rise in the total number of referrals due to the breast cancer activity being relocated to QVH as the Cancer Hub

Elective care - admitted

Queen Victoria Hospital NHS Foundation Trust

Daycase - Phase Three plan (% of historic)	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Phase 3 requirement	80%	90%	90%	90%	90%	90%	90%
BSUH	59%	71%	90%	90%	90%	90%	90%
WSHFT	70%	90%	90%	90%	90%	90%	90%
ESHT	80%	86%	90%	90%	90%	90%	90%
QVH	42%	52%	86%	89%	92%	95%	93%
Sussex Total	**67%**	**80%**	**90%**	**90%**	**90%**	**90%**	**90%**
Sussex Total pp gap vs Phase 3 requirements %	**-13%**	**-10%**	**0%**	**0%**	**0%**	**0%**	**0%**
Sussex Total pp gap vs Phase 3 requirements #	**-1,915**	**-1,622**	**-40**	**-10**	**0**	**0**	**0**
Sussex IS providers plan	**660**	**552**	**577**	**577**	**577**	**577**	**577**

Elective Ordinary - Phase Three plan (% of historic)	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Phase 3 requirement	80%	90%	90%	90%	90%	90%	90%
BSUH	76%	85%	90%	82%	82%	90%	90%
WSHFT	70%	90%	90%	90%	90%	90%	90%
ESHT	65%	75%	78%	80%	75%	90%	90%
QVH	55%	85%	86%	74%	92%	85%	90%
Sussex Total	**69%**	**85%**	**87%**	**82%**	**84%**	**89%**	**90%**
Sussex Total pp gap vs Phase 3 requirements %	**-11%**	**-5%**	**-3%**	**-8%**	**-6%**	**-1%**	**0%**
Sussex Total pp gap vs Phase 3 requirements #	**-225**	**-123**	**-61**	**-144**	**-124**	**-15**	**0**
Sussex IS providers plan	**238**	**273**	**288**	**288**	**288**	**288**	**288**

Activity by POD	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	Third phase requirement						
Day Case	80%	90%	90%	90%	90%	90%	90%
Elective Inpatient	80%	90%	90%	90%	90%	90%	90%

	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	QVH Final Submission						
Day Case Plan	42%	52%	86%	89%	92%	95%	93%
Day Case Actual	**72%**	**78%**	**77%**	**86%**	**67%**		
Day Case 1920 Activity	834	1017	959	759	898		
Day Case 2021 Activity	603	795	737	656	601		
Elective Inpatient Plan	55%	85%	86%	74%	92%	85%	90%
Elective Actual	**71%**	**81%**	**80%**	**80%**	**55%**		
Elective 1920 Activity	309	305	322	292	309		
Elective 2021 Activity	216	246	256	233	170		

Activity by POD	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	QVH Final Submission						
Day Case	-38%	-38%	-4%	-1%	2%	5%	3%
Elective Inpatient	-25%	-5%	-4%	-16%	2%	-5%	0%

PERFORMANCE COMMENTARY

- Significant challenges with planned daycase (DC) and inpatient activity for January due to Covid-19 surge response.
- Impact of return to cancer hub role in January with sessions being provided to external providers towards the end of the month.
- Routine activity stood down during surge phase.

FORWARD LOOK / PERFORMANCE RISKS

- Operational service risks to deliver activity remain whilst in Covid-19 surge phase and undertaking cancer hub role.

Elective care – non-admitted

Queen Victoria Hospital NHS Foundation Trust

First OP - Phase Three plan (% of historic)	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Phase 3 requirement	100%	100%	100%	100%	100%	100%	100%
BSUH	78%	87%	95%	95%	95%	100%	100%
WSHFT	82%	100%	100%	100%	100%	100%	100%
ESHT	83%	90%	92%	93%	93%	100%	100%
QVH	76%	80%	83%	84%	86%	95%	98%
Sussex Total	**81%**	**92%**	**95%**	**96%**	**95%**	**100%**	**100%**
Sussex Total pp gap vs Phase 3 requirements %	**-19%**	**-8%**	**-5%**	**-4%**	**-5%**	**0%**	**0%**
Sussex Total pp gap vs Phase 3 requirements #	**-7,456**	**-3,374**	**-1,965**	**-1,590**	**-1,750**	**-154**	**-58**
Sussex IS providers plan	**388**	**452**	**452**	**452**	**452**	**452**	**452**

Follow up OP - Phase Three plan (% of historic)	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Phase 3 requirement	100%	100%	100%	100%	100%	100%	100%
BSUH	87%	95%	99%	96%	96%	100%	103%
WSHFT	82%	100%	100%	100%	100%	100%	100%
ESHT	82%	96%	100%	100%	100%	100%	100%
QVH	82%	84%	87%	89%	91%	96%	100%
Sussex Total	**83%**	**95%**	**98%**	**98%**	**98%**	**99%**	**101%**
Sussex Total pp gap vs Phase 3 requirements %	**-17%**	**-5%**	**-2%**	**-2%**	**-2%**	**-1%**	**1%**
Sussex Total pp gap vs Phase 3 requirements #	**-11,520**	**-3,525**	**-1,545**	**-1,538**	**-1,681**	**-381**	**0**
Sussex IS providers plan	**376**	**593**	**622**	**622**	**622**	**622**	**622**

Activity by POD	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	Third phase requirement						
Outpatient (new)	100%	100%	100%	100%	100%	100%	100%
Outpatient (follow up)	100%	100%	100%	100%	100%	100%	100%

Activity by POD	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	QVH Final Submission						
Outpatient (new)	76%	80%	83%	84%	86%	95%	98%
Outpatient actual	**79%**	**74%**	**79%**	**75%**	**57%**		
Outpatient (new) 1920 Activity	3026	3578	3246	2382	3517		
Outpatient (new) 2021 Activity	2403	2650	2548	2880	2010		
Outpatient (follow up)	82%	84%	87%	89%	91%	96%	100%
Outpatient actual	**99%**	**92%**	**100%**	**103%**	**81%**		
Outpatient (f up) 1920 Activity	9717	11345	10379	8914	10293		
Outpatient (f up) 2021 Activity	9665	10468	10431	9264	8367		

Activity by POD	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	QVH Final Submission						
Outpatient (new)	-24%	-20%	-17%	-16%	-14%	-5%	-2%
Outpatient (follow up)	-18%	-16%	-13%	-11%	-9%	-4%	0%

PERFORMANCE COMMENTARY

- Both planned non admitted first appointments and follow up appointments are behind plan due to surge response.

FORWARD LOOK / PERFORMANCE RISKS

- Ongoing activity impact due to surge response.

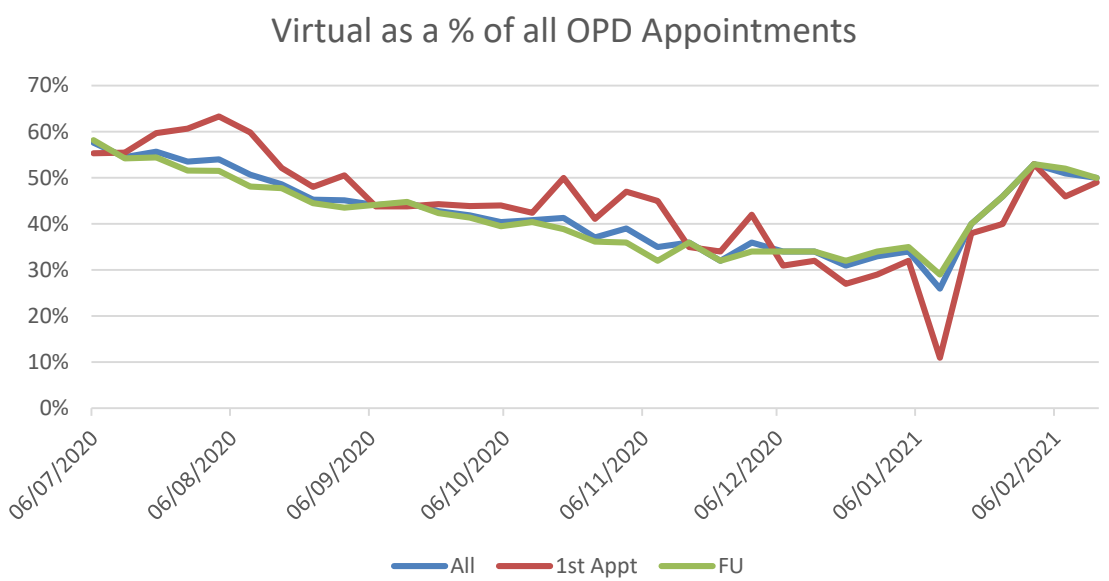
Elective care – virtual outpatients first & follow up

Queen Victoria Hospital NHS Foundation Trust

First OP Virtual % - Phase Three plan	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Phase 3 requirement	**25%**	**25%**	**25%**	**25%**	**25%**	**25%**	**25%**
BSUH	25%	25%	24%	24%	24%	24%	25%
WSHFT	25%	25%	25%	25%	25%	25%	25%
ESHT	25%	25%	25%	25%	25%	25%	25%
QVH	32%	32%	33%	31%	31%	33%	31%
Sussex Total	**26%**	**26%**	**25%**	**25%**	**25%**	**25%**	**25%**

Follow up OP Virtual % - Phase Three plan	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Phase 3 requirement	**60%**	**60%**	**60%**	**60%**	**60%**	**60%**	**60%**
BSUH	60%	60%	60%	60%	60%	60%	60%
WSHFT	60%	60%	60%	60%	60%	60%	60%
ESHT	60%	60%	60%	60%	60%	60%	60%
QVH	60%	60%	60%	60%	60%	60%	60%
Sussex Total	**60%**	**60%**	**60%**	**60%**	**60%**	**60%**	**60%**

Activity by POD	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	QVH Final Submission						
First OP Virtual (FA)	32%	32%	33%	31%	31%	33%	31%
First OP Virtual	42%	43%	35%	27%	43%		
Follow up OP Virtual (FU)	60%	60%	60%	60%	60%	60%	60%
Follow up OP Virtual actual	39%	36%	34%	33%	46%		



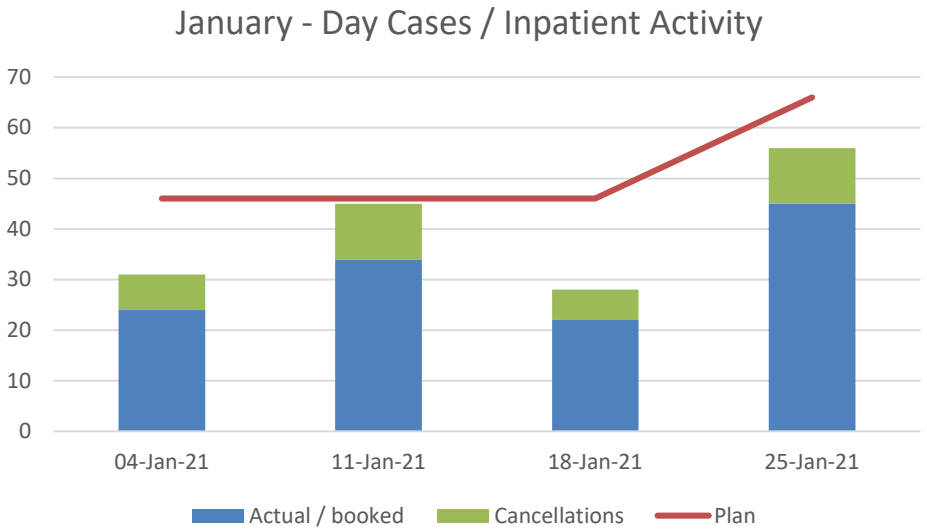
PERFORMANCE COMMENTARY

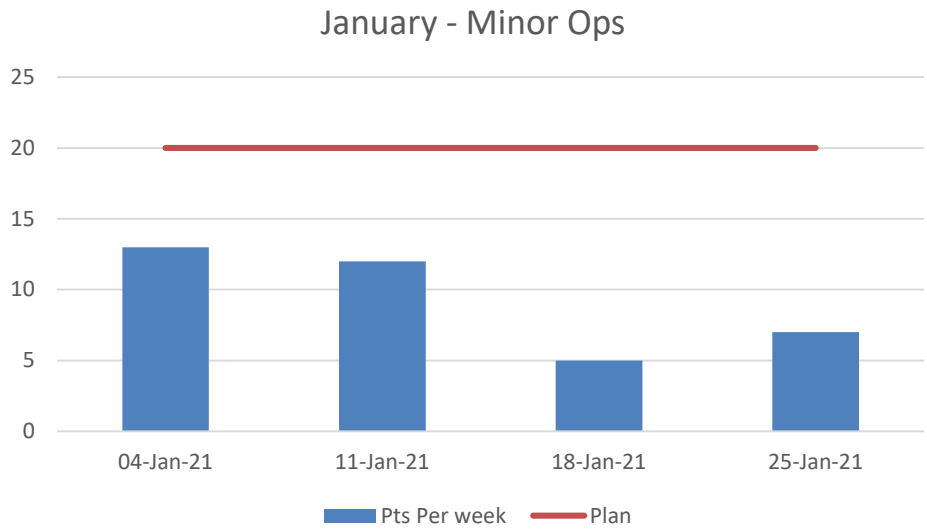
- Increase in first and follow up appointment virtual activity to above plan due to surge and lockdown measures.

FORWARD LOOK / PERFORMANCE RISKS

- Virtual Task & Finish group established to drive forward virtual engagement in the long term.

Independent Sector Utilisation





PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
• Elective throughput challenged during this surge phase. • High levels of cancellations and ongoing work to address this and maximise utilisation. • Uncertainty around booking of P4 (routine)patients, now resolved. • 10 day isolation period caused scheduling challenges; this has been reduced to 3 days. • Ongoing work to identify skin and hands patients that TMC can schedule directly. • Activity impacted by case complexity; longer plastics cases impact on activity throughput. • Minor ops challenged; reduction in referrals and anticipated mutual aid referrals from WSHFT.	• Improved performance against daycase trajectory • Ongoing challenges with minor ops delivery against plan due to changes to expected skin mutual aid requirements • Risks going forward relate to uncertainty in the independent sector contract post March 2021.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**4 March 2021**		**Agenda reference:**	**48-21**	
Report title:	**Finance Report 2020/21 – Month 10**				
Sponsor:	Michelle Miles – Director of Finance and Performance				
Author:	Michelle Miles – Director of Finance and Performance				
Appendices:	Finance Performance Report Month 10 - Report				
Executive summary					
Purpose of report:	To provide the Board with an overview of the Trust's financial performance.				
Summary of key issues	The Trust I&E position is £533k favourable against the YTD revised plan at month 10 under the Block Contract arrangements. This is due to better income received than plan and lower spend on non-pay due to the slowing of the recovery. For the financial year end the trust is forecasting a breakeven position against the revise plan. Expenditure run rate (both Pay and Non-Pay) in 2021 is at 99% of expenditure levels compared to the same period 2019/20. Underspend against nursing is broadly consistent and is driven by vacancies not fully backfilled although, some of this underspend is offsetting overspend against AHP line (mainly within Perioperative Care). Overspend against the Admin & Clerical line is driven by budgetary changes in order to bring budget aligned with recently submitted revised plan. Activity levels have gone down considerably compared to planned levels across all activity types due to trust undertaking Cancer hub related activity. These activity levels do not include activity undertaken at the McIndoe The cash position of the Trust remains favourable due to the level and timing of the block payments arrangement this year. Block income arrangement indicated to continue for 2021-22 quarter 1. Further guidance for 21/22 planning is anticipated in March. Debtors have improved in month but with an increase in invoiced debtors due to Q3 SLA invoicing instalments. Work is ongoing with regards to the over 90 days debtors. Creditors for NHS increased in month due mainly to P2P Q3 invoicing and Philips Capital project. Capital is forecast to be under spent by c£400k. Significant work is currently being undertaken to bring prioritised bids from 21/22 into 20/21. The covid capital has now been received for all projects within the timeframe.				
Recommendation:	To note the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):			KSO3:	KSO4:	KSO5:
			Operational excellence	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	KS04 – Financial Sustainability				
Corporate risk register:	KS04 – Financial Sustainability				
Regulation:					
Legal:					
Resources:	No current resources.				
Assurance route					
Previously considered by:	Finance & Performance Committee				
	Date:	22/02/21	Decision:	N/A	
Next steps:	Financial performance is currently monitored against revised plan submitted in November 2020 in line with national requirements, and will continue to be so during the remainder of the financial year				

Queen Victoria Hospital
NHS Foundation Trust

Trust Board Finance Report
January 2020-21

Michelle Miles – Director of Finance and Performance

2020-21 M10 - Financial Performance vs plan

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance Month 10 2020/21
Income and Expenditure

	In Month £'000				Year to Date £'000				Forecast Outturn		
	Prior year Outturn	Plan	Actual	Variance	*Prior year Outturn*	Plan	Actual	Variance	Plan	Forecast	Variance
Income											
Patient Activity Income	*5,219*	5,691	5,692	1	*54,076*	56,836	56,610	(226)	68,217	67,327	(890)
Other Operating Income	*7*	182	193	11	*3,959*	1,855	2,187	332	2,220	2,310	90
Block projected top up	*0*	764	764	1	*0*	6,394	6,592	199	7,921	7,921	0
Total Income	***5,226***	**6,636**	**6,649**	**13**	***58,035***	**65,085**	**65,389**	**305**	**78,357**	**77,557**	**(800)**
Pay											
Substantive	*(3,791)*	(5,379)	(4,035)	1,344	*(37,740)*	(41,841)	(40,972)	869	(50,268)	(49,247)	1,021
Bank	*(261)*	(165)	(200)	(35)	*(2,722)*	(1,289)	(1,854)	(565)	(1,622)	(2,225)	(603)
Agency	*(153)*	(18)	(88)	(70)	*(1,969)*	(180)	(570)	(390)	(216)	(684)	(468)
Total Pay	***(4,205)***	**(5,562)**	**(4,323)**	**1,239**	***(42,431)***	**(43,311)**	**(43,396)**	**(85)**	**(52,107)**	**(52,156)**	**(49)**
Non Pay											
Clinical Services & Supplies	*(526)*	(426)	(582)	(155)	*(5,422)*	(4,275)	(3,396)	879	(5,130)	(4,075)	1,054
Clinical Services & Supplies - Med & Surg	*(602)*	(590)	(172)	417	*(5,830)*	(5,894)	(4,500)	1,394	(7,074)	(5,400)	1,674
Drugs	*(124)*	(129)	(101)	29	*(1,238)*	(1,269)	(964)	305	(1,523)	(1,157)	366
Establishment Expenses	*(169)*	(278)	(220)	59	*(2,740)*	(2,466)	(2,006)	460	(2,959)	(2,377)	582
Consultancy	*(21)*	1	(30)	(31)	*(156)*	(146)	(205)	(59)	(173)	(246)	(72)
Other non pay	*(541)*	(1,683)	(469)	1,213	*(4,092)*	(3,341)	(5,872)	(2,531)	(4,274)	(7,047)	(2,773)
Total Non Pay	***(1,982)***	**(3,106)**	**(1,574)**	**1,532**	***(19,478)***	**(17,391)**	**(16,943)**	**448**	**(21,134)**	**(20,302)**	**832**
Non Operational Expenditure	*(137)*	(156)	(149)	7	*(1,318)*	(1,562)	(1,520)	42	(1,874)	(1,832)	42
Non Operating Income	*2*	2	0	(2)	*20*	21	1	(20)	25	1	(24)
Depreciation and amortisation	*(200)*	(329)	(306)	23	*(2,812)*	(3,291)	(3,248)	43	(3,949)	(3,949)	0
Total Expenditure	***(6,523)***	**(9,151)**	**(6,352)**	**2,799**	***(66,018)***	**(65,534)**	**(65,106)**	**427**	**(79,039)**	**(78,239)**	**800**
Surplus / (Deficit)	***(1,297)***	**(2,515)**	**297**	**2,812**	***(7,983)***	**(449)**	**283**	**732**	**(682)**	**(682)**	**(0)**
Top up to be clawed back				0			(199)	(199)			0
Adjustment to B/E				0				0			0
Surplus / (Deficit)	***(1,297)***	**(2,515)**	**297**	**2,812**	***(7,983)***	**(449)**	**84**	**533**	**(682)**	**(682)**	**(0)**

Summary

The Trust is reporting £533k favorable variance against the revised plan year to date at month 10 inclusive of £199k clawed back top up related to first half of the financial year to achieve breakeven months 1-6 position.

At month 10 trust is forecasting to hit the revised plan but this will be constantly reviewed and will be updated (if necessary) in line with activity/spend as we progress through the phase 3 during the last quarter of the financial year .

In January, Trust providing Cancer hub related activity effected the core trust activities resulting in DC being 67% , EL 55%, OP New 57% and OP Follow up only at 81% as compared to like for like period last financial year however, expenditure is broadly the same for like for like period last financial year. These activity figures do not include activity in the McIndoe undertaken by QVH staff.

Income Currently operating under Block payments regime, YTD income of £65.3m includes £55.1m Block Contract income, £6.3m top-up, £1.3m Education and Training, £530k SMSKP and £1.05m for P2P. **Pay** YTD broadly on plan. **Non Pay** down in line with activity with YTD cost £1.9m lighter than the same period last financial year.

Run Rate

Queen Victoria Hospital NHS
NHS Foundation Trust

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Income													
Patient Activity Income	5,219	4,824	7,885	5,606	5,663	5,652	5,635	5,650	5,979	5,935	6,110	4,688	5,692
Other Operating Income	7	346	(653)	502	461	(29)	156	323	(223)	6	359	711	193
Block projected top up	0	0	0	557	557	557	555	557	556	557	414	1,321	764
Comprehensive Income	0	0	665	0	0	0	0	0	0	0	0	0	0
Total Income	***5,226***	***5,169***	***7,898***	***6,664***	***6,680***	***6,179***	***6,346***	**6,531**	**6,312**	**6,498**	**6,883**	**6,720**	**6,649**
Pay													
Substantive	(3,791)	(3,695)	(3,879)	(4,019)	(3,930)	(4,048)	(4,434)	(4,187)	(4,042)	(4,114)	(4,005)	(4,157)	(4,035)
Bank	(261)	(297)	(122)	(105)	(142)	(64)	(99)	(102)	(465)	(206)	(219)	(252)	(200)
Agency	(153)	(132)	(286)	(16)	(19)	(34)	(33)	(27)	(63)	(101)	(100)	(89)	(88)
Total Pay	***(4,205)***	***(4,124)***	***(4,287)***	***(4,140)***	***(4,092)***	***(4,146)***	***(4,566)***	***(4,316)***	***(4,570)***	***(4,421)***	***(4,324)***	***(4,498)***	***(4,323)***
Non Pay													
Clinical Services & Supplies	(526)	(307)	(135)	(363)	(347)	(398)	(630)	(731)	448	(303)	(331)	(160)	(582)
Clinical Services & Supplies - Med & Surg	(602)	(579)	(780)	(422)	(303)	(295)	(491)	(375)	(551)	(512)	(691)	(688)	(172)
Drugs	(124)	(119)	(115)	(15)	(25)	(174)	(95)	(98)	(91)	(145)	(93)	(127)	(101)
Establishment Expenses	(169)	(296)	(251)	(230)	(260)	(111)	(178)	(186)	(239)	(256)	(183)	(142)	(220)
Consultancy	(21)	(32)	(26)	(56)	(3)	1	2	(8)	(31)	(31)	(17)	(32)	(30)
Other non pay	(541)	(450)	(1,868)	(488)	(633)	(507)	(633)	(425)	(965)	(398)	(881)	(473)	(469)
Total Non Pay	***(1,982)***	***(1,783)***	***(3,176)***	***(1,575)***	***(1,571)***	***(1,485)***	***(2,025)***	***(1,823)***	***(1,429)***	***(1,645)***	***(2,197)***	***(1,621)***	***(1,574)***
Non Operational Expenditure	(137)	(136)	(120)	(158)	(132)	(172)	(174)	(153)	(153)	(153)	(126)	(149)	(149)
Non Operating Income	2	2	2	1	0	0	0	0	0	0	0	0	0
Depreciation and amortisation	(200)	(276)	(359)	(285)	(285)	(279)	(278)	(278)	(556)	(344)	(347)	(290)	(306)
Total Expenditure	***(6,523)***	***(6,317)***	***(7,940)***	***(6,157)***	***(6,079)***	***(6,082)***	***(7,044)***	***(6,570)***	***(6,707)***	***(6,562)***	***(6,993)***	***(6,559)***	***(6,352)***
Surplus / (Deficit)	***(1,297)***	***(1,148)***	***(42)***	***507***	***601***	***97***	***(698)***	***(40)***	***(395)***	***(65)***	***(111)***	***161***	***297***
Top up to be clawed back				***(507)***	***(601)***	***(97)***						***(199)***	
Adjustment to B/E							***698***	***40***	***395***				
Surplus / (Deficit)	***(1,297)***	***(1,148)***	***(42)***	***(0)***	***0***	***0***	***0***	***(0)***	***(0)***	***(65)***	***(111)***	***(37)***	***297***

Income- Patients activity income in M10 back to the monthly average levels after a dip in month 9 due to NHS England Block payments alignment to the YTD block contract values. Similarly reduction in Other Operating income in M10 as compared to M9 is mainly driven by retrospective receipts for Covid19 funding covering periods M7-9 and lateral flow test income in M9. Block projected top up value for M10 is representative of monthly system's top up payment i.e. £764k/month for M7-12.

Pay- Substantive staff cost relatively lower than previous months mainly due to leavers mainly within Perioperative care but overall pay broadly in line with Q3 averages, agency spend is consistent with previous months and is driven mainly by agency radiologist/consultant. Bank staff cost is lighter than previous months driven by staffing requirement in line with lower levels of activity in January.

Non Pay. Clinical Supplies spend down as opposed to previous two month which saw an increase due to high levels of stock within theatres in line with phase 3 anticipated activity. Drugs cost in M10 is proportionate to the activity and is aligned with the drug reporting system.

Cash Flow

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance Month 10 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**	**11,529**	**11,918**	**11,376**	**11,354**	**11,677**	**12,151**	**12,572**
Receipts												
Receipts from contract income	11,713	6,842	6,042	6,575	7,045	6,157	5,709	5,798	5,804	5,959	5,959	5,959
Top up block income	1,113	557	557	557	557	617	0	1,113	1,540	860	860	860
Receipts from other income	132	439	76	190	122	77	110	183	87	174	120	120
Public Dividend Capital Received	0	0	0	39	0	6,391	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**	**7,725**	**13,242**	**5,819**	**7,093**	**7,431**	**6,993**	**6,939**	**6,939**
Payments												
Payments to NHS Bodies	(453)	(254)	(356)	(1,445)	(1,033)	(753)	(359)	(361)	(515)	(316)	(316)	(316)
Payments to non-NHS bodies	(3,440)	(1,789)	(1,602)	(1,273)	(1,345)	(1,467)	(1,685)	(1,682)	(1,755)	(1,930)	(1,930)	(1,930)
Net payroll payment	(2,333)	(2,261)	(2,280)	(2,331)	(2,304)	(2,414)	(2,395)	(2,411)	(2,472)	(2,389)	(2,389)	(2,389)
Payroll Taxes	(1,113)	(1,154)	(1,082)	(1,126)	(1,119)	(1,143)	(1,214)	(1,140)	(1,212)	(1,194)	(1,194)	(1,194)
Pensions Payment	(656)	(683)	(675)	(677)	(651)	(685)	(709)	(688)	(699)	(690)	(690)	(690)
PDC Dividends Payment	-	-	-	-	-	-	-	(833)	-	-	-	(854)
Loan Interest & Repayment	-	-	(460)	-	(0)	(6,391)	-	-	(454)	-	-	-
Total Payments	**(7,995)**	**(6,141)**	**(6,455)**	**(6,852)**	**(6,496)**	**(12,853)**	**(6,362)**	**(7,115)**	**(7,108)**	**(6,518)**	**(6,518)**	**(7,372)**
Net Cash Movement	**4,963**	**1,697**	**220**	**509**	**1,229**	**389**	**(543)**	**(22)**	**323**	**474**	**421**	**(433)**
Actual Closing Balance	**7,874**	**9,571**	**9,791**	**10,300**	**11,529**	**11,918**	**11,376**	**11,354**	**11,677**	**12,151**		
Forecast Closing Balance											**12,572**	**12,138**
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

Cash Summary

- There is currently a high cash balance which covers about 1.8 months of average spend. This is due to the current covid-response finance regime of block payments being made one month in advance (being £6.3m per month). There is also receipt of some prior year contract performance income .
- The prepayment regime ceases in March and therefore there will be a risk of corresponding drop in cash balances. Block payments for 21/22 will commence on the 8th of April 21.
- 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.

Debtors

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance Month 10 2020/21

Debtors

	Jan 20 £000	Feb 20 £000	Mar 20 £000	Apr 20 £000	May 20 £'000	Jun 20 £'000	Jul 20 £'000	Aug 20 £'000	Sep 20 £'000	Oct 20 £'000	Nov 20 £'000	Dec 20 £'000	Jan 21 £'000	In Month Change £000
NHS Debtors														
0-30 Days Past Invoice Due Date	774	2,477	3,570	2,277	345	222	221	131	90	182	249	1,189	927	**(262)**
31-60 Days Past Invoice Due Date	156	(150)	(86)	242	1,769	70	75	62	92	14	68	14	5	**(9)**
61-90 Days Past Invoice Due Date	103	75	20	376	(276)	1,466	112	72	63	77	14	68	8	**(60)**
Over 90 Days Past Invoice Due Date	2,640	2,658	1,935	2,307	2,609	2,586	3,840	2,792	2,321	2,054	1,848	1,619	1,661	**43**
Total NHS Debtors	**3,673**	**5,061**	**5,440**	**5,202**	**4,447**	**4,343**	**4,248**	**3,056**	**2,566**	**2,327**	**2,180**	**2,889**	**2,601**	**(288)**
Non NHS Debtors														
0-30 Days Past Invoice Due Date	245	155	757	709	80	147	150	55	64	87	43	87	90	**3**
31-60 Days Past Invoice Due Date	107	17	7	112	596	184	16	41	21	7	57	9	24	**15**
61-90 Days Past Invoice Due Date	5	88	17	7	110	130	21	16	38	2	7	57	8	**(49)**
Over 90 Days Past Invoice Due Date	422	367	474	461	340	434	556	590	435	468	361	388	410	**22**
Total Non NHS Debtors	**779**	**626**	**1,256**	**1,288**	**1,126**	**896**	**743**	**702**	**558**	**564**	**468**	**541**	**533**	**(8)**
Other Debtors Less Than One Year	1,495	1,558	1,847	7,787	14,008	19,642	341	571	592	564	989	(41)	42	
Total Debtors	**5,947**	**7,245**	**8,542**	**14,278**	**19,581**	**24,881**	**5,332**	**4,329**	**3,716**	**3,456**	**3,637**	**3,389**	**3,176**	
NHS : Non NHS ratio	*0.82*	*0.89*	*0.81*	*0.80*	*0.80*	*0.83*	*0.85*	*0.81*	*0.82*	*0.80*	*0.82*	*0.84*	*0.83*	

Summary

The month 10 total debtor balance of £3.17m is 56% lower than the average monthly balance of £7.2m in 2019-20. This is largely due to the covid block contract payment regime that removes the time lags created by flex and freeze arrangements and the recovery of aged debts relating to prior years activity performance billing.
The Trade debtors balance decreased by £0.3m (9%) from month 9.
The top 5 NHS Debtors are NHS England, Health Education England, Aneurin Bevan Lhb, Maidstone And Tunbridge Wells NHS Trust and NHS Northern, Eastern And Western Devon CCG.
The top Non NHS debtors are The Mcindoe Centre, Sussex Community Dermatology Service and Thames Valley Housing Association. Financial services will continue to review Aged Debts with the aim of resolving any disputes.

Other Debtors consists mainly of the net effect of income accruals, adjustments for prepayments, provisions and other non-invoiced debtors such as VAT and the injury cost recovery scheme.

Creditors

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance Month 10 2020/21

Trade Creditors

	Jan 20 £000	Feb 20 £000	Mar 20 £000	Apr 20 £000	May 20 £'000	Jun 20 £'000	Jul 20 £'000	Aug 20 £'000	Sep 20 £'000	Oct 20 £'000	Nov 20 £'000	Dec 20 £'000	Jan 21 £'000	In Month Change £'000
NHS Creditors														
0-30 Days Past Invoice Due Date	665	663	950	1,115	1,182	558	446	380	323	302	196	363	278	(85)
31-60 Days Past Invoice Due Date	122	35	485	165	163	133	107	155	39	9	109	103	117	14
61-90 Days Past Invoice Due Date	568	135	44	416	412	769	66	42	155	19	27	84	90	6
Over 90 Days Past Invoice Due Date	1,399	1,669	1,806	1,790	1,821	2,250	1,772	1,270	1,111	1,180	665	698	722	24
Total NHS Creditors	**2,754**	**2,503**	**3,285**	**3,486**	**3,577**	**3,711**	**2,391**	**1,847**	**1,629**	**1,510**	**996**	**1,248**	**1,207**	**(41)**
Non NHS Creditors														
0-30 Days Past Invoice Due Date	1,293	2,080	2,318	993	764	402	358	292	566	342	843	1,138	513	(330)
31-60 Days Past Invoice Due Date	109	87	149	170	72	57	146	43	31	55	37	30	410	373
61-90 Days Past Invoice Due Date	238	178	78	20	7	75	35	103	12	7	5	31	12	6
Over 90 Days Past Invoice Due Date	245	117	266	230	111	153	10	160	41	26	20	26	16	(4)
Total Non NHS Creditors	**1,885**	**2,462**	**2,811**	**1,414**	**954**	**688**	**550**	**597**	**650**	**430**	**905**	**1,224**	**949**	**44**
Other Creditors Less Than One Year	(973)	(860)	(660)	(570)	(716)	(548)	(74)	(366)	(402)	(106)	(15)	(975)	(340)	
Total Creditors	**3,666**	**4,105**	**5,435**	**4,330**	**3,816**	**3,850**	**2,867**	**2,078**	**1,877**	**1,834**	**1,886**	**1,497**	**1,816**	
NHS : Non NHS ratio	***0.59***	***0.50***	***0.54***	***0.71***	***0.79***	***0.84***	***0.81***	***0.76***	***0.71***	***0.78***	***0.52***	***0.50***	***0.56***	

Summary

- The trade creditors balance at month 10 is £1.8m compared to a 2019 average of £4.0m.
- NHS/Non NHS balances decreased by £0.3m (13%) from month 9.
- The top 5 NHS Creditors are Medway Nhs Foundation Trust, East Kent Hospitals University NHS Foundation Trust, Brighton And Sussex University Hospitals Nhs Trust, East Sussex Healthcare Nhs Trust and Dartford And Gravesham Nhs Trust.
- The top 3 Non NHS Creditors are Canon Medical Systems Ltd, Synergy Health (UK) Ltd and Sussex Community Dermatology Service.
- The other creditors balance reflects the adjustment back to the balance sheet value for items within the trade creditors total which have not yet been validated to be accounted for on the general ledger but have been included in the aged creditors balance for completeness.
- The BPPC percentage has increased in month by 2% and the average days to payment has reduced to 6 days.
- 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.

Capital

Queen Victoria Hospital NHS
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	0	200
Replacement theatre pendants	0	0	0	150	150	0	150
Rehab. unit refurbishment	1	4	(3)	120	120	120	0
Fire door replacements	0	0	0	102	102	45	57
Critical infrastructure	120	104	16	0	501	223	278
Other	870	91	779	391	555	381	175
Total Estates Projects	**991**	**199**	**792**	**963**	**1,628**	**768**	**860**
Medical Equipment							
Fluoroscopy	490	396	94	396	490	490	0
Other	105	269	(164)	127	268	862	(593)
Total Medical Equipment	**595**	**665**	**(70)**	**523**	**758**	**1,352**	**(593)**
Information Management & Technology (IM&T)							
Clincal portal	0	0	0	372	0	0	0
IT infrastructure refresh	172	172	0	0	372	372	0
Other	569	504	66	431	823	786	37
Total Information Management & Technology (IM&T)	**741**	**675**	**66**	**803**	**1,195**	**1,158**	**37**
Contingency				738	176	0	176
Total 2020/21 Programme	**2,327**	**1,540**	**787**	**3,027**	**3,758**	**3,278**	**480**
Covid-19 Expenditure	0	564	(564)	0	501	613	(112)
Total Capital	**2,327**	**2,104**	**223**	**3,027**	**4,259**	**3,891**	**368**

Summary

The 2020/21 capital programme was originally set at £3,027k, excluding Covid-19 expenditure. Further central funding has since been secured for improvements to critical infrastructure (£500k), an ultrasound machine (£90k), equipment to promote agile working in the Radiology department (£90k), virtual clinics (£20k) and cyber security (£31k), bringing the revised plan total to £3,758k.

Initially, EMT gave outline approval for projects totaling £2,289k, leaving an unallocated contingency reserve of 738k. Subsequently a number of items have been authorised from the contingency reserve and the plan has been revised accordingly.

Covid-19 projects have delayed the original Estates capital programme and there is little that can be done to make up the shortfall by year-end. EMT has therefore authorised the bringing forward of £688k of equipment purchases from the 2021/22 capital programme to fill most of the gap. Work is underway to ensure that the proritised purchased will be delivered before 31st of March. If timelines slip, the equipment will go back through the proritisation process for 21/22.

In the IM&T programme, it will not be practicable to undertake the Clinical Portal project and the funding (£372k) has been redirected to refreshing IT infrastructure equipment, notably PCs and laptops.

We have now learnt that we have been granted £501k towards expenditure incurred as a result of Covid-19. This is £112k less than our expected expenditure due to some of the projects falling outside of the timeframe. The deficit will be met from the contingency reserve.

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Date: 16th February 2021

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
- Ongoing discussions about the future organisational form of QVH creates an uncertainty impacting on recruitment and retention of a workforce with the right skills and experience.
- The impact on recruitment and retention across the Trust leads to an increase in bank and agency costs and having longer term issues for the quality of patient care and staff engagement

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
- 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
- Staff survey results and SFFT staff engagement have shown improvement, continuing with the 2019 national staff survey results. Preparation underway for 2020 outcome
- Overseas nurses having a positive impact, contract ongoing
- Workforce 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 heightened risk to BAME workforce

Initial Risk 3(C)x 5(L)=15, moderate
Current Risk Rating 4(C)x 4(L)=16, moderate
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.
- 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. Monitoring impact of second wave
- Impact of potential merger on attraction and retention of workforce

Future Opportunities
- Closer partnership working with Sussex Health and Care Partnership - ICS.
- Capitalise on our work as a cancer hub as a place to work
- On going discussions with Western/BSUH

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
- monthly challenge to Business Units at Performance reviews reset by exception
- 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 and stability in some KPI's
- Overseas recruitment continues, but with delays due to pandemic, improving picture
- Work to finalise ESR hierarchy with ledger
- 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
- Workforce Restoration and Recovery workstreams ongoing monitoring

Gaps in controls / assurance
- Management competency and capacity in workforce planning
- Continuing resources to support the development of staff – optimal use of apprenticeship levy budget

NHS
Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**Thursday 4th March 2021**		**Agenda reference:**	**50-21**	
Report title:	**Workforce Report – February 2021 Report – January 2021 data**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD,				
Author:	Lawrence Anderson, Deputy Director of Workforce/ Felicity King, Workforce Services Manager				
Appendices:	Workforce Report – KPI's and narrative				
Executive summary					
Purpose of report:	The Workforce and OD report for February 2021 (January 2021 data) is provided in the format consistent with the Trust OD plans and NHS Staff Survey themes.				
Summary of key issues	Recruitment activity is updated in the report as standard Workforce KPIs and COVID related absence has stabilised Overseas nurses are now in the Trust The first dose vaccination programme was very well received, 2nd dose in March Staff survey is publicly embargoed until 11th March 2021.				
Recommendation:	The committee 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 • Engaged and motivated staff deliver better quality care (KSO1)				
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:	Finance & Performance Committee				
	Date:	22/02/21	Decision:	Information	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Workforce & Organisational Development

Workforce Report – February 2021

(Data Reporting Period - January 2021)

KPI Summary

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020/21			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	Compared to Previous Month
Establishment WTE *Note 1				1007.59	1007.59	1028.35	1028.14	1028.14	1028.14	1028.14	1028.14	1030.33	1030.18	1036.20	1037.20	**1035.09**	▼
Staff In Post WTE				891.18	901.25	914.01	907.53	913.06	921.43	922.58	920.90	922.67	923.09	933.53	928.06	**927.02**	▼
Vacancies WTE				116.41	106.34	114.34	120.61	115.08	106.71	105.56	107.24	107.66	107.09	102.67	109.14	**108.07**	▼
Vacancies %	>12%	8%<>12%	<8%	11.55%	10.55%	11.12%	11.73%	11.19%	10.38%	10.27%	10.43%	10.45%	10.40%	9.91%	10.52%	**10.44%**	▼
Agency WTE				15.53	13.27	13.72	6.22	3.77	5.13	5.70	6.82	11.12	10.10	11.95	10.80	**10.83**	▲
Bank WTE *Note 2				70.34	71.63	72.90	34.07	31.38	33.72	47.47	59.00	57.61	64.72	66.60	65.44	**76.20**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	13.75%	13.65%	12.90%	12.86%	12.84%	12.05%	11.74%	11.22%	10.65%	10.05%	10.49%	10.60%	**10.54%**	▼
Monthly Turnover				1.48%	0.45%	0.96%	0.68%	1.05%	0.68%	0.75%	1.05%	0.70%	0.70%	0.84%	0.99%	**1.56%**	▲
12 Month Rolling Stability % *Note 3	<70%	70%<>85%	>=85%	80.99%	81.35%	85.53%	85.33%	85.46%	86.39%	86.25%	87.08%	89.12%	89.44%	89.11%	89.07%	**88.87%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	3.01%	3.08%	4.37%	3.06%	2.09%	2.01%	2.77%	2.68%	2.88%	2.99%	3.26%	3.20%	*TBC*	▼
% staff appraisal compliant (Permanent & Fixed Term staff) *Note 4	<80%	80%<>95%	>=95%	87.05%	86.44%	84.36%	81.40%	80.02%	78.61%	78.27%	80.86%	80.58%	80.00%	80.60%	84.03%	**82.03%**	▼
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 5	<80%	80%<>90%	>=90%	92.11%	94.47%	92.35%	91.51%	91.91%	92.18%	91.88%	92.58%	90.80%	90.82%	91.02%	91.92%	**92.30%**	▲

Friends & Family Test - Treatment Quarterly staff survey to indicate likelihood of recommending QVH to friends & family to receive care or treatment	**Measure** Extremely likely / likely % : Extremely unlikely / unlikely%	**2019-20 National Survey Of 572 responses: 92% : 2%**	**2020-21 National Survey TBC**
Friends & Family Test - Work Quarterly staff survey to indicate likelihood of recommending QVH to friends & family as a place of work	**Measure** Extremely likely / likely % : Extremely unlikely / unlikely%	**2019-20 National Survey Of 560 responses: 72% : 10%**	**2020-21 National Survey TBC**

19-20 & 20-21 ▲Responses ▼ Likely ▲Unlikely
19-20 & 19-21 ▲Responses ▲ Likely ▼Unlikely

*Note 1 -2020/21 establishment updated in September backdated to April 20
*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 - % Staff Appraisal August 20 has been adjusted for GMC medics who are exempt from appraisals due to Covid-19.
*Note 5 - RAG rating updated in June 2019 for Statutory & Mandatory Training. Compliance changed from 95% to 90% however,individual compliance remains at 100%

Goal 1: Engagement and Communication

a) 2020 NHS Staff Survey

The 2020 NHS Staff Survey closed on 27th November 2020. QVH has received a response rate of **59%** (616 respondents from an eligible sample of 1049 staff) in comparison to last year which was **58%** (586 respondents from an eligible sample of 1009 staff). We have received initial reports from Picker (our Staff Survey provider) but we are awaiting the official Co-ordination Center reports so we can can analyse comparator data. As soon as we receive these reports, work will commence to interrogate the data for trends and themes for 2020. The information is currently embargoed until 11th March 2021

b) Restoration and Recovery – COVID-19

Coronavirus – COVID-19 continues to be at the forefront of the Trust's workforce challenges. At time of writing we are not clear on the impact of the additional shielding requirements announced.

The Trust continues to contribute to the system wide plans and initiatives. Restoration and recovery continues with a number of workstreams now business as usual including terms and conditions, education and learning. Flexible/Agile working and full and timely utilisation of healthroster remain key focusses for 2021.

Agile working

We have started to see some stability across the workforce in relation to the impact of infection rates and the requirements for self isolation. The joint protocol with IT works well whereby there is a pool of IT equipment that can be mobilised in around 48 hours of request to ensure that where staff are able to work at home for the period of self isolation they can be supported to do so.

We are also making great strides to address to review the Trust's Flexible Working Policy ahead of its planned review date, to improve our offering and support for both flexible working but also the ability to exercise more smart and agile working practices

Covid Vaccine

Over the last two weeks in January we have vaccinated almost all of our QVH staff and hundreds of other health and care staff. We thanked the incredible number of people involved in setting up and running a vaccination hub that ensured that there was not a waste of a single dose.

In total we vaccinated 1895 people, of which 961 were QVH staff, 934 were staff from other organisations. In addition 139 QVH staff accessed a vaccination elsewhere. The number of BAME staff vaccinated is 134

Health and Wellbeing

Our Stay Well agenda introduced the launch of the Sussex new mental health service called Staff in Mind. Staff in Mind is a new confidential NHS service for health and care staff working across Sussex who may be experiencing emotional or psychological difficulties. It offers staff the opportunity to take a quick, easy and discreet online self-assessment and referral for a full clinical assessment followed by priority access to appropriate treatment services or support where required. Since its launch last week, over 200 self-assessment forms have been completed.

The Stay Well team have been busy re-issuing support and guidance in relation to managing through the ongoing pandemic particularly in relation to stress, anxiety and mental health generally.

Workforce Disability Equality Standards (WDES) 2020

QVH's annual WDES report was published publicly in January. Some of the headlines from this were

- 5% of the QVH workforce have disclosed a disability
- 8% of our workforce have not answered the question of whether or not they have a disability
- In recruitment, 28% of non-disabled applicants are successful from being shortlisted to being offered the role, compared to 16% of disabled applicants being appointed. This is an increase of 4% of disabled applicants being appointed compared with last year.

Equality and Diversity action plans will be updated at a future committee meeting

Staff Awards

In January we publicised our Annual QVH Staff Awards encouraging staff to nominate colleagues and departments in various catagories. We also continued celebrate our staff with service by awarding long service certificates and awards. Around 300 nominations for the staff awards are currently being processed

Please note, vacancy reporting within the Workforce Report is done so on the basis of staff in post and unfilled posts within the Trust Establishment

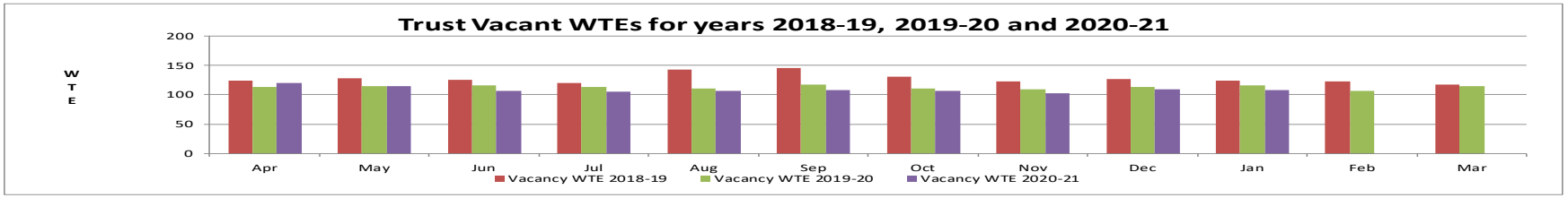
Goal 2: Attraction and Retention

a) *Vacancies*

VACANCY PERCENTAGES	Nov-20	Dec-20	Jan-21	Compared to Previous Month
Corporate	14.68%	15.64%	15.21%	▼
Eyes	7.82%	7.54%	8.11%	▲
Sleep	9.12%	9.12%	12.05%	▲
Plastics	-3.21%	-3.21%	1.60%	▲
Oral	7.25%	6.78%	5.60%	▼
Periop	13.78%	15.00%	16.85%	▲
Clinical Support	7.54%	9.01%	8.80%	▼
Outpatients	8.90%	8.90%	12.59%	▲
Director of Nursing	4.69%	4.69%	3.09%	▼
Operational Nursing	10.20%	10.23%	8.49%	▼
Community Services	20.33%	25.80%	30.73%	▲
QVH Trust Total	9.91%	10.52%	10.44%	▼

	Posts advertised this month	Recruits in Pipeline
Corporate	13.00	5.47
Eyes	0.00	0.00
Sleep	0.00	0.00
Plastics	3.00	2.00
Oral	0.00	0.00
Periop	8.00	8.40
Clinical Support	2.00	2.61
Outpatients	0.00	0.00
Director of Nursing	3.00	1.00
Operational Nursing	3.73	6.14
Community Services	0.00	0.80
QVH Trust Total	32.73	26.42
of which Qual Nurses / Theatre Practs (external)	6.00	*7.07*
of which HCA's & Student/Asst Practs (external)	5.00	*2.00*

MEDICAL RECRUITMENT (WTE)	Posts advertised this month	Recruits in Pipeline
Clinical Support	0.00	0.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*0.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*0.00*
Plastics	3.00	4.00
of which are Deanery Trainees, Trust Registrars or Fellows	*1.00*	*4.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*2.00*	*0.00*
Eyes	0.00	4.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*0.00*
of which are SAS doctors	*0.00*	*4.00*
of which are Consultants (including locums)	*0.00*	*0.00*
Sleep	0.00	0.00
Oral	0.60	0.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*0.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.60*	*0.00*
Periop	0.00	9.10
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*9.10*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*0.00*
Community Services	0.00	0.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*0.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*0.00*
QVH Trust Total	3.60	17.10
of which are Deanery Trainees, Trust Registrars or Fellows	*1.00*	*13.10*
of which are SAS doctors	*0.00*	*4.00*
of which are Consultants (including locums)	*2.60*	*0.00*



'Staff in Post' has decreased since last month to 927.02 WTE. Vacancy levels have slightly decreased since last month to 10.44% after the budgeted establishment decreased.

There were 16.4wte starters, new staff to QVH. Of these 2.92 were qualified nurses all in Perioperative Services Directorate, 8.64 unqualified nurses/HCA's including 5wte international nurses in Perioperative Services and 3.64wte in Operational Nursing. The remaining new starters were in Clinical Support, Eyes, and Corporate Services Directorates.

There were 2.89wte leavers of these 4.04wte admin and clerical, 1.46wte were qualified nurses, 2wte HCA, 0.76 nursing associate. All other leavers were spread across the staff groups. Corporate Services had the largest amount of leavers with 5.04wte followed by Clinical Support with 2.5wte.The leaving reasons were varied ranging from retirement, flexible retirement, end of fixed term contract and various voluntary reasons.

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b) International Recruitment

		Started	Offered and Accepted (WTE) remaining*	Expected to start in the next month	Expected to start within 2-3 months	Expected to start within 4-6 months
Critical Care (Yeovil)		**4**	**0**	**0**	**0**	**0**
Other Nurse (Yeovil)		**5**	**0**	**0**	**0**	**0**
Theatres / Recovery (Yeovil)		**17**	**0**	**0**	**0**	**0**
Theatres / Recovery (Medway)		**3**	**2**	**0**	**2**	**0**
Grand Total		**29**	**2**	**0**	**2**	**0**

After a lot of flight changes, arrival date changes and discussions on where nurses would isolate we are pleased to welcome our 6 remaining Yeovil nurses to the trust. All six arrived between 24 and 31 January with all having 10 days isolation.

Three arrived on site in early February and moved into Meridian Way, with three more shorlty after.

Intense OSCE preparation has been implemented by both the support team at Yeovil and also Jo Davis at QVH, with online training and practice sessions in preparation for practice OSCE's on either 22 February or 3 March.

It is then anticipated that all six will be fully registered by the end of March 2021.

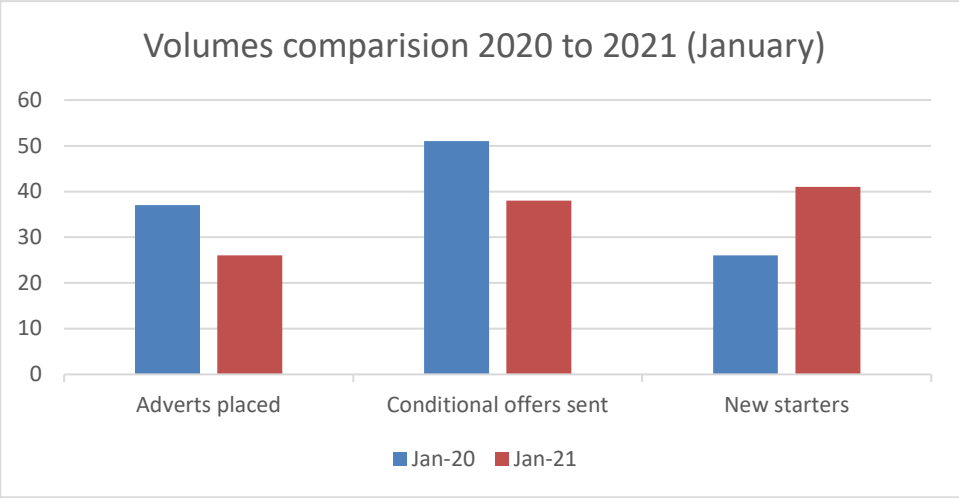
The two remaining Medway nurses are now well on the way to coming with one arriving at Medway in early March and the second early April, both will remain at Medway until they have taken their OSCE and should arrive at QVH eight weeks after UK arrival (May and June) with full registration.

c) Recruitment Data

Surprisingly there was a significantly higher volume of starters in January (41) compared to the previous month and the same month last year. With 28 conditional offers sent out of a total of 229 applicants received. These figures include bank staff and internal moves.

We have had another admin bank drive and have appointed an additional 13 people, with the success of our bank campaigns being evident in the number that are then offered substantive roles within the Trust; a great outcome for the candidates and QVH. In addition we have appointed 11 clinical bank staff (8 HCA and 3 RMN).

The busiest area for recruitment in January was Therapies, with 37 applicants received where we will see the success of any candidates within February's data.

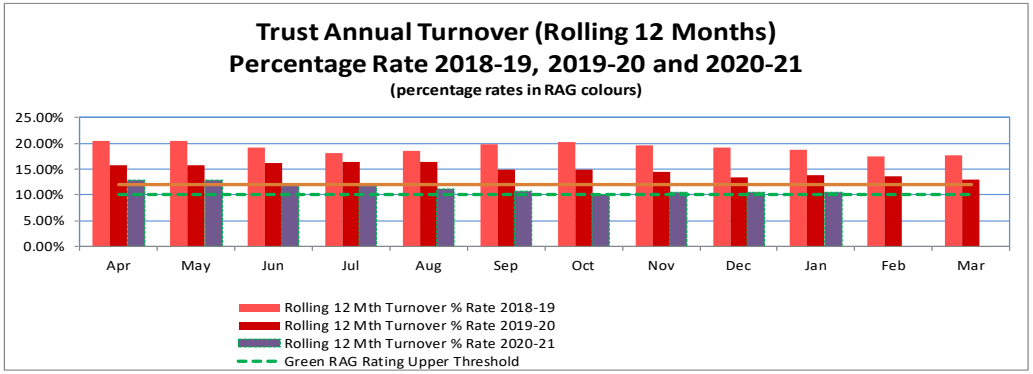


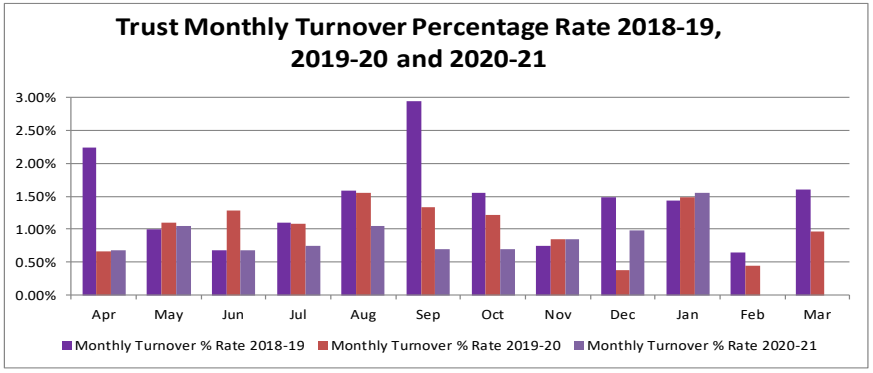
Row Labels	WTE appointed
BANK Dental Nurse	1
BANK Healthcare Assistant	8
Staff Nurse (BANK)	2
Administrative Assistants (Bank)	3
BANK Admin Assistant	6
BANK Secretary	4
Grand Total	24

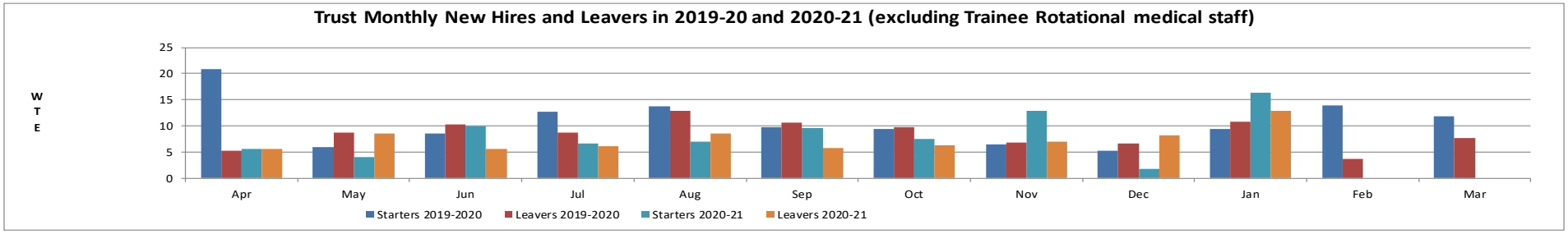
d) Turnover, New Hires and Leavers

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Nov-20	Dec-20	Jan-21	Compared to Previous Month
Corporate %	9.78%	9.78%	11.29%	▲
Eyes %	28.79%	32.19%	31.53%	▼
Sleep %	14.37%	10.76%	10.23%	▼
Plastics %	10.40%	10.34%	8.32%	▼
Oral %	8.19%	8.23%	8.11%	▼
Peri Op %	13.09%	13.03%	12.61%	▼
Clinical Support %	10.34%	8.86%	11.82%	▲
Outpatients %	24.88%	24.99%	14.47%	▼
Director of Nursing %	5.21%	3.90%	4.93%	▲
Operational Nursing %	4.73%	5.55%	5.54%	▼
Community Services %	20.12%	27.82%	25.41%	▼
QVH Trust Total %	10.49%	10.60%	10.54%	▼

MONTHLY TURNOVER excl. Trainee Doctors	Nov-20	Dec-20	Jan-21	Compared to Previous Month
Corporate %	0.57%	0.57%	2.88%	▲
Eyes %	0.00%	3.12%	0.00%	▼
Sleep %	0.00%	0.00%	2.94%	▲
Plastics %	0.00%	0.00%	0.00%	◄►
Oral %	1.31%	0.00%	0.00%	◄►
Peri Op %	1.30%	2.22%	1.34%	▼
Clinical Support %	0.00%	1.13%	2.88%	▲
Outpatients %	0.00%	0.00%	0.00%	◄►
Director of Nursing %	0.00%	0.00%	1.11%	▲
Operational Nursing %	1.25%	1.07%	0.57%	▼
Community Services %	9.11%	0.00%	11.11%	▲
QVH Trust Total %	0.81%	0.99%	1.56%	▲







The Trust's 12 month rolling turnover currently sits at 10.54% and the monthly turnover at 1.56%. The monthly turnover does remain slightly over our trust KPI figure of 10%. However our new international nurses are not included in these figures due to covid isolation as per government guidelines and NHS Employers guidance requiring the trust to see the ID documents and paperwork before entering into ESR. As a consequence of this the turnover figures may be slightly higher but these will be amended in next months report.
The 12 month rolling stability has gone down slightly to 88.87% from 89.07%.

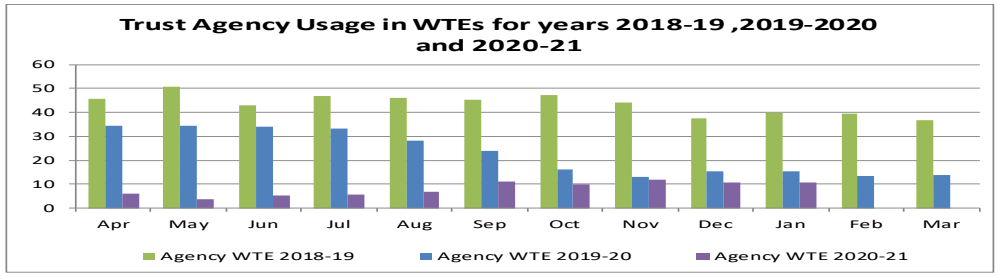
e) Temporary Workforce

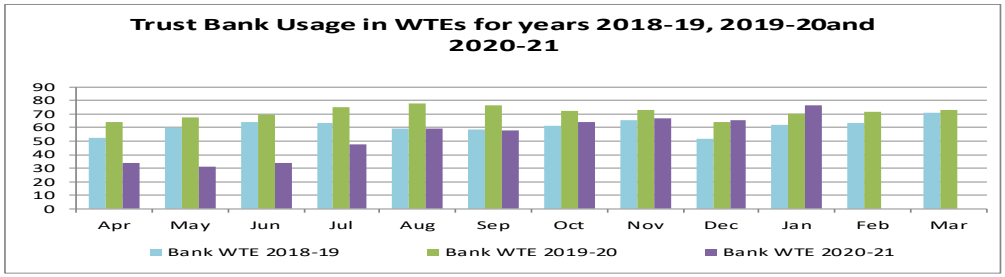
Agency				
BUSINESS UNIT (WTE)	Nov-20	Dec-20	Jan-21	Compared to Previous Month
Corporate	1.89	1.93	1.20	▼
Eyes	0.00	0.00	0.00	◄►
Sleep	0.00	0.00	0.00	◄►
Plastics	0.00	0.00	0.00	◄►
Oral	0.00	0.00	0.00	◄►
Periop	3.96	2.70	3.71	▲
Clinical Support	3.24	2.84	2.83	▼
Outpatients	0.00	0.00	0.00	◄►
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	2.54	3.01	3.09	▲
Community Services	0.32	0.31	0.00	▼
QVH Trust Total	11.95	10.80	10.83	▲

Bank				
BUSINESS UNIT (WTE)	Nov-20	Dec-20	Jan-21	Compared to Previous Month
Corporate	9.58	9.70	9.25	▼
Eyes	1.22	0.54	0.56	▲
Sleep	2.62	3.11	2.87	▼
Plastics	1.79	1.67	2.22	▲
Oral	2.49	3.53	3.63	▲
Periop	17.66	17.08	21.09	▲
Clinical Support	7.45	7.96	8.74	▲
Outpatients	1.38	2.01	1.41	▼
Director of Nursing	2.92	2.51	2.79	▲
Operational Nursing	18.78	17.02	22.92	▲
Community Services	0.69	0.30	0.71	▲
QVH Trust Total	66.60	65.44	76.20	▲

Agency				
STAFF GROUP (WTE)	Nov-20	Dec-20	Jan-21	Compared to Previous Month
Qualified Nursing	5.72	5.00	6.80	▲
HCAs	0.00	0.00	0.00	◄►
Medical and Dental	1.76	1.70	0.92	▼
Other AHP's & ST&T	2.58	2.17	1.91	▼
Non-Clinical	1.89	1.93	1.20	▼
QVH Trust Total	11.95	10.80	10.83	▲

Bank				
STAFF GROUP (WTE)	Nov-20	Dec-20	Jan-21	Compared to Previous Month
Qualified Nursing	26.42	22.62	31.83	▲
HCAs	8.66	9.85	8.36	▼
Medical and Dental	5.84	5.54	6.91	▲
Other AHP's & ST&T	4.12	3.40	4.34	▲
Non-Clinical	21.55	24.03	24.76	▲
QVH Trust Total	66.60	65.44	76.20	▲





This month agency has remained at the same level as last month, however there were increases in qualified nursing within Perioperative Services and Operational Nursing. All other staff groups and Business Units saw a decrease in usage.

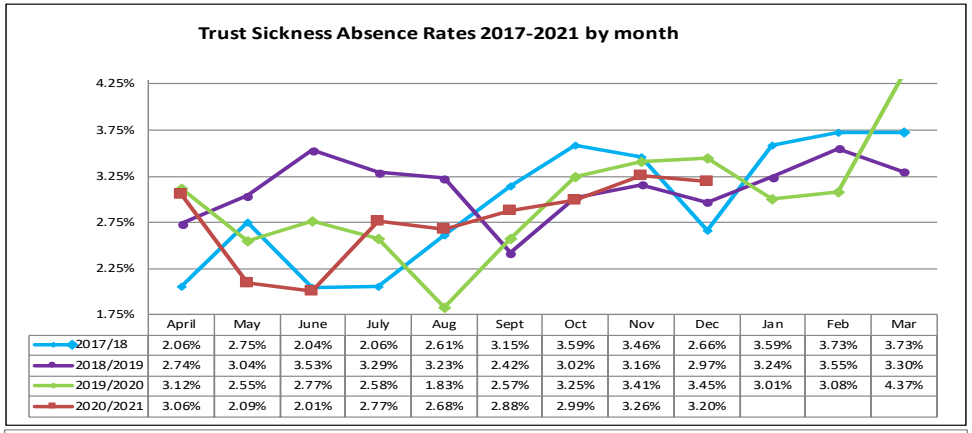
Bank usage has increased from last month with an end position of 78.20wte. Increases were seen in all staff groups apart from HCA's where there was a decrease. Qualified nursing saw the biggest increase by 9.21wte. The increases were seen predominantly in Perioperative Services and Operational Nursing. This is expected as the vaccine hub is staffed by bank and accounted for 4.24wte. Increases were also in Burns Centre, Peanut Ward and CCU, Day Surgery and Recovery.

Goal 3: Health and Well-being

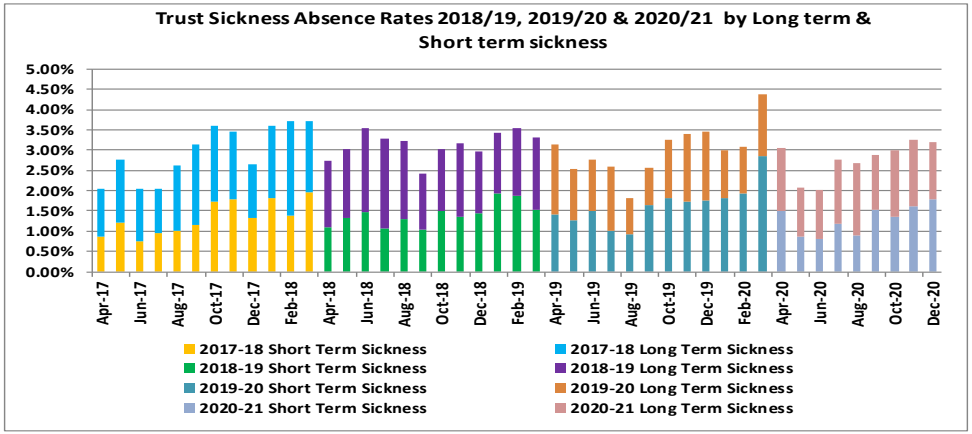
SHORT TERM SICKNESS	Oct-20	Nov-20	Dec-20	Compared to Previous Month
Corporate	0.95%	0.77%	0.58%	▼
Clinical Support	1.45%	3.46%	0.87%	▼
Plastics	0.54%	0.92%	1.13%	▲
Eyes	1.40%	1.38%	0.82%	▼
Sleep	1.30%	0.08%	1.92%	▲
Oral	1.06%	1.57%	2.07%	▲
Periop	0.67%	1.36%	1.64%	▲
Outpatients	1.94%	1.17%	3.35%	▲
Director of Nursing	1.66%	3.80%	3.52%	▼
Operational Nursing	2.79%	2.01%	3.39%	▲
Community Services	0.00%	0.28%	0.89%	▲
QVH Trust Total	1.36%	1.61%	1.78%	▲

LONG TERM SICKNESS	Oct-20	Nov-20	Dec-20	Compared to Previous Month
Corporate	1.68%	0.92%	0.41%	▼
Clinical Support	1.30%	1.99%	0.97%	▼
Plastics	1.69%	0.52%	0.31%	▼
Eyes	3.19%	3.10%	3.07%	▼
Sleep	0.00%	0.97%	2.25%	▲
Oral	3.68%	2.21%	2.01%	▼
Periop	1.65%	1.63%	1.68%	▲
Outpatients	2.88%	5.89%	6.20%	▲
Director of Nursing	0.00%	0.00%	1.54%	▲
Operational Nursing	2.02%	2.34%	1.67%	▼
Community Services	0.00%	0.00%	0.00%	◄►
QVH Trust Total	1.63%	1.65%	1.42%	▼

ALL SICKNESS (with RAG)	Oct-20	Nov-20	Dec-20	Compared to Previous Month
QVH Trust Total	2.99%	3.26%	3.20%	▼



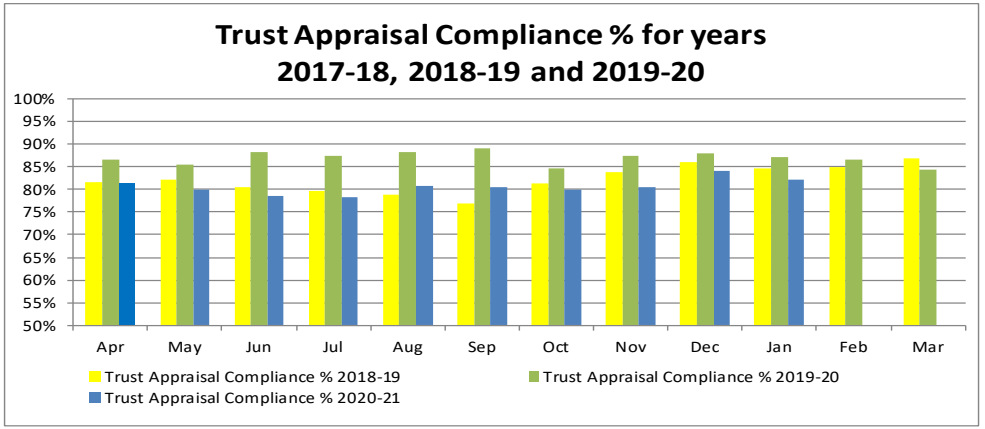
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	2.06%	2.75%	2.04%	2.06%	2.61%	3.15%	3.59%	3.46%	2.66%	3.59%	3.73%	3.73%
2018/2019	2.74%	3.04%	3.53%	3.29%	3.23%	2.42%	3.02%	3.16%	2.97%	3.24%	3.55%	3.30%
2019/2020	3.12%	2.55%	2.77%	2.58%	1.83%	2.57%	3.25%	3.41%	3.45%	3.01%	3.08%	4.37%
2020/2021	3.06%	2.09%	2.01%	2.77%	2.68%	2.88%	2.99%	3.26%	3.20%			



The Trust's sickness absence has remained stable ending the month on 3.20%, just outside of our KPI of 3%. In December 0.30% was covid related with 16 occasions. The business unit with the highest sickness was in Outpatients at 9.55%, followed by Director of Nursing and Operational Nursing. Sleep and Outpatients had the biggest increase on last month.
Top 3 absence reasons by occurrences is cold cough and flu, gastrointestinal problems and other musculoskeletal problems. Indicative figures for January sickness currently stand at 3.37% and covid related sickness as 0.99% with 40 occurrences.

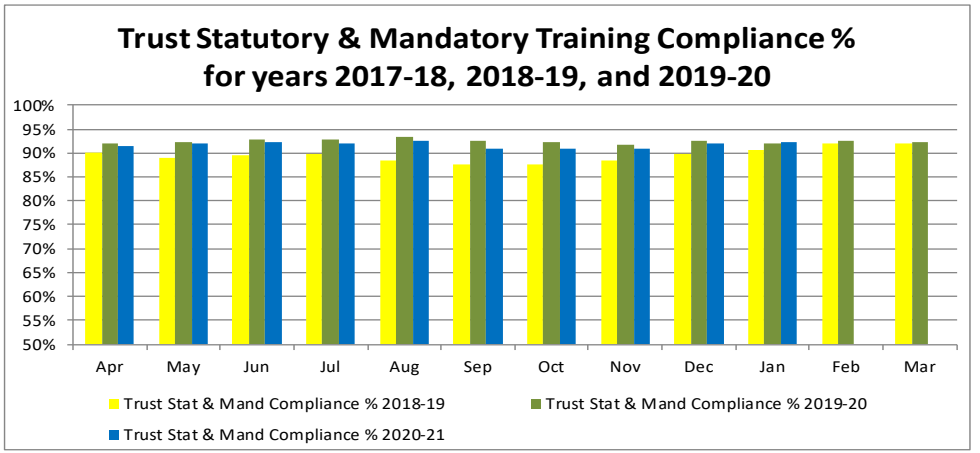
Goal 4: Learning and Education

APPRAISALS	Nov-20	Dec-20	Jan-21	Compared to Previous Month
Corporate	57.81%	70.00%	68.04%	▼
Eyes	88.89%	90.00%	60.00%	▼
Sleep	93.75%	96.88%	96.77%	▼
Plastics	62.12%	59.42%	58.46%	▼
Oral	80.00%	80.00%	79.73%	▼
Peri Op	91.82%	93.55%	93.92%	▲
Clinical Support	86.24%	91.59%	91.59%	◄►
Outpatients	72.41%	73.33%	78.57%	▲
Director of Nursing	94.23%	94.34%	94.34%	◄►
Operational Nursing	90.61%	92.92%	88.73%	▼
Community Services	80.00%	73.33%	76.92%	▲
QVH Trust Total	80.60%	84.03%	82.03%	▼



Staff Appraisal rate has decreased to 82.03% from 84.03%last month. This is figure has been adjusted for GMC medics who are exempt due to Covid-19. Best performing was Sleep (96.77%) who were above the trust's KPI of 95%, and increases were seen in Community Services, Perioperative Services and Outpatients. Worst performing is Plastics at 58.46% and Eyes had the biggest decrease of 30% on last month.

MANDATORY AND STATUTORY TRAINING	Nov-20	Dec-20	Jan-21	Compared to Previous Month
Corporate	90.93%	91.05%	90.87%	▼
Eyes	89.45%	91.58%	93.11%	▲
Sleep	91.88%	93.23%	93.80%	▲
Plastics	77.62%	78.14%	79.44%	▲
Oral	90.15%	91.04%	91.42%	▲
Peri Op	91.28%	93.27%	93.30%	▲
Clinical Support	94.25%	95.66%	96.92%	▲
Outpatients	99.59%	98.78%	99.56%	▲
Director of Nursing	95.25%	95.69%	95.16%	▼
Operational Nursing	93.71%	94.28%	94.35%	▲
Community Services	88.76%	89.35%	93.06%	▲
QVH Trust Total	91.02%	91.92%	92.30%	▲



Statutory and mandatory training has increased on last month to 92.30%. All units are above trust KPI apart from Plastics (79.44%) and there were increases across all business units apart from Corporate Services and Director of Nursing. The best performing competency is Infection Control level 1 – 3 yearly (96.14%), worst performing is Resuscitation- Paediatric Life Support 1 yearly (86.11%) . IG now sits at 88.08%, an increase on last month.

The first doctors' induction of 2021 took place on 3 Feb, bringing new anaesthetics and core surgical trainees to QVH. The London rotation was delayed for a month, which means that an additional induction will be run in March to welcome a further cohort of anaesthetics trainees. The Medical Education team work closely with colleagues in HR Advice and Resourcing to make sure that everything comes together as planned.

There are a number of surgeons coming to QVH from around the region to perform their urgent breast surgery operations, needing access to the QVH IT systems, so the Medical Education Manager has been working closely with operational leads to ensure that they have the access they require.

All specialties are continuing to deliver teaching to trainee doctors, making use of the available technology and larger rooms to allow for social distancing. Plans for external courses and medical student electives still have to be on hold, but the team hopes to restart this activity later in 2021.

A review of BLS training has been completed and all medical and dental staff are now being encouraged to book on to one of the hour long updates run by the resus team.

The Education Centre was successfully used to deliver the first phase of the vaccination programme, and will be used again in March for the second dose.

Medical Appraisals: 78 GMC and GDC registrants have Covid PDR exemptions, which have been removed from the total number of staff requiring an appraisal. At department level, the exempt staff have been removed from the staff headcount when calculating % for PDR compliance. At BU level, the exempt staff have been removed when calculating the PDR compliance.

Business Unit	Department	Assignment Count	Required	Achieved	Compliance % Before Covid Exemption	Compliance % After Covid Exemption
Community Services	276 200005 SLR Rheumatology	1	1	1	100.00%	100.00%
Plastics	276 200011 Plastic Surgery	60	60	27	45.00%	87.10%
Sleep	276 200013 SLR Sleep Studies	3	3	1	33.33%	100.00%
Eyes	276 200015 SLR Corneo Plastics	13	13	6	46.15%	85.71%
Oral	276 200018 SLR Orthodontics	11	11	7	63.64%	77.78%
Oral	276 200019 SLR Maxillofacial	36	36	13	36.11%	59.09%
Community Services	276 200025 SLR Respiratory	1	1	0	0.00%	0.00%
Perioperative Care	276 210001 Anaesthetics	31	31	7	22.58%	87.50%
Clinical Support	276 210006 Diagnostic Imaging	3	3	1	33.33%	50.00%
Clinical Support	276 210008 Histopathology	1	1	0	0.00%	0.00%

Goal 5: Talent and Leadership

Leadership, OD and Talent Management Group:

Sussex Health and Care Partnership (HCP) Leadership, OD and Talent Group, chaired by the QVH Workforce Director, are collaborating on a range of initiatives to support management and leadership across the integrated healthcare system (ICS). Due to current circumstances, a decision has been taken to postpone leadership development and coaching activities across the ICS to assist until April 2021.

Bitesize Coaching: The Leadership Academy is currently offering Healthcare staff an opportunity to access a 45 minute bitesize coaching session. This has been advertised to all staff at QVH via Connect.

Other activities in focus:

Apprenticeships: QVH celebrated the contribution apprentices make to the Trust during National Apprenticeship Week on 8th – 14th February 2021. An article in Connect and our QVH social media pages was picked up by three external media outlets and was developed into articles celebrating the work that was achieved. As an outcome the team have received more enquiries from staff about undertaking apprenticships

https://www.midsussextimes.co.uk/health/apprenticeship-queen-victoria-hospital-east-grinstead-helps-woman-achieve-dream-qualification-3127591

https://www.wscountytimes.co.uk/health/apprenticeship-queen-victoria-hospital-east-grinstead-helps-woman-achieve-dream-qualification-3127591

https://www.crawleyobserver.co.uk/health/apprenticeship-queen-victoria-hospital-east-grinstead-helps-woman-achieve-dream-qualification-3127591

COVID19 implications*:* As a result of the current situation and government guidelines OD & L continue with steps to risk assess QVH offerings and tailored initiatives to reduce/minimise the risk of spread. Therefore we continue to:

- advise staff, where possible to complete eLearning;
- ask new starters to complete pre-hire eLearning;
- deliver shortened Corporate Induction programme (focused on eLearning);
- postponing or using virtual options for apprenticeships;
- run core face-to-face mandatory training sessions (using PPE);
- reduce places on any mandatory face-to-face courses to allow for social distancing (using PPE);
- postpone any external face-to-face offerings until later in the year.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04 March 2021**		**Agenda reference:**	**51-21**	
Report title:	Board effectiveness review				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Authors:	Clare Pirie, Director of communications and corporate affairs Hilary Saunders, Deputy Company Secretary				
Appendices:	A: Board seminars and presentations 2020/21 B: Development of individual Board members C: Details of NED champions at QVH D: Board committee terms of reference				
Executive summary					
Purpose of report:	The purpose of this report is to consider the performance of the Board of Directors at QVH and identify any actions needed to ensure that the Board has the skills, experience and approach needed to ensure the Trust remains an innovative and high performing organisation.				
Summary of key issues	This paper is structured around the eight key lines of enquiry of the Care Quality Commission's well led domain, In contrast with previous years, and as a result of the ongoing pandemic, opportunities for board development has been restricted in 2020/21				
Recommendation:	The Board is asked to: • **AGREE** the contents of this review, noting that detail will be included in the 2020/21 annual report and accounts. • **APPROVE** the Board sub-committee terms of reference.				
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:	This paper enables the Trust to comply with the FT Code of Governance				
Legal:	None				
Resources:	This paper seeks best use of existing resources.				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:	• This evaluation will be noted in the Annual Report and Accounts • Assuming approval, terms of reference will take immediate effect.				

Report to:	Board of Directors
Meeting date:	4 March 2021
Agenda item reference no:	51-21
Sponsor:	Clare Pirie, Director of communications and corporate affairs
Author:	Clare Pirie, Director of communications and corporate affairs
Date of report:	25 February 2021
Appendix:	A: Board seminars and presentations 2020/21 B: Development of individual Board members C: Details of NED champions at QVH D: Board committee terms of reference

QVH Board of Directors Effectiveness review

Introduction

The purpose of this report is to consider the performance of the Board of Directors at QVH and identify any actions needed to ensure that the Board has the skills, experience and approach needed to ensure the Trust remains an innovative and high performing organisation.

This paper builds on the process of regular review undertaken by each committee to the Board and enables the Trust to comply with the FT Code of Governance, which requires the Board to undertake a formal annual evaluation of its own performance and that of its committees and individual directors. The Code requires that details of this evaluation are included in the Annual Report and Accounts.

This paper is structured around the eight key lines of enquiry of the Care Quality Commission's well-led domain, highlighting developments in year.

Recommendation

The board of directors is asked to:

- **AGREE** the contents of this evaluation, noting that it will be referenced in the 2020/21 annual report and accounts.
- **APPROVE** the attached committee terms of reference for the next twelve months.

CQC theme		Developments at Board level in 2020/21
1. Leadership	The most effective Boards are those that drive organisational performance especially at times of great stress and change. Sound leadership creates an organisational culture of continuous improvement, motivated staff, and enhancing its long-term sustainability.	The development activities undertaken by individual directors are summarised in Appendix B, and while opportunities and the capacity of directors to undertake personal development over the past year were significantly impacted, all Board members have ensured they are well equipped to deliver in their roles. The Trust has a well-developed appraisal process, which is used to identify individual development needs. The Chief Executive has agreed with each executive director a personal development plan as part of their individual appraisal. The Chair conducts annual non-executive director appraisals and is herself appraised by the senior independent director; the Chair and NEDs also have individual development needs documented and reviewed through this process. Whilst the full Board would usually dedicate a day each year to a facilitated Board development process, in 2020/21 this was not possible.
2. Vision and strategy	The strategic focus in 2020/21 has been around securing the long-term future of QVH.	QVH is an outward looking organisation with a strong track record of engaging with system working. Through 2020/21 of members of the Board have continued to engage with partners throughout the region. The operational focus on becoming a regional cancer hub in the context of the pandemic has contributed to QVH visibility and attracted praise for the swift response and high quality of services. Governors and staff have been kept well informed through virtual meetings and written briefings.
3. Culture	As an effective board, we need to shape a culture for the organisation, which reflects QVH's values and is ambitious, self-directed, responsive, and encourages innovation. We have a commitment to openness and transparency and to put patients and communities at the centre of everything we do. Board members are also expected to exemplify the seven Nolan Principles of	QVH has a strong culture of celebrating success. Although the staff awards ceremony had to be postponed in 2020 as a result of COVID, we invited nominations in January 2021. In a short time we received more than 300 nominations from staff, as well as nominations from the public for the outstanding patient experience. There are currently no plans for an awards ceremony but those nominated will receive individual letters from the chief executive and there will be a prize draw. The process of recognising educational achievements and long service has continued through one to one visits from members of the Board and celebration in internal communications. Throughout the year the Board received regular updates on the five goals of the people and organisational development strategy (engagement and communication, attraction and retention,

CQC theme		Developments at Board level in 2020/21
	public life: selflessness, integrity, objectivity, accountability, openness, honesty, leadership.	health and well-being, learning and education, talent and leadership), work which plays an important role in supporting the QVH values and culture. The 2020 staff survey results are embargoed until 11 March 2021 and will be considered in detail by the Board when available. All Board members have been subject to the Fit and Proper Persons Test since it was introduced in 2014/15. This declaration is included with all Board papers as a reminder and signed off on appointment and annually by the Chair.
4. Governance	Good governance involves clarity about structures, processes and systems of accountability; at QVH, these are regularly reviewed and improved.	QVH has a highly successful model for governor engagement, with motivated and supportive governors and a lead governor role on board committees that enables them to see NEDs at work and more fully discharge their responsibilities around holding NEDs to account. The individual governors attending committees changed in line with the governors' nomination and election procedures, with the quality of engagement remaining strong. A significant number of new governors have joined the council of governors following recent elections. They all joined pre-election events setting out the role of governors, and post-election induction briefings. As we continue work towards a possible merger, governors' understanding of their roles and responsibilities is particularly important and in response to requests from new governors an additional governors' seminar is planned for March. The council of governors has also agreed a programme of work related to possible merger. In July 2020, the Board revised and approved its Standing Financial Instructions, Standing Orders and Schedule of Matters Reserved for the Board. The Deputy Co Sec delivers a minute writing course, raising the standard of minutes across the organisation to ensure that we have a good record of assurance and decision-making. Whilst noting national evidence that care should be taken to ensure NED 'champion' roles do not dilute the independence of NEDs and their role on a unitary board, QVH has agreed a small number of issues where it is helpful to have a named NED. These are set out in Appendix C.

CQC theme		Developments at Board level in 2020/21
5. Risks and performance	The Board continues to ensure that the organisation has a robust and effective risk management system. The corporate risk register is reviewed by the Board at each meeting. Public board agendas are structured around the Trust's five key strategic objectives (KSOs). Each KSO is prefaced by the relevant part of the BAF, (with overall BAF summary included in the Chief executive's report). Detailed explanations of changes to risk scores are provided within each relevant section.	Active engagement with a meaningful Board assurance framework is evidenced throughout the year including: • May 2020: CRR for KSO2 moved from 12 to 16 due to the impact of the pandemic and subsequent cessation of non-urgent elective work. • July 2020: Introduction of an integrated pandemic governance process to ensure the Trust could proactively manage new and emerging risks, whilst overseeing implementation of restoration and recovery phases. • November 2020: CRR for KSO4 reduced from 25 to 20 to reflect the Trust's break-even position as a result of the block contract. • January 2021: Board reviewed and approved current risk appetite • January 2021: Changes to risk descriptions within KSOs 1 and 5 to ensure better alignment with regard to workforce challenges.
6. Information	QVH Board papers include a good level of detail on quality, operations and finance and the Board works to ensure these are considered in a holistic way. A programme of sub-committee assessments identifies ways in which papers and processes can be further improved.	On a quarterly basis, the Audit committee continues to undertake a deep dive into an individual key strategic objective, seeking assurance in respect of gaps and controls. The Audit committee reviewed its effectiveness in December 2020. Main areas of discussion were around how risk appetite should be used in practice when making decisions in board and committee meetings, and also how we should oversee risks on the BAF and associated risk registers, monitor the action plans to mitigate/reduce the risk and link this to the different sources of assurance. These areas were subsequently taken forward for discussion by the Board at its seminar in the same month. In addition, the chair noted that refinement of the BAF assurance model would continue, with a greater emphasis on where the Committee might gain assurance. In October 2020 members of the charity committee carried out an assessment of effectiveness concluding overall that they were satisfied that this is a well-managed committee providing a high level of assurance that donors' money is being well used. It was noted that it has been an unusual year for fundraising and that the committee had not been able to deliver on its objective of engaging more with the fundraising agenda not just grant making, this will be carried forward into 2021. The annual finance and performance committee effectiveness review was undertaken in January 2021. The committee chair noted the most significant issue is the timeliness of the

CQC theme		Developments at Board level in 2020/21
		papers; however, this is due to the timetable and having to feed into the Board of Directors meeting. The committee members agreed not to change the timescale. The quality and governance committee evaluation process is underway at the time of writing. An update, together with the latest copy of the committee terms of reference for approval, will be presented to the board in May.
7. Engagement	The Board ensures it continues to meet its responsibility to engage with stakeholders through various means including attendance of a QVH patient, where possible, at each public session to describe their experience of care at the Trust. Where difficult to arrange the Board receives an update from the director of nursing on a recent patient experience. The Friends and Family Test was suspended at a national level in response to the pandemic, however there is regular and continued scrutiny of feedback on patient experience. The Lead Governor role continues to enable strong and direct engagement between governors and the Board. All members of the Board attend the quarterly meetings of the Council of Governors.	Changed ways of working in the pandemic mean face to face meetings with staff have not been possible, but Board members have continued to engage with staff in various ways. The chief executive has held frequent online staff briefings with other executive and non-executive directors joining these. NEDs have also joined various virtual team meetings. There is significant and ongoing work related to the possible merger with the organisation to be formed by the merger of Western Sussex Hospitals NHS FT and Brighton University Hospitals NHS Trust; key stakeholders including NHS partners, QVH members and MPs across Kent Surrey Sussex have received updates on the case for change and next steps. QVH staff have been engaged through chief executive briefings, attendance at departmental and team meetings, attendance at consultants' fora. A staff Q&A has been updated when new issues arise and shared through internal communications channels. The Friends and Family Test was suspended from March 2020, data submission resumed from December 2020 for acute and community providers. The December data was submitted in early January 2021 and will be published in February. During the suspension if patients wanted to give feedback about their experience or raise concerns, they were directed to the Patient Experience Manager. Patient feedback throughout the last year has been very positive, alongside psotive comments from clinicians from other trusts who have been able to use QVH for cancer surgery.
8. Improvement	Continuous improvement is one of the core values of QVH. To support this we have identified a need to adopt a service improvement methodology.	We hope the leadership of Western and BSUH will support the initiation at QVH of Patient First, the successful improvement methodology that is used by those trusts.

CQC theme		Developments at Board level in 2020/21
	Board committees continue to undertake their annual effectiveness reviews, These self-assessments support the Board's evaluation of performance. Actions taken as a result are described above.	

Board development
As a small trust the funds available for Board development work are limited and as in all areas of the Trust, personal development is achieved through networks, shadowing, opportunities provided at no cost by national bodies such as NHS Providers, Federation of Specialist Hospitals, Healthcare Financial Management Association, NHS Improvement as well as more specialist professional bodies. Board members at QVH have a strong presence in national and regional professional bodies, both contributing and benefiting from these relationships and opportunities.

Board members work hard to balance the time commitment needed for their role at QVH with identifying time to step outside of the Trust for personal development. The culture at QVH encourages and supports personal development while recognising that for executive directors, creating the time needed is often a challenge. Capacity for personal development time was more of a challenge in 2020, and opportunities were more limited, but directors have ensured they are well equipped to maintain their roles.

All individual members of the Board, both executive and non-executive, have participated in development opportunities during 2020/21 as shown in Appendix B and have agreed personal development plans. Appendix B should not be considered a comprehensive list as executive directors spend a considerable proportion of their time on meetings outside of the Trust, but each director has identified what they consider their key personal development opportunities over the year.

Board seminars and clinician presentations
In addition to the Board seminars shown in Appendix A, Board members regularly attend the joint hospital governance committee which meets every six weeks and has a clinical focus including the findings of clinical audit, learning from national and local issues of clinical safety, clinical innovation.

Statutory and mandatory training
All Board members remain up to date with core training in areas like information governance and fire safety.

Director competencies
The Kark review, led by Tom Kark QC, reported back on the effectiveness of the fit and proper person tests for senior NHS staff making seven recommendations. A national decision on implementation will follow and for now the fit and proper persons tests is still applied, but Kark also suggested all directors (executive, non-executive and interim) should meet specified standards of competence to sit on the board of any health providing organisation. These are listed below and Board members consider them in setting personal development plans.

- Board governance;
- Clinical governance;
- Financial governance;
- Patient safety and medical management;
- Recognising the importance of information on clinical outcomes;
- Response to serious clinical incidents and learning from errors;
- The importance of learning from whistleblowing and ‘speaking up’;
- Empowering staff to make autonomous decisions and to raise concerns;
- Ethical duties towards patients, relatives and staff;
- Complying and encouraging compliance with the duty of candour;

- The protection, security and use of data;
- Current information systems relevant to health services;
- The importance of issues of equality and diversity both within the hospital in workforce issues and in relation to appointments to the Board
- An understanding of the importance of complying on a personal basis with the Nolan principles

Board development in 2021/22

The programme of Board seminars and clinical presentations will continue, ensuring Board members are well equipped to carry out their duties. Any specific suggestions for Board sessions should be discussed with the chair or the director of communications and corporate affairs.

Appendix A
Board seminars and presentations in 2020/21

Date	Event
02 April 2020	**Board private session** Approval of various COVID governance arrangements (seminar cancelled due to COVID)
04 June 2020	**Board seminar** • Recovery plan • Finance review including Going Concern and revaluation methodology • COVID19 update • Update on work with WSHFT related to partnership • Serious Incidents and never events reporting/methodology
06 August	**Board seminar** • Review of QVH as a cancer hub • Update on work with WSHFT related to partnership
26 August	**Board seminar** Presentation on how we can meet our Workforce Race Equality Standard (WRES) aspirations: Cavita Chapman, Head of EDI, and Olivia King, Regional Equality Manager South East Region
03 Sept 2020	**Board meeting session in private** Strategic development
01 October 2020	**Board seminar** • Plot the Dots presentation from Karen Hayllar, NHSI/E • Board to Board session with Western/BSUH
03 December 2020	**Board seminar** BAF, QVH risk appetite statement and corporate risk register review including discussion around: • How do/should we use risk appetite in practice when making decisions in board/committees? • Through our board and board committees, how do/should we oversee risks on the BAF and associated risk registers, monitor the action plans to mitigate/reduce the risk and link this to the different sources of assurance? Update on Sussex acute providers collaboration
04 February 2021	**Board seminar** Discussion of approach to strategic case Update on Sussex acute providers collaboration

Appendix B
Development of individual board members

	EVENT
Beryl Hobson	Inequality related issues • Sussex Trusts seminar - understanding the BAME issues arising from Covid • Sussex Chairs - Covid19 and Inequalities • NHS Providers - Race inequality - safe space meeting • Mentoring / reverse mentoring of our BAME network co-chairs Attending NHS Providers Chair and CEO events; Training sessions included: • Emergence of resilient leadership • An expert's insight on online board meetings • Leading through uncertainty Training sessions developed and delivered • Role of the Chair in a pandemic (Association of Chairs) x 2 Good Governance Institute events • The White Paper • From wellbeing guardians to the covid crisis - the ever expanding role of the NED
Paul Dillon--Robinson	• Involved with the HFMA in a variety of roles; tutoring at Masters level and delivering webinars on a range of management areas, that required reading up on developments. Facilitating their Operating Game (Acute / Community and ICS versions), coaching individuals in the NHS, as well as skills coach for a group of AAT apprentices • Non-executive member of the Rural Payments Agency's Audit & Risk Assurance Committee (ARAC), interim chair until April 2020, which also put me on the DEFRA ARAC which I re-joined in November as a non-executive member. Enabled me to compare and contrast with central government practice • Undertook governance reviews of independent schools, to a best practice checklist, making recommendations for improvement • Self-certified that I have maintained my CPD for the ICAEW, through reading publications and exploring areas of relevant interest.
Kevin Gould	• NHS Providers Conference • Regional NHS Audit Chairs Forum • Conference on value in higher education • Accounting for sustainability (A4S) summit • Various audit committee technical update seminars (mostly big 4) • Webinars on board responses to climate change, social impact, anti-money laundering, diversity and inclusion
Gary Needle	• PWC seminar Feb 2021 on The NHS People Plan • NHS Providers annual conference

	• PWC NED network seminars on: Integrated Care Systems; Risk Management and the role of the Audit Committee; Equalities and BAME networks • Regional presence enhanced by membership of the QVH Future Program Board. • International presence enhanced by independent role as a Consultant Planning Advisor to the Minister of Public Health in Qatar.
Karen Norman	• NHS Providers half day seminar on Statistical Process Control • Revalidated registration for Nursing and Midwifery Council • Visiting Professor, Doctorate in Management Programme, Business School, University of Hertfordshire. Supervising 6 Doctoral research students and teaching on international programme requiring keeping abreast of contemporaneous management and leadership literature. • Visiting Professor, School of Nursing, Kingston University and St George's, University of London. Teach at Masters level on Leadership and Management of Change module and Complexity and Reflexive Management for Band 5 nurses development programme requiring keeping abreast of contemporaneous NHS, nursing and clinical issues • NHS Providers Conference Sessions, including Board Assurance re. Covid.
Steve Jenkin	• Member of Sussex Health & Care Partnership (SHCP) Executive Group • Attendee of Gold system call on daily, weekly calls during pandemic • Role in SHCP - acute representative on MH Steering Group and member of Sussex Acute Collaborative Network • SRO for QVH Programme Board • Staff and Governor briefings on partnership working • NHS Providers CEO & Chairs briefings • Equality, Diversity & Inclusion session from NHSE/I • Weekly attendance at NHSE/I SE Regional Director's meeting • Sussex BAME conference and workshop
Keith Altman	• STP/ICS meetings • Sussex Acute Collaborative meetings • Responsible Officer network meetings • Board & QGC seminars • SE Medical Directors' briefings • NHS Medical Director webinar
Abigail Jago	• Part year MBA • Sussex women's director network • STP chief operating officers group
Michelle Miles	• Member of the ICS CFO Finance leadership group • SIRO annual training day • Member of ACMA • Attend national and regional CFO/DoF forums

Geraldine Opreshko	• Chair of the Sussex Health & Care Partnership Leadership, OD and Talent Management Meeting • NHS Employers Monthly HR Directors forums for SE England • ICS Workforce Directors forum, meeting weekly through pandemic • Sussex HCP People Committee • National webinars from NHS Chief People's office • SRO for Workforce Restoration and Recovery Workstream • Joint SRO for QVH Hospital Vaccination hub • Member of CIPD
Clare Pirie	• NHS Providers seminar on risk management • Webinar with various trusts nationally on use of Facebook and other platforms for internal communications • Attends national and regional communications and engagement sessions • Legal requirements and best practice related to merger – various discussions with external experts and directors in trusts that have merged or are considering merger
Nicky Reeves - joined the board as interim DoN in November 2020	• NHS Providers Executive Director Induction • Caldicott Guardian Training • Trust representative on Silver system calls during Covid incident response • Member of Sussex and Regional CNO Groups • Member of Sussex Clinical Harm Review Group • Member of Clinical Leadership Group Board

Appendix C: Non-Executive Director Statutory and Regulatory Roles

There are a number of requirements for NED roles which have not been brought together in a national document; this appendix was developed through liaison with NHSI and the NHS Providers CoSec network. Nationally there is a view that the named NED approach may impact on the independent role NEDs and care should be taken not to take on executive responsibilities. The QVH use of named NEDs has been shaped with this in mind.

Area	Role	Reference	Requirement	Comment
Board governance	Senior independent director	S36. Trust Constitution	A Senior Independent Director (SID) shall be appointed by the Board of Directors in consultation with the Council of Governors, and may also fulfil the role of the Deputy Chair.	GN is designated SID
Emergency Preparedness	NED Lead for Emergency Preparedness	NHSE Core Standards for Emergency Preparedness, Resilience and Response Guidance	Organisations must have an appointed Accountable Emergency Officer (AEO)/Chief Executive who is a board level director and responsible for EPRR in their organisation. This person should be supported by a non-executive board member.	SJ is designated AEO and is supported by Interim Director of Nursing (NR) KN is designated NED
Finance	Procurement Non-Executive Director	NHS TDA/Use of resources		No requirement at this stage
Information governance	NED lead for cyber-security	NHSI		No requirement at this stage
Security Management	Security Management Non-Executive Director	TIAA refers the most recent guidance as 2005	Key requirement is to have an executive director acting as the Security Management Director; QVH is complaint in that respect. Having a NED as a champion is considered good practice, so they can hold the executive director to account.	No requirement
Freedom to Speak up	Non-Executive Director FTSU	Guidance for boards on Freedom to	The trust should have a named non-executive director responsible for speaking up (as well as named executive) and both should be clear about their role and responsibility.	KG is designated NED

Area	Role	Reference	Requirement	Comment
		Speak Up in NHS trusts and NHS foundation trusts	Senior leaders should be knowledgeable and up to date about FTSU and the executive and non-executive leads aware of guidance from the National Guardian's Office. Senior leaders should be able to readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. They should be able to provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. Senior leaders should be able to describe the part they played in creating and launching the trust's FTSU vision and strategy.	GO is designated executive lead
Whistleblowing	Non-Executive Director for Whistleblowing	NA	Whilst the terms 'whistleblowing' and 'speaking up' are used interchangeably, there are distinct differences with regard to whistleblowing due to the legislation which relates to it (the Public Interest Disclosure Act (PIDA) 1988).	Trust policy states if an issue remains unresolved, the complainant may write to the Chair, who may designate one or more NED to investigate on their behalf.
Quality/ Patient Safety	Quality Non-Executive Lead	Francis Enquiry	Recommendation no: 204 All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors. All provider organisations must have at least one executive director who is a registered nurse.	KN is designated NED.
Patient care	Non-Executive Lead for End of Life Care	More Care, Less Care Report 2013	Recommendation no. 28 The Review panel recommends that the boards of healthcare providers providing care for the dying give responsibility for this to one of its members – preferably a lay member whose focus will be on the dying patient, their relatives and carers – as a matter of urgency. This is	Recommendation, (not requirement). Given the low level of End of Life Care at QVH, this will have

Area	Role	Reference	Requirement	Comment
			particularly important for acute hospitals, where the Review panel has found most cause for concern.	good oversight from the clinical NED.
	NED Responsible for Doctors Disciplinary	General Medical Council	Maintaining high professional standards in the modern NHS (2005) webarchive.nationalarchives.gov.uk/20130107105354/.../dh_4103344.pdf 4All serious concerns must be registered with the Chief Executive and he or she must ensure that a case manager is appointed. The Chairman of the Board must designate a non-executive member "the designated member" to oversee the case and ensure that momentum is maintained. The Board is responsible for designating one of its non-executive members as a "designated Board member" under these procedures. The designated Board member is the person who oversees the case manager and investigating manager during the investigation process and maintains momentum of the process. This member's responsibilities include: • receiving reports and reviewing the continued exclusion from work of the practitioner; • considering any representations from the practitioner about his or her exclusion; • considering any representations about the investigation;	There is no requirement for a designated NED as the Chair will appoint a NED as and when appropriate.
	NED Lead for learning from deaths	Implementing the Learning from Deaths framework: key requirements for trust boards 2017	The Learning from Deaths framework requires each trust's board to identify a NED to oversee the trust's approach to Learning from Deaths.	KN is designated NED
Operations	**NED for Cancer performance**	Cancer Alliance	Cancer Alliance has in previous year suggested to the Director of Operations that there should be a NED aligned to this specific area	All NEDs are responsible for scrutiny of this issue.

D R A F T Terms of reference

Name of governance body

Audit Committee

Constitution

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

Accountability

The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The Committee is authorised by the Board of Directors to:

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

Purpose

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

Duties and responsibilities

On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust's:

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

   In particular, the Committee will review the adequacy and effectiveness of:
   - All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board of directors.
   - The underlying assurance processes, including the board assurance framework, that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

Reviewed by Audit in December 2020
For approval by the Board of Directors at its meeting on 04 March 2021

- The draft quality accounts, including the rigour of the process for producing the quality accounts, in particular whether the information included in the report is accurate and whether the report is representative of both the services provided by the Trust, and of the issues of concern to its stakeholders.
- The Board of Director sub-committees, including terms of reference, workplans and span of reporting on an annual basis.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by NHS Protect.

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

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

2. Financial reporting

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

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

The Committee shall review the annual report and financial statements before submissions to the Board of Directors focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statement in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances

The Committee should review the Trust's standing financial instructions, standing orders and the scheme of delegation on an annual basis and make recommendations for change to the Board of Directors.

Internal audit

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2013 and provides appropriate independent assurance to the Committee, Chief Executive (as accounting officer) and Board of Directors. This will be achieved by:

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

External audit
The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment allow (and making recommendations to the council of governors when appropriate).
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual audit plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation.
- Reviewing all external audit reports, including the Trust's annual quality report (before its submission to the board of directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

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

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

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

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

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

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission and the NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

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

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

Meetings

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

The Committee will meet quarterly.

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

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

The Board of Directors, Chief Executive (as accounting officer), representative of the external auditor and head of internal audit may request additional meetings if they consider it necessary.

Chairing

The Committee shall be chaired by a non-executive director, appointed by the Trust Chair following discussion with the Board of Directors.

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

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

Secretariat

The Deputy Company Secretary shall be the secretary to the Audit Committee and shall provide administrative support and advice to the chair and membership. The duties of the secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the Chair
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers

- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the Committee's work programme.

Membership

Members with voting rights

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

Ex-officio attendees without voting rights

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

In attendance without voting rights

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

- Executive Director of Finance.
- Executive Director of Nursing.
- The secretary to the Committee (for the purposes described above).
- Designated deputies (as described below).
- Any other member of the Board of Directors, senior member of Trust staff or advisor considered appropriate by the chair of the Committee, particularly when the Committee will consider areas of risk or operation that are their responsibility.
- Representative of the QVH Council of Governors.

The Chair, members of the Committee and the Governor representative shall commit to work together according to the principles established by the Trust's policy for engagement between the Board of Directors and Council of Governors.

Quorum

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

Attendance

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

Attendees may, by exception and with the consent of the chair, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act on behalf of the Committee attendee.

Papers

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

Reporting

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

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

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

The Committee will also report to the Board of Directors at least annually on its work in support of the annual governance statement, specifically commenting on:

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

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

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

The Committee chair and governor representative shall report verbally at quarterly meetings of the Council of Governors.

Review

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency.

The next scheduled review of these terms of reference will be undertaken by the Committee in December 2020 in anticipation of approval by the Board of Directors at its meeting in March 2021.

* Definitions

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

D R A F T Terms of reference

NAME OF GOVERNANCE BODY

Finance and Performance Committee (F&PC)

CONSTITUTION

The Finance and Performance Committee ("the Committee") is a standing committee of the Board of Directors, established in accordance with the Trust's standing orders, standing financial instructions and constitution.

ACCOUNTABILITY

The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.

AUTHORITY

The Committee is authorised by the Board of Directors to seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary.

PURPOSE

The purpose of the Committee is to assure the Board of Directors of:

- Delivery of financial, operational and workforce performance plans and targets.
- Delivery of the Trust's strategic initiatives.

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

- The Trust's assets and resources in relation to the achievement of its financial plans and key strategic objective four: financial sustainability.
- The Trust's operational performance in relation to the achievement of its activity plans and key strategic objective three: operational excellence.
- The Trust's workforce profile in relation to the achievement of key performance indicators and key strategic objective five: organisational excellence.
- Business planning assumptions, submissions and acceptance/delivery of targets.

To fulfil its purpose, the Committee will also:

- Identify the key issues and risks requiring discussion or decision by the Board of Directors.
- Advise on appropriate mitigating actions.
- Make recommendations to the Board as the amendment or modification of the Trust's strategic initiatives in the light of changing circumstances or issues arising from implementation.

DUTIES AND RESPONSIBILITIES

Duties

Financial and operational performance

- Review and challenge construction of operational and financial plans for the planning period as defined by the regulators.
- Review, interpret and challenge in-year financial and operational performance.
- Review, interpret and challenge workforce profile metrics including sickness absence, people management, bank and agency usage, statutory and mandatory training compliance and recruitment.
- Oversee the development and delivery of any corrective action plans and advise the Board of Directors accordingly.

- Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the Board of Directors.
- Refer issues of quality or specific aspects of the Quality and governance committee's remit, and maintain communication between the two committees to provide joint assurance to the Board of Directors.

Estates and facilities strategy and maintenance programmes

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

Information management and technology strategy, performance and development

- Review the delivery of the Trust's IM&T strategy and planned development programmes as agreed by the Board of Directors.

Capital and other investment programmes and decisions

- Oversee the development, management and delivery of the Trust's annual capital programme and other agreed investment programmes.

- Evaluate, scrutinise and approve the financial validity of individual significant investment decisions (that require Board approval), including the review of outline and full business cases. Business cases that require Board approval will be referred to the Committee following initial review by the Executive Management Team and/or Capital Planning Group.

Cost improvement plans

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

Business development opportunities and business cases

- Evaluate emerging opportunities on behalf of the Board of Directors.

Consider the merit of developed business cases for new service developments and service disinvestments prior to submission to the Board of Directors for approval.

Responsibilities

On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust's:

- Monthly financial and operational performance.
- Estates strategy and maintenance programme.
- Information management and technology strategy, performance and development.

The Committee will make recommendations to the Board in relation to:

- Capital and other investment programmes.
- Cost improvement plans.
- Business development opportunities and business cases.

CHAIRMANSHIP

The Committee shall be chaired by a non-executive director, appointed by the Trust Chair following discussion with the Board of Directors.

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

MEETINGS

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

The Committee will meet once in each calendar month, on the fourth Monday of the month.

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

SECRETARIAT

The Executive Assistant to the Director of finance and performance shall be the secretary to the Committee and shall provide administrative support and advice to the chair and membership. The duties of the secretary shall include but not be limited to:

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

MEMBERSHIP

Members with voting rights

The following posts are entitled to membership of the Committee and shall have full voting rights:

- Three Non-Executive Directors (including Committee chair)
- Chief Executive
- Director of Finance and performance
- Director of Operations
- Director of Workforce and Organisational Development

Ex-officio members without voting rights

- The Director of Nursing

In attendance without voting rights

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

- Representative of the QVH Council of Governors.
- The secretary to the Committee (for the purposes described above).
- Any member of the Board of Directors or senior manager considered appropriate by the chair of the Committee.

The Chair, members of the Committee and the Governor Representative shall commit to work together according to the principles established by the Trust's policy for engagement between the Board of Directors and the Council of Governors.

QUORUM

For any meeting of the Committee to proceed, two non-executive directors and one executive director of the Trust must be present.

ATTENDANCE

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

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

PAPERS

Papers to be distributed to members and those in attendance at least three clear days in advance of the meeting.

REPORTING

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

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

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

The Committee chair and governor representative shall report verbally at quarterly meetings of the Council of Governors.

REVIEW

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency.

The next scheduled review of these terms of reference will be undertaken by the Committee in February 2021 in anticipation of approval by the Board of Directors at its meeting in March 2021.

*DEFINITIONS

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

D R A F T Terms of reference

Name of governance body

Nomination and Remuneration ('Nom and Rem' or 'N&R') Committee

Constitution

The Nomination and remuneration committee (the Committee) is constituted as a statutory non-executive committee of the Trust's Board of Directors.

Accountability

The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The Committee is authorised by the Board of Directors to:

- Appoint or remove the chief executive, and set the remuneration and allowances and other terms and conditions of office of the chief executive.
- Appoint or remove the other executive directors and set the remuneration and allowances and other terms and conditions of office of the executive directors, in collaboration with the chief executive.
- Consider any activity within its terms of reference.
- Seek relevant information from within the Trust. (All departments and employees are required to co-operate with any request made by the committee).
- Instruct independent consultants in respect of executive director remuneration.
- Request the services and attendance of any other individuals and authorities with relevant experience and expertise if it considers this necessary to exercise its functions.

Purpose

The purpose of the Committee is to:

- Determine the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board of Directors, making use of the output of the board evaluation process as appropriate, and to make recommendations to the Board, as applicable, with regard to any changes.
- Work with the chief executive to identify and appoint candidates to fill all executive director and other positions that report to the chief executive.
- Work with the chief executive to decide and keep under review the terms and conditions of office of executive directors and other positions that report to the chief executive, including:
    - Salary, including any performance-related pay or bonus;
    - Provisions for other benefits, including pensions and cars;
    - Allowances;
    - Payable expenses;
    - Compensation payments.

- Set the overall policy for the remuneration packages and contractual terms of the executive management team.

Duties and responsibilities

Duties (nominations)

- When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment.
- Use open advertising or the services of external advisers to facilitate candidate searches.
- Consider candidates from a wide range of backgrounds on merit against objective criteria.
- Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.
- Ensure that proposed appointees meet the "fit and proper person test", and confirm their awareness of the circumstances which would prevent them from holding office.
- Consider any matter relating to the continuation in office of any executive director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

Duties (remuneration)

- Establish and keep under review the national NHSI VSM pay strategy and associated QVH VSM pay principles in respect of executive board directors and other positions that report to the chief executive.
- Establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.
- Use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors and other positions that report to the chief executive, while ensuring that increases are not made where Trust or individual performance do not justify them.
- Monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.
- The Committee will work with the chief executive to determine the remuneration of the other executive directors.

Responsibilities

On behalf of the Board of Directors, the Committee has the following responsibilities:

- To identify and appoint candidates to fill posts within its remit as and when they arise.
- In doing so, to adhere to relevant laws, regulations, trust policies and the principles and provisions regarding the levels and components of executive directors' remuneration as defined by section D of the FT *Code of Governance.*.
- To be sensitive to other pay and employment conditions in the Trust.
- To keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

- To give full consideration to and make plans for succession planning for the chief executive and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.
- To sponsor the Trust's leadership development and talent management programmes to support succession plans and meet specific recruitment and retention needs.
- To ratify the recommendations of the Employer Based Awards Committee for medical and dental Clinical Excellence Awards

Meetings

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

The Committee will usually meet three times a year.

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

The Board of Directors, Chief Executive and Director of workforce and organisational development may request additional meetings if they consider it necessary.

Chairing

The Committee shall be chaired by the chair of the Trust.

If the chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the Committee shall be chaired by the senior independent director of the Trust.

Secretariat

The Director of Corporate affairs and communications, working closely with the Director of Workforce and organisational development, shall be the secretary to the Committee and provide administrative support and advice to the chair and membership. The duties of the secretary shall include but not be limited to:

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

Membership

Members with voting rights

The Committee shall comprise all non-executive directors of the Trust who shall each have full voting rights.

Ex-officio attendees without voting rights

- Chief Executive
- Director of Workforce and Organisational Development

In attendance without voting rights

- The secretary to the Committee (for the purposes described above)

- Any other member of the Board of Directors, senior member of Trust staff or external advisor considered appropriate by the chair of the Committee.

Quorum

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

Attendance

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

Attendees, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Papers

Meeting papers shall be distributed to members and attendees at least five clear days* prior to the meeting.

Reporting

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

The Committee chair shall prepare a report of each Committee meeting for submission to the Board of Directors at its next formal business meeting.

Review

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency.

The next scheduled review of these terms of reference will be undertaken by the Committee before approval by the Board of Directors at its meeting in March 2021.

* Definitions

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