NHS
Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 6 May 2021

Session in public
11:00 – 13:15

Annual declarations by directors 2021/22

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 (PGS) Director Long Meadow Views management Company Limited	PGS may have clients who are NHS related organisations (eg Royal Colleges) of who provide services to the NHS (eg charities)	48% share of PGS	Nil	None (apart from declares above)	Nil	Family members are directors of PGS (see above)
Paul Dillon-Robinson Non-Executive Director	Nil	Independent consultant (self-employed) – see HFMA	Nil	Nil	NIL	Independent consultant working with the Healthcare Financial Management Association (including NHS operation game, HFMA Academy and coaching and training)	Nil
Kevin Gould Non-Executive Director	Director, Sharpthorne Services Ltd	Nil	Nil	Independent Member of the Board of Governors, Staffordshire University Independent Member of the Audit & Risk Committee at Grand Union Housing Group Director, Look Ahead Care & Support Trustee, Centre for Alternative Technology	Director, Look Ahead Care & Support	Nil	Nil
Gary Needle Non-Executive Director	T&G Needle Property Development Ltd	Nil	Nil	Chair of Board of Trustees, East Grinstead Sports Club	Nil	Nil	Nil
Karen Norman Non-Executive Director	Nil	Nil	Nil	Nil	Visiting Professor, Doctorate in Management Programme, Complexity and Management Group, Business School, University of Hertfordshire Visiting Professor, School of Nursing, Kingston University and St George's, University of London	Nil	NIl
Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Keith Altman	Maxfax Medical Limited	Nil	Nil	Nil	Nil	Nil	Nil

Medical Director							
Michelle Miles, Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Nicky Reeves Director of Nursing	Nil	Nil	Nil	Trustee of McIndoe Burns Support Group	Nil	Nil	Nil
Other members of the board (non-voting)							
Abigail Jago Director of operations	Nil	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 persons declaration

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 a governor of the trust under given circumstances known as the "fit and proper person test". By completing and signing an annual declaration form, QVH governors confirm their awareness of any facts or circumstances which prevent them from holding office as a governors 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	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul Dillon-Robinson Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kevin Gould Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gary Needle Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Karen Norman Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Keith Altman Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Michelle Miles Director of Finance	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nicky Reeves Director of Nursing	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other members of the board (non-voting)							
Abigail Jago Director of operations	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Geraldine Opreshko Director of HR & OD	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Clare Pirie Director of Communications & Corporate Affairs	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
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Michelle Miles, Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Nicky Reeves Director of Nursing	Nil	Nil	Nil	Trustee of McIndoe Burns Support Group	Nil	Nil	Nil
Other members of the board (non-voting)							
Abigail Jago Director of operations	Nil	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 persons declaration

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Kevin Gould Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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Keith Altman Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Michelle Miles Director of Finance	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nicky Reeves Director of Nursing	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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Geraldine Opreshko Director of HR & OD	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Clare Pirie Director of Communications & Corporate Affairs	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 06 May 2021
11:00 – 13:15

Agenda: session held in public			
Welcome			
60-21	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
61-21	**Freedom to speak up** *Sheila Perkins, FTSU guardian*	*Assurance*	1
62-21	**Draft minutes of the meeting held on 04 March 2021** *Beryl Hobson, Chair*	*approval*	4
63-21	**Matters arising and actions pending** *Beryl Hobson, Chair*	*review*	12
64-21	**Chair's report** *Beryl Hobson, Chair*	*to note*	13
65-21	**Chief executive's report** *Steve Jenkin, Chief executive*	*assurance*	16
66-21	**Overarching strategic corporate risks** *Steve Jenkin, Chief executive*	*assurance*	26
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
67-21	**Board Assurance Framework** *Nicky Reeves, interim Director of nursing, and* *Keith Altman, Medical director*	*assurance*	29
68-21	**Quality and governance assurance** *Karen Norman, Non-executive director*	*assurance*	31
69-21	**Corporate risk register (CRR)** *Nicky Reeves, interim Director of nursing*	*review*	34
70-21	**Quality and safety report** *Nicky Reeves, interim Director of nursing, and* *Keith Altman, Medical director*	*assurance*	41
71-21	**7-day services assurance** *Keith Altman, Medical director*	*assurance*	87
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
72-21	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*assurance*	97

73-21	**Financial, operational and workforce performance assurance** *Paul Dillon-Robinson, Committee chair*	*assurance*	99
74-21	**Operational performance** *Abigail Jago, Director of operations*	*assurance*	102
75-21	**Procurement of Central Sterile Service Department (CSSD) Outsourced Service.** *Michelle Miles, Director of finance*	*approval*	117
76-21	**Business Planning and Budget Setting Update 2021/22** *Michelle Miles, Director of finance*	*approval*	120
Key strategic objective 5: organisational excellence			
77-21	**Board assurance framework** *Geraldine Opreshko, Director of Workforce and OD*	*assurance*	125
78-21	**Workforce monthly report** *Geraldine Opreshko, Director of Workforce and OD*	*assurance*	126
79-21	**Staff survey results** *Geraldine Opreshko, Director of Workforce and OD*	*assurance*	142
Governance			
80-21	**QVH governor representative roles** *Clare Pirie, Director of communications and corporate affairs*	*approval*	184
81-21	**Self-certification of NHS Provider licence conditions** *Clare Pirie, Director of communications and corporate affairs*	*approval*	195
82-21	**Update to QVH Board of Directors effectiveness review: Q&GC self-effectiveness review and ToRs for approval** *Clare Pirie, Director of communications and corporate affairs*	*approval*	199
83-21	**Annual board declarations of interest/Fit and proper person test** *Clare Pirie, Director of communications and corporate affairs*	*assurance*	-
84-21	**Audit committee** *Kevin Gould, Committee chair*	*assurance*	206
Any other business (by application to the Chair)			
85-21	*Beryl Hobson, Chair*	*discussion*	-
Questions from members of the public			

86-21	*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*	-

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/05/2021**		**Agenda reference:**	**61-21**	
Report title:	**Freedom to Speak Up Guardian**				
Sponsor:	Shelia Perkins, FTSU Guardian				
Author:	Shelia Perkins, FTSU Guardian				
Appendices:					
Executive summary					
Purpose of report:	To update the Board on matters raised by staff through the Freedom to Speak Up route.				
Summary of key issues	• Six concerns raised in last six months • All matters acknowledged and dealt with • Ineffective communication a key driver for concerns raised				
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:	None			
Corporate risk register:	None			
Regulation:	None			
Legal:	None			
Resources:	None			
Assurance route				
Previously considered by:				
	Date:		Decision:	
Next steps:				

Report to: Board of Directors
Meeting date: 06 May 2021
Reference number: 61-21
Report from: Sheila Perkins, FTSU guardian
Author: Sheila Perkins, FTSU guardian
Appendices: None
Report date: 27 April 2021

Freedom to Speak Up Guardian

1. In the last six months I have had contact with six members of staff who raised concerns. I have been able to meet with staff face to face where appropriate, and had telephone contact where this wasn't possible.

Month	
October 2020 - December 2020	3
January 2021 - March 2021	3
Total	**6**

Staff Demographic	
Nursing	3
Allied Health Professionals	2
Medical / Dental	1
Administrative Staff	

Themes	
Patient experience (no safety issues)	0
Patient experience potential safety issues	0
Staffing levels	0
HR Issues	1
Bullying/unacceptable behaviour from managers / team leader	3
Other	1
COVID related	1

2. All concerns were acknowledged and dealt with; in most cases this took the form of a conversation with the appropriate manager.

3. HR was able to clarify leave policy with staff who raised concerns.

4. One conversation related to the merger talks; the member of staff and a group of colleagues had already raised their concerns, in writing, with Steve Jenkin.

5. Three members of staff brought concerns that fit in the bullying / unacceptable behaviour category; I want to clarify that in all three cases it was a lack of clear and effective communication that was the main factor. Two members of staff were able to meet with their managers and address this. The third member of staff has had support to address this.

6. Although I have to log the concerns under specific headings used nationally, I want to identify where ineffective communication causes concern for staff at QVH – this has been a constant theme in the time I have been in this role.

7. The issue raised related to Covid has been dealt with and I have offered further support to that member of staff.

8. No concerns were raised anonymously.

9. I am aware that other concerns have been raised by staff that haven't come via FTSU guardian; I find it reassuring that staff are able to raise their concerns directly with the most appropriate person.

Sheila Perkins, FTSU Guardian

	Minutes (Draft & Unconfirmed)	
Meeting:	**Board of Directors (session in public)** **Thursday 4 March 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)
	Keith Altman, (KA)	Medical Director
	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)
In attendance:	Hilary Saunders (HS)	Deputy company secretary (minutes)
	Nicolle Ferguson (NF)	Patient experience manager **[item 34-21]**
	Joy Curran (JC)	Guardian of safe working **[item 43-21]**
	Peter Shore (PS)	Lead governor
Public gallery:	11 public governors, 1 staff governor, 1 staff member, SE CQC inspector	

Welcome

33-21 **Welcome, apologies and declarations of interest**

The Chair opened the meeting and welcomed those in the public gallery.

There were no apologies and no new declarations of interest.

Standing items

34-21 **Patient story**

This was a standing item scheduled for the beginning of each public meeting as a reminder that the patient was at the centre of everything we do.

The patient joined the meeting from Northern Ireland (NI) where she lived. She had been referred to QVH as this was the only hospital able to provide the specialist treatment needed. The patient described her experience of facial palsy and explained how the Facial Palsy clinic was a lifeline to her and other patients. She went on to describe the challenges associated with commuting to and from QVH which she had been required to do prior to the introduction of virtual clinics.

The virtual clinics had been introduced before COVID and the patient had been an 'early adopter' of the new technology. Whilst there had been difficulties in implementation, much of these had been addressed over the last 12 months, with more virtual clinics being rolled out as a result of the pandemic. The patient experience manager also commented that information provided to both staff and patients on how to use the virtual clinic system had greatly improved over the last twelve months.

The Chair thanked the patient for describing both favourable and less favourable elements of her experience. The Board concurred it was helpful to hear about the areas still needing some improvement.

The Board sought clarification as to the level of psychological support patients received. As someone living in Northern Ireland, the patient described her experience as quite negative whilst noting this was not due to lack of support from the Trust. The Board commented that additional charitable funding for psychological therapy had been secured for cancer patients and queried whether this might be an option for other services. NR advised that the Psychological therapies

	team were offering virtual clinics which might be something to consider. The Board commented on the continuous need to treat patients holistically. There were no further questions and the Chair thanked the patient on behalf of the Board for taking the time today to describe her experience.
35-21	**Draft minutes of the meeting held on 07 January 2021** The minutes of the meeting were **approved** as a correct record, subject to the following amendment: Wording under item 17-21 to read: *'areas of challenge remain in RTT18 (both open pathway performance and patients waiting greater than 52 weeks) and the 31 day cancer standard. However the RTT52 remains ahead of the phase 3 plan'.*
36-21	**Matters arising and actions pending** The Board received the latest Matters Arising update. All items were now closed.
37-21	**Chair's report** The Board received the Chair's report. In response to a question, BH advised that the BAME network was still being developed and not yet at the stage of establishing mentoring/allyship. There were no further questions and the Board **noted** the contents of the update.
38-21	**Chief executive's report** SJ presented his latest report which included the overall BAF, dashboard and media update. In the final month of this financial year, SJ felt it timely to reflect on how well staff had continued to work, particularly in the initial stages of the pandemic. An early change had been QVH taking on the role of regional cancer hub, and as CEO it had been gratifying to receive the significant amount of positive feedback from both patients and visiting consultants. As a testament to how well staff had adapted throughout the year, 300 nominations had been received in this year's staff awards in recognition of individuals and teams who had continued to support patients against the backdrop of a global pandemic. SJ went on to recognise those staff with long standing service, paying particular tribute to Jennifer Francis who was celebrating 45 years' service with QVH. He also thanked Jeremy Collyer Deputy Medical Director and Consultant Maxillofacial Surgeon, who would be leaving QVH in April after many years of outstanding service. Finally, the CEO recognised the success of the COVID vaccination programme which had been rolled out to staff and other local health and social care workers. Work had paused now until rollout of the second dose; in the meantime, QVH is providing support to the Crawley hub as part of Sussex Integrated Care System (ICS) programme. The Board considered the contents of the report and update, seeking additional clarification as follows: • That the Trust was now operating under the new funding framework which came into effect in Q3. Additional costs relating to COVID are now prospective and at ICS level (rather than retrospective and organisational level). • A detailed analysis of high level strategic risks will be presented at the next meeting. All board members would be invited to comment prior to presentation of the final version. **[Action: SJ]** • That the majority of staff who had left the Trust recently were either retiring or coming to the end of fixed term contracts. Whilst remaining mindful of anxiety around the future merger, the Trust had not seen staff 'voting with their feet' and this is also reflected in the latest workforce report. Board members concurred that they had also seen evidence of staff optimistic about benefits of merger. • A key risk in 2021/22 was how to keep staff engaged, motivated and supported through a time of great change. SJ reiterated that as an organisation, QVH takes the health and wellbeing of

	our staff very seriously. Mitigations in place included investment in the Stay Well initiatives; Leadership Academy opportunities for healthcare staff; Staff Awards (noted earlier) which have been very well received and regular staff briefings. It was equally important to maintain Mandatory and Statutory Training (MAST) scores; in January, there had been an increase in both MAST and appraisal rates, and our rolling turnover rate had in fact improved by 3% during the past year. • It was too early to know whether the two-way text process had improved efficiency; initial figures suggested around 50% response rate, with the majority confirming they would be attending. Prior to the pandemic the number of patients failing to attend an appointment was high. It was hoped that the new system would result in a 2% reduction; KPIs would be established in April and progress monitored. The focus moved on the White paper. SJ reminded the Board that trusts have been working with their system partners for several years in sustainability and transformation partnerships (STPs) and more recently integrated care systems (ICSs). Proposals contained within the White paper aimed to build on this strategic direction of travel. Leadership and co-leadership roles within the new system would continue to evolve. Additional clarification was provided as follows: • That NHS trusts and foundation trusts would remain separate statutory bodies, with functions and duties broadly as at present. • The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. However there will be a new duty to compel providers to have regard to the system financial objectives to ensure both providers and ICS NHS bodies are mutually invested in achieving financial control at system level. • The Sussex ICS already exists and supports collaborative approaches to health and social care. Whilst it is still very early on in the process, the work collating data on acute services in Sussex is useful groundwork for thinking about how to strengthen some services. It was still unclear when this document would be put in the public domain by the ICS but SJ would keep both the Board and Council apprised. • QVH is based in Sussex, and our relationships with Kent and Surrey remain critical. The White paper was shifting the existing framework from competition to collaboration which would compel organisations to work together. The Board noted that the concept would enable provider collaboratives to work cross borders, but the detail of how this would operate in practice was still being worked through. • The Board expressed disappointment that the White Paper had fallen short of setting out the role of social services in working with NHS colleagues. There were no further comments and the Board **noted** the contents of the report and update.
Key strategic objectives 1 and 2: outstanding patient experience and world class clinical services	
39-21	**Board assurance framework** The Board received the latest BAF for KSO1, noting the amount of work currently ongoing around risk management at board committee level. KA presented the BAF for KSO2, asking the Board to note recently revised risks as follows: • Potential for harm to patients due to long waits for surgery • Maintaining safe & effective clinical services evidenced by excellent outcomes & clinical governance • Developing a robust research & innovation strategy along with potential collaboration with Brighton & Sussex medical school (BSMS) if there is a future merger There were no further comments and the Board **noted** the contents of the latest update.
40-21	**Quality and governance assurance** In response to a question about whether QVH progress on harm reviews was consistent with other providers in terms of number undertaken and results, KN said that there was a great deal of national and regional work ongoing but currently it was not possible to answer this question; significant progress had been made at QVH on the process for reviews, which are now being

	devolved to clinical specialisms to undertake. NR added that national guidance on benchmarking was expected, and that QVH clinical specialisms might be hard to benchmark.
41-21	**Corporate risk register** The Board received the latest CRR, seeking additional clarification as follows: • That the recently added risk regarding workforce succession planning related to staff in radiology, not radiography, and was as a result of the age profile of some staff. It was noted, however that there was also a national challenge associated with recruitment of radiographers. • The new risk relating to staffing within our critical care unit was as a result of the need to reconfigure patient pathways to maintain our 'green site' status. Changes had made staff flexibility difficult so it was agreed to add this to the register. The situation had improved since Christmas. • Coding backlog (risk 1148). The Trust had now recruited two coders and procured the new encoder system. Once software was implemented and coders fully inducted, the risk will be downgraded. There were no further comments and the Board **noted** the contents of the update.
42-21	**Quality and safety report** The Board received the joint report from the Director of Nursing and the Medical Director. NR asked the Board to note the inclusion for the first time of the Infection Prevention and Control board assurance framework; this was presented for information as a result of a change in guidelines. NR also added her congratulations to those responsible for the successful rollout of the flu and COVID vaccination programmes. KA thanked Martin Jones, who was stepping down after three years as clinical director in plastics. Martin was commended for his support throughout the pandemic. BH would write separately to thank him for his contribution. **[Action: BH]**
43-21	**Guardian of safe working** The chair welcomed the QVH guardian of safe working, JC, and thanked her for undertaking this important role. JC highlighted that the paper was made up of two quarterly reports, submitted nationally as required, with additional narrative. In response to a question about how the pandemic has affected doctors and dentists in training at QVH, JC said that the training of every junior doctor in the country had been impacted. At QVH no trainees were redeployed. There had been some differences in practical experience and rota in the first wave; the education programme was back to full levels and all juniors have had the relevant experience and passed their annual training progression meetings. The Board noted that since the paper was written, access to rest facilities has been improved with the end of PPE storage in the surgeons mess and provision of a room for maxfacs trainees. Ideally there would be provision in the main hospital building but that is not easy to achieve; there is c.£12k to spend on a dedicated areas when identified. The Board asked for an update on this at the next meeting. **[Action: KA]** In response to a question about the higher number of exception reports and additional locum hours in plastics JC stated that the working hours are safe. She went on to explain that the requirement for night shifts and the need to cover the McIndoe Centre had been challenging and the chief executive has been looking at this very seriously. AJ added that the Trust has changed the management of trauma so that patients don't have to return to site and work is needed on how space is used to support this. The Board congratulated JC and all those involved in education on helping QVH trainees through a difficult time.
44-21	**Health Care Worker Flu Vaccination Information** NR presented a report on this year's successful seasonal flu vaccination programme. This highlighted the increased update for both frontline staff and the workforce as a whole. There were no questions and the Board **noted** the contents of the update.

Key strategic objectives 3 and 4: operational excellence and financial sustainability	
45-21	**Board assurance framework** AJ presented the BAF for KSO3, highlighting the challenge around the independent sector (IS) and the Trust's capacity in general. The Board was reminded that at the start of the pandemic NHS Trusts were given access to independent sector hospitals and QVH had worked closely with The McIndoe Centre; however, the national contract had changed and there was now uncertainty - particularly with regard to funding arrangements. SJ advised that in December, the national waiting list stood at 4.5m, with 225k waiting in excess of 52 weeks for treatment. When compared to last year's figure of 1.6k, the impact was clear. This would inevitably be compounded by the challenge around pensions following yesterday's budget announcement. Recognising the scale of the challenge, the Board asked when the Trust might achieve zero patients waiting more than 52 weeks for surgery. The Trust was already looking at different modelling options; however, because of the extreme level of uncertainty around funding arrangements and independent sector and additional capacity, together with the lack of guidance from NHSE it would not be possible to predict at this stage. The impact of COVID was still being felt and although there had been some improvements in the system, the Trust was not at the point of resuming normal levels of activity. The Board was also reminded of current critical care challenges (highlighted earlier), and also the risks around schools re-opening and new variants of COVID. MM presented the BAF for KSO4. The Trust had broken even for the first half of the year, and in months 7-12 was predicated to achieve plan; as a result, the risk rating was currently at 20 despite the underlying deficit. The Board was reminded again of work currently underway to ensure consistency of risk ratings across all five BAFs. There were no further comments and the Board **noted** the contents of the update.
46-21	**Financial, operational and workforce performance assurance** PDR summarised that the Trust was working with high levels of uncertainty and the finance and performance committee had spent time looking in detail at surge capacity, the use of the independent sector and associated risks. The indicators around workforce are good with the committee aware of the risks. The funding currently received by the Trust is exceptional and does not represent the underlying financial position. In response to a question about the theatre productivity programme, AJ said that it would partially address current challenges by aiming for the full utilisation of sessions even in the context of patients needing to self-isolate and short notice cancellations. Issues remained about the total number of theatre sessions available, related to the loss of sessions associated with running amber and green pathways; estate challenges; availability of independent sector sessions. Most cancer hub work will be repatriated but timescales are yet to be determined for some providers. Covid has forged stronger relational links with other providers at regional and ICS level which have included helpful conversations around KPIs, challenges and sharing best practice.
47-21	**Operational performance** AJ presented the latest operational performance report, highlighting the biggest risks within the KSO3 domain as: • The ongoing impact of waiting list backlog • Challenges around independent sector provision and potential funding to address recovery • Theatre capacity. The Board considered the report, seeking the following additional assurance: • Although likely to be issued shortly, there is currently no national guidance around how 52-week waits should be managed. It was anticipated that focus would be on treating urgent cases prior to long waiters. ICS shared perspective is firstly cancer patients followed by urgent clinical priorities and diagnostics and then RTT long waits. • With the exception of 31-day target, compared with other trusts, QVH has performed strongly. The majority of 31-day long waits relate to skin and that the Trust had recently agreed a 1-year fixed term locum consultant post to fast-track these referrals.

	• The Board noted internal and external mitigations in place to manage the risks to our capacity to deliver recovery plans. There were no further comments and the Board **noted** the contents of the update.
48-21	**Financial performance** MM presented the latest financial performance report, highlighting in particular: • The Trust's favourable variance as a result of the block contract arrangements which will enable us to achieve plan at year-end. • The ICS position would also be taken into consideration as well as the Trust's own position for the first time. • The Trust has received the full amount of COVID capital applied for. • The Trust was still awaiting full year-end guidance. The Board asked about the process for approval of the 2021/22 and business plan. Although the end of year guidance was still pending, budget setting, which based on 2019/20 activity levels, was progressing. As recovery and restoration plans came into effect this would be flexed, but the Board would be apprised of any changes. Draft budgets would be submitted to the Finance and performance committee at end of March and then presented to Board for approval. There were no further questions and the Board **noted** the contents of the update.
Key strategic objective 5: organisational excellence	
49-21	**Board Assurance Framework** The Board received the latest BAF for KSO5 which remained unchanged since the previous meeting.
50-21	**Workforce monthly report** GO presented the workforce report, highlighting in particular: • That KPIs have remained stable, even improving in some areas. Given concerns around merger this was very positive. • A high number of starters joined the Trust in January. Despite COVID we were still able to bring over a further six overseas nurses who will join at the end of March. • The staff survey remains embargoed until 11 March so it isn't possible to report results in the public domain. • The slight increase in the use of bank staff relates to COVID absence. Despite this, absence rates remain stable generally, and will continue to be monitored on a daily basis. • Plans for rollout of the second dose vaccine appointments will be completed by the end of the week. The Board considered the report and update, seeking additional clarification as follows: • The number of staff who have declined the COVID vaccine and Trust policy for those who do so. System complexities meant the Trust does not have access to this data. However recently released guidance issued by the NHS Chief People officer advised that individual meetings should be arranged with every staff member who had declined to enable their line managers to explain the benefits of the vaccine. The requirement states that this should be handled sensitively and, respecting that this is an individual decision, staff should not be asked outright why they had declined. The Board agreed that a supportive, educational approach would be more effective. • From available data, it would seem that between 70-80% of BAME staff have had the vaccine. The BAME network co-chairs had been active in supporting staff in their decision making process. • Anecdotal evidence suggested that although staff had been psychologically impacted by COVID, some were reluctant to take up support offered. GO stated that high numbers of staff have taken advantage of the support; the Trust would continue to remind staff of what was available and encourage them to take the time to access this. Role modelling by senior managers was also important to create an environment of psychological safety.

	• Whilst some trusts would be offering staff an extra day's annual leave in recognition of extraordinary efforts over the last year, we had introduced a package of measures as an ongoing thank you which was felt to be more appropriate to QVH. There were no further comments and the Board **noted** the contents of the update.
Governance	

51-21	**Board effectiveness review**
	CP presented a review of the Board's performance over the last 12 months, designed to identify any action required to ensure it has the skills, experience and approach required. The scope of this review was a requirement of the FT code of governance
	
	Reviewing board effectiveness could be subjective, but CP felt the strong degree of trust amongst board members had enabled a good level of constructive challenge. Content of the review would be included in the 2020/21 annual report and accounts.
	
	The Board considered the report, noting in particular:
	• The report recognises the pragmatic view the Board took on COVID, with appropriate focus on operational delivery. It also recognised that the developments in the ICS and the direction of the NHS in general had created significant uncertainty.
	• Some work undertaken over the last year on culture has been very helpful in terms of a better understanding with regard to the merger.
	• The report had also highlighted:
	  ○ The significant achievement in establishing a BAME network this year, resulting in positive feedback from colleagues across the Trust.
	  ○ The seminar led by Karen Hayllar from NHSI/E which had provided analysis techniques and encouraged the board to use data, to identify and focus on a problem and how best to address it.
	
	The Chair thanked CP for her report. She noted the difficulties that all board members had faced in undertaking their remit over the last year and thanked them for their continuous support.
	
	There were no further questions and the board **agreed** the contents of the review, noting that detail will be included in the 2020/21 annual report and accounts, and **approved** the Board sub-committee terms of reference for the next 12 months.

Any other business	
52-21	There were none
Questions from members of the public	
53-21	**Questions from members of the public** BH advised that the following questions had been raised in advance by members of the public. 1. *The numbers of QVH staff receiving the COVID vaccine appear to be very high. What proportion of staff have declined the vaccine for other than medical reasons? How many of such staff are in patient facing roles?* This had already been answered in part under item 50-21; the lead governor, who had raised the query, sought additional clarification as to the number of staff included in the total. GO advised that these were headline figures only which currently also included bank staff and volunteers, and further analysis was needed before this information could be released. 2. *When are you going to release the Sussex Acute Services review into the public domain?* This had been addressed under item 38-21. The Sussex Acute Services review was commissioned by the ICS and it was not in the gift of QVH to publish it; the ICS are currently considering when it will be published. BH advised that The Trust had received a further question relating to information provided to governors which she did not intend to read out as it referred to a member of staff by name. The

	Board was aware of the question, and also aware that the CEO had already responded to all members of Council on the matter of the information provided to governors. This question had also raised the issue of timeliness of our response to governors. BH reminded those present that, as made clear in our case for change, the hospital has very small teams, with often only one person handling queries. This means that responses can take longer than we would like. However, we already have in place several means of communicating with Council, and BH would be asking the Governors' Steering Group to consider this matter further. There were no further questions and the meeting was closed.

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	March	38-21	CEO report	Standing items	Detailed analysis of high level strategic risks to be presented.	SJ	May	On May agenda	Pending
2	March	42-21	Q&S report	KSO2	BH to send letter of thanks to Martin Jones	BH	ASAP	Complete	Complete
3	March	43-21	GoSW	KSO2	Update on dedicated rest areas for medical staff to be provided to BoD.	KA	May		Pending

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/05/21**		**Agenda reference:**	**64-21**	
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				

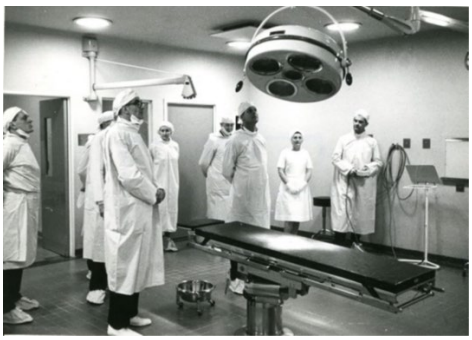
Report to:	**Board of Directors**
Meeting date:	06 May 2021
Agenda item:	64-21
Report from:	Beryl Hobson, Chair
Date of report:	26 April 2021

Chairs Report

1. HRH The Duke of Edinburgh

We were saddened to hear of the death of HRH the Duke of Edinburgh. The Duke was Patron of the Guinea Pig Club, formed by Sir Archibald McIndoe for the WW2 aircrew who were treated at QVH. Over the time I have been Chair at QVH, I have been delighted to meet some of the remaining Guinea Pigs. I was privileged to join them at the unveiling of the Guinea Pig Club Monument by the Duke of Edinburgh at the National Memorial Arboretum in Staffordshire in 2016.

Our friends at East Grinstead Museum have shared this photo with us from an occasion when HRH Prince Philip, the Duke of Edinburgh, visited our hospital in 1965. Pictured here (centre) in one of the operating theatres, he spent time chatting to staff and finding out more about our work.



2. HRH the Duke of Cambridge

At a recent regional directors call with Chairs and CEOs in the South East region we were joined by HRH the Duke of Cambridge, who wanted to thank the NHS leaders for their work during the pandemic. He also asked us to pass on his thanks to all our staff, which we did through Connect, our weekly staff newsletter.

3. East Grinstead Museum

We maintain close links with East Grinstead museum which curates many of the historical artefacts about the hospital and the Guinea Pig Club. I recently attended an online talk on “Women’s Art Work: Surgical Drawings by Dickie Orpen and Mollie Lentaigne”. Mollie Lentaigne was a Medical Artist at QVH from 1941-45. Sir Archibald McIndoe took her under his wing to produce drawings to record his surgical procedures. These were subsequently published in papers and books written by McIndoe and the Museum is now the custodian of some 300 of her unique drawings.
I would highly recommend any future talks at the Museum.

4. Chair and NED activity

a. Board Seminar

Since the last public board meeting, the board held one seminar in April. At that meeting we agreed that the Strategic Case for a potential merger would not be available in April and that the tentative date (only ever put forward as the earliest possible date) would be later than 01 October.

b. NED assurance

As I mentioned in my last report, NEDs across the NHS have had to reconsider how we undertake our roles when we are unable to conduct our usual in-person visits around the hospital. The NEDs have been joining online fora including the CEO's meetings with staff, the Head of Nursing meetings, consultants and Clinical directors meetings and have met with the three newly appointed staff governors. In addition I have resumed my usual 'walk-abouts', mindful of the need to ensure high standards of infection control. It was lovely to be able to see staff face to face (or rather mask to mask) again. I have always been very grateful to our staff for being so open and candid with me, and for being willing to tell me how they are finding their work 'warts and all'. I know the other NEDs are looking forward to the time when we can undertake more in person meetings in an infection-safe manner.

5. Integrated Care Systems

I am delighted to report that our colleagues in Kent and Medway have been accredited as an Integrated Care System (ICS) with effect from 1 April 2021. The ICS will build on the work of the Sustainability and Transformation Partnership (STP) which started in 2016. QVH provides services to patients across Kent and Medway and I continue to attend the 2 weekly meetings of the chairs of Kent provider trusts.

The Chair of Sussex Health and Care Partnership ICS, Bob Alexander, has recently been appointed as Interim Chair of Imperial College Healthcare NHS Trust, where he was previously a Non-Executive Director. Bob will continue to Chair the Sussex ICS until the summer, when we understand that an independent ICS Chair will be appointed (this recruitment will be undertaken by NHSEI).

6. Governors

The Council of Governors met on 12th April when we welcomed the new and re-elected governors. In advance of the public meeting the Governors seminar received presentations on the current NHS environment within which QVH is operating, the role of the Council regarding statutory transactions and an update on QVH burns service. The CEO presentation in the public meeting focussed on the priorities for QVH on restoration and recovery.

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

KSO1 and 2 were reviewed at the Quality and Governance Committee, 26/04/2021. KSO 3, 4 and 5 were reviewed at the Finance and Performance Committee 26/04/2021. 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 May trust board .

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/05/2021**		**Agenda reference:**	**65-21**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	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	• Update on QVH role in pandemic and thank you from Project Wingman • 2021/22 Priorities and operating planning guidance • Integrating 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:	19/04/21	Decision:	Noted
Next steps:				

CHIEF EXECUTIVE'S REPORT
MAY 2021

TRUST ISSUES

Covid-19

A minute's silence to remember those who have died in the pandemic was organised nationally by charity Marie Curie for 12 noon on Tuesday, 23 March. The first national stay-at-home order was announced a year earlier on 23 March 2020. Since then there have been over 140,000 deaths linked to coronavirus in the UK. The past 12 months have also seen coronavirus vaccines developed from scratch, with 33.6m people in the UK having now received a first dose and almost 12.6m are fully vaccinated.

During the second wave of the pandemic, QVH once again supported visiting surgeons from six trusts across Kent, Surrey and Sussex with their breast cancer patients. The last of these visits took place on 23 April and we received very positive feedback including one from a Kent surgeon who wrote:

"I just wanted to say a huge thank you on behalf of the whole breast team and all our patients for helping us out for the last 4 months. All the staff have been very helpful and accommodating of our requests and done their best for the patients. Our patients constantly provide feedback to us about how lovely and friendly the staff were and how they made the whole experience less stressful."

Project Wingman

To say thank you to QVH staff for their work during the pandemic, the team from Project Wingman have been visiting us for two weeks.

Project Wingman was founded at the start of the pandemic, to set up and run 'first class style' mobile airport lounges in hospitals, crewed by current or ex-aviation workers who volunteer their time to help.

From Monday 26 April Wellbee the Wingman Wheels converted double decker bus was parked up by the main hospital entrance, near the therapy building, to provide a space for our staff to take a break, have a chat, and generally be somewhere a bit different. The aim of Wellbee is to have a bright and jolly atmosphere similar to going on holiday! They also provide hot and cold drinks, and a selection of snacks free of charge.

2020 NHS Staff Survey findings

Last month saw the publication of 2020 NHS Staff Survey findings. This year saw nearly 600 (59%) QVH employees complete the survey, 1% increase on 2019. Three key messages from staff are:

- 71% would recommend our organisations as a place to work
- 94% would be happy with standard of care provided by the organisation if friend/relative needed treatment
- 87% believe care of patients/service users is organisation's top priority
- The survey is covered in more detail in the workforce report to the Board.

Priorities for 2021/22

As we commence the new financial year, QVH will receive block funding for the first half of the year. We have commenced our recovery plan in line with planning guidance issued by NHSEI on 25 March. In particular our focus will be addressing key operational challenges including cancer standards, our long waiters and transforming outpatient services. Our work with University Hospitals Sussex to consider the benefits of a possible merger will progress with the development of the strategic case for review in the summer and potential full business case thereafter. Our priorities also include the health and wellbeing of our staff after an exhausting year living with the covid pandemic.

Creation of University Hospital Sussex
Western Sussex Hospitals (WSHT) and Brighton and Sussex University Hospitals (BSUH) joined forces on 1 April 2021 to create a new NHS Foundation Trust: University Hospitals Sussex. Before the merger, WSHT and BSUH had been working together under a shared leadership for nearly four years under a management agreement signed in April 2017. During that time, BSUH became the fastest-improving acute hospital trust in England, emerging from special measures and earning a Care Quality Commission (CQC) rating of Good overall and Outstanding for caring.

Possible merger University Hospitals Sussex and QVH
Work related to the possible merger was largely paused during the pandemic and there have been considerable changes over the last 12 months. These include the formal establishment of University Hospitals Sussex (UHSussex) on Thursday 1 April; national developments around integrated care systems; and changed NHS priorities following COVID.

Over the next few months we will be working with partners on developing the strategic case for possible merger, taking into consideration this changed context. We will seek to develop the strategic case with a range of stakeholders and expect the strategic case to be completed for review in the summer.

Both organisations have agreed that October 2021, previously described as the earliest date for a possible merger, is not a date that we are working towards. The strategic case will lay out a clear timeline for the potential merger.

New clinical director for plastics
Congratulations to Siva Kumar who has been appointed our new clinical director for plastics, taking over from Martin Jones.

Siva joined QVH around six years ago, holds a MBA and is currently undertaking a senior clinical leader's course with the Kings Fund. His clinical work includes skin cancer; microsurgical reconstruction; trauma; breast reconstruction; general plastic surgery.

We thank Martin for all his hard work over the past three years in that role.

Nomination
Kokila Ramalingam specialty team lead for plastic and reconstructive surgery, has been shortlisted in two categories for the prestigious national BAME Health & Care Awards 2021. Identified in the categories for Compassionate and Inclusive Leader as well as Role Model, Kokila has been shortlisted for her proactive approach in anticipating the needs of the patients planned for surgery in coming weeks; her bravery and consistency in challenging other more senior clinical staff to meet required standards; her gentle determination; and commitment in supporting for incoming overseas nurses.

Integrated Performance Dashboard Summary
Our Integrated Performance Dashboard summary is being revamped to take into account the new planning guidance issued recently, in particular under operations. This will be available for our next Board meeting. In addition, a revised Staff Friends and Family Test is being introduced nationally from 1 July incorporating nine questions, which will also be included in the dashboard.

Board Assurance Framework (BAF)
The entire BAF was reviewed at executive management meeting (19/04/2021) alongside the corporate risk register. KSO 1 and 2 were reviewed at the Quality and Governance Committee, 26/04/2021. KSO 3, 4 and 5 were reviewed 26/04/21 at the Finance and Performance Committee. Changes since the last report are shown in underlined type on the individual KSO sheets.

Media
Appendix 1 shows a summary of QVH media activity during February and March 2021; reflecting particular interest around cancer.

SUSSEX ICS ISSUES
Covid-19 Vaccination
At the time of writing, Sussex had surpassed the 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 in January for first dose and a second week at the end of March, staff from QVH continued to support the vaccination hub at Crawley Hospital run by Sussex Community NHS Foundation Trust.

NATIONAL SCENE
Waiting lists
Around 4.7 million people were waiting for routine operations and procedures in England in February 2021 - the most since 2007, NHS England figures show. Nearly 388,000 people were waiting more than a year for non-urgent surgery compared with just 1,600 before the pandemic began.

During January and February, the pressure on hospitals caused by Covid-19 was particularly acute. NHS England said two million operations took place despite the winter peak.

NHS England recently announced that a £1bn fund would be used to help trusts restore operations and other services to get as many people treated as possible.

Professor Stephen Powis, national medical director for the NHS in England, said treating 400,000 patients with Covid-19 over the course of the last year had "inevitably had an impact on the NHS".

2021/22 Priorities and operational planning guidance
Published on 25 March 2021 by NHSEI: operational planning guidance sets out six priorities for the year ahead, and asks systems to develop fully triangulated plans across activity, workforce and money for the next six months.

These arrangements are supported by an additional £8.1bn of funding to reflect the ongoing impact of Covid-19. Six priorities are:

1) supporting the health and wellbeing of staff, and taking action on recruitment and retention
2) delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
3) building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services
4) expanding primary care capacity to improve access, local health outcomes and address health inequalities
5) transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
6) working collaboratively across systems to deliver on these priorities.

Additional £1bn has been allocated for elective recovery at a system level on going beyond agreed plans. Systems asked to develop fully triangulated plans across activity, workforce and money for H1 (months 1-6 inclusive). Draft plans are due by 6 May and final plans by 3 June.

Integrating Care Systems
Integrating services continues to be at the heart of NHS policy. From April 2021, all organisations within the NHS will be required to work together as Integrated Care Systems (ICSs), involving:

- Stronger partnerships in local 'places' between the NHS, local government and others with a more central role for primary care in providing joined-up care
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale

At present, collaboration is on a voluntary basis and ICSs themselves have no statutory status. However, the government's legislative proposals set out in the white paper *Integration and Innovation: working to improve health and social care for all* (February 2021) intends that ICSs become statutory organisations in 2022 through changes to primary legislation.

If approved by Parliament, the new legislation will make participation in an ICS mandatory for all NHS organisations and strengthen the range of levers available for encouraging collaboration within a system. Existing ICS arrangements (Sussex Health & Care Partnership became an ICS on 27 April 2020) will form a strong basis for these changes, but each system will need to understand the implications of these changes (both collectively and individually) and consider how their current arrangements need to change or evolve. In particular, the role of providers in these systems will need to be informed by the earlier guidance issued by NHSEI *Next steps to building strong and effective integrated care systems across England* (November 2020) which makes recommendations regarding the role of provider collaboratives.

Statutory ICSs will comprise an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body. The proposals for ICSs are designed to provide a core set of requirements for each system that the partners can then supplement with local arrangements. There is a recognition of the need to avoid a one-size-fits-all approach and enable flexibility for local areas to determine the best system arrangements for them.

The ICS NHS Body, which will include NHS provider representatives, will be responsible for developing a plan to meet the health needs of their population, developing a capital plan for NHS provision and securing the provision of health services to meet population needs. It will have a duty to meet the system financial objectives allocated to it by NHS England.

The reforms do not change the governance structures, statutory financial duties or CQC arrangements of NHS Trusts and Foundation Trusts. Further, the ICS NHS Body will not have the power to direct them. However, they will be subject to additional requirements for closer working with other providers and with commissioners, including through a new duty to collaborate, and the ICS NHS body will be able to compel them to have regard to system financial objectives to support achievement of financial control at system level. ICSs and providers will also be able to make use of new powers to set up joint committees and new guidance on joint appointments.

Fourth Annual Survey of Freedom to Speak Up Guardians (FTSU)

Freedom to Speak Up Guardians' perceive that overall the speaking up culture is improving, with 84% of respondents feeling that the speaking up culture in their organisation had improved in the last 12 months. But the survey also reveals that there remains variation between the support of leaders and managers within organisations. Speaking up can only be effective if leaders listen up and follow up.

Leaders set the tone when it comes to fostering an effective speak up culture, and this needs to filter throughout the entire organisation. The national survey found while we continue to see improvements, there remains a gap in how valued guardians feel by middle managers compared to senior leaders.

Where detriment is indicated as a result of speaking up, managers are among the groups identified as a potential source of this treatment.

The National Guardian's Office recently launched a new Freedom to Speak Up e-learning package, in association with Health Education England. The first module – Speak Up – is for all workers. The second module, Listen Up, for managers, focuses on listening and understanding the barriers to speaking up. A final module, Follow Up, for senior leaders will be launched later in the year to support the development of Freedom to Speak Up as part of the strategic vision for organisations and systems. We will be reviewing these materials and considering how best to use at QVH?

Steve Jenkin
Chief Executive

QVH media update – February 2021

Supporting patients with cancer

Ian Francis, our associate medical director and director of clinical strategy, was interviewed by BBC Radio Sussex about our role as a specialist surgical cancer centre during the pandemic. The interview, aired on 5 February, followed stories in the media about people with suspected cancer being less likely to seek medical help whilst there is a prevalence of COVID-19 in the community, and also reports that people with cancer are waiting longer for their treatment.

Ian explained how we have, and continue to support patients with high-risk cancers (head and neck, breast and skin) from across Sussex, Surrey and Kent; how we are minimising the risk of COVID-19 at QVH; and why it has been important that we play this unique and worthwhile role in supporting people with cancer and the health system in the South East.

Apprenticeship week

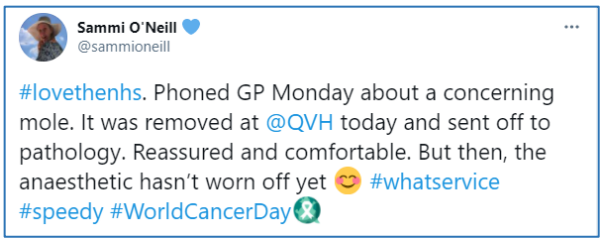
To mark apprenticeship week (8-14 February), we issued a press release sharing the story of one of our staff who was able to further her career thanks to our commitment in investing in apprentices. Jo Walls studied for a Level 5 Human Resources Consultant/Partner Certificate, alongside her role as a workforce e-systems specialist in the HR team. Her story received a range of regional media mentions including the Mid Sussex Times; West Sussex County Times; Crawley Observer; and the InYourArea website.

Maintaining the NHS estate

The Mid Sussex Times ran an article citing newly released figures from NHS Digital around the cost of improving the standard of the NHS estate. The piece states that nearly £10 million is required to "eliminate the maintenance backlog" at QVH. It includes syndicated national figures and quotes from NHS Providers which featured in a range of regional press relating to other hospital trusts.

Connecting through social media

This month we were able to use our social media channels to join in several awareness campaigns/days. As well as a series of posts linking in with apprenticeship week, we took part in the World Cancer Day social media takeover on 4 February, highlighting how we are supporting patients with cancer. We explained our role as a specialist surgical cancer hub for Sussex, Surrey and Kent, as well as the support our QVH Macmillan Cancer Information and Support Centre offers.



One tweet, posted by a patient who came to us on World Cancer Day itself to have a mole removed, received 291 likes – the most popular QVH-related tweet for some time.

We also explored the roles of two members of our histopathology team on 'women in science day' (11 February). Fiona Lawson, our laboratory services manager, and Suzanne Hatter, an advanced practitioner in histopathology, explained why they chose to pursue careers in biomedical science.

Name check from Amanda Redman
Actress Amanda Redman was interviewed by Platinum magazine, cited in the Daily Mail, where she talks about how her burn scars, sustained in an accident when she was 18 months old, made her who she is today. Amanda mentions her personal connection with a burns storyline that featured in TV show The Good Karma Hospital, and how she returned to QVH to help research it after receiving treatment here as a child.

Press releases issued in February

- Apprenticeship helps Jo achieve her dream qualification

We also published the following information on our website

- Coronavirus information and advice for our patients and visitors – updated standing item
- Celebrating women in science

QVH media update – March 2021

Our radiology team praised for teamwork in national NHS report
News that our radiology team was praised in an NHS national report for making the most efficient use of its team to help increase capacity gained media interest. The report by the Getting It Right First Time (GIRFT) programme, examines ways of meeting the ever-increasing demand on radiology units in England within the constraints of COVID-19, whilst shaping a better service for those who use it.

The report recognised a new role we have created, radiology department assistants (RDAs), to help improve patient experience and efficiency of our department. The NHS nationally suffers with a shortage of radiology staff, however this new RDA role has increased our staff retention. The news was featured in the Clinical Services Journal website and the InYourArea website.

QVH Charity's investment in our hospital
Last year, against the backdrop of a global pandemic and thanks to the generosity of its supporters, QVH Charity has continued to invest in our hospital. This achievement and examples of some of the projects funded were featured as a full-page article in RH Uncovered magazine's East Grinstead edition, and also as a news story on its website.

The charity wants to continue investing in initiatives that will make a real difference to our staff and patients and the article is hoped to inspire future fundraisers to get involved.

Best foot forward
BBC Radio Sussex spoke to Edmund and Sarah Byrne on 18 March about their support of QVH Charity. Aged 79 and 77 years old respectively, they set themselves a target to walk a minimum of a marathon (26 miles) each week from the first lockdown on 23 March 2020. By the first anniversary of lockdown, they met their target of walking 1,500 miles and raised around £1,000.

“Those cancer nurses are phenomenal”
In an interview with the Daily Mail, horseracing jockey Jamie Moore explains how during the Cheltenham Festival last year (an event he will never forget as he was catapulted out of his saddle whilst on target to win), his wife Lucie found a lump and was diagnosed with breast cancer. Jamie talks about dropping her off at "East Grinstead Hospital", how she had chemotherapy in Brighton and "I know everyone goes on about the NHS, but those cancer nurses are phenomenal."

Investing in the future of training
Last September many of our surgeons were involved in creating a unique virtual reality learning experience for trainees in the UK and worldwide. The idea was devised by Jag Dhanda, consultant maxillofacial and head & neck reconstructive surgeon, with help from QVH colleagues, and used 360 cameras to film surgical techniques including patient examination, instrument set up and surgical procedures on cadavers at the Brighton and Sussex Medical School anatomy department. Based on the success of the course, the medical school has been awarded a £344,000 grant to create and deliver future training. This news was featured on ITV Meridian, including an interview with Jag, and on the Med Tech news website.

Connecting through social media
We continued to use our social media channels to join in several awareness campaigns/days. This included supporting facial palsy awareness week at the start of the month with a series of posts featuring quotes from patients, links to the videos we have on our YouTube channel, and thanking QVH Charity for funding equipment, such as a nerve monitor, which helps improve the quality of life of those we see in our facial palsy clinics.

We also supported #HealthcareScienceWeek and #WorldOralHealthDay highlighting the work of our teams.

Press releases issued in March
- Our radiology team praised for teamwork in national NHS report

We also published the following information on our website
- Coronavirus information and advice for our patients and visitors – updated standing item

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/05/2021**		**Agenda reference:**	**66-21**	
Report title:	**Overarching Strategic Corporate Risks**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:					
Executive summary					
Purpose of report:	To update the Board on our overarching strategic corporate risks for 2021/22, their rationale and initiatives taken to manage those risks				
Summary of key issues	• Building on what we have learned during the pandemic to transform the delivery of safe services including the acceleration of restoration of elective care and virtual appointments • Health and wellbeing of staff key to recovery from pandemic • Securing a sustainable future for QVH				
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:	This document reflects and should be read in the context of the BAF				
Corporate risk register:	This document reflects the corporate risk register, setting out three overarching risks				
Regulation:	N/A				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	66-21
Date of meeting:	06 May 2021
Report from:	Steve Jenkin, CEO
Report author:	Kelly Stevens, Head of quality and compliance
Date of report:	29 April 2021
Appendices:	NA

Overarching Strategic Corporate Risks

Introduction:
Following the Board seminar in December 2020, three overarching risks to delivering the Trust's corporate objectives, and the ongoing safe delivery of clinical services were identified, namely:

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

Each risk represents an aggregated collection of more specific risks, which are set within the backdrop of the Covid -19 pandemic, the need to accelerate the restoration and recovery of services safely, and a possible merger arrangement with a partner trust.

Oversight:
The Board agreed that these risks would be reflected within the CEO's report to ensure focus is maintained at all times. In reviewing these risks, the five individual BAFs should be referenced and related to these strategic risks. It should be noted the process of reviewing and discussing these issues will be ongoing through EMT.

1. Risk one: maintaining patient and staff safety through pandemic

Rationale:
The Covid-19 pandemic has created the need for enhanced infection control procedures and there has been a related increase in capacity constraints (physical and workforce), which has led to delays in treating patients and impacted on patient experience. We need to build on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care, and work collaboratively across systems to deliver on these priorities.

Trust initiatives include:

- External audit of the Trust's risk management framework received substantial assurance
- Robust infection prevention and control procedures have been reviewed by the CQC with no concerns raised
- *Tell Nicky* forum for staff to anonymously raise concerns around safety to the director of nursing and quality
- Flexible staff annual leave process to combat tiredness, overwork and ongoing pressure resulting from Covid-19 pandemic
- Psychological therapies offer individualised support for staff members
- Designated quiet staff space available to take time out
- Ambitious restoration and recovery plan and trajectory in progress, including waiting list initiatives
- Clinical support for service and pathway redesign to improve outcomes for our current cohort of patients
- Implementation of virtual clinics model to allow patient to attend from anywhere
- Support of the Independent Sector to deliver services for QVH patients where pertinent

2. **Risk two: Keeping our staff engaged, motivated, supported through a time of great change**

Rationale:
Ongoing demands of the Covid-19 pandemic have led to increased delays in patient treatment pathways, which may lead to a reduced patient experience. There is currently uncertainty about future waves, which could impact further. QVH staff are rightly proud of our patient care and to date this has been an important motivator.

QVH also has a reliance on key individuals for service delivery and there is limited contingency to support gaps, which may adversely affect staff morale and perceptions on how well they are able to deliver patient care and the back office services which are essential to supporting this care.

QVH has been working with partners on developing the strategic case for possible merger, taking into consideration this changed context. The strategic case will be developed with a range of stakeholders with expected completion over the summer.

Trust initiatives include:

- Designated quiet staff space available to take time out
- Psychological therapies offer individualised support for staff members
- Ongoing staff wellbeing support and sessions offered
- *Leading the Way* qualifications and short courses offered
- Project Wingman (as referred in CEO report) to raise staff morale
- Reinvigoration of Team Brief meetings to disseminate information to all staff and gather feedback
- Ongoing staff briefings
- Flexible staff annual leave (able to carry over five days into the new financial year) to combat tiredness, overwork and ongoing pressure resulting from Covid-19 pandemic

3. **Risk three: securing a sustainable future for QVH**

Rationale:
The NHS is experiencing significant, sustained, growth in demand across all core services as a result of population growth and health trends. Like elsewhere in England, Sussex now faces a very significant challenge. There is a national drive for increased collaboration and integration of clinical services across Sussex, Surrey and Kent driven by local integrated care systems (ICSs).[1] A review of Sussex acute provider data expected to be published by the ICS shortly, includes additional collaboration opportunities, which can be explored to achieve a material improvement in patient access and quality of care in the short, medium and longer term.

National Burn Care Standards specify that burns units should be co-located with a number of other clinical services which are not available on the QVH site. It also recommends co-location with a Major Trauma Centre (MTC).

QVH has an underlying financial deficit. Although the Trust was able to deliver its financial obligations in 2020/21 due to the exceptional funding regime through the pandemic, future service provision is unlikely to breakeven within a tariff style funding regime.

Trust initiatives include:

- *Ask Steve* – comment/question functionality added to intranet for staff to raise issues related to potential merger
- Weekly Clinical Directors meeting to ensure clinical engagement in possible merger discussions
- QVH Board executives and Chair represent QVH at regional steering groups
- Reinvigoration of Team Brief meetings to disseminate information to all staff
- Ongoing staff briefings

[1] Integrating care: Next steps to building strong and effective integrated care systems across England (November 2020)

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality &Governance
Date last reviewed 15th April 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
- R&R governance group approving clinical changes, established amber and green pathway, 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 April 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
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
- 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:	06/05/2021		**Agenda reference:**	**68-21**	
Report title:	Quality and Governance Assurance				
Sponsor:	Karen Norman, Committee chair				
Author:	Gary Needle, NED, Committee member				
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 also updates the Board on assurance related to clinical harm reviews, clinical risks, clostridium difficile, patient experience, patient safety and compliance with national standards for seven- day service delivery. The report notes the development of the first QVH Research and Innovation Strategy.				
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): *[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:	The Committee received updates on the relevant BAF summaries and was assured of appropriate revisions to the Corporate Risk Register and the BAF reviews, in line with assurance issues raised within the reporting period.				
Corporate risk register:	As above				
Regulation:	Compliance with regulated activities in the Health and Social Care Act, 2008, and the CQC essential standards of quality and safety.				
Legal:	As above				
Resources:	As documented in the paper				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	68-21
Date of meeting:	06/05/2021
Report from:	Karen Norman, committee chair
Report author:	Gary Needle, committee member
Date of report:	28 April 0221
Appendices:	NA

Quality and governance committee assurance

The Q&GC wish to bring the following matters from those considered at our meeting on 26 April to the attention of the Board:

1. **Committee effectiveness audit report**
   Q&GC discussed the results of the self-assessment audit. Assurance was taken from the primarily positive responses. Constructive suggestions for improvement included changes to the way in which the agenda is organised and increasing the use of statistical process control charts for key performance metrics. The Committee will follow up on these issues.

2. **Covid-19 update**
   The committee offered congratulations on the successful delivery of the second round on vaccinations for staff. Cancer activity levels have reduced in line with repatriation of patients by other hospitals but assurance was received that increased service levels can be restored in the event of a third wave.

3. **Patient Safety Summary Exception report**
   No serious incidents were reported during the period 01/02/21 to 31/03/2021. The patient safety agenda continues to be maintained to a high standard.

4. **Clinical Harm Reviews**
   This is an evolving process. The high number of cases for review is presenting challenges to medical staff who are also under pressure to increase the levels of direct patient care. The committee was assured that the appropriate processes are being followed with priority given to patients with cancer waiting over 104 days and other patients waiting over 52 weeks, in accordance with national guidance. No moderate or serious harm has been identified thus far.

5. **Corporate Risk Register: Patient Safety Risks**
   Excellent progress has been made on recruitment of operating theatre nurses. The committee took note of risks related to the “EVOLVE” document management system and were assured that a monthly report on this matter is considered at the Finance and Performance Committee.

6. **Update on Clostridium Difficile cases**
   QVH has historically had small numbers of patients diagnosed with CDiff. During February and March, there was a marked increase (total 7 cases). The Committee took assurance from the extensive actions that have been taken in accordance with the infection prevention and control policy and also from the support received from our Clinical Commissioning Groups.

7. **Patient Experience Report**
   Significant assurance on patient experience was taken from the most recent results from the "Friends and Family Test": of inpatients who responded, 100% said they would recommend QVH.

8. **Quality and Safety Report**
   The Committee welcomed the news that paediatrician onsite support has recommenced. The key metrics provide assurance that patient safety continues to be the primary focus for the Trust whilst also maintaining a positive patient experience.

9. **Seven Day services assurance**
   Assurance was received that the QVH, as a specialist hospital, meets the two standards required, despite some challenges with documentation that are being addressed.

10. **Research and Innovation Strategy 2021 -2023**
    The Committee welcomed the first research and innovation strategy for QVH and congratulated Zaid Sadiq, clinical lead for research and innovation, and his team.

Recommendation
The Board is asked to **note** the contents of this update.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06 May 2021**		**Agenda reference:**	**69-21**	
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:	To provide the Board with 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	• 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
	• Key changes to the CRR this period:
	  • Three new corporate risks added and one local risk escalated to corporate risk
	  • One corporate risk closed
	  • Two risks rescored: remaining on CRR				

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:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***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 trusts are required to have a corporate risk register and systems in 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:	Quality and governance committee				
	Date:	26/04/2021	Decision:	Noted	
Previously considered by:	Finance and performance committee				
	Date:	26/04/2021	Decision:	Noted	
Next steps:					

Corporate Risk Register Report: February and March 2021 Data

Key updates

Corporate Risks added between 01/2/2021 and 31/03/2021: 3

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
4x3=12	1210	Pandemic Flu Covid-19 Clinical Challenges	DoN: splitting of risk into clinical and operational
3x5=15	1198	Medical Workforce Sleep Unit	GM - Sleep
3x5=15	1164	Repeat prescriptions in Sleep Services	GM - Sleep

Corporate Risks closed this period: 1

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x4=12	1209	Maxillofacial trauma service	R/V with MD: Maxfac trauma issue has improved and is no longer the concern that it was

Corporate Risks rescored this period: 3

Risk ID	Service / Directorate	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore
1167	Corneo	Lack of Failsafe Officer	4x4=16	4x3=12	Post recruited to, awaiting start date (following which can be closed)
1163	X-Ray	Inadequate Consultant radiologist cover	4x4=16	4x3=12	Fixed term locum wishes to remain, on-call moving to outsource model in March
834	Paediatrics	Non compliance with national guidelines for paediatric care	4x2=8	4x3=12	Change in identified 'controls': due to C-19 there are currently no paediatricians onsite at QVH - 24/7 cover for advice by telephone is available

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 69 risks on the Trust Risk Register as at 6th April 2021, of which 19 are corporate, with the following modifications occurring during this reporting period (February and March 2021 incl):

- Three new corporate risks added and one local risk escalated to corporate risk
- One corporate risk closed
- Two risks rescored: remaining on CRR

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 19 corporate risks open on the trust risk register as at the end of March 2021.

Three of the corporate risks are within the higher grading category:

	No harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2					
Possible 3				**6 ID: 834, 968, 1163, 1167, 1192, 1210**	**0**
Likely 4			**5 ID: 1040, 1077, 1136, 1148, 1168,**	**2 ID: 1125, 1179**	**0**
Certain 5			**5 ID1140, 1189, 1164, 1198, 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.

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

- Effective
- Caring
- Well led
- Responsive

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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1210	09/02/2021	Pandemic Flu Covid-19 Clinical Challenges	Staff required to work in different ways.□ National guidance being updated on regular basis□ Adverse impact on patient experience - particularly linked to restricted visiting and infection control recommendations.□ Potential Covid-19 outbreaks in either workforce or patient cohorts	R&R governance meetings weekly□ Open door IPACT policy□ Generic email address for queries or concerns □ Case by case management regarding visiting restrictions□ Asymptomatic staff testing both via Lateral Flow and Optigene□ Patient screening pre admission□ Optigene screening for trauma patients□ Management of "accompanying" carers with patients coming to OPD□ Remote check in to avoid numbers in waiting rooms.□ Virtual clinics when possible □ □	Nicola Reeves	Karen Carter-Woods	Patient Safety	12	8	**March 2021** R&R Governance meeting fortnightly. CCG support for recent nosocomial issue with C Diff. Updated visitor guidance in place	KSO1 KSO2
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	**March 2021**: □ Band 5: 1.08 WTE vacancy □ Band 6: 0.75 WTE vacancy □ When HNU opens vacancy will increase for band 5 to 3.58 WTE □	KSO1
1198	09/03/2021	Medical Workforce Sleep Unit	Risk to long-term stability of diagnosis and prescribing for patients in Sleep Unit due to age profile >60 years and retired status of majority of existing substantive medical workforce. Requires succession planning.□	Current Workforce <60 years old/not retired:□ 1 PA - respiratory and sleep disordered breathing - locum/bank:□ 8 PA - Associate Specialist Registrar sleep disordered breathing and sleep - bank/locum >2 years.□ Succession/strategy planning underway.	Abigail Jago	Philip Kennedy	Compliance (Targets / Assessments / Standards)	15	9		KSO3
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 staff□ □ Unable to support any new work elsewhere in Trust	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	**30/3/2021** 2wte band 7 pharmacist posts out to advert. 0.8wte band 7 covering band 8a mat leave started but 0.4wte band 7 now left. Bank part time band 2 started to help in office with contracts. MSO post to be readvertised after easter. Band 2 and band 5 JDs to be completed. Looking for new band 7 locum to cover remaining pharmacist vacancies and additional work to support sleep prescribing□ 24/2/21 0.4wte band7 pharmacist handed in notice making 2wte vacant. Amalgamated all the 3 job descriptions to make rotation in hope will be more appealing. Job description gone to panel. Awaiting fixed term mat leave cover to start (delay in completing HR checks). Didn't appoint to MSO post - person offered cannot work enough hours - bank covering some duties. Writing band 5 technician job description as part of restructure. reviewing band 2 assistant job description for avert as apprentice from start. Bank and agency covering vacancies□ 29/12/20 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 B8a 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	**9/3/21:** reviewed at RPC meeting - Radiology Services Manager is exploring potential of apprenticeship post and / or US training post.□ 22-02-2021 - bank CT/MRI radiographer started today. Stall to apprenticeship due to course being deferred until September next year. □ □ 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 operational 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	Kathy Brasier	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
1167	01/01/2020	Lack of Failsafe Officer	GIRFT and HII recommendations state that every Ophthalmology Department should have a dedicated Failsafe Officer to reduce the risk of patients being lost to follow up and to reduce the risk of undue delays to follow up appointments.□	Current Failsafe duties reside with Business Manager, Service Manager and Service Co-ordinator. However, there is insufficient resource to manage failsafe procedures adequately.	Abigail Jago	Marc Tramontin	Patient Safety	12	8	**March:** reviewed at Gov meeting - post recruited to, awaiting start date at which point Risk can be closed.□ February: applicants shortlisted, interviews w/c 1st March□ 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.□ 4/2/20: reviewing internal efficiencies to support; post identified within Business Planning.□ HSIB National report published with multiple recommendations	KSO1 KSO2 KSO3
1164	26/03/2021	Repeat prescriptions in Sleep Services	The consultants are spending more and more time as patient numbers increase, having to complete prescriptions including Controlled Drugs (without seeing patient)on a monthly basis for patients requiring off licence medication GP's refuse to prescribe. Sometimes the consultants are not present to carry out these prescriptions resulting in patients being without meds. Patients are having to travel long distances to collect the medication from pharmacy	Attempting to set up shared care agreement which has been on-going for 3 years.□ Working with Pharmacy to develop a 'monitoring pharmacist' for repeat prescriptions.□ Request patient inform us in a timely manner of requests for repeat prescriptions□ Business Case in planning for dedicated pharmacist in Sleep□ □	Abigail Jago	Philip Kennedy	Patient Safety	15	6		KSO1 KSO2 KSO3

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
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	12	8	**22-03-2021** - The on-call is now being outsourced to a company meaning the consultant who was covering can take leave. We have a fixed term locum who is keen to stay and a bank consultant who also wants to stay and support the service. Currently, we have better resiliency for medical workforce.□ 22-02-2021 - on-call moving to outsource model in March. Policy update for March CGG presentation and then HMT approval. This will mean IF can take meaningful A/L moving forward. Fixed term locum wants to remain. Global fellowship stalled due to pandemic.□ □ 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.□	KSO1 KSO3 KSO5
1148	24/07/2019	Clinical coding backlog	Coding backlog now at significant level □ Potential to impact income recovery□ Clinical indicator data unavailable	-overtime approved□ -agency approved: restraints obtaining agency workers□ -monitoring reports 3x weekly□ -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	Mary Gwynn	Finance	12	6	**29/03/2021** - Encoding software (Medicode) installed in test environment and integration work planned. Monmouth support reduced to test how in house team cope with current activity levels but will be closely monitored.□ □ March 2021□ - Two new starters currently attending coding standards course.□ - Implementation of encoding software underway - PO raised and approved, IT approved, planning in progress.□ - Funding for support contract approved in business case submitted in business planning.□ - Process to write specification for support required has begun□ - Mentoring for experienced and trainee staff planned□ - Two members of staff identified to undertake ACC qualification to become senior clinical coders.□ □ 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□ □	KSO4
1140	19/03/2019	Current PACS contract ending in June 2020	QVH is in a consortium for PACS/RIS/VNA with 5 other trusts from Surrey & Sussex. □ Philips provide a managed PACS/RIS/VNA (Vendor neutral archive) service to QVH and the other 5 trusts. The current contract was extended in 2016 to allow the contract to run until June 2020 under the 5+2 terms of the original contract. □ All 6 trusts have stated they want to remain in this consortium and potentially expand it to include another Surrey trust.□ There is now limited time available to re-procure PACS/RIS/VNA before the current contract runs out; without which there will be no PACS system.□ There is currently no project board or business case aligned to this procurement process. □ ESHT has said they are happy to lead on the project, with input from all trusts as and when requested.□ The data in the VNA is known to be incorrect across all sites, and if the S&S PACS consortium approve a plan to move PACS providers then the migration of data may need to occur from PACS to PACS - this will add a delay for migration.□	ESHT have said they will lead on a re-procurement process for the consortium. □ Philips have said they will extend the current contract - costs will need to be agreed as hardware will need replacing.	Michelle Miles	Sarah Solanki	Information Management and Technology	15	4	□ **22-03-2021** - VNA work still not complete. Less risk to QVH due to current level of PACS storage. OBS documents sent back from QVH for PACS procurement part. Moderation meetings occurring this week. RIS contract sign off needed by 31-03-2021. Documents being checked by CIO. Timelines for data migration etc. remain aggressive. □ 22-02-2021 - OBS document has gone out to the framework to the 3 vendors. Planned OBS scoring for team in March. Placeholders sent. VNA work moving forward slowly. CRIS BC awaiting BC approval confirmation from remaining trusts. Background work is going on for the CRIS project.□ □ 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 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	Mr Paul Drake	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.□ Update 07.02.21: increased risk of RTT position and number of 52wks due to the second wave and the trust stopping all theatre activity for P3 and P4 patients. QVH has now resumed providing additional capacity for cancer patients on behalf of organisations from Kent, Surrey and Sussex.	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 corneo plastic trajectory due to non-consultant medical cover - full service review underway. 52WW trajectory behind plan due to high levels of patients choosing to defer treatment.□ 5/7/19: R/V with Exec Lead - RTT open pathway performance on track with trajectory; 52 week waits challenges ongoing regarding patient choice - national issue, escalated to NHSI and commissioners□ 5/4/19: R/V with Exec Lead - capacity planning complete; activity to deliver 2019/20 plan has been signed off with Commissioners and on track with revised trajectory□ 8/3/19: 2019/20 capacity planning underway including potential independent sector activity - on track with performance plan□ 14/2/19: Exec lead r/v - RTT plan agreed with commissioners and on track re: 52 wk waits and percentage performance□ Update (Oct '18): RTT validation programme complete. RTT Action Plan in place & being monitored through fortnightly System Task & Finish group, weekly assurance call with NHSI & via internal assurance processes. Revised trajectories being agreed with Commissioners. Clinical Harm Reviews underway.□ 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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
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	□ **5/2/21**: International recruits x 6 commenced in (supernumerary)posts - Osce's in March. Recovery remains 3wte RN's short, bank / agency backfill. Overall much improved position from early last year.□ 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. 28th 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	**22-03-2021** - template specification documents shared with RSM today. RSM to arrange meeting with PM to go through equipment banding. etc. RSM has scoped Prospective site for MRI with estates and PM. Estates and RSM scoped size of unit required. PM/estates communication around services / power requirements needed. the framework that can support MES should be completed by 31-03-2021.□ □ 22-02-2021 - Project manager has spoken to framework representative today re MES. framework representative shared some documentation for us to use. PM to organize next meeting. No formal news re allocation of NHSEI shared assets currently. □ □ 28-01-2021 - Brief MES meeting held this week with commercial solutions framework lead. Project stages and timelines talked through. DoF identified the need for a project manager - to be scoped. Next steps are for framework lead 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 that these assets may be transferred to the trust: 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. □ 3-11-2020 - 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.□	KSO1 KSO2 KSO3
968	20/06/2016	Delivery of commissioned services whilst not meeting all national standards/criteria for Burns	-Potential increase in the risk to patient safety□ -on-call paediatrician is 1 hour away in Brighton□ -Potential loss of income if burns derogation lost□ -no dedicated paediatric anaesthetic lists	*Paeds review group in place□ *Mitigation protocol in place surrounding transfer in and off site of Paeds patients□ *Established safeguarding processes in place to ensure children are triaged appropriately, managed safely□ *Robust clinical support for Paeds by specialist consultants within the Trust□ *All registered nursing staff working within paediatrics hold an appropriate NMC registration *Robust incident reporting in place□ *Named Paeds safeguarding consultant in post□ *Strict admittance criteria based on pre-existing and presenting medical problems, including extent of burn scaled to age.□ *Surgery only offered at selected times based on age group (no under 3 years OOH)□ *Paediatric anaesthetic oversight of all children having general anaesthesia under 3 years of age.□ *SLA with BSUH for paediatrician cover: 24/7 telephone advice & 3 sessions per week on site at QVH	Nicola Reeves	Liz Blackburn	Compliance (Targets / Assessments / Standards)	12	4	**February 2021**: reviewed at Paeds Governance meeting - nil to update.□ 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
677	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.□ □ January 2020:□ 2019/20 □ Performance M8: deficit of £5.6m YTD; £0.8m less than plan. Clinical income under-recovery has been partially offset by expenditure underspends.□ Full year forecast deficit of £8.4m; £1.0m worse than plan□ Cost savings of £0.8m YTD; Savings of £1.2m identified; £0.5m less than plan□ Finance & Use of Resources – 3 (Planned 4).□ November□ 2019/20 Performance M6: deficit of £4.1m YTD; £61k better than plan. Clinical income under-recovery has been partially offset by expenditure underspends.□ Full year forecast deficit of £8.1m; £0.6m worse than plan □ Cost savings of £1.2m identified; £0.5m less than plan□ Finance & Use of Resources – 3 (Planned 4).□ August □ 2019/20 Performance Month 3 YTD £438k behind plan due to income shortfall □ Current run rate forecast deficit of £11m (□ CIP performance £205k/£178k for YTD Month 3 □ Finance & Use of Resources – 3 (Planned 4).□	KSO4
834	09/09/2015	Non compliance with national guidelines for paediatric care.	Unavailability of a Paediatrician to review a sick child causing □ 1. Harm to child□ 2. Damage to reputation□ 3. Litigation	1. Service Level Agreement with BSUH providing some Paediatrician cover and external advice. □ 2. Consultant Anaesthetists, Site practitioners and selected Peanut Ward staff EPLS trained to recognise sick child and deal with immediate emergency resuscitation.□ 3. Policy reviewed to lower threshold to transfer sick children out □ 4. Readmission of infected burns criteria reviewed to raise threshold for admission□ 5. Operating on under 3 year olds out of hours ceased unless under exceptional circumstances□ With regards to SLA for paediatrician cover, □ 1. Continuous dialogue with consultants and business managers□ 2. Annual review meeting - Sept/October 2015□ □ Forward plan: to address areas of highest risk of complications with improved collaboration with BSUH to deliver inpatient Burns care to children in the Royal Alex hospital in Brighton. Aiming for Sept 2016□ □ Audit of all transfers out carried out on monthly basis and reviewed during Paediatric meeting.□ Burns outcomes monitored during LSEBN M&M annual review. Data reviewed by all the local burns services.□ Current strict control of cases and comorbidity permitted on QVH site□ Use of PEWS to enable identification and early management and referral of unwell children	Keith Altman	Dr Edward Pickles	Patient Safety	12	4	**March 2021**: r/v DoN and Head of Patient Safety - SLA under review□ February 2021: r/v DoN and Head of Patient Safety - rescored to CRR□ January 2021: due to C-19 there are currently no paediatricians onsite at QVH - 24/7 cover for advice by telephone is available.□ July 2020: meeting held with BSUH & they continue to support this service□ 23/5/19:BC reviewed at Board and by Exec Team in BSUH - not approved. Alternative plans under discussion.□ 19/11/18: R/V at Paeds Gov meeting - Business Case in progress, to be submitted to CGG January 2019□ 24/5/2018: r/v with MD - Darzi fellow in post to lead pathway and joint programme board established.□ 22/1/18: MOU agreed by BSUH & QVH Boards; formation of clinical working group underway.□ SLA with BSUH remains under re-negotiation: 3 days per week agreed for 52 weeks P.A.□ 24/7/17: reviewed with Exec lead - Paeds burns care to be first priority in Brighton partnership MOU	

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/05/2021**		**Agenda ref:**	**70-21**	
Report title:	Quality & Safety Board Report				
Sponsor:	Nicky Reeves, Director of Nursing and Quality				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	• COVID-19 update April 2021 • Infection Prevention and Control board assurance framework April 2021				
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 Committee'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 • Increase in Clostridium difficile cases • Continued response to Covid-19 pandemic • Infection Control Covid BAF				
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:**	**KSO2:**	**KSO3:**	KSO4:	KSO5:
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	*Financial sustainability*	***Organisational excellence***
Implications					
Board assurance framework:	The Quality Report contributes directly to the delivery of KSO 1 and 2, elements of KSO 3 and 5 also impact on this.				
Corporate risk register:	CRR reviewed as part of the report compilation –and the workforce and RTT18 risk impact the most on quality, safety and patient experience.				
Regulation:	The Quality Report contributes and provides evidence of compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's Essential Standards of Quality and Safety.				
Legal:	As above: The Quality and Safety Report uphold the principles and values of The NHS Constitution for England and the communities and people it serves – patients and public – and staff.				
Resources:	The Quality and Safety Report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	26/04/2021	Decision:	Noted	
Next steps:					

Executive Summary - Quality and Safety Report, May 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. 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. The second doses of the Covid-19 vaccine were successfully rolled out during March 2021. Covid update and IPACT BAF discussed at Q&G can be found in appendix one. Paediatric on site medical support has been recommenced. There have been seven cases of Clostridium Difficile identified in two wards in the Trust during February and March. We have fully engaged with PHE, CQC and the CCG. The process has been managed via three times weekly multidisciplinary meetings. In addition, the CCG have provided additional infection control support to review our policy and pathways. To date there have been no recommendations to change any of our procedures. All the patients remain clinically well.
Medical Director	**Medical Staffing** Two new clinical directors have recently been appointed. Mr Siva Kumar is the new Clinical Director for Plastics. He takes over the role from Mr Martin Jones who has given three years of excellent service and leadership to Plastics. Dr Tim Vorster has been appointed to the substantive clinical director role for Peri-operative & Clinical Support Services. Two new consultants have been appointed. Annemarie Kennedy as Consultant Orthoplastic Surgeon and Lauren Hardwick as Consultant Orthodontist. **Clinical Harm Reviews** This is an evolving process. There has been no harm of moderate or above confirmed so far. There were 12 cases of potential moderate harm in February 2021 and none in March 2021. These cases of potential moderate harm are being reviewed to determine the actual level of harm.

Report by Exception - Key Messages

Domain	Issue raised	Action taken
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 continues. In addition Lateral Flow testing kits have been rolled out to a number of staff to assist with diagnosis of asymptomatic Covid positive staff.

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
		Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
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	3	4	7
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%	90%	99%	90%	98%	81%	83%	90%	83%	99%	93%	99%	94%	95%	92%
MRSA screening - trauma	95%	95%	89%	61%	84%	94%	99%	98%	99%	100%	99%	95%	96%	94%	92%
Incidents															
Never Events	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Serious Incidents	0	0	0	0	1	0	0	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	1	3	2	3	4	3	3	2	3	3	4	0	5	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		99%	99%	99%	99%	98%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Non-clinical cancellations on the day		8	5	1	1	0	6	4	5	7	8	0	0	2	39
Needlestick injuries	0	0	1	0	0	0	0	3	0	0	3	4	3	3	17
Pressure ulcers (all grades)(Theatre metric)		2	0	1	1	1	0	0	0	0	0	0	0	1	4
Paediatric transfers out (<18 years)		1	1	0	1	0	2	0	0	0	1	1	0	0	5
Medication errors															
Total number of incidents involving drug / prescribing errors		7	7	11	10	5	1	7	16	7	6	6	9	10	95
No & Low harm incidents involving drug / prescribing errors		6	6	9	9	4	1	6	12	7	5	6	8	8	81
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		0.8	1.5	2.1	0.9	0.8	0.0	0.6	2.2	0.0	0.6	0.0	0.7	1.1	0.9
Pressure Ulcers Hospital acquired - category 2 or above		0	0	1	0	2	0	0	0	1	2	0	1	0	7
VTE initial assessment (Safety Thermometer)	95%	96%	nc	nc	91%	100%	100%	100%	94%	100%	100%	100%	100%	100%	99%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	95%	91%	nc	nc	100%	100%	100%	100%	100%	97%	97%	100%	100%	93%	99%
Patient Falls resulting in no or low harm (inpatients)		3	2	0	2	4	3	3	2	5	4	4	6	2	37
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	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 February there were 3 overnight cases on 3 occasions and there were three nights when the ward was “closed”. In March there were 16 patients overnight on 13 occasions, there was one nights when the ward was “closed.”

February safe staffing data demonstrates compliance across all the bands with staffing levels above 95% of the required template. 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%

Feb-21

	Planned staff			Actual staff				Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA		RN	NA	HCA	RN	NA	HCA
DAY	4738	161	2070	4657.5	161	1978	Total Hrs Planned and Actual	NIGHT 3680	69	644	3657	69	632.5
				98.3%	100.0%	96%	% Planned Hrs Met				99.4%	100.0%	98.2%
			6969			6796.5	Total Hrs Planned & Actual - Combined reg & support			4393			4359
						97.5%	% Planned Hrs Met - Combined reg & support						99.2%

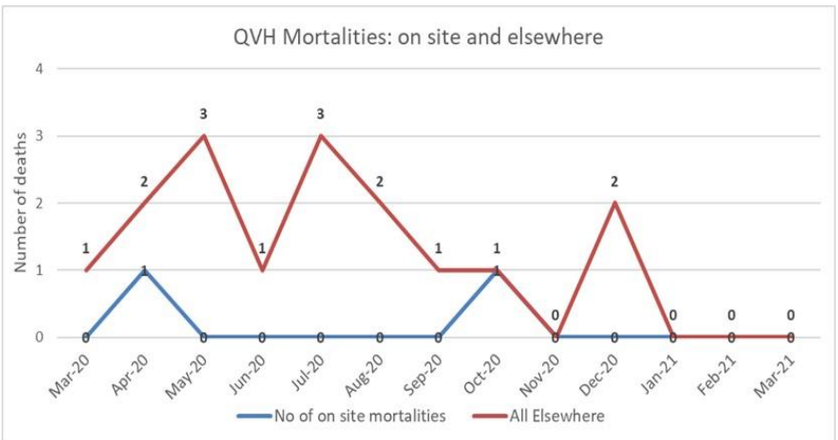
March safe staffing data demonstrates compliance across all the bands with staffing levels above 95% of the required template. Staffing levels are reviewed on a regular basis and as a minimum three times a day. Use of the Safe Care Live module is also supporting the team to make real time staffing decisions. The head and neck unit has remained incorporated within Margaret Duncombe ward during February and March to make best use of the resources.

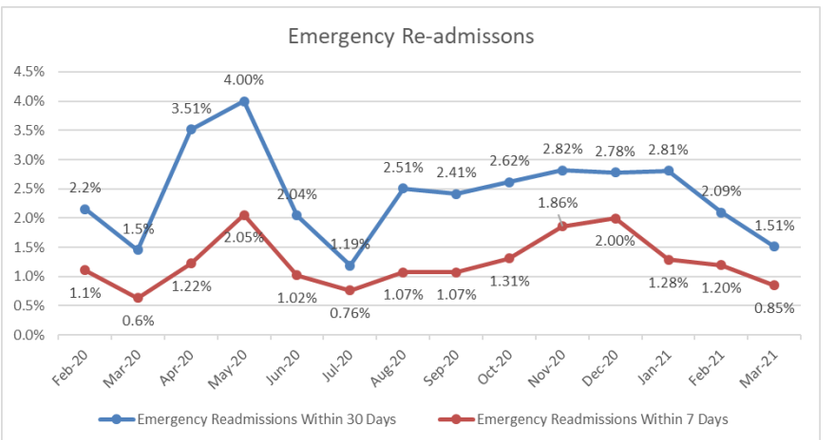
Combined Staffing exc. Site — Target 95%

Mar-21

	Planned staff			Actual staff				Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA		RN	NA	HCA	RN	NA	HCA
DAY	5256	195.5	2369	5186.5	195.5	2277	Total Hrs Planned and Actual	NIGHT 4071	161	1104	3979	161	1035
				98.7%	100.0%	96%	% Planned Hrs Met				97.7%	100.0%	93.8%
			7820			7659	Total Hrs Planned & Actual - Combined reg & support			5336			5175
						97.9%	% Planned Hrs Met - Combined reg & support						97.0%

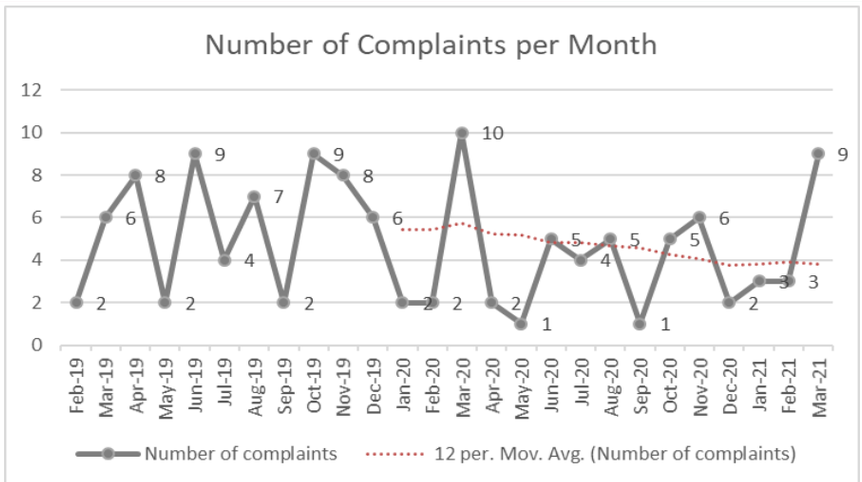
Effective - Performance Indicators

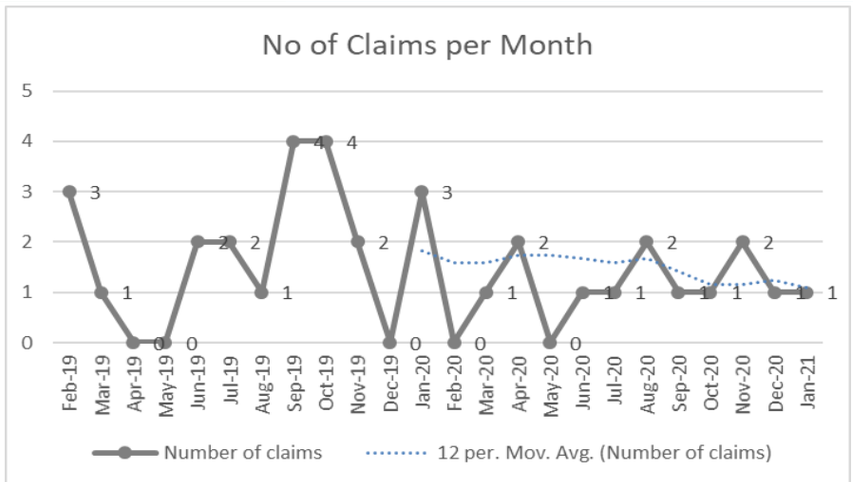




Mortalities Report			Q4 2019/20	Q1 2020/21			Q2 2020/21			Q3 2020/21			Q4 2020/21		
			Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Mortalities within 30 days of an inpatient episode or outpatient procedure	Inpatient	No of on site mortalities	0	1	0	0	0	0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

Caring - Current Compliance - Complaints and Claims





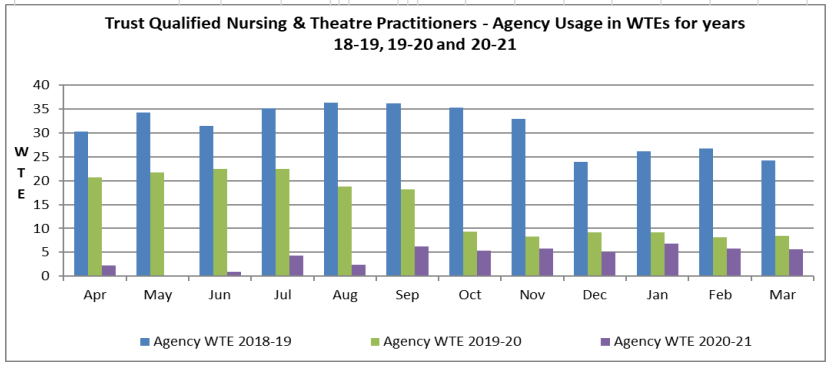
	Q4 2019/20			Q1 2020/21			Q2 2020/21			Q3 2020/21			Q4 2020/21
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of complaints	10	2	1	5	4	5	1	5	6	2	3	3	9
Complaints per 1000 spells	0.65	0.18	0.09	0.40	0.27	0.35	0.06	0.28	0.33	0.12	0.20	0.20	0.51
Number of claims	1	2	0	1	1	2	1	1	2	1	1	1	0
Claims per 1000 spells	0.07	0.18	0.00	0.08	0.07	0.14	0.06	0.06	0.11	0.06	0.07	0.07	0.00
Number of cases referred to PHSO	0	0	0	0	0	0	0	0	3	0	0	0	0

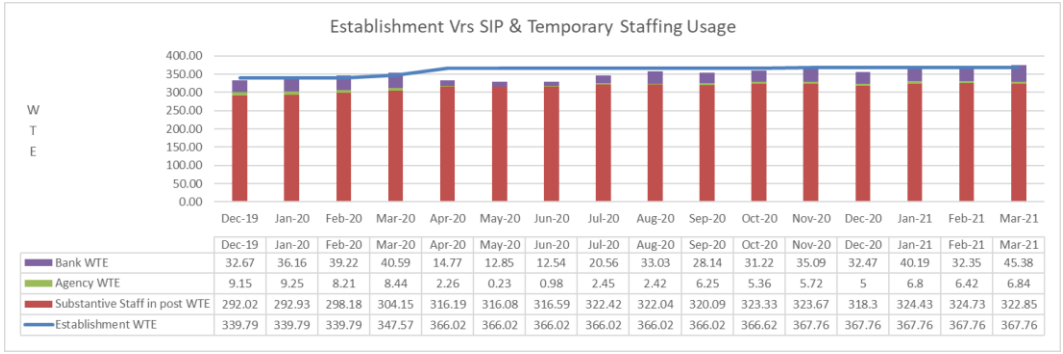
Nursing Workforce - Performance Indicators

ALL QUALIFIED & UQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020-21			Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)				347.57	366.02	366.02	366.02	366.02	366.02	366.02	366.62	367.76	367.76	367.76	367.47	367.47	◄►
Staff In Post WTE				304.15	316.19	316.08	322.52	322.42	322.04	320.09	323.33	323.79	318.30	324.43	324.73	322.85	▼
Vacancies WTE				43.42	49.83	49.94	43.50	43.60	43.98	45.93	43.29	43.97	49.46	43.33	42.74	44.62	▲
Vacancies %	>18%	12%<>18%	<12%	12.49%	13.61%	13.64%	11.88%	11.91%	12.02%	12.55%	11.81%	11.96%	13.45%	11.78%	11.63%	12.14%	▲
STARTERS WTE (Excluding rotational doctors)				4.41	0.51	2.23	5.01	0.61	2.00	2.00	3.63	3.00	0.00	11.56	1.00	1.00	◄►
LEAVERS WTE (Excluding rotational doctors)				1.02	3.91	3.00	0.00	2.32	2.75	1.00	1.00	4.61	4.36	4.18	0.00	2.88	▲
Starters & Leavers balance				3.39	-3.40	-0.77	5.01	-1.71	-0.75	1.00	2.63	-1.61	-4.36	7.38	1.00	-1.88	
Agency WTE (Data From Healthrostar)				8.44	2.26	0.23	0.98	2.45	2.42	6.25	5.36	5.72	5.00	6.80	6.42	6.84	▲
Bank WTE (Data From Healthrostar)				40.59	14.77	12.85	12.54	20.56	33.03	28.14	31.22	35.09	32.47	40.19	32.35	45.38	▲
Trust rolling Annual Turnover %	>=12%	10%<>12%	<10%	9.71%	9.95%	10.27%	8.67%	8.46%	8.23%	7.79%	7.44%	8.35%	9.21%	8.90%	8.93%	9.34%	▲
Monthly Turnover				0.00%	1.31%	1.01%	0.00%	0.77%	0.91%	0.33%	0.33%	1.51%	1.10%	1.14%	0.00%	0.95%	▲
Sickness Absence %	>=4%	4%<>3%	<3%	6.30%	3.64%	2.21%	1.67%	3.30%	2.54%	2.94%	3.82%	3.87%	4.50%	4.48%	3.13%	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





	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	Feb-21	Mar-21
Bank WTE	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	32.35	45.38
Agency WTE	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	6.42	6.84
Substantive Staff in post WTE	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	324.73	322.85
Establishment WTE	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	367.76	367.76

Medical Workforce - Performance Indicators

Metrics	Quarter 1 2020/21			Quarter 2			Quarter 3			Quarter 4			12 month rolling
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Medical Workforce													
Turnover rate in month, excluding trainees	0.00%	0.28%	1.12%	0.00%	3.28%	1.01%	1.06%	0.87%	1.08%	1.08%	0.00%	2.70%	12.63%
Turnover in month including trainees 9%	0.70%	0.17%	1.42%	0.71%	15.26%	4.07%	5.98%	0.55%	2.07%	0.69%	3.26%	6.77%	40.56%
Management cases monthly	0	0	0	0	0	0	0	0	1	0	0	0	1
Sickness rate monthly on total medical/dental headcount	1.63%	1.52%	0.65%	0.31%	0.55%	1.56%	2.42%	2.03%	1.71%	1.67%	1.24%	TBC	1.35%
Appraisal rate monthly (including deanery trainees)	81.40%	74.85%	62.05%	57.74%	74.51%	77.27%	75.25%	85.88%	76.14%	76.83%	78.05%	83.81%	N/A
Mandatory training monthly	87%	87%	86%	86%	86%	81%	80%	82%	85%	85%	82%	81%	N/A
Exception Reporting – Education and Training	0	0	0	1	0	1	0	1	0	0	0	1	4
Exception Reporting – Hours	0	0	0	5	0	4	0	1	0	2	3	1	196

Medical & Dental Staffing

The April doctors induction plans are in place, with new trainees in OMFS, Radiology and Plastics starting at the Trust. The delayed March induction also successfully welcomed new Anaesthetics trainees.

The Medical Education Manager is working with key stakeholders to implement a new Education Contract with HEE, to assure the provision of learners and funding to 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 plans for external courses are still on hold but medical student electives have restarted in line with the government's lockdown exit plans.

The Education Centre was used to deliver both phases of the vaccination programme and has now been returned to use for education and training.

The Local Faculty Group and Local Academic Board meetings took place in February and March, via MS Teams, to ensure that educational governance for medical and dental training continued. The next Junior Doctors' Forum is planned for April.

COVID-19 UPDATE APRIL 2021

The cancer work initially taken on during the second wave of Covid is now being decreased as the surrounding providers return to business as usual.

We continue to utilise the redesigned surgical pathways to ensure QVH is able to deliver the speciality care required.

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

QVH continues to participate 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.

We continue to see small numbers of staff exhibiting covid symptoms and these are managed via the national testing system.

Staff who were shielding are being supported back in to the workplace following risk assessment to ensure their safety.

Managers are starting to consider how to re integrate staff back in the teams after long periods of home working

QVH continues to participate in the twice weekly system call and holds an incident call once per week to ensure the situation is being managed and the most up to date data is disseminated to the teams.

The incident room remains manned 7 days per week.

Covid-19 Vaccination Roll out

During 2 weeks in March QVH rolled out the second doses of the Covid-19 to our staff and other local health and social care workers. Again, this was a collaborative multidisciplinary approach and there was positive feedback from many of the staff who were vaccinated.

We have now ceased our support of the Crawley vaccine hub as the staff are required on site to deliver the increasing activity.

Infection Prevention and Control Board Assurance Framework (IPC BAF).
An updated version of the IPC BAF document is included in appendix 1 for information.

Appendix 2 (Updates from V1.6 highlighted in yellow)

Infection Prevention and Control board assurance framework April 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. **March 2021 Updates** Operating hours for the optigene lab

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
			increased to ensure a 7 day a week service is provided with screening being available at the weekend for trauma admissions. Robust screening and isolation for all elective patients and screening for trauma patients continue. Screening process for staff utilising optigene and lateral flow with no increase in cases seen.

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		**March 2021 update** No changes made

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 **March 2021 update** Consultant Microbiologists invited to attend the Burns weekly MDT using MS teams

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 **March 2021 update** National guidance relating to visitors reviewed but no changes made to current reduced visitations.
• 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	• Information on trust website and the hospital telephone system has been updated • Plan in place for this – no patients in this category to date		

written information available to prompt patients' visitors and staff to comply with hands, face and space advice.			

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 • triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is	• 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. • All in patient's elective or trauma are swabbed. All patients returning to care home are screened 48 hours in advance	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 19 in line with current national requirements and this is documented in the patients notes. **March 2021 update**

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
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) • ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.			No changes made to any of the admission pathways. Separate wards/areas remain for elective patients who have isolated and are screened, trauma patients who are not isolated and/or screened and for any patient who displays symptoms or is deemed to be a high risk with clear theatre pathways detailed in the SOP

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• 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 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	• 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	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

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
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 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	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 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.		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 distancing. **March 2021 update** No changes made

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
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 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	• 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 • 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
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 • 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			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• 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 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			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
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 COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert	• 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 **March 2021 update** No changes

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. **March 2021 update** No changes made, government guidance monitored to ensure we are maintaining compliance with all national guidance relating to screening both admissions and discharges as required.

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 **March 2021 update** No changes, IPC remains on-call out of normal working hours to provide support for staff

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 **March 2021 update** Individuals who require additional support in relation to infection control requirements for example ensuring appropriate FFP3 available, support with staff

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		screening are supported as individual cases to ensure they are managed appropriately Risk assessments for clinically vulnerable staff have been completed by department leads and where needed reasonable adjustments made to ensure staff are protected whilst at work. Vaccination programme for staff completed with second dose vaccinations given in March.

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:	06/05/2021		**Agenda reference:**	**71-21**	
Report title:	Seven-day services assurance				
Sponsor:	Keith Altman, Medical Director				
Author:	Keith Altman, Medical Director				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance that QVH meets 7-day services clinical standards				
Summary of key issues	• QVH as a specialist hospital has had CCG agreement that we need to meet the priority standards 2 and 8, only. Standards 2: All emergency admissions seen by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. Standard 8: All patients with high dependency seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established review by a consultant at least once per 24h, 7 days per week, unless it has been determined this would not affect the patient's care pathway. [NB for these purposes a consultant is defined as any doctor on the specialist register, CCT holders]. • NHSE/I do not now require QVH to submit its results. • In recent audits maxillofacial and hand trauma met overall standard at 92%. In high dependency cases the standard was met at 100% for once daily review but 80% for twice daily review and this is likely due to poor documentation, especially as CCU medical staff continuously review these patients 7 days per week. • Mitigations include written notes being scanned for Evolve and missed in the audits and head & neck surgeons attending remotely and this not being noted.				
Recommendation:	Recent audits of 7 day services provide assurance that QVH is currently near compliant with Priority Standards 2 and 8, except for twice daily review likely due to poor documentation.				
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:	KSO2: Access to hospital services				
Corporate risk register:	None				
Regulation:	NHSE/I				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

7 Day Hospital Services Self-Assessment

Organisation	**Queen Victoria Hospital NHS FT**
Year	**2019/20**
Period	**Autumn/Winter**

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	**Overall standard met at 92%**. 80% for maxillofacial trauma, 100% & 96% for hand trauma ta weekends and weekdays, respectively. Issues with poor documentation of time and named consultant review. Consultant job plans in anaesthetics, burns and plastic surgery allow for full compliance with local standards for Clinical Standard 2 and 8 seven days per week. Full pharmacy services are only provided 5 days per week. The 7DS risk is mitigated through site practitioner access to pharmacy and telephone advice available from GSTT 24/7 when pharmacy is closed. There is no evidence that safer staffing levels on wards and critical care are influenced by the day of the week. We monitor deaths on site, and off site within 30 days of surgery. Low mortality numbers (c5 per year) do not allow for conclusions on any weekend effect. Transfer out of patients is monitored as part of the clinical indicator programme. Transfers at weekend proportionally less at weekends (confirmed on 2019 data).	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available off site via formal arrangement	
		Ultrasound	Yes available on site	Yes available on site	
	Formal network agreement for medical referral and review, for pathology and radiology via BSUH SLA. Memorandum of Understanding with aspirations to increase clinical and managerial collaboration between two trusts. Likley partnership with supporting trust by 2020. CT now on-site since Dec 2018, but currently only 5 day working hours service. SLA in place for out of hours. Aspiration to increase to 7 days. Business plan for translocatable MRI in progress.	Echocardiography	Yes available on site	Yes available off site via formal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available off site via formal arrangement	
		Upper GI endoscopy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Interventional Endoscopy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Emergency Surgery	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
	Formal network agreement for medical referral and review, for pathology and radiology via BSUH SLA. Memorandum of Understanding with aspirations to increase clinical and managerial collaboration between two trusts. Possible merger with supporting trust by 2020.	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available off site via formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	High dependency patients on CCU had a consultant review by maxillofacial/head and neck surgeons at least once daily in **80%** cases of 43/54 bed days. A clear pathway of care was established every morning for each patient **(100%)**. Issues with poor documentation of time reveiwed and named consultant. The standard was not met for twise daily review and this is likely due to poor doucmentation as above. Action has been taken and email sent to teams to remind them to document this. All patients with Level 2 or 3 critical care needs reviewed twice daily, and as required. Anaesthetic and critical care consultant out of hours job planning enables twice daily consultant review across seven days in these areas. Documentation specifically captures twice daily critical care review and, in particular, weekend handover. Renewed CCU discharge paperwork. Efficient escalation protocols in critical care. CCU consultant present at morning and evening handover meetings with trauma and hospital at night teams. Day time consultant cover of ICM is limited to 2 consultants / week, working in 2 – 3 day blocks, plus on-call cover at weekend. Consistency of ST5-7 cover is also limited to 2 -3 registrars / week. Ward transfers at nights and weekends only in very exceptional cases. Critical care inspected by CQC in Feb 2019 ('Good' in all domains) and SECCCN in April 2019 - positive report. We do not meet all critical care service specifications in terms of 24/7 FICM accredited critical care consultants or co-location, but mitigation to the satisfaction of network and CQC, and reflects case mix. Once daily review of all non-elective patients in QVH on daily ward round well-embedded (100% on 2018 audit data). Capture of daily 'Board rounds' in plastic and OMFS trauma and delegation of review still remains a deficit. E-obs and electronic handover tool funding approved, with potential for automated NEWS2 escalation, virtual ward rounds, AKI and sepsis alerts by end March 2020. Live direct entry forms for EPR in development. Accurate, legible,	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Standard 1 - Excellent Friends and Family feedback, however, not yet split into collection on weekday versus weekend. Standard 3 - Professions Allied to Medicine, including SALT, OT, Dietetics, Pharmacy, Psychology, are generally provided on a 5 day / week basis. QVH specialist case mix does not require full MDT review for vast majority of cases admitted at weekend. Physiotherapy is available 24/7. Standard 4 - MDT handover well embedded for wards, critical care and whole hospital, with high satisfaction in GMC training survey. Capture of handover information, including delegation of review, to form part of patient record not yet finalised, and remains priority for 2020/21. Standard 7 SLA with Sussex Partnership NHS Foundation trust for 24/7 mental health needs, plus on-site psychological services department (5 days/week). Particular requirements of reconstruction and burns patients considered and well catered for. Standard 9 Infrequent delayed transfers of care for our patient cohort, which are generally ambulatory. Discharge planning begins on admission. Access to community of all QVH urgent services via specialty consultants on-call. Standard 10 Detailed in Annual Quality Report and Quality and Safety Strategy. All pillars of clinical governance and clinical risk management provided and adhered. Trainees supported and feedback regularly collected. Review of patient outcomes looks at: patient experience, patient safety and clinical effectiveness. Clinicians monitor their outcomes (eg, PROMs) and discussed at appraisal meetings.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
N/A

Clinical Standard 8	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Standard 2 - Maxillofacial Emergency admissions

- Identified 10 emergency admissions from week beginning in January 2021 over 7 days
- 8/10 patients had a consultant review within 14 hours = 80%
- All admissions were seen within an hour of admission by a registrar or fellow and discussed with the on-call consultant within 14 hours of admission

Findings: lack of documentation of time seen and consultant name in the notes of 2/10 of the selected cohort.

Standard 8 – Head & Neck High Dependency Inpatients

- 10 patients audited for the duration of their CCU stay at QVH.
- These patients were admitted between 17/12/20 to 28/01/21.
- Each day is divided into an AM and a PM review
- In total, these 10 patients spent 54 days on CCU (average LOS 5.4 days)
- There was a consultant review at least once in each 24 hour period on 80% of the days (43/54)

- A clear pathway of care was established every morning for each patient (100%)

Findings: lack of documentation of time seen and consultant name in the notes of 2/10 of the selected cohort.

Hand Trauma 7DS

WEEKEND

	Con Rv	Documented
DSU	100%	94%
IP	100%	100%
TOTAL	100%	95%

WEEKDAY

	Con Rv	Documented
DSU	96%	30%
IP	100%	78%
TOTAL	96%	38%

- **Con Rv** (<14 hrs) includes F2F assessment and/or virtual review of case photographs, imaging and management plan.
- **Documented** = Consultant review (<14 hrs) documented in medical notes in appropriate manner

Seven day services March 2021

Standard 2

- All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital

Target = >90%

Standard 8

- All patients with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, 7 days a week, unless it has been determined that this wouldn't affect the patients care pathway

Target = >90%

2 emergency trauma audits:

1. Maxillofacial trauma admissions January 2021 (Mr Zaid Sadiq): 80% over 7 days.
2. Hand trauma admissions March 2021 (Mr Rob Pearl): 100% weekend & 96% weekday over 7 days.

Overall: 92% (target reached for Standard 2)

High dependency in patients on CCU - 17/12/20 to 28/01/21 – Standard 8

1. There was a consultant review at least once in each 24 hour period on 80% of the days (43/54 bed days)
2. A clear pathway of care was established every morning for each patient (100%)

Findings:

Poor documentation of time seen and consultant name in records for all three audits.

Mitigations:

It was noted that in some cases as written notes were made during rounds that were then sent off for scanning on to Evolve, they were not available for the audits resulting in the perceived lack of documentation. In addition, some of the head & neck surgeons sign in to ward rounds remotely rather than attend in person, resulting in them not being noted as attending by the member of staff writing up the record.

Action: Email sent to remind teams that documentation of time seen and consultant review must be recorded whenever possible.

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed : 21 April 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
- Reduced capacity due to reconfiguration of services to support green and amber elective pathways and infection prevention control requirements
- Reduced capacity due to Rowntree procedure limits
- Covid-19 non urgent activity step down
- 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
- Sentinel Lymph Node demand [CRR 1122]
- Current and further imminent managerial team gaps
- Capacity to deliver NHSE, system and QVH recovery and transformation requirements

Future risks
- Further COVID-19 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 and implementation underway
- Agreed system approach to capacity and demand
- Weekly RTT and cancer PTL meetings ongoing
- Development of revised operational processes underway to enhance assurance and grip
- 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
- Reduced Independent Sector capacity post April 2021
- Challenges in available administrative bank staff to support scheduling teams
- Theatre capacity due to Rowntree theatre procedure limits

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance | **Committee: Finance & Performance** | **Date last reviewed 21st April 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 12)

- The Trust has submitted draft year end details to NHSI/E. At present the Trust is finalising the year end position ready for audit.
- Guidance for 21/22 has now been received and the Trust is working through the envelopes for submission on the 6th of May.
- ~~Further guidance on the 21/22 financial regime is expected the last week of march.~~
- ~~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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**4 March 2021**		**Agenda reference:**	**73-21**	
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 indicators for March were strong, particularly for Cancer, but the future remains challenging as recovery builds up. Workforce indicators remain stable. Initial year-end financial results are forecasting a surplus, but may be subject to system / regional change. The committee agreed to recommend a break-even budget, at corporate level, for H1, but further work is need for the full year – not least given uncertainty over funding in H2.				
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:	KSO2:	**KSO3: x**	**KSO4: x**	**KSO5: x**
	Outstanding patient experience	*World-class clinical services*	***Operational excellence***	***Financial sustainability***	***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 looks in detail at allocated corporate risks				
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: 6 May 2021
Reference no: 73-21
Report from: Paul Dillon-Robinson, Committee Chair
Report date: 27 April 2021

Financial, operational and workforce performance assurance

Introduction

The finance and performance committee met on 26th April, and continued to balance a review of historic performance with discussion on current and future challenges. It also met on 22nd March where, amongst its regular items, it reviewed the results of the staff survey and updates on the Corneo Plastics service review and budget setting.

1. Operational performance

March's operational performance indicators were a strong set and the committee was keen to welcome them and recognise the significant work that lay behind them, particularly with regards to the progress with cancer KPIs.

Looking to 2021/22 there is a significant change in the ICS element to planning, both in terms of the system expectations as well as capacity. The focus will be on "excessive waits" but it is also unclear what impact relaxation of lockdown may have on primary care referrals.

The risks to delivery for the Trust cover people (availability of both substantive and temporary workforce), "hard" capacity (in terms of both independent sector and our own estate and theatres) and the uncertainty / complexity in planning for the year ahead. Much of the complexity is meeting the planning needs, for instance validation of our waiting lists and prioritising health inequalities, which takes people away from other roles, as well as the push for improvement and encouraging people to do things differently.

2. Workforce performance

The Trust's KPIs remain stable. A slight increase in Bank staff in March related to the Covid vaccination / testing, and the committee sought assurance on the improvement in appraisal and MAST compliance.

The committee was informed of the high profile being given to staff well-being, and the number of initiatives being developed. It discussed support for those returning to site and overseas staff with concerns for family overseas.

It noted the actions and progress with the Workforce Diversity Action Plan.

3. Financial performance

The committee received a brief summary of the initial month 12 financial out-turn and noted a number of late announcements on funding from NHSE and year-end adjustments, as well as the fact that further changes may arise from system and regional changes to the final funding allocations for 2020/21.

The committee also discussed at length the budget setting for 2021/22 and agreed with a break-even budget for H1 (the first half of the year) at corporate level. It was recognised that there was too much uncertainty over the funding for H2 to agree a budget for the full financial year, and that further work on phasing budgets for pay and non-pay was needed. It

also noted that there is 2% efficiency requirement for this year, as well as the cost pressures and service improvements proposed.

4. Other

The committee received updates on:

- the Corneo and Oral service reviews and the actions being undertaken to further validate the data, explore practices, consider services and how to interact with commissioners
- the annual review of the asset impairment approach
- remedial action for two corporate risks, Radiology and Histopathology, and welcomed the recent actions that had led to a lowering in the residual risk assessment.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/05/2021**		**Agenda reference:**	**74-21**	
Report title:	**Operational Performance Report**				
Sponsor:	Abigail Jago, Director of Operations				
Authors:	Operations Team				
Appendices:					
Executive summary					
Purpose of report:	To provide the Board with an update regarding operational performance and phase 3 delivery				
Summary of key issues	Key items to note in the operational report are: • Operational performance in month • Continued Covid-19 impact, changes to independent sector contract and cancer hub requirements • Recovery planning requirements and position				
Recommendation:	The Board 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:	26/04/21	Decision:	Noted	
Next steps:					

Operational Performance Report & Phase 3 Update

Abigail Jago, Director of Operations

April 2021

Trust Board

Contents

Headlines

Queen Victoria Hospital NHS Foundation Trust

In month performance / items to note

- Performance **meeting national / local set standards** for 2WW cancer, 62 day cancer, faster diagnosis cancer standard, 104 day cancer waits, 62 day cancer backlog, histology reporting and MIU 4 hour standard.
- Performance **meeting recovery trajectory** for 31 day cancer.
- Performance **behind plan** for DMO1 due to patient choice.
- **Independent sector:** The Horder elective activity theatre sessions available from the end of March significantly reduced due to NHS contract changes.

Forward look

- As of the end of March QVH stood down provision of additional capacity for surgical cancer treatments on behalf of organisations from Kent, Surrey and Sussex with the exception of Dartford and Gravesham NHS Trust. This will support QVH activity recovery.
- Continued outpatient improvement work ongoing to support the use of virtual to reduce footfall due to COVID-19 prevalence and enhance patient experience.
- Sleep activity challenges due to staffing

Issues of concern / risks to performance delivery

- Theatre capacity
- Reduced independent sector provision
- Sleep staffing position

Performance Summary

Queen Victoria Hospital
NHS Foundation Trust

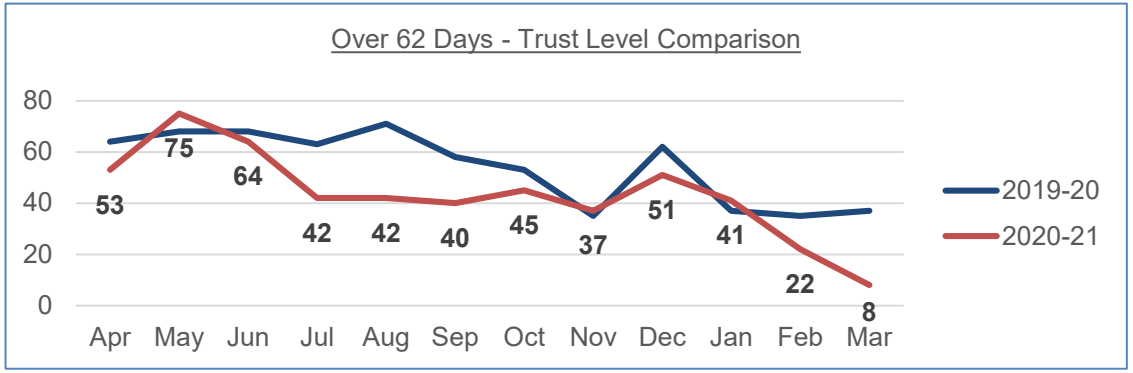
	KPI	TARGET / METRIC	SOURCE	APR20	MAY20	JUN20	JUL20	AUG20	SEP20	OCT20	NOV20	DEC20	JAN21	FEB21	MAR21
CANCER	Cancer 2WW	93%	National	83.8%	89.5%	77.1%	84.5%	98.4%	99.7%	98.7%	99.4%	98.9%	90.7%	98.2%	-
	Cancer 62 day	85%	National	90.9%	95.9%	88.2%	77.5%	91.3%	85.3%	81.2%	86.6%	85.7%	85.3%	87.5%	-
	Cancer 31 day	96%	National	98.2%	98.5%	93.1%	89%	93.9%	89.7%	92.2%	93.3%	92.8%	89.7%	94.8%	-
	Faster Diagnosis	75%	National	67.4%	79.9%	77.1%	82.5%	75.3%	67.8%	82.2%	75.1%	77.1%	73.7%	82.8%	-
	Cancer 104 day	Internal trajectory	Local	4	12	39	15	9	5	6	9	12	20	11	10
	Cancer 62 day backlog	Internal trajectory	Local	53	75	64	42	42	40	45	37	51	41	22	8
DIAGNOTICS	DMO1 Diagnostic waits	99% <6 weeks	National	72.4%	28.09%	73.3%	84.9%	86.8%	92.0%	94.9%	98.1%	96.3%	98.80%	99.15%	98.92%
	Histology TAT	90% <10 days	Local	93%	96%	95%	99%	92%	95.0%	95.0%	98.0%	96.0%	88.0%	94.0%	94.0%
	Imaging reporting	% <7 days	N/A	99.0%	98.6%	99.4%	98.5%	98.6%	98.2%	98.6%	98.5%	98.5%	97.9%	98.4%	97.0%
EXCESSIVE WIATS	RTT52	Phase 3	ICS	38	100	185	320	461	555	608	563	623	740	907	903
	RTT78	N/A	N/A	1	3	3	4	8	10	16	29	32	43	62	87
	RTT104	N/A	N/A	-	-	-	-	-	-	-	-	-	-	-	2
PHASE 3 ACTIVITY	Day Case	Phase 3	ICS	-	-	-	-	-	72%	78%	77%	86%	67%	55%	95%
	Elective inpatient	Phase 3	ICS	-	-	-	-	-	71%	81%	80%	80%	55%	48%	65%
	Outpatient (new)	Phase 3	ICS	-	-	-	-	-	79%	74%	79%	75%	57%	65%	89%
	Outpatient (follow up)	Phase 3	ICS	-	-	-	-	-	99%	92%	100%	103%	81%	89%	118%
	First OP Virtual	Phase 3	ICS	-	-	-	-	-	42%	43%	35%	27%	43%	45%	39%
	Follow up OP Virtual	Phase 3	ICS	-	-	-	-	-	39%	36%	34%	33%	46%	45%	42%
MIU	MIU	95% discharged <4hrs	National	100%	100%	100%	100%	99.8%	98.5%	100%	100%	99.6%	100%	99.8%	100%
RAG	Deteriorating position or plans / cause for concern			Improving position or plans / local trajectories on track						Delivery of national / local standard					

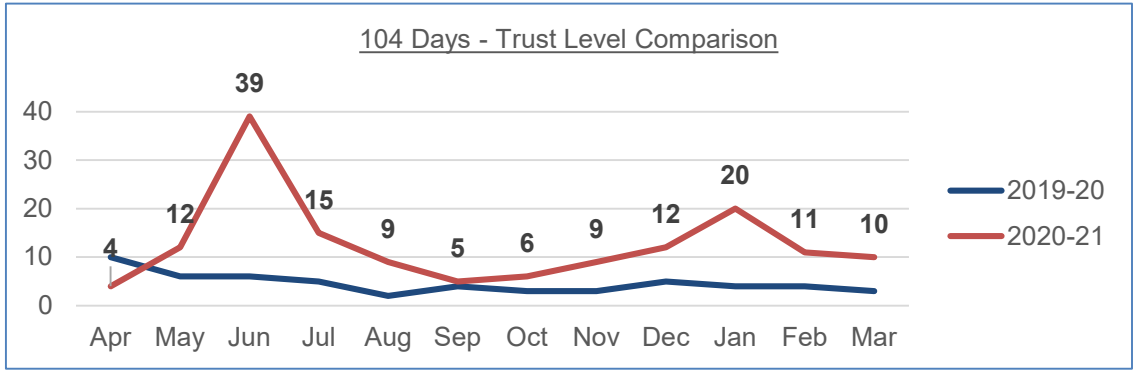
Cancer

Performance Dashboard / 62 days / 104 day backlog

Queen Victoria Hospital NHS Foundation Trust

Trust Level	Q1 2020-21			Q2 2020-21			Q3 2020-21			Q4 2020-21			Change from last month
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Two Week Wait	83.8%	89.5%	77.1%	84.5%	98.4%	99.7%	98.7%	99.4%	98.9%	90.7%	98.2%		↑
62 Day Referral to Tx	90.9%	95.9%	88.2%	77.5%	91.3%	85.3%	81.2%	86.6%	85.7%	85.3%	87.5%		↑
Faster Diagnosis	67.4%	79.9%	77.1%	82.5%	75.3%	67.8%	82.2%	75.1%	77.1%	73.7%	82.8%		↑
62 Day Con Upgrade	100.0%	57.1%	100%	89.7%	77.8%	88.2%	100%	85.7%	100%	92.9%	91.7%		↓
31 Day Decision to Tx	98.2%	98.5%	93.1%	89%	93.9%	89.7%	92.2%	93.3%	92.8%	89.7%	94.8%		↑
31 Day Sub Treat	100.0%	100.0%	85.7%	75%	92%	100%	100%	90.5%	95.2%	100%	87.5%		↓





PERFORMANCE COMMENTARY

- QVH were compliant against 4 of the 6 cancer metrics in February 2021.
- **31 day** – QVH remains behind standard for February. Improvement plan in place
- **31 day subsequent** – Standard not met reporting 2 breaches in skin due to unavoidable medical delays.
- **Screening** - QVH did not treat any patients on this pathway in February.
- **62 day backlog** and **over 104 day** – the Trust met the agreed trajectory for March.

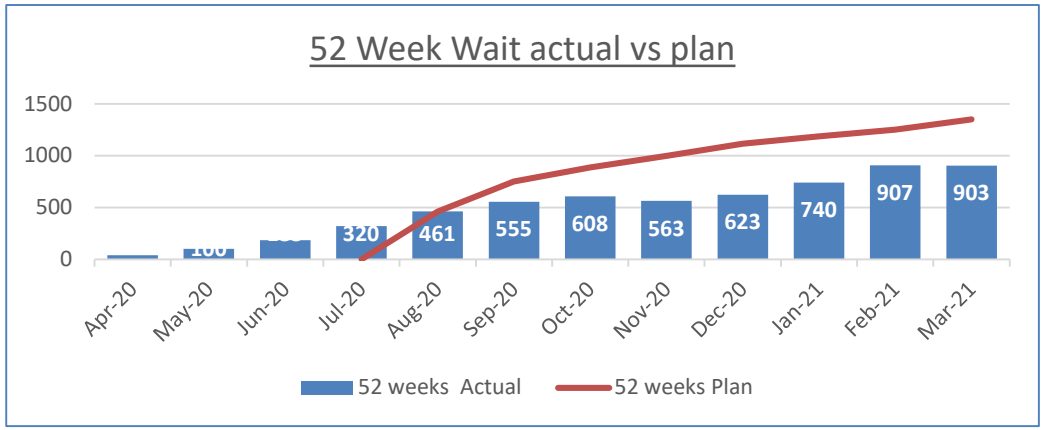
FORWARD LOOK / PERFORMANCE RISKS

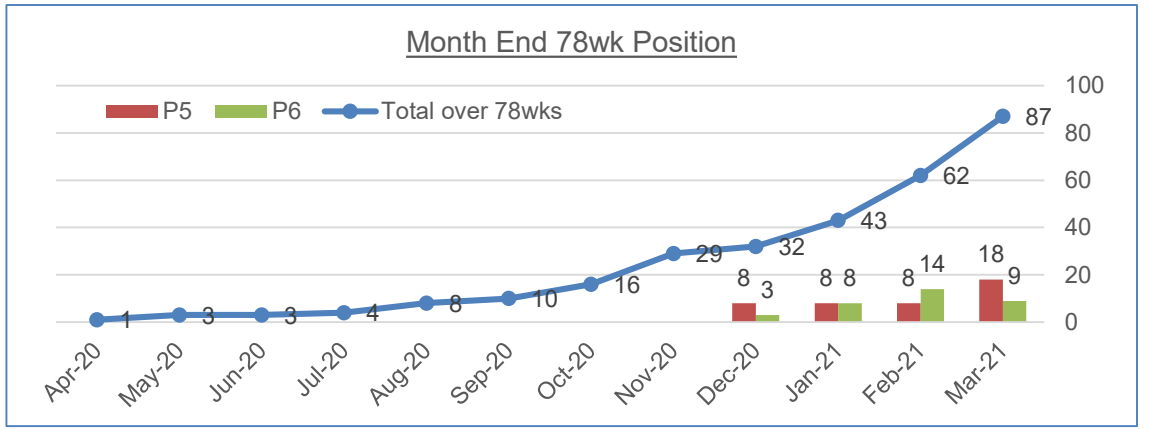
- The unvalidated performance for **2WW**, **62 day** and **FDS** for March is above plan.
- A significant performance risk for **62 day** plan in April is breast, due to the rise in the number of immediate referrals and challenges in aligning theatre dates with the visiting consultant and QVH capacity.
- **31 day –** QVH remain behind plan for March, which is still driven by skin. The locum skin consultant post started in April.
- **62 day backlog** and **over 104 day** – the Trust is on track to meet the trajectory for April. A risk for QVH remains the inclusion of late referrals from other trusts.

Excessive Waits

52WW / 78WW / 104WW

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	907	903
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	10,416	11,002
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%	9%	8%

PERFORMANCE COMMENTARY

- Small reduction in number of patients waiting more than 52 weeks in March. 89 patients waiting over 52 weeks are a P5 or P6 (i.e. patient deferred)
- Plastic surgery remains the most challenged specialty for 52 and 78 weeks.
- A further reduction in the number of patients between 41-51 weeks in month, due to decreased referrals seen in April, May, and June during wave 1.
- In month the Trust report 2 breaches over 104 weeks, both are within plastics; one has a TCI (To come in) date, the other is a P5.
- 68% of patients waiting over 78 weeks have a TCI date.

FORWARD LOOK / PERFORMANCE RISKS

- Increased levels of patients waiting > 52 weeks expected. Recovering modelling is underway
- Predicting to report a total of 133 over 78 weeks in April.
- Ongoing risk around patients delaying treatment for COVID related reasons.

Phase 3 Activity

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%**	**55%**	**95%**
Day Case 1920 Activity	834	1017	959	759	898	839	647
Day Case 2021 Activity	603	795	737	656	601	462	617
Elective Inpatient Plan	55%	85%	86%	74%	92%	85%	90%
Elective Actual	**71%**	**81%**	**80%**	**80%**	**55%**	**48%**	**65%**
Elective 1920 Activity	309	305	322	292	309	324	266
Elective 2021 Activity	216	246	256	233	170	155	173

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

- Daycase above plan due to reduced in month baseline resulting from the stand down of activity in wave 1
- Inpatient activity remains challenged due to support for cancer hub, theatre capacity and shift to daycase activity.

FORWARD LOOK / PERFORMANCE RISKS

- Improved performance with cancer hub role stood down from the end of March.
- Reintroduction of routine activity as surge phase has finished; progress with restoration plans.
- Admitted challenges relate to theatre capacity
- Ongoing risk around patients delaying treatment for COVID reasons until all restrictions are lifted.

Phase 3 Activity

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%**	**65%**	**89%**
Outpatient (new) 1920 Activity	3026	3578	3246	2382	3517	3056	2815
Outpatient (new) 2021 Activity	2403	2650	2548	2880	2010	1998	2511
Outpatient (follow up)	82%	84%	87%	89%	91%	96%	100%
Outpatient actual	**99%**	**92%**	**100%**	**103%**	**81%**	**89%**	**118%**
Outpatient (f up) 1920 Activity	9717	11345	10379	8914	10293	9036	8696
Outpatient (f up) 2021 Activity	9665	10468	10431	9264	8367	8046	10265

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

- Planned non admitted follow up appointments exceed the target in March due to reduced baseline activity levels in March 20.
- Planned non admitted first appointments remain behind plan, but have recovered in month.

FORWARD LOOK / PERFORMANCE RISKS

- Ongoing risk around patients delaying treatment for COVID reasons until all restrictions are lifted.

Phase 3 Activity

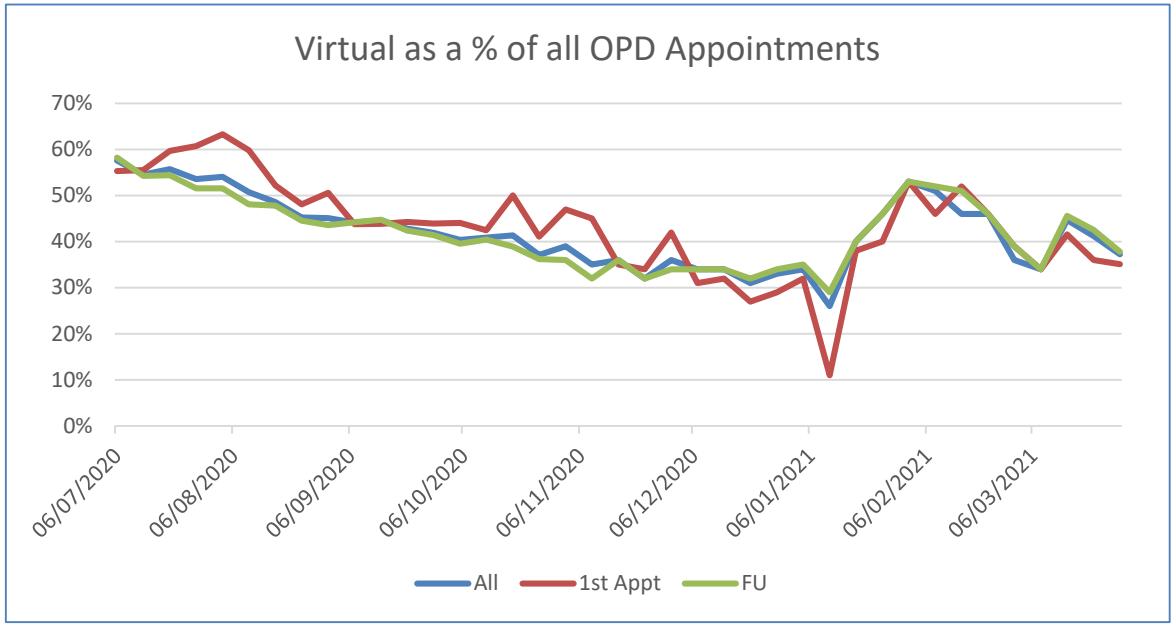
Elective care – virtual outpatients: first & follow up

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%	45%	39%
Follow up OP Virtual (FU)	60%	60%	60%	60%	60%	60%	60%
Follow up OP Virtual actual	39%	36%	34%	33%	46%	45%	42%



PERFORMANCE COMMENTARY

- First appointments for virtual activity remain above plan.
- Follow up appointments for virtual activity remain below plan.

FORWARD LOOK / PERFORMANCE RISKS

- Virtual Task & Finish group continues to drive forward programme of works.
- Planning guidance 2021/22 stipulates new virtual targets from April at least 25% of all appointments should be virtual (telephone or video).

Recovery – position and gap analysis (1)

Queen Victoria Hospital NHS Foundation Trust

Work continues in the planning and delivery of elective activity. Planning guidance has now been issued and gap analysis for the ICS and provider complete.

THEME	REQUIREMENT	POSITION	GAP / FURTHER WORK
Governance	Create clear accountability for elective recovery, and implement key supporting tools, at system level, including common tracking of waiting lists; clinical review and prioritisation; dynamic planning of elective capacity and shared capacity, demand and monitoring data	**ICS:** Sussex-wide Planned Care Board in place with accountability to the Sussex Acute Collaborate Network. QVH **QVH:** Recovery through Diagnostic and Elective Care Board System approaches to shared PTL and validation underway.	NA
Independent Sector (IS)	Plans should make full use of available NHS and Independent Sector (IS) capacity through the new IS contract framework (the 'NHS Increasing Capacity Framework'), linked to proposal for evolved mechanisms for effective working, contracting and planning to establish how we can most effectively use IS capacity to support recovery over the next two to three years.	**ICS**: Sussex Wide IS Work Stream – plans in place for Q1. **QVH**: Reduced capacity with Horder. Ongoing discussions to maximise opportunity. Work underway with alternative providers (Tunbridge Wells Spire). Reduced capacity is a risk for recovery.	• Risk relating to available capacity • Patient cohorts meeting required access criteria
Recovery Trajectories and Elective Recovery Fund	The threshold level is set against a baseline value of all elective activity delivered in 2019/20. For April 2021 it will be set at 70%, rising by 5 percentage points in subsequent months to 85% from July. Acute providers' access to the ERF will be subject to meeting 'gateway criteria' including addressing health inequalities, transformation of outpatient services, implementing system led elective working, tackling the longest waits and supporting staff.	• First cut activity plans developed and submitted. Theatre capacity a challenge. • Discussions underway for system wide approach to health inequalities programme.	• Further develop activity plans • Implementation plan for PIFU (patient initiated follow up) and advice and guidance (A&G) • Development of health inequalities work programme
Prioritisation	Systems will be expected to prioritise the clinically most urgent patients, e.g. for cancer and P1/P2 surgical treatments	**ICS:** Consistent with priority principles agreed at Planned Care Board/SACN. **QVH**: Prioritisation in place	NA

Recovery – position and gap analysis (2)

Queen Victoria Hospital NHS Foundation Trust

THEME	REQUIREMENT	POSITION	GAP / FURTHER WORK
Pathway Transformation	To reduce variation in access and outcomes, systems are expected to implement whole pathway transformations and thereby improve performance in three specialties: cardiac, musculoskeletal (MSK) and eye care with support via the National Pathway Improvement Programme. The aim should be to achieve what was top quartile performance against benchmarks on those pathways. The National Pathway Improvement Programme in conjunction with GIRFT will support the development of and accredit plans.	**ICS:**Priority Specialty Pathway Redesign Groups for Ophthalmology which will encompass GIRFT programme **QVH**: QVH is progressing ophthalmology through ICS Programme. Case supported for EPR within 2021/2 capital allocation which will support the programme	
Addressing Health Inequalities	Address the longest waiters and ensure health inequalities are tackled with a particular focus on analysis of waiting times by ethnicity and deprivation including: • Use waiting list data (pre and during pandemic), including for clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations • Prioritise service delivery by taking account of the bottom 20% by IMD and black and minority ethnic populations for patients on the waiting list and not on the waiting list, including through proactive case finding • Use system performance frameworks to measure access, experience and outcomes for black and minority ethnic populations and those in the bottom 20% of IMD scores • Evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts	**ICS**: Place based health inequalities analysis and plans are being developed via Sussex Health Inequalities Programme and this will provide an overarching approach and framework for tackling health inequalities in Sussex. Consideration of health inequalities (via completion of Equality Health Impact Assessments) will be a priority in all planned care work streams. Analysis will be undertaken of current and pre COVID waiting lists by deprivation, age and ethnicity to identify those patient cohorts that have been disproportionately impacted and to identify appropriate interventions and support.	Further work required to develop QVH programme including identification of capacity to deliver

Recovery – position and gap analysis (3)

Queen Victoria Hospital NHS Foundation Trust

THEME	REQUIREMENT	POSITION	GAP / FURTHER WORK
Diagnostics	Additional capacity and efficiency should be maximised through new Community Diagnostic Hubs (CDHs) and pathology and imaging networks. All systems are expected to work with regions to deliver increased capacity to meet the diagnostic needs for their population, in line with the recommendations of the Richards review. System plans should set out their proposals for how this additional capacity will be delivered, including through the development of CDHs	**ICS**: Delivery via Diagnostic and CDH Work Stream **QVH**: Delivery via CDS workstream	
System PTLs	Management of Patient Tracking Lists (PTLs), including for cancer patients at a system level using NHS and IS capacity to the benefit of the whole system population.	**ICS / QVH**: Workplan via the System PTL work stream under the Sussex Design Group	NA
Outpatient Transformation	Embed outpatient transformation, taking all possible steps to avoid outpatient attendances of low clinical value and redeploying that capacity where it is needed. Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation (equivalent to c.40% of outpatient appointments that don't involve a procedure). Systems are required to demonstrate progress by introducing Patient-Initiated Follow-up (PIFU), or similar alternative, in at least three major outpatient specialties per provider Collaboration across primary and secondary care to treat more patients without the need for an onward referral, including increasing uptake of Advice and Guidance or other measures such as referral triage.	**ICS:** Outpatient transformation work stream via the Sussex Design Group setting model approach with delivery at place/ by provider. Programme will need to ensure appropriate linkages/engagement with primary care and community via the PCCN – particularly for A&G and PIFU. **QVH:** Outpatient Improvement Board being re-established to oversee implementation.	Further work required for A&G and PIFU implementation. Ongoing work re virtual roll out.

Recovery – position and gap analysis (4)

Queen Victoria Hospital NHS Foundation Trust

THEME	REQUIREMENT	POSITION	GAP / FURTHER WORK
Clinical Validation	Incorporate clinically led, patient focused reviews and validation of the waiting list on an ongoing basis, to ensure effective prioritisation and management of clinical risk. Plans should include: • shared decision making and treatment reviews between patients and clinicians, keeping waiting patients informed of next steps in their treatment, including discussion of alternative treatment options. • maintaining waiting list data quality through close interrogation of patient-level PTL data and the application of system-wide data review processes, including close partnership working with primary care and adherence to guidance on Evidence Based Interventions. • detailed validation, by providers, of the weekly Waiting List Minimum Dataset (MDS) uploads, to ensure waiting list data are complete and accurate. • clinical validation, focusing on diagnostic and non-admitted pathways, providing evidence of how long-waiting patients will be regularly reviewed and risk assessed.	Delivery at provider level with standardisation of approach via a new work stream under the Sussex Design Group. Will require ICS wide response to new Diagnostic validation programme (May to June) and non admitted (tbc) and will need to include adherence to current ICS clinical policies and national Evidence Based Interventions.	NA
Patient Communication	Maintain effective communication with patients including proactively reaching out to those who are clinically vulnerable	**ICS**: Workstream in place. QVH work dovetails to system work	QVH to confirm patient communication plan
Workforce	Access available support to help deploy the innovative approaches to optimising workforce capacity that are best suited to local system needs, including system wide workforce planning, passporting to allow flexible working of employed and bank staff between organisations	Need to ensure linkages to system workforce programmes	

Recovery – cancer position and gap analysis

Queen Victoria Hospital NHS Foundation Trust

THEME	REQUIREMENT	POSITION	GAP / FURTHER WORK
Returning 62 day backlogs to less than or better than Feb 2020 levels	Returning the number of people waiting for longer than 62 days to the level we saw in February 2020 or to the national average in February 2020 where this is lower. To meet the Surrey and Sussex Cancer Alliance wide target of having no more than 5% of the PTL waiting over 62 days.	Currently within required standard. Improvement plan is in place to ensure sustainable delivery.	Improvement plan implementation
Delivery of Faster Diagnosis Standard by Q3	On track for delivery	Planned delivery of local trajectory with compliance in Q1 ahead of the standard. Improvement plan in place to support sustainable delivery.	Improvement plan implementation
Meet increased levels of referrals and treatments required	Meeting the increased levels of referrals and treatment required to address the shortfall in number of first treatments by March 2020	Standards currently being met. Some uncertainly re total demand going forward due to unmet need.	
Delivery of Cancer Waiting Times Standards	A renewed focus on improving performance against existing waiting times standards.	Improvement plan in place to support the sustainable delivery of all cancer waiting time standards.	Improvement plan implementation.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/05/2021	**Agenda reference:**	**75-21**		
Report title:	Procurement of Central Sterile Service Department (CSSD) Outsourced Service				
Sponsor:	Michelle Miles – Director of Finance & Performance				
Authors:	Malcolm Dorman – Procurement Consultant Louise Elliott – Head of Procurement				
Appendices:	N/A				
Executive summary					
Purpose of report:	Board approval is required to direct award Sterile Service contract to incumbent supplier at value of circa £1,950,000 over three years. (The Trusts Scheme of Delegation requires the Board to approve contracts above £1m).				
Summary of key issues	• Current contract expires 31 August 2021 • Compliant procurement route for direct award of contract with current provider for continuation of service • Close working with current provider bringing about efficiencies and service improvements • COVID and resource pressures delayed alternative procurement process • Break in provision of service would close Theatres				
Recommendation:	The Board is asked to **APPROVE** the option of direct awarding the CSSD contract for the period of three years to our current provider Steris				
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:	KS04 – Financial Sustainability				
Corporate risk register:	None				
Regulation:	None				
Legal:	Public Procurement Regulations; these regulation set out rules for compliant public contracts.				
Resources:	None				
Assurance route					
Previously considered by:	Executive Management Team				
	Date:	28/04/21	Decision:	Recommended for approval	
Next steps:	If approved today the contract through the framework will be agreed and signed between the two parties and a new three year contract entered into, whilst work started on new procurement.				

Report to:	Board Directors
Agenda item:	75-21
Date of meeting:	06/05/2021
Report from:	Michelle Miles, Director of Finance and Performance
Report authors:	Malcolm Dorman, Procurement Consultant Louise Elliott, Head of Procurement
Date of report:	27/04/2021
Appendices:	N/A

Procurement of Central Sterile Service Department (CSSD) Outsourced Service

Introduction

With the current Central Sterile Service Department (CSSD) outsourced services provided by Steris, whose contract is due for renewal 31st August 2021, this paper provides an overview on the suggested Framework direct award for the continuation of service at the value of circa £1,950,000. Direct Award means a form of call-off contract from a Framework Agreement whereby best value is pre-established within the framework terms, and a contractor is appointed without the requirement for further competition.

Executive summary

The CSSD service provides sterilisation of medical devices, equipment and consumables and is an integral part of the theatre service within the Trust.
The annual value of the service is circa £650k. The current contract is due to expire in August 2021, but due to COVID and resource pressures, the Trust have been unable to start work on a full procurement process which would be required if we were to contract with a new provider to ensure that transfer and mobilisation could take place effectively and also ensure that any new provider provides a robust and cost effective service.

The procurement department have been looking at a compliant way to extend the services with our incumbent supplier Steris, as well as ensuring best value, for a reasonable time period to ensure a full and robust procurement exercise can take place. The route outlined in this paper is to direct award to Steris via the Shared Business Service (SBS) Framework which is a framework where by best value has already been tested. A three year contract is proposed to enable Steris to continue to provide the improvements in the service provision that the Trust have been working with them on in order to bring positive changes and efficiencies in to the way the service is provided and the way the Trust works with the provider. The total value of this contract would be circa £1,950,000. The three year contract would also allow time for a sourcing strategy to be created, a compliant tender process to be undertaken and the transfer and mobilisation of services to be completed.

Situation

The CSSD services are critical to the Trust and therefore required going forward. However, the existing agreement cannot be extended any further beyond the current end date of 31st August 2021.

The Trust requires continuity of CSSD services as without them the Trust would be unable to deliver surgical services, due to unavailability of sterile surgical equipment. This would result in hospital closure. Therefore, there can be no break in provision whilst a service provider is sought.

With the annual value of the agreement being circa £650k the Procurement team would normally complete a tender exercise. Unfortunately, as the existing agreement ends in August 2021 there would not be enough time to run a standalone compliant tender process and allow for mobilisation and service transfer to a new service provider. By using a framework the best value is already pre-established within the framework terms.

Steris have recognised and have been supporting the Trust in looking at areas where they can provide tools and services to improve on efficiency both within the service provided and the Trust:

a. Scanning and storage.
b. Repair process and instrument procurement.
c. Endoscopy processing.
d. On site staff support.

As a result, Steris have been working on an eighteen month plan to transform the service to ensure that a fully managed service is delivered to the Trust, which will free up Trust staff time and ensure less risk of items not being available for surgery and reducing repair and instrument costs.

Background
The provision of the CSSD services have been delivered to the Trust via a contract with Steris (who took over the original services from Synergy via a company buy-out during the contract term). The contract was awarded in 2014 with an initial term of five years with two years optional extensions, which were subsequently taken up. Theatres, Infection Control and Procurement work closely with Steris who continue to work with the Trust to look at ways to improve the service. Where Steris are expanding their portfolio, so they are supporting the Trust further with looking at the efficiencies and other initiatives they may be able to support us with, a lot of which have been delayed due to COVID restrictions.

Assessment
The options that have been assessed are:

i. Extend the existing agreement for another year to enable an OJEU process to be completed. However, this option is open to legal challenge, as the existing agreement has been extended beyond the allowable term. Under a legal challenge an injunction could be sought by another third party provider which could mean that the services provided by Steris would have to cease until resolution was sought in the Courts. The Trust could also potentially have to pay any challenging party loss of profit.
ii. A direct award via the Shared Business Service (SBS) Framework agreement, for a period of three years to Steris at the value of circa £1,950,000.
Via this agreement, this would enable a compliant route to re-contract with Steris in order for them to implement their initiatives for the transformation of the service provision. This would also enable a tendering process to be undertaken prior to the end of this agreement by which time the Trust would seek a provider to mirror the best practices and efficiencies already embedded.

Recommendation
The Board is asked to **APPROVE** the option of direct awarding the CSSD contract for the period of three years to our current provider Steris.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/06/2021**		**Agenda reference:**	**76-21**	
Report title:	**Business Planning and Budget Setting Update**				
Sponsor:	Michelle Miles, Director of Finance & Performance				
Author:	Tony Reeves, Associate Director Business Development Mejero Uwejeyah, Associate Director of Finance				
Appendices:	NA				
Executive summary					
Purpose of report:	To present the Business Planning and Budget Setting for **approval** for H1 2021/22				
Summary of key issues	This report sets out key business planning requirements, the Trust finance submission and budget setting for approval. <u>Business Planning</u> • Plans co-ordinated through system for submission. • Finance plan for M1-6 of 21/22 based on 20/21 Q3 income and expenditure. • Funding contingent on meeting recovery objectives. • System Funding – default organisational plans based on Q3 actuals for income and expenditure. 0.5% inflation applied to commissioner contract values. • Efficiency requirement of £800k which relates to a 2% savings level and additional planned COVID expenditure of £500k which is classed as out of envelope. • Elective recovery plan exceeding national targets which is estimated to generate an additional £4m of income, subject to number of adjustments to baselines being agreed with NHSE. <u>Budget Setting</u> • Budget has been set for H1 (M1-6). The trust is required to achieve a breakeven position. • Budgets have been reviewed and agreed with the budget holders and the responsible Director and challenged through Star Chamber.				
Recommendation:	The Board is requested to **approve** the budget for H1 2021/22				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	KS04				
Corporate risk register:	KSO4 - Financial Sustainability				
Regulation:	NHS Constitution for approved budgets				
Legal:					
Resources:					
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	26/04/21	Decision:	Recommended for approval	
Next steps:	Final Plan Submission 03/06/2021				

Queen Victoria Hospital NHS
NHS Foundation Trust

Business Planning and Budget Setting

23rd April 2021

Financial Regime

Queen Victoria Hospital NHS
NHS Foundation Trust

- System funding envelope for Q1 and Q2 (H1) based on 20/21 including system top-up and COVID allocation.
- Block payment arrangements remain in place for H1 – signed contracts not required.
- Block payments to be amended to reflect application of inflation and distribution of additional funding. Non-system block funding and NHSE contracts to be uplifted by 0.5%.
- Financial arrangements include efficiency requirements – 0.28% applied to growth in block payments, system top-up and COVID payments. Systems funded in 20/21 in excess of sustainable position carried forward from 19/20 will have targeted reductions in system top-up funding.
- Default organisational plans generated based on Q3 actuals. Systems can then agree adjustments or changes to distribution including inflation/growth allocations.
- No 21/22 CQUIN scheme – funding included in blocks and in 21/22 tariff when issued.
- Providers need to recover positions in terms of other income via recovery of non-NHS income streams, utilisation of capacity for ERF funding or decommissioning of associated costs. Additional fixed income support will be available in H1 to systems.

Trust Finance Plan Submission – H1

Queen Victoria Hospital NHS
NHS Foundation Trust

The below tables set out the basis for the Trust's Finance Plan Submission as per guidance:

QVH H1 income and expenditure derived from Q3 actuals:	Plan H1 £'000	Income growth £'000	FYE Expenditure £'000	Adjusted plan £'000
Income	39,836	790		40,626
Expenditure	-40,104	0	-801	-40,905
Less: annual leave accrual	0			0
Total H1 provider adjusted financial position	-268	790	-801	-279
less gains on disposal of assets	-6			-6
H1 adjusted financial position less gains on disposals	-274			-285
system reallocation of local organisation contribution	274			285
Revised local organisation contribution (excluding gains on disposal of assets)	0	0	0	0

	£'000
Elective Recovery Fund income	4,058
Additional expenditure to deliver the elective recovery targets in excess of envelope affordability	-4,058
Total	0

Covid expenditure outside of envelope – Rapid testing	275
Total efficiencies	800

Budget setting - H1

Queen Victoria Hospital NHS
NHS Foundation Trust

This paper is to provide an update on the 2021/22 Budget setting process and final approval.
The Budget represents the H1 position for the Trust.
All budgets have been reviewed and signed off with all budget holders and the responsible Director.
The principles for reviewing and signing the budgets were as follows.

Budget start point is 20/21 M11 Forecast outturn.

Income

- Budget for Block contract to be set in line with current block payments for Oct –Dec 20 extrapolated for H1, which includes Block, Top-up and Covid.
- Other income budget set as appropriate.

Pay

- 20/21 Forecast outturn
- Cost pressures identified, vacancies required above the outturn
- Service developments agreed in year.
- Full year effect of posts started in 20/21.

Non Pay

- 20/21 Forecast outturn
- Cost pressures identified, vacancies required above the outturn
- Service developments agreed in year.
- Full year effect of services started in 20/21.

To meet the requirements of returning to 19/20 activity levels, Clinical non pay budgets have been set as per 19/20 outturn and adjusted in line with the activity requirements.

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Date: 28th April 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 longer terms impact of second wave & vaccination programme
- 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 UHSussex

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 activities business and usual and stability in some KPI's
- Overseas recruitment successful and will be reviewed as part of business planning, improving picture
- Work to finalise ESR hierarchy with ledger
- Some positive gains from the 2020 NHS Staff survey results, but generally stable
- Stay Well Team, health and wellbeing initiative established to support staff through the pandemic
- Workforce Restoration and Recovery workstreams ongoing monitoring, mainly BAU

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/05/2021**		**Agenda reference:**	**78-21**	
Report title:	**Workforce Report: April 2021 (March data)**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD,				
Author:	Lawrence Anderson, Deputy Director of Workforce Felicity King, Workforce Services Manager				
Appendices:					
Executive summary					
Purpose of report:	The Workforce and OD report for April 2021 (March 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 KPI's and COVID related absence has stabilised Overseas nurses are now in the Trust The first and second dose vaccination programme was very well received Report includes the quarterly starters and leavers overview				
Recommendation:	The Board is asked to note the report				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	**KSO1:** ***Outstanding patient experience*** ✓	KSO2: *World-class clinical services* ✓	KSO3: *Operational excellence* ✓	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence*** ✓
Implications					
Board assurance framework:	• KSO5. Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care • 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:	26/04/2021	Decision	Noted	
Previously considered by:					
	Date:		Decision		
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Workforce & Organisational Development

Workforce Report – April 2021

(Data Reporting Period - March 2021)

KPI Summary

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020/21			Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Establishment WTE *Note 1				1028.35	1028.14	1028.14	1028.14	1028.14	1028.14	1030.33	1030.18	1036.20	1037.20	1035.09	1042.49	**1042.49**	◄►
Staff In Post WTE				914.01	907.53	913.06	921.43	922.58	920.90	922.67	923.09	933.53	928.06	927.02	932.50	**934.23**	▲
Vacancies WTE				114.34	120.61	115.08	106.71	105.56	107.24	107.66	107.09	102.67	109.14	108.07	109.99	**108.26**	▼
Vacancies %	>12%	8%<>12%	<8%	11.12%	11.73%	11.19%	10.38%	10.27%	10.43%	10.45%	10.40%	9.91%	10.52%	10.44%	10.55%	**10.38%**	▼
Agency WTE				13.72	6.22	3.77	5.13	5.70	6.82	11.12	10.10	11.95	10.80	10.83	9.78	**10.55**	▲
Bank WTE *Note 2				72.90	34.07	31.38	33.72	47.47	59.00	57.61	64.72	66.60	65.44	76.20	66.31	**87.81**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	12.90%	12.86%	12.84%	12.05%	11.74%	11.22%	10.65%	10.05%	10.49%	10.60%	10.63%	10.25%	**10.76%**	▲
Monthly Turnover				0.96%	0.68%	1.05%	0.68%	0.75%	1.05%	0.70%	0.70%	0.84%	0.99%	1.66%	0.20%	**1.45%**	▲
12 Month Rolling Stability % **Note 3**	<70%	70%<>85%	>=85%	85.53%	85.33%	85.46%	86.39%	86.25%	87.08%	89.12%	89.44%	89.11%	89.07%	88.87%	89.06%	**88.91%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	4.37%	3.06%	2.09%	2.01%	2.77%	2.68%	2.88%	2.99%	3.26%	3.20%	3.48%	**2.50%**	*TBC*	▼
% staff appraisal compliant (Permanent & Fixed Term staff) *Note 4*	<80%	80%<>95%	>=95%	84.36%	81.40%	80.02%	78.61%	78.27%	80.86%	80.58%	80.00%	80.60%	84.03%	82.03%	83.69%	**86.32%**	▲
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 5*	<80%	80%<>90%	>=90%	92.35%	91.51%	91.91%	92.18%	91.88%	92.58%	90.80%	90.82%	91.02%	91.92%	92.30%	91.47%	**91.65%**	▲

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**	19-20 & 20-21 ▲Responses ▼ Likely ▲Unlikely
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 & 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 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). Initially embargoed the report was presented to the Board in Public in May. Further details can be located on the Staff Survey Co-ordination Centre website: https://www.nhsstaffsurveyresults.com/. A set of results for each locality 3 area has also been produced and has been issued to the General Managers and Heads of Nursing of these respective areas.

b) Restoration and Recovery – COVID-19

Coronavirus – COVID-19 continues to be at the forefront of the Trust's workforce challenges due to the activity plans . The Government's official shilding period ended on 31st March 2021

The Trust continues to contribute to the system wide plans and initiatives. Restoration and recovery continues but has now been incorporated into 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 infection rates and the requirements for self isolation and shielding. 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 have now introduced a trust wide Agile Working Policy ahead of its planned review date (a full review of the Flexible Working Policy), to improve our offering and support for both flexible working but also the ability to exercise more smart and agile working practices

Covid Vaccine

In the last week of March the Trust offered a second vaccination to all of our QVH staff and hundreds of other health and care staff. This has been a huge coordinated efford and has lead to at least 89% of Trust staff having received both doses of the vaccine.

Health and Wellbeing

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. The recent focus has centred upon directing staff to support and guidance regarding the return to the workpace following a shielding and the anxieties some indviduals may face in this regard.

Relaunch the Staff Friends and Family Test

Currently being piloted, all providers will be required to relaunch the Staff Friends and Family Test from 1st July 2021 and will be based on the 9 engagement theme questions from the annual Staff Survey. These provide insight into motivation, involvement and advocacy which we know to be strongly correlated with positive organisational and individual outcomes.

Motivation	q2a - I look forward to going to work.
Motivation	q2b - I am enthusiastic about my job.
Motivation	q2c - Time passes quickly when I am working.
Involvement	q4a - There are frequent opportunities for me to show initiative in my role.
Involvement	q4b - I am able to make suggestions to improve the work of my team / department.
Involvement	q4d - I am able to make improvements happen in my area of work.
Advocacy	q18a - Care of patients / service users is my organisation's top priority.
Advocacy	q18c - I would recommend my organisation as a place to work.
Advocacy	q18d - If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.

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

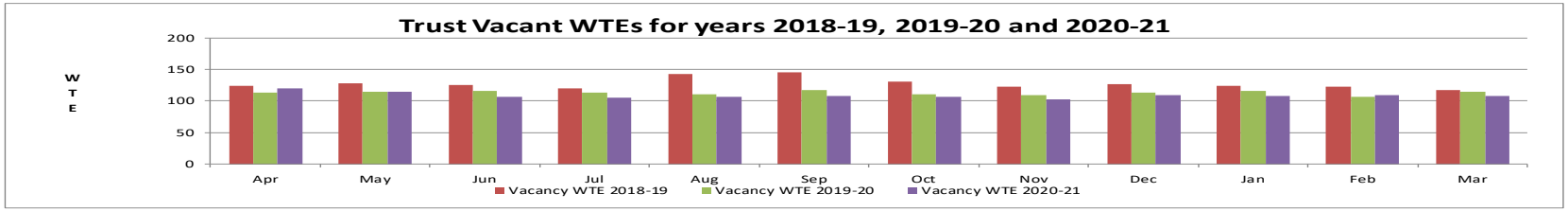
Goal 2: Attraction and Retention

a) *Vacancies*

VACANCY PERCENTAGES	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Corporate	15.21%	15.60%	14.55%	▼
Eyes	8.11%	8.05%	10.88%	▲
Sleep	12.05%	8.66%	8.66%	▼
Plastics	1.60%	-0.59%	-1.72%	▼
Oral	5.60%	4.42%	3.10%	▼
Periop	16.85%	12.36%	13.20%	▲
Clinical Support	8.80%	12.08%	9.95%	▼
Outpatients	12.59%	17.02%	23.70%	▲
Director of Nursing	3.09%	5.23%	-13.75%	▼
Operational Nursing	8.49%	9.68%	9.24%	▼
Community Services	30.73%	30.73%	30.73%	▲
QVH Trust Total	10.44%	10.55%	10.38%	▼

	Posts advertised this month	Recruits in Pipeline
Corporate	12.80	3.00
Eyes	3.00	2.00
Sleep	0.00	0.00
Plastics	0.00	0.60
Oral	0.80	0.00
Periop	3.00	5.00
Clinical Support	8.00	0.00
Outpatients	0.00	0.00
Director of Nursing	1.00	1.72
Operational Nursing	11.75	7.75
Community Services	0.00	0.00
QVH Trust Total	40.35	20.07
of which Qual Nurses / Theatre Practs (external)	6.14	*8.47*
of which HCA's & Student/Asst Practs (external)	9.61	*5.00*

MEDICAL RECRUITMENT (WTE)	Posts advertised this month	Recruits in Pipeline
Clinical Support	0.00	2.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*2.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*0.00*
Plastics	10.00	17.00
of which are Deanery Trainees, Trust Registrars or Fellows	*8.00*	*14.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*2.00*	*3.00*
Eyes	2.00	2.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*0.00*
of which are SAS doctors	*2.00*	*2.00*
of which are Consultants (including locums)	*0.00*	*0.00*
Sleep	0.00	0.00
Oral	2.20	3.20
of which are Deanery Trainees, Trust Registrars or Fellows	*1.00*	*2.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*1.20*	*1.20*
Periop	0.00	3.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*3.00*
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	14.20	27.20
of which are Deanery Trainees, Trust Registrars or Fellows	*9.00*	*21.00*
of which are SAS doctors	*2.00*	*2.00*
of which are Consultants (including locums)	*3.20*	*4.20*



SIP has increased by 1.74wte with an end position in March of 934.24wte. We are yet to have month 12 establishment confirmed so we have based these figures on the Month 11 budgeted establishment. Our vacancy rate has reduced to 10.38%.

In March there were 7.08wte starters (excluding Junior Doctors) 1.61wte were Nursing staff in Theatres and ITU. Other starters were in Clinical support (2.8wte), Maxillofacial (1wte), Plastics (1wte) and Building and engineering (0.67wte).

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	2	0	0
Grand Total		29	2	2	0	0

All International Nurses are now working with full NMC registration

The two remaining Medway nurses are arriving in Medway next week with them expecing to arrive at QVH mid May with full registration. Both will be moving into Meridian Way and the Resourcing Team are working to ensure that everything is in place and supporting them to complete all paperwork and processes in good time.

There have been no more resignations from the International Nurses and one has been appointed as Deputy Matron following a competitve recruitment campaign.

c) Recruitment Data

A slight reduction in the number of adverts placed with 30 for March, totalling 36.6 WTE advertised.

The Head and Neck Unit attracted 21 applicants, 6 of which were offered and are currently being processed.

Departments have been busy interviewing a total of 88 candidates with Head and Neck interviewing the msot and saw 13 candidates via MSTeams and Hotel Services a very close second with 12 candidates interviewed.

Two AAC's have taken place with appointments made in Plastics and Orthodontics.

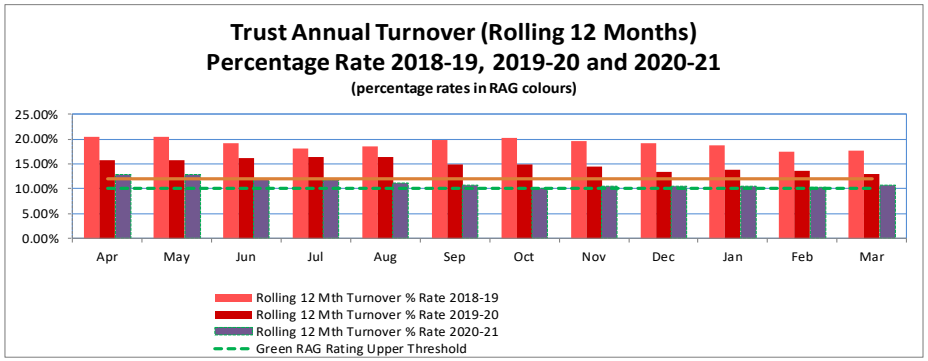
An increase in conditional offers sent to 29, 21 candidates going through pre employment checks and another 13 with start dates confirmed.

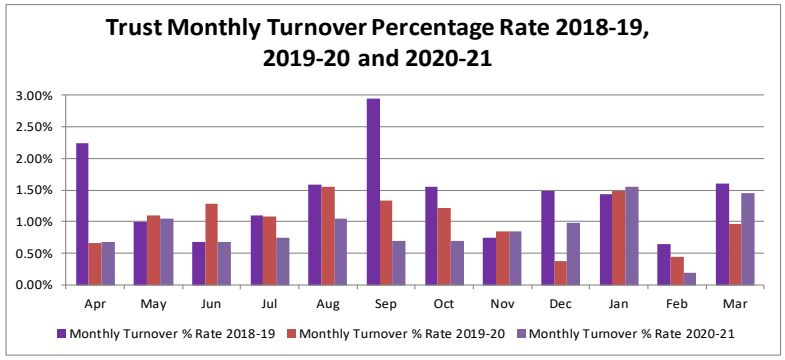
Job title	Grade	Advertising	Interview	Offer	Starting	Grand Total
BANK Dental Nurse	NHS AfC: Band 4		1			1
BANK Healthcare Assistant	NHS AfC: Band 2	1		1		2
Staff Nurse (BANK)	NHS AfC: Band 5			2	2	4
BANK Admin	NHS AfC: Band 2			1		1
BANK Dental Nurse	NHS AfC: Band 4				2	2
		1	**1**	**4**	**4**	**10**

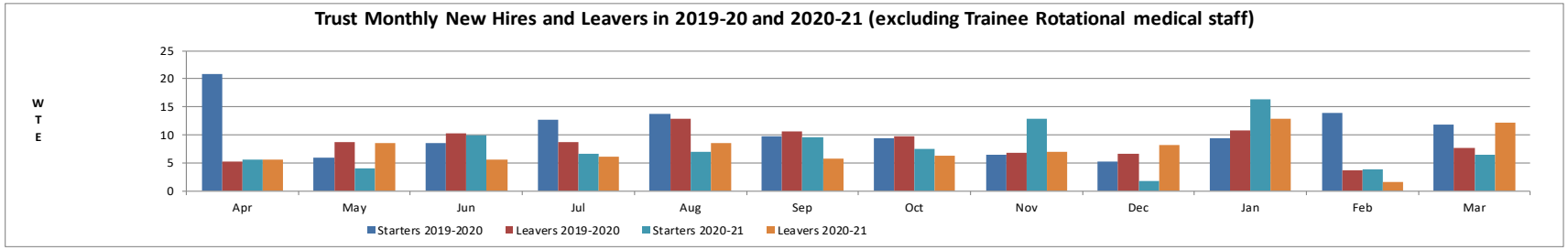
d) Turnover, New Hires and Leavers

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Corporate %	11.29%	10.63%	10.75%	▲
Eyes %	31.53%	27.96%	28.41%	▲
Sleep %	10.23%	10.03%	10.07%	▲
Plastics %	8.32%	6.47%	3.57%	▼
Oral %	8.11%	7.99%	10.90%	▲
Peri Op %	12.61%	12.23%	13.57%	▲
Clinical Support %	11.82%	11.90%	11.94%	▲
Outpatients %	14.47%	19.28%	24.56%	▲
Director of Nursing %	4.93%	4.91%	5.16%	▲
Operational Nursing %	5.54%	5.52%	5.39%	▼
Community Services %	25.41%	25.41%	25.41%	◄►
QVH Trust Total %	10.54%	10.25%	10.76%	▲

MONTHLY TURNOVER excl. Trainee Doctors	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Corporate %	2.88%	0.00%	1.12%	▲
Eyes %	0.00%	0.00%	3.13%	▲
Sleep %	2.94%	0.00%	0.00%	◄►
Plastics %	0.00%	0.00%	1.68%	▲
Oral %	0.00%	0.00%	3.15%	▲
Peri Op %	1.34%	0.00%	2.19%	▲
Clinical Support %	2.88%	1.14%	0.99%	▼
Outpatients %	0.00%	0.00%	4.78%	▲
Director of Nursing %	1.11%	0.00%	0.00%	◄►
Operational Nursing %	0.57%	0.37%	0.52%	▲
Community Services %	11.11%	0.00%	0.00%	◄►
QVH Trust Total %	1.56%	0.20%	1.45%	▲







The Trust's 12 month rolling turnover currently sits at 10.76% and the monthly turnover at 1.45%. The monthly turnover does remain slightly over our trust KPI figure of 10%. The increase in turnover both annual and monthly is on trend for this time of year.

The 12 month rolling stability has decreased from 89.06% to 88.91%.

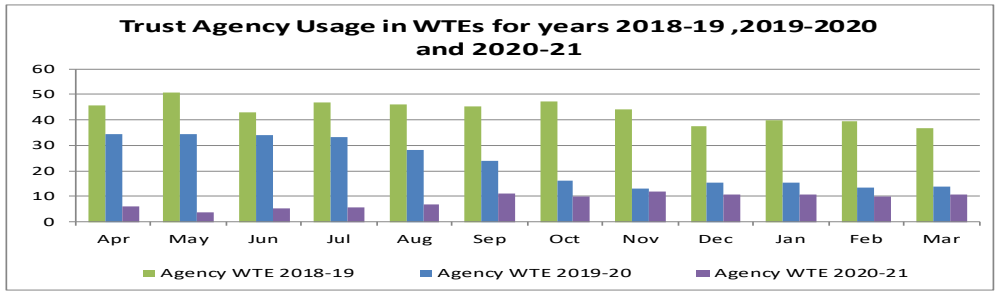
e) Temporary Workforce

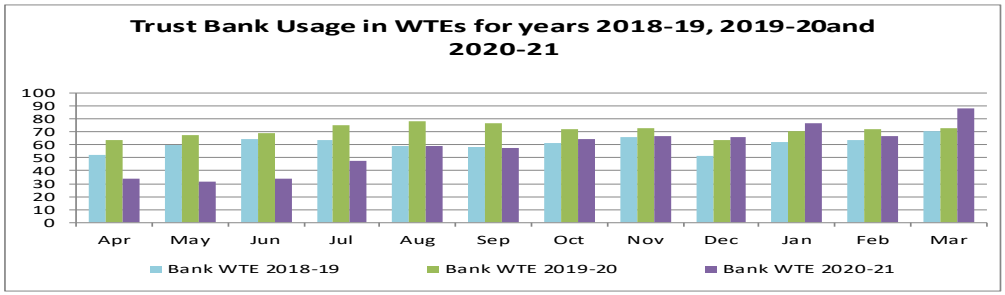
Agency				
BUSINESS UNIT (WTE)	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Corporate	1.20	0.92	1.06	▲
Eyes	0.00	0.00	0.00	◄►
Sleep	0.00	0.00	0.00	◄►
Plastics	0.00	0.00	0.00	◄►
Oral	0.00	0.00	0.00	◄►
Periop	3.71	3.65	4.07	▲
Clinical Support	2.83	2.44	2.65	▲
Outpatients	0.00	0.00	0.00	◄►
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	3.09	2.77	2.77	◄►
Community Services	0.00	0.00	0.00	◄►
QVH Trust Total	10.83	9.78	10.55	▲

Bank				
BUSINESS UNIT (WTE)	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Corporate	9.25	11.31	13.57	▲
Eyes	0.56	0.35	0.62	▲
Sleep	2.87	3.18	3.12	▼
Plastics	2.22	1.00	1.84	▲
Oral	3.63	3.00	2.09	▼
Periop	21.09	18.20	22.70	▲
Clinical Support	8.74	6.92	10.80	▲
Outpatients	1.41	2.18	2.34	▲
Director of Nursing	2.79	2.91	4.32	▲
Operational Nursing	22.92	16.01	25.08	▲
Community Services	0.71	1.27	1.33	▲
QVH Trust Total	76.20	66.31	87.81	▲

Agency				
STAFF GROUP (WTE)	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Qualified Nursing	6.80	5.81	5.71	▼
HCAs	0.00	0.61	1.13	▲
Medical and Dental	0.92	0.92	1.09	▲
Other AHP's & ST&T	1.91	1.52	1.56	▲
Non-Clinical	1.20	0.92	1.06	▲
QVH Trust Total	10.83	9.78	10.55	▲

Bank				
STAFF GROUP (WTE)	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Qualified Nursing	31.83	25.60	35.61	▲
HCAs	8.36	6.75	9.77	▲
Medical and Dental	6.91	3.68	4.07	▲
Other AHP's & ST&T	4.34	3.47	4.66	▲
Non-Clinical	24.76	26.81	34.75	▲
QVH Trust Total	76.20	66.31	87.81	▲





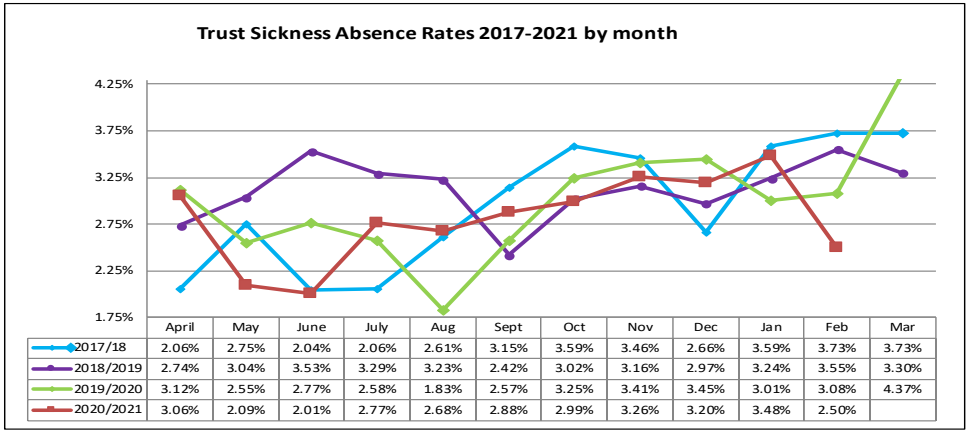
This month bank and agency usage has increased to 91.36wte combined total (agency 10.55wte, bank 87.81wte). Bank saw an increase of 21.50wte some of this can be attributed to the administration of the second dose of the covid vaccine and covid related bank for the community pod and covid screening lab (in total 6.37). Also as we approached the end of the year staff would have been taking their annual leave which too contributes to the increase in bank usage. As a staff group nursing saw the biggest increase of 10.01wte followed by non-clinical staff (+7.94wte) and HCA's (+3.02wte). As expected operational nursing saw the biggest increase followed by periop and clinical support. Agency increased slightly from February by 0.77wte to 10.55wte.Slight increases were seen in Corporate, Peri op and Clinical support and were across all staff groups apart from Qualified Nursing.

Goal 3: Health and Well-being

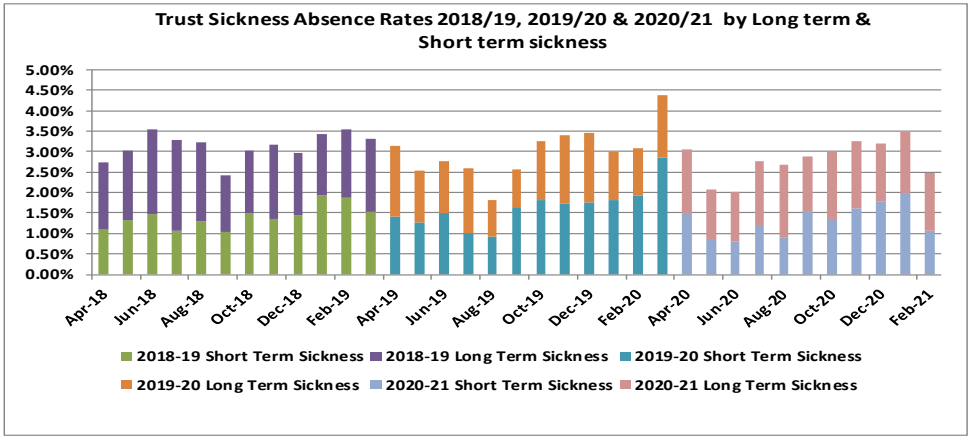
SHORT TERM SICKNESS	Dec-20	Jan-21	Feb-21	Compared to Previous Month
Corporate	0.58%	2.35%	0.93%	▼
Clinical Support	0.87%	1.75%	0.63%	▼
Plastics	1.13%	0.20%	0.94%	▲
Eyes	0.82%	1.51%	0.33%	▼
Sleep	1.92%	0.60%	0.36%	▼
Oral	2.07%	2.32%	1.04%	▼
Periop	1.64%	1.29%	0.70%	▼
Outpatients	3.35%	0.00%	0.17%	▲
Director of Nursing	3.52%	1.23%	0.48%	▼
Operational Nursing	3.39%	3.89%	2.37%	▼
Community Services	0.89%	0.25%	0.35%	▲
QVH Trust Total	1.78%	1.98%	1.06%	▼

LONG TERM SICKNESS	Dec-20	Jan-21	Feb-21	Compared to Previous Month
Corporate	0.41%	0.01%	1.09%	▲
Clinical Support	0.97%	1.65%	1.69%	▲
Plastics	0.31%	1.31%	1.26%	▼
Eyes	3.07%	0.30%	0.00%	▼
Sleep	2.25%	5.85%	7.05%	▲
Oral	2.01%	1.24%	1.15%	▼
Periop	1.68%	2.16%	1.72%	▼
Outpatients	6.20%	6.44%	2.02%	▼
Director of Nursing	1.54%	0.62%	0.00%	▼
Operational Nursing	1.67%	1.82%	1.35%	▼
Community Services	0.00%	0.00%	0.00%	◄►
QVH Trust Total	1.42%	1.51%	1.43%	▼

ALL SICKNESS (with RAG)	Dec-20	Jan-21	Feb-21	Compared to Previous Month
QVH Trust Total	3.20%	3.48%	2.50%	▼



	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%	3.48%	2.50%	

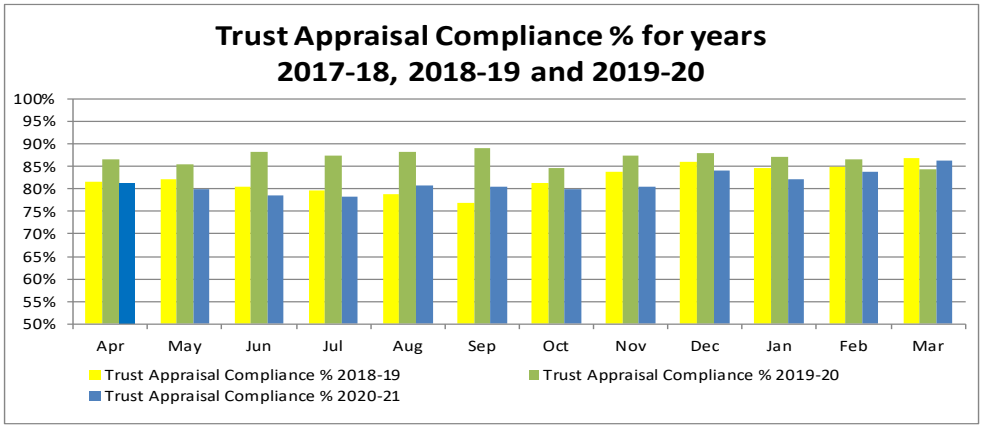


The Trust's sickness absence has decreased ending the month on 2.5%, within of our KPI of 3%. In February 0.6% was covid related.

Absence top 3 reasons by absence occurances are; Cold, Cough, Flu – Influenza (31), Headache / migraine (15) and Other musculoskeletal problems (13). Decreases were seen in all business units apart from Plastics and Sleep. Outpatients had the biggest in month decrease.

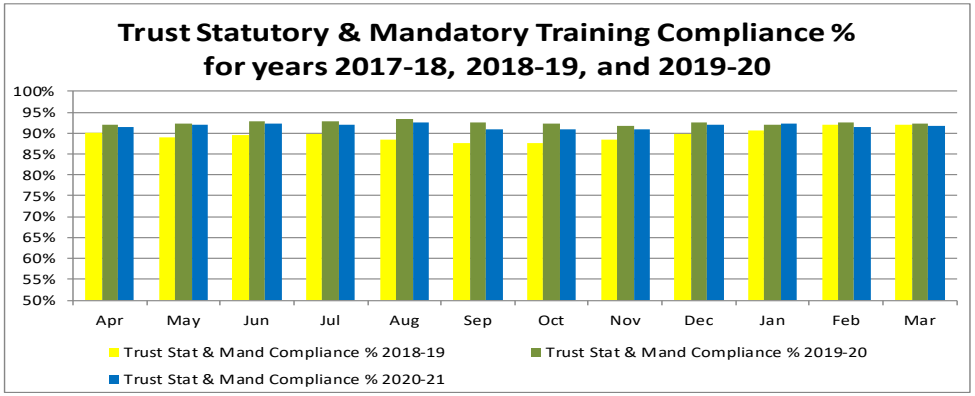
Goal 4: Learning and Education

APPRAISALS	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Corporate	68.04%	72.96%	78.79%	▲
Eyes	60.00%	63.33%	62.07%	▼
Sleep	96.77%	96.88%	96.88%	◄►
Plastics	58.46%	71.88%	80.00%	▲
Oral	79.73%	72.37%	75.95%	▲
Peri Op	93.92%	93.42%	91.61%	▼
Clinical Support	91.59%	91.00%	94.64%	▲
Outpatients	78.57%	85.19%	80.00%	▼
Director of Nursing	94.34%	88.68%	96.08%	▲
Operational Nursing	88.73%	90.23%	90.23%	◄►
Community Services	76.92%	76.92%	91.67%	▲
QVH Trust Total	82.03%	83.69%	86.32%	▲



Staff Appraisal rate has increased further to 86.32% from 83.69% last month. This is figure has been adjusted for GMC medics who are exempt due to Covid-19. Increases were seen in 6 business units which community seeing the biggest in month increase. Decreases were seen in Eyes, peri op and outpatients. The lowest performing business unit is Eyes at 62.07%, followed by Oral (75.95% and Plastics (78.79%).

MANDATORY AND STATUTORY TRAINING	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Corporate	90.87%	88.83%	90.26%	▲
Eyes	93.11%	92.59%	93.18%	▲
Sleep	93.80%	90.60%	89.82%	▼
Plastics	79.44%	77.95%	77.57%	▼
Oral	91.42%	89.57%	90.28%	▲
Peri Op	93.30%	93.43%	92.85%	▼
Clinical Support	96.92%	96.93%	95.80%	▼
Outpatients	99.56%	97.80%	97.16%	▼
Director of Nursing	95.16%	95.80%	95.66%	▼
Operational Nursing	94.35%	93.00%	94.02%	▲
Community Services	93.06%	99.31%	98.61%	▼
QVH Trust Total	92.30%	91.47%	91.65%	▲



Statutory and mandatory training has decreased from last month to 91.65%. All units are above trust KPI (90%) apart from Plastics (77.57%) and Sleep (89.82%)). The best performing Directorate is Community Services at 98.61%. %. Infection Prevention and Control - Level 1- 1 yearly has the lowest compliance with 80.56%. IG stands at 86.74%.

The April doctors induction plans are in place, with new trainees in OMFS, Radiology and Plastics starting at the Trust.

The Education Centre was successfully used to deliver the second phase of the vaccination programme, and the centre has now been returned to use for educational purposes.

The Local Faculty Group and Local Academic Board meetings took place in February and March, via MS Teams, to ensure that educational governance for medical and dental training continued. The next Junior Doctors' Forum is planned for April.

All specialties are continuing to deliver teaching to trainee doctors. Plans for external courses are still on hold, but the team hopes to restart this activity later in 2021, and medical student electives will restart shortly.

The Medical Education Manager is working with key stakeholders to implement a new Education Contract with HEE, to assure the provision of learners and funding to QVH, and is also working with the finance team on the implementation of the new Trust expenses system and how it will accommodate the HEE study leave and relocation expenses requirements.

Medical Appraisals: 76 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	0	0.00%	100.00%
Plastics	276 200011 Plastic Surgery	60	60	25	41.67%	80.65%
Sleep	276 200013 SLR Sleep Studies	3	3	1	33.33%	100.00%
Eyes	276 200015 SLR Corneo Plastics	14	14	7	50.00%	100.00%
Oral	276 200018 SLR Orthodontics	13	13	9	69.23%	69.23%
Oral	276 200019 SLR Maxillofacial	34	34	13	38.24%	56.52%
Community Services	276 200025 SLR Respiratory	1	1	0	0.00%	0.00%
Perioperative Services	276 210001 Anaesthetics	29	29	5	17.24%	71.43%
Clinical Support	276 210006 Diagnostic Imaging	3	3	1	33.33%	50.00%
Clinical Support	276 210008 Histopathology	2	2	1	50.00%	100.00%

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, continue to collaborate on a range of initiatives to support management and leadership across the integrated healthcare system (ICS). In April 2021 a meeting was held to re-establish priorities and have a stocktake of the work completed to date. The group will continue to meet on a regular basis to look at the People Plan outcomes and how we can as the Sussex HCP support this crucial work moving forward in a digital environment including:

- ***Developing Excellence, Together***: Roffey Park online leadership programme
- ***Foundation Coaching:*** Shift offering onto a virtual platform
- ***ILM Level 3 Coaching:*** Already a virtual offering with a programme underway
- ***OD Practitioners Programme:*** Commencing a new programme to support people that use OD practice within their roles
- ***Rosalind Franklin:***
- ***Stepping Up local:***

Other activities in focus:

Admin & Clerical Programme: OD&L is working with NHSElect to introduce a programme aimed at this group of staff across QVH. We aim to to advertising the programme in April 2021 and starting in May 2021. This offering will be delivered online via internal and external resources.
Apprenticeships: The Apprenticeship Policy Statement has been been updated to reflect current arrangements in place and is awaiting ratification.
Corporate Induction: The Induction Policy is due to be reviewed in June 2021 and OD&L are in the process of reviewing the content.

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 infection. We have started to explore how training and education activities can become more blended in delivery late this year.

Quarterly report on starters and leavers

In the last quarter, we have had 27.32wte starters and 28.47wte leavers excluding doctors in training. During January to March 2021 we welcomed 13.96wte Doctors in training and said goodbye to 12.40wte Doctors in Training.

By Staff Group the Starters are as follows:

Staff Group	Sum of WTE
Add Prof Scientific and Technic	0.80
Additional Clinical Services	9.64
Administrative and Clerical	4.11
Allied Health Professionals	2.20
Healthcare Scientists	3.00
Medical and Dental	3.00
Nursing and Midwifery Registered	4.57
Total	**27.32**

By Business Unit the Starters are as follows:

Business Unit	Sum of WTE
276 Clinical Support (Div)	6.00
276 Corporate (Div)	2.47
276 Eyes (Div)	1.00
276 Operational Nursing (Div)	4.89
276 Oral (Div)	1.00
276 Perioperative Care (Div)	9.96
276 Plastics (Div)	1.00
276 Sleep (Div)	1.00
Total	**27.32**

Additional Clinical Services Staff group had the most new starters for the period, which were across Operational Nursing (3.64wte) and Perioperative Services (6wte). These were 2.64wte Band 2/3 HCA's, 1 Nursing Associate (Operational Nursing) and 6wte Pre-Registration Theatre practitioners recruited as part of our overseas campaign.

In Qualified Nursing, there were 4.57wte starters within ITU (0.61wte), 0.96wte in Day Surgery and 3wte in Theatres including their newly appointed Theatre Manager.

The Admin and Clerical staff group were recruited mostly in the Corporate directorate (2.47wte) but also in Operational Nursing (1 Administrator) and 1 Cancer Coordinator in Plastics.

Clinical Support saw the appointment of 2.2wte Physiotherapists, 0.8 Pharmacist and 2wte Healthcare Scientist Practitioners in the Covid Testing Lab. Sleep had 1 new starter in the role of a Deputy Sleep Lead.

Medical and Dental staff group had 3wte excluding the Doctors in Training. These were 1wte Specialty Doctor in Eyes and 2wte Consultants in Oral (1wte) and Eyes (1wte). Both Consultants had retired and returned as part of flexible retirement.

The recruitment source for 11.36wte starters were from other NHS organisations, 6wte abroad, 5.71wte from other private sectors, 1.61wte from no employment, 0.64wte Return to practice and 2wte from Education/Training.

By Staff Group the Leavers are as follows

Staff Group	Sum of WTE
Add Prof Scientific and Technic	0.80
Additional Clinical Services	4.49
Administrative and Clerical	10.83
Allied Health Professionals	3.00
Estates and Ancillary	2.00
Medical and Dental	4.00
Nursing and Midwifery Registered	3.34
Total	**28.47**

By Business Unit the Leavers are as follows

Business Unit	Sum of WTE
276 Clinical Support (Div)	4.40
276 Community Services (Div)	1.12
276 Corporate (Div)	7.04
276 Director of Nursing (Div)	0.46
276 Eye (Div)	1.00
276 Operational Nursing (Div)	2.55
276 Oral (Div)	2.00
276 Outpatients (Div)	2.00
276 Perioperative Care (Div)	5.38
276 Plastics (Div)	1.00
276 Sleep (Div)	1.52
Total	**28.47**

Excluding doctors in training, there were 28.47 Leavers between January and March 2021.

There were leavers in all of the business units and most of the staff groups apart from Healthcare Scientists. The highest group of leavers were admin and clerical with 10.83wte leavers spread across Outpatients (2wte), Corporate (5.04wte), Eyes (1wte), Operational Nursing (1.55wte), Sleep (0.75wte) and Perioperative care (0.5wte) directorates. Of these staff were in various roles and the band 2 and 3 Admin Officers/Receptionist/Ward clerk making up nearly half of the Admin and Clerical Leavers (5.03wte).

Medical and Dental staff group had 4wte leavers, including 3wte consultants (Oral 2wte and Clinical Support 1wte) and 1wte Trust Specialty Doctor (Plastic Surgery)All 3 consultants have returned/are returning under Flexible Retirement . Nursing and Midwifery had 3.34wte of which 2.34wte were Qualified Nurses in Site Practitioners, Operation Nursing (ITU), Pre Assessment and Theatres 1.88wte in Perioperative Services. Also in Perioperative Services 3wte HCA's left the trust.

In Clinical Support 3.4wte staff left who were Add Prof and Tech (Pharmacy 0.4wte) and an Allied Health professional (Physiotherapist 3wte).
Community Services saw 1.12wte leavers, 0.4 in psychotherapy and 0.72wyte Nurse Associate in Ent Community.
Sleep had a Sleep Technician (0.77wte) leave and 2wte ancillary staff in Corporate directorate.

Reasons for leaving were 7.43wte retirement/flexi retirement, 1.8wte end of fixed term contract, 0.64wte Dismissal and all other were for various (9) voluntary reasons but most notably relocation (5.68wte). Of these 10.05wte went to other NHS organisations, 4.5wte Other Private or Public Sectors, 1wte Armed Forces, 0.77 Third Sector, 1.68wte no employment and 10.47wte did not wish to disclose where/if they were going to employment.

-ends-

Report cover-page					
References					
Meeting title:	**Board Meeting**				
Meeting date:	**06/05/2021**		**Agenda reference:**	**79-21**	
Report title:	**Overview of QVH Staff Survey Results 2020**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Author:	Annette Byers, Head of Organisational Development and Learning				
Appendices:	Staff Survey Report 2020 – Themes and Trends overview				
Executive summary					
Purpose of report:	The 2020 NHS Staff Survey Results were embargoed until 11 March 2021 and have not been available to present at public Board until now. They were reviewed in detail at the Finance & Performance Committee at the end of March. The reports compare information from QVH comparator/benchmark groups and QVH historical data. The report sets more context and provides more detail against each of the themes The appendix provides an at a glance view of themes and trends with some assumption around the impact of COVID.				
Summary of key issues	• Slightly improved response rate over 2019 and slightly better than average across comparator group • For the first time we tried a mixed mode response to the survey due to COVID • Some areas of positive improvement over previous years • COVID appears to have impacted on some areas where scores have deteriorated (and improved) • Just 10 themes this year rather than 11 as one section (appraisals) removed				
Recommendation:	The Board is asked to note the contents of this report				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience* ✓	KSO2: *World-class clinical services*	KSO3: *Operational excellence* ✓	KSO4: *Financial sustainability* ✓	KSO5: *Organisational excellence* ✓
Implications					
Board assurance framework:	The challenges are reflected in KSO 5 Organisational Excellence				
Corporate risk register:	n/a				
Regulation:	Results are reviewed by local commissioners and CQC				
Legal:	n/a				
Resources:	Dedicated time to support development within teams				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	22/03/21	Decision:	For information	
Next steps:					

Report to:	Board Directors
Agenda item:	79-21
Date of meeting:	06 May 2021
Report from:	Geraldine Opreshko, director of workforce and organisational development
Report author:	Annette Byers, Head of Organisational Development and Learning
Date of report:	29 April 2021
Appendices:	Themes and trends

2020 NHS Staff Survey Board Report

1. Introduction

1.1 For the 2020 NHS Staff Survey there are 10 themes compared to 11 in the 2019 survey. These are Equality, Diversity and Inclusion, Heath & Wellbeing, Immediate Managers, Morale, Quality of Care, Safe Environment (bullying & harassment), Safe Environment (violence), Safety Culture, Staff Engagement and Team Working. Quality of Appraisals was the theme removed from this year's survey due to the pandemic.

1.2 The calculation for the immediate managers theme has changed this year due to the omission of one of the questions which previously contributed to the theme ("My manager supported me to receive this training, learning or development"). This change has been applied retrospectively so data for 2016-2020 shown in any charts will be comparable, but these figures will not be directly comparable to the results reported in previous years.

1.3 Physical violence/harassment, bullying and abuse data relating to the reporting of incidents of physical violence at work (Q12d) and harassment, bullying or abuse at work (Q13d) has been updated this year. Data cleaning rules are applied retrospectively, so all historical data reported in 2020 will be cleansed according to the new rule, rendering the trend results comparable. Therefore, while the trend data reported is comparable, it is not directly comparable with results previously published.

1.4 The number of questions in the 2020 reduced from 90 to 78.

1.5 For 2020 Queen Victoria Hospital NHS Foundation Trust (QVH) took the decision to run a mixed mode survey. Specific areas were selected to receive either an online or paper survey. Paper mode showed a 49% return rate vs online of 62% once ineligibles were removed. The table below shows details on the response rate.

	Paper	Online	Total
Invited	248	811	1059
Blank	17	2	19
Completed	121	495	616
Excluded	0	0	0
Ineligible	1	2	3
Left organisation	0	7	7
Not returned	109	293	402
No further mailings	0	11	11
Opted out	0	0	0
Undelivered	0	1	1

1.6 QVH surveyed **1049** eligible staff compared to **1009** in 2019. Of these, **616** responded making a **59%** return, an increase from **58%** the year before. The 2020 benchmarking group for acute specialist trusts has **14** organisations and showed a **56%** return rate overall. See appendix 1 for some background group comparator response rates.

	2016	2017	2018	2019	2020
Best	69.1%	62.0%	63.2%	69.6%	65.6%
Your org	55.5%	54.9%	52.2%	58.1%	58.7%
Median	49.7%	52.8%	52.8%	58.1%	56.1%
Worst	39.2%	38.0%	40.5%	46.3%	38.6%

1.7 The QVH People & OD strategy sets out the Trusts vision, ambitions and plans for the development of QVH, through our workforce, and is based around five key workforce and OD goals which link with many of the themes in the staff survey:

People and OD Goals	Staff Survey Themes
1. Engagement and Communication	- Staff Engagement and Team Working
2. Attraction and Retention	- Morale
3. Health and Wellbeing	- Health & Wellbeing and Safe Environment
4. Learning and Education	-
5. Talent and Leadership	- Immediate Managers

2. Headline Results

2.1 Out of the **75** positive questions asked in the 2020 NHS Staff Survey, **3** were significantly better, **62** had no significant difference and **10** were significantly worse than 2019 (see appendix 2 results).

2.2 The core questions which feed into the board reports are shown below. There has been a slight decrease of 1% for Q18a and Q18c, but QVH has seen a 2% increase for Q18d.

Q	Description	2016	2017	2018	2019	2020
Q18a	Care of patients/service users is organisation's top priority	82%	81%	86%	88%	**87%**
Q18c	Would recommend organisation as place to work	62%	57%	62%	72%	**71%**
Q18d	If friend/relative needed treatment would be happy with standard of care provided by organisation	91%	88%	91%	92%	**94%**

2.3 This year, the staff engagement scores are calculated from key questions in the survey, grouped into three categories. These are advocacy, involvement and motivation. The overall QVH engagement score for 2020 is **7.4%**, a slight decrease of 0.1% from 2019.

2.4 A summary of QVH's most and least improved results from 2020 below will be looked at in greater detail across departments to identify if there are any trends in relation to specialties and/or particular staff groups.

2019	2020	Q	Most improved from last survey
37%	59%	11d	In last 3 months, have not come to work when not feeling well enough to perform duties
74%	84%	13a	Not experience harassment, bullying or abuse from patients/service users, their relatives or members of the public
70%	77%	17b	Would feel secure raising concerns about unsafe clinical practice
61%	67%	4f	Have adequate materials, supplies and equipment to do my work
36%	41%	11a	Organisation definitely takes positive action on health and wellbeing

2019	2020	Q	Least improved from last survey
67%	56%	4i	Team members often meet to discuss the team's effectiveness
71%	61%	11c	In the last 12 months, have not felt unwell due to work related stress
54%	46%	6c	Relationships at work are unstrained
63%	56%	6b	I have a choice in deciding how to do my work
43%	36%	9b	Communication between senior management and staff is effective

2.5 Of the 10 themes agreed for the 2020 NHS Staff Survey, QVH's results show an improvement in **2** out of **10** themes, **3** remained at the same level and **5** decreased compared to 2019. The table below presents the results of significance testing conducted on this year's theme scores and those from last year. It details the theme scores for both years and the number of responses each of these are based on. The final column contains the outcome of the significance testing:

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	573	**9.2**	597	Not significant
Health & wellbeing	**6.3**	579	**6.5**	599	Not significant
Immediate managers †	**7.2**	578	**7.0**	601	Not significant
Morale	**6.6**	569	**6.4**	591	Not significant
Quality of care	**7.9**	511	**7.9**	531	Not significant
Safe environment - Bullying & harassment	**8.2**	575	**8.4**	569	Not significant
Safe environment - Violence	**9.8**	577	**9.8**	597	Not significant
Safety culture	**7.0**	573	**7.0**	594	Not significant
Staff engagement	**7.5**	580	**7.4**	607	Not significant
Team working	**7.0**	572	**6.5**	602	↓

2.6 The 10 staff survey themes provide a balanced overview of organisational performance on staff experience. All themes are scored on a 0-10pt scale, and reported as mean scores. A higher score indicates a more favourable result.

3. Key comparisons

3.1 When compared with comparator group of **14** Specialist Acute Trusts, our scores are average overall. QVH ranks above average on **0**, average on **8** and slightly below average on **2**.

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.8	7.3	6.7	8.1	9.0	9.9	7.5	7.6	7.0
Your org	9.2	6.5	7.0	6.4	7.9	8.4	9.8	7.0	7.4	6.5
Average	9.2	6.5	7.1	6.4	7.9	8.4	9.8	7.0	7.4	6.8
Worst	8.4	6.1	6.8	6.2	7.6	7.7	9.3	6.9	7.1	6.5

3.2 When compared with the comparator group scores above, QVH can identify key results. QVH are average on the themes of *Equality, Diversity & Inclusion, Health & Wellbeing, Immediate Managers, Morale, Quality of Care, Bullying & Harrassment, Violence, Safety Culture and Staff Engagement.* The below average theme is *Team Working*, and increased remote working due to the pandemic is likely to have impacted on this score.

4. Key themes in detail

4.1 Theme 1: Equality, Diversity & Inclusion

	2016	2017	2018	2019	2020
Best	9.6	9.5	9.5	9.5	9.5
Your org	9.1	9.2	9.3	9.3	9.2
Average	9.3	9.3	9.3	9.2	9.2
Worst	8.9	8.8	8.6	8.6	8.4

Related questions: *Q14, Q15a, Q15b and Q26b*
Change from 2019: *0.1% decrease*
Rating compared to benchmarking group: *average*

4.2 Theme 2: Health & Well-Being

	2016	2017	2018	2019	2020
Best	6.8	6.6	6.6	6.6	6.8
Your org	6.1	6.0	6.2	6.3	6.5
Average	6.3	6.3	6.3	6.3	6.5
Worst	5.7	6.0	5.7	5.8	6.1
Responses	499	506	493	579	599

Related questions: *Q5h, Q11a, Q11b, Q11c and Q11d*
Change from 2019: *0.1% increase*
Rating compared to benchmarking group: *average*

4.3 Theme 3: Immediate Managers

	2016	2017	2018	2019	2020
Best	7.1	7.2	7.3	7.3	7.3
Your org	6.5	6.9	7.0	7.2	7.0
Average	6.9	7.0	7.0	7.1	7.1
Worst	6.3	6.6	6.7	6.7	6.8

Related questions: *Q5b, Q8c, Q8d, Q8f and Q8g*
Change from 2019: *0.2% decrease*
Rating compared to benchmarking group: *0.1% below average*

4.4 Theme 4: Morale

	2018	2019	2020
Best	6.7	6.6	6.7
Your org	6.2	6.6	6.4
Average	6.3	6.4	6.4
Worst	5.8	5.8	6.2

Related questions: *Q4c, Q4j, Q6a, Q6b, Q6c, Q8a, Q19a, Q19b and Q19c*
Change from 2019: *0.2% decrease*
Rating compared to benchmarking group: *average*

4.5 Theme 5: Quality of Care

	2016	2017	2018	2019	2020
Best	8.3	8.2	8.1	8.1	8.1
Your org	7.7	7.5	7.8	7.9	7.9
Average	7.8	7.8	7.9	7.9	7.9
Worst	7.2	7.4	7.4	7.4	7.6

Related questions: *Q7a, Q7b and Q7c*
Change from 2019: *0.2% increase*
Rating compared to benchmarking group: *average*

4.6 Theme 6: Safe Environment – Bullying & Harassment

	2016	2017	2018	2019	2020
Best	8.9	8.9	8.8	8.7	9.0
Your org	8.2	8.3	8.2	8.2	8.4
Average	8.3	8.4	8.2	8.3	8.4
Worst	7.8	7.9	7.9	7.8	7.7

Related questions: *Q13a, Q13b and Q13c*
Change from 2019: *0.2% increase*
Rating compared to benchmarking group: *average*

4.7 Theme 7: Safe Environment – violence

	2016	2017	2018	2019	2020
Best	9.9	9.9	9.9	9.9	9.9
Your org	9.6	9.6	9.7	9.8	9.8
Average	9.7	9.8	9.8	9.8	9.8
Worst	9.2	9.3	9.2	9.2	9.3

Related questions: *Q12a, Q12b and Q12c*

Change from 2019: *same*
Rating compared to benchmarking group: *average*

4.9 Theme 8: Safety Culture

	2016	2017	2018	2019	2020
Best	7.4	7.4	7.6	7.5	7.5
Your org	6.6	6.6	6.8	7.0	7.0
Average	6.9	6.9	6.9	7.0	7.0
Worst	6.4	6.6	6.7	6.9	6.9

Related questions: *Q16a, Q16c, Q16d, Q17b, Q17c and Q18b*
Change from 2019: *same*
Rating compared to benchmarking group: *average*

4.10 Theme 9: Staff Engagement

	2016	2017	2018	2019	2020
Best	7.6	7.7	7.7	7.7	7.6
Your org	7.2	7.1	7.3	7.5	7.4
Average	7.5	7.4	7.4	7.5	7.4
Worst	6.8	7.0	7.0	7.1	7.1

Related questions: *Q2a, Q2b, Q2c, Q4a, Q4b, Q4d, Q18a, Q18c and Q18d*
Change from 2019: *0.1% decrease*
Rating compared to benchmarking group: *average*

4.11 Theme 10: Team Working

	2016	2017	2018	2019	2020
Best	6.9	7.1	7.3	7.1	7.0
Your org	6.7	6.5	6.7	7.0	6.5
Average	6.7	6.8	6.9	6.9	6.8
Worst	6.3	6.4	6.5	6.5	6.5

Related questions: *Q4h and Q4i*
Change from 2019: *0.5% decrease*
Rating compared to benchmarking group: *0.3% below average*

5. Staff engagement

5.1 In line with the national picture, QVH has previously struggled with staff engagement scores. This year QVH has seen a slight downturn in the overall engagement score (from **7.5** to **7.4**). The table also highlights professional groupings engagement scores:

Comparisons with the Organisation average By Locality Staff Groups 2020 Results	Number of respondents	Staff Engagement Score	Would recommend organisation as place to work	If friend/relative needed treatment would be happy with standard of care provided by organisation	Care of patients/service users is organisation's top priority	Able to make suggestions to improve the work of my team/department	Opportunities to show initiative frequently in my role	Able to make improvements happen in my area of work	Often/always look forward to going to work	Often/always enthusiastic about my job	Time often/always passes quickly when I am working
			Advocacy overall 7.9			Involvement overall 6.9			Motivation overall 7.4		
2020 Average	616	7.4	7.2	8.5	8.1	7.3	7.1	6.4	6.8	7.5	7.8
2019 Average	586	7.5	7.2	8.4	8.1	7.5	7.3	6.5	6.9	7.7	7.9
2018 Average	501	7.3	6.7	8.3	7.9	7.3	7.1	6.3	6.7	7.5	7.8
Add Prof Scientific and Technic	49	7.1	6.9	8.4	8.1	6.9	6.9	6.2	6.1	7.1	7.3
Additional Clinical Services	90	7.2	6.8	8.2	8.1	6.6	7.1	5.6	7.0	7.8	7.4
Administrative and Clerical	211	7.4	7.0	8.8	8.1	7.3	7.0	6.4	6.5	7.2	8.1
Allied Health Professionals	35	7.8	8.3	8.8	8.5	8.1	7.6	7.3	6.7	7.5	7.8
Estates and Ancillary	26	7.1	7.0	7.8	8.2	6.1	6.0	6.6	7.5	7.5	7.4
Medical and Dental	72	7.5	7.4	8.4	7.6	7.3	7.2	6.2	7.4	8.0	8.2
Nursing and Midwifery Registered	106	7.6	7.5	8.3	8.2	7.8	7.5	6.6	6.9	7.8	8.0

Key:

10.0
>0.4 pts above
<0.4 pts below
In between

5.2 When breaking down the staff data using the RAG rating, it highlights levels of engagement for various groups of staff at QVH. Summary data analysis has been calculated using trends shown in the Picker RAG Table Report:

- Staff groups: Additional Professional Scientific and Technical Staff are less engaged than other staff groups (6.9 vs 7.4 organisation average)
- Age: 21–30 remain significantly less engaged than other groups (6.9 vs org average of 7.4)
- Disability: Respondents with a disclosed disability are less engaged than those without (6.9 vs 7.5)
- Ethnicity: Those from an African, Indian or any other Asian background are more engaged than those from a White background.
- BME: BME staff are more engaged than white staff members (7.7 vs 7.1)
- Gender: Males are slightly more engaged than females or those who prefer not to say (7.7 vs 7.4)
- Religion: Hindu staff members are more engaged than Christian staff members (8.3 vs 7.5). Those with no religion or would not prefer to say (7.3 vs 6.9) are also lower than the organisation average

5.3 Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) can be viewed in appendix 3 and 4.

6. 2019 Staff Survey Improvement Themes

6.1 Questions/areas of improvement

In addition to comparator group changes (3.2), a more in-depth analysis of the 2020 NHS Staff Survey question data highlights specific questions/areas where QVH has improved:

Theme	Q	Description	2019	2020
N/A	Q4f	Have adequate materials, supplies and equipment to do my work	61%	67%
2	Q5h	Satisfied with opportunities for flexible working patterns	56%	60%
6	Q7a	Satisfied with quality of care I give to patients/service users	88%	92%
2	Q11a	Organisation definitely takes positive action on health and well-being	36%	41%
2	**Q11d**	**In last 3 months, have not come to work when not feeling well enough to perform duties**	37%	59%
7	**Q13a**	**Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public**	74%	84%
9	Q17b	Would feel secure raising concerns about unsafe clinical practice	70%	77%
1	**Q26b**	**Disability: organisation made adequate adjustment(s) to enable me to carry out work**	73%	82%

6.2 Questions/areas for development

In addition to the comparator group comparisons (3.2), further analysis of the question data identifies specific questions/areas where QVH needs to focus its actions for improvement:

Theme	Q	Description	2019	2020
4	Q4c	Involved in deciding changes that affect work	56%	50%
10	Q4h	Team members have a set of shared objectives	75%	69%
10	**Q4i**	**Team members often meet to discuss the team's effectiveness**	67%	56%
4	Q4j	I receive the respect I deserve from my colleagues at work	76%	70%
N/A	Q5d	Satisfied with amount of responsibility given	79%	74%
4	Q6b	I have a choice in deciding how to do my work	63%	56%
4	**Q6c**	**Relationships at work are unstrained**	54%	46%
3	Q8b	Immediate manager can be counted on to help with difficult tasks	76%	70%
3	Q8c	Immediate manager gives clear feedback on my work	66%	62%
3	Q8d	Immediate manager asks for my opinion before making decisions that affect my work	60%	55%
3	Q8e	Immediate manager supportive in personal crisis	81%	77%
3	Q9b	Communication between senior management and staff is effective	43%	36%
2	**Q11c**	**In last 12 months, have not felt unwell due to work related stress**	71%	61%

9	Q16d	Staff given feedback about changes made in response to reported errors/near misses/ incidents	58%	54%

7. Themes summary

7.1 Based on the above findings, overall the Trust has managed to maintain largely positive survey results in comparison to the national picture in a challenging environment. There are a number of areas that QVH have made some improvement within the 2020 NHS Staff Survey but must remain a focus in order to continue enhancing staff experience. Both of the areas that have shown improvements were recognised in the 2019 staff survey as areas that needed improvement:

- Health & Well-being (People & OD Strategy Goal 3)
- Safe Environment - Bullying & Harassment (People & OD Strategy Goal 3)

7.2 QVH will continue to triangulate key findings from the NHS staff survey report, with the Picker report, People & OD Strategy, Staff Friends and Family Test (once reinstated) and the stay/exit interviews to ensure we effectively listen and respond to staff needs.

7.3 Particularly in relation to the 2020 NHS Staff Survey results, we need to focus on:

- Team Building (People & OD Strategy Goal 1)

Over and above the primary area identified in the survey, other areas that need improvement include:

- Immediate Managers (People & OD Strategy Goal 5)
- Morale (People and OD Strategy Goal 2)
- Staff engagement (linked to People and OD Strategy Goal 1)

7.4 Looking at the overall results, it appears there may be a correlation between the impact of Covid-19 and the responses to some of the themes in the 2020 survey. The Health & Wellbeing theme improved and HR offered staff a range of resources and support through the StayWell initiative. Themes that need improvement are where the impact of social distancing and remote working can be seen (i.e. team working, immediate managers, morale, staff engagement).

8. Summary Ongoing Actions:

8.1 Bringing together the key areas throughout the report, the goals outlined in the People and OD Strategy and a full analysis of the data will enable QVH to identify specific interventions to support the areas for development. This will be undertaken in collaboration with key stakeholders including business units, communications, and colleagues in Workforce and Organisational Development & Learning. In the meantime we will continue with a range of ongoing QVH interventions already underway or about to commence, including:

- Ongoing promotion of education, learning and development across virtual platforms and as the year progresses offer a more blended approach to learning
- Further promotion of our successful apprenticeship programmes across the trust
- Continue to promote and develop management and leadership opportunities in house and externally across the wider system
- Working with business units in relation to specific team interventions and staff survey themes
- Ongoing promotion of a range of wellbeing events
- Promotion of Trust benefits
- Monitoring the mover/leavers survey to get qualitative and quantitative data to inform future attraction and retention interventions

9. Recommendation/next steps

9.1 It is crucial for managers to review the results for each locality and take responsibility for:

- Reviewing comparative data for 2019/2020 to identify improvements and areas to focus on
- Sharing results with their localities
- Seeking ideas to inform improvements
- Developing and implementing a joint/agreed action plan

- Sharing regular updates/outcomes on implementation with teams and senior management

9.2 At a corporate level, initiatives need to include:

- Reviewing our approach to agile working on a longer term basis
- Reviewing staff survey data in relation to Equality, Diversity and Inclusion and update action plan
- Involving the Freedom to Speak up Guardian and BAME network co-chairs by sharing relevant and appropriate narrative to support their programmes of work
- Working with key theme trust leads on implementation of strategy/communications

Appendix 1: Background comparator response rates

Gender:

	Male	Female	Prefer to self-describe	Prefer not to say
Your org	20.3%	75.5%	0.2%	4.1%
Average	22.5%	73.9%	0.2%	3.4%
Responses	587	587	587	587

Age:

	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.3%	9.3%	21.9%	25.6%	41.0%	1.9%
Average	0.3%	17.6%	26.0%	25.4%	28.2%	1.2%
Responses	581	581	581	581	581	581

Ethnicity:

	White	Mixed/Multiple ethnic background	Asian/Asian British	Black/African/ Caribbean/Black British	Other ethnic group
Your org	85.3%	1.7%	9.1%	3.0%	0.3%
Average	83.7%	1.9%	10.1%	2.8%	0.5%
Responses	572	572	572	572	572

Sexuality:

	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	90.1%	1.4%	1.0%	0.3%	7.2%
Average	90.1%	2.1%	1.3%	0.5%	6.4%
Responses	583	583	583	583	583

Religion:

	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other	Prefer not to say
Your org	38.2%	48.6%	0.3%	2.6%	0.2%	0.9%	0.2%	1.5%	7.5%
Average	33.0%	48.8%	0.7%	2.1%	0.3%	2.3%	0.2%	1.3%	6.6%
Responses	586	586	586	586	586	586	586	586	586

Long lasting health condition or illness:

	Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?	Has your employer made adequate adjustment(s) to enable you to carry out your work?
Your org	20.1%	83.4%
Average	17.0%	76.7%
Responses	583	74

Parental/Caring responsibilities:

	Do you have any children aged from 0 to 17 living at home with you, or who you have regular caring responsibility for?	Do you look after, or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age?
Your org	38.6%	26.3%
Average	38.9%	28.3%
Responses	583	582

Occupational Group:

	Registered Nurses and Midwives	Nursing or Healthcare Assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical / Healthcare Scientists	Commissioning staff	Admin and Clerical	Central Functions / Corporate Services	Maintenance / Ancillary	General Management	Other
Your org	20.8%	8.5%	12.3%	14.6%	6.5%	0.2%	19.0%	8.8%	3.7%	3.0%	2.6%
Average	22.5%	6.4%	7.8%	14.1%	8.9%	0.1%	17.9%	7.6%	3.2%	3.7%	3.8%
Responses	568	568	568	568	568	568	568	568	568	568	568

Appendix 2: All scores

Question topic	Q	Description	2019	2020
Your job	Q2a	Often/always look forward to going to work	65%	62%
	Q2b	Often/always enthusiastic about my job	77%	75%
	Q2c	Time often/always passes quickly when I am working	79%	78%
	Q3a	Always know what work responsibilities are	89%	88%
	Q3b	Feel trusted to do my job	93%	91%
	Q3c	Able to do my job to a standard I am pleased with	84%	84%
	Q4a	Opportunities to show initiative frequently in my role	76%	74%
	Q4b	Able to make suggestions to improve the work of my team/dept	79%	76%
	Q4c	Involved in deciding changes that affect work	56%	50%
	Q4d	Able to make improvements happen in my area of work	61%	59%
	Q4e	Able to meet conflicting demands on my time at work	46%	49%
	Q4f	Have adequate materials, supplies and equipment to do my work	61%	67%
	Q4g	Enough staff at organisation to do my job properly	42%	45%
	Q4h	Team members have a set of shared objectives	75%	69%
	Q4i	Team members often meet to discuss the team's effectiveness	67%	56%
	Q4j	I receive the respect I deserve from my colleagues at work	76%	70%
	Q5a	Satisfied with recognition for good work	63%	64%
	Q5b	Satisfied with support from immediate manager	76%	73%
	Q5c	Satisfied with support from colleagues	83%	82%
	Q5d	Satisfied with amount of responsibility given	79%	74%
	Q5e	Satisfied with opportunities to use skills	76%	73%
	Q5f	Satisfied with extent organisation values my work	54%	53%
	Q5g	Satisfied with level of pay	36%	34%
	Q5h	Satisfied with opportunities for flexible working patterns	56%	60%
	Q6a	I have realistic time pressures	28%	27%
	Q6b	I have a choice in deciding how to do my work	63%	56%
	Q6c	Relationships at work are unstrained	54%	46%
	Q7a	Satisfied with quality of care I give to patients/service users	88%	92%
	Q7b	Feel my role makes a difference to patients/service users	93%	91%
	Q7c	Able to provide the care I aspire to	78%	78%
Your managers	Q8a	My immediate manager encourages me at work	72%	70%
	Q8b	Immediate manager can be counted on to help with difficult tasks	76%	70%
	Q8c	Immediate manager gives clear feedback on my work	66%	62%
	Q8d	Immediate manager asks for my opinion before making decisions that affect my work	60%	55%
	Q8e	Immediate manager supportive in personal crisis	81%	77%
	Q8f	Immediate manager takes a positive interest in my health & well-being	76%	74%
	Q8g	Immediate manager values my work	75%	74%
	Q9a	I know who senior managers are	84%	83%
	Q9b	Communication between senior management and staff is effective	43%	36%
	Q9c	Senior managers try to involve staff in important decisions	36%	36%
	Q9d	Senior managers act on staff feedback	36%	33%
Your health, well-being and safety at work	Q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	62%	64%
	Q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	45%	43%
	Q11a	Organisation definitely takes positive action on health and well-being	36%	41%
	Q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	70%	69%
	Q11c	In last 12 months, have not felt unwell due to work related stress	71%	61%
	Q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	37%	59%
	Q11e	Not felt pressure from manager to come to work when not feeling well enough	70%	71%
	Q11f	Not felt pressure from colleagues to come to work when not feeling well enough	76%	75%
	Q11g	Not put myself under pressure to come to work when not feeling well enough	6%	7%
	Q12a	Not experienced physical violence from patients/service users, their relatives or other members of the public	95%	96%
	Q12b	Not experienced physical violence from managers	100%	99%
	Q12c	Not experienced physical violence from other colleagues	99%	98%
	Q12d	Last experience of physical violence reported	52%	55%
	Q13a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	74%	84%
	Q13b	Not experienced harassment, bullying or abuse from managers	91%	88%
	Q13c	Not experienced harassment, bullying or abuse from other colleagues	82%	81%
	Q13d	Last experience of harassment/bullying/abuse reported	49%	52%
	Q14	Organisation acts fairly: career progression	89%	86%
	Q15a	Not experienced discrimination from patients/service users, their relatives or other members of the public	96%	96%
	Q15b	Not experienced discrimination from manager/team leader or other colleagues	93%	92%
	Q16a	Organisation treats staff involved in errors/near misses/incidents fairly	58%	60%
	Q16b	Organisation encourages reporting of errors/near misses/incidents	91%	90%
	Q16c	Organisation takes action to ensure errors/near misses/incidents are not repeated	71%	73%
	Q16d	Staff given feedback about changes made in response to reported errors/near misses/incidents	58%	54%
	Q17a	Know how to report unsafe clinical practice	96%	98%
	Q17b	Would feel secure raising concerns about unsafe clinical practice	70%	77%
	Q17c	Would feel confident that organisation would address concerns about unsafe clinical practice	62%	64%
Your organisation	Q18a	Care of patients/service users is organisation's top priority	88%	87%
	Q18b	Organisation acts on concerns raised by patients/service users	79%	81%
	Q18c	Would recommend organisation as place to work	72%	71%
	Q18d	If friend/relative needed treatment would be happy with standard of care provided by organisation	92%	94%
	Q18e	Feel safe in my work (New for 2020).	-	88%
	Q18f	Feel safe to speak up about anything that concerns me in this organisation (New for 2020).	-	72%
	Q19a	I don't often think about leaving this organisation	54%	52%
	Q19b	I am unlikely to look for a job at a new organisation in the next 12 months	60%	59%
	Q19c	I am not planning on leaving this organisation.	68%	65%
Background information	Q26b	Disability: organisation made adequate adjustment(s) to enable me to carry out work	73%	82%

This section contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Appendix 3: Workforce Race Equality Standards (WRES)

This section includes the 2017, 2018, 2019 and 2020 trust/CCG and benchmarking group median results for q13a, q13b&c combined, q14,and q15b split by ethnicity (by white / BME staff).

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months:

	2017	2018	2019	2020
White: Your org	22.7%	24.6%	25.3%	16.0%
BME: Your org	30.4%	27.6%	27.4%	18.3%
White: Average	22.1%	22.1%	21.0%	16.6%
BME: Average	15.6%	18.5%	20.2%	18.6%
White: Responses	427	419	483	463
BME: Responses	56	58	73	82

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months:

	2017	2018	2019	2020
White: Your org	22.1%	24.5%	21.2%	21.4%
BME: Your org	17.9%	22.8%	34.2%	34.9%
White: Average	22.5%	25.1%	23.2%	21.6%
BME: Average	25.3%	27.3%	29.4%	28.7%
White: Responses	426	416	481	462
BME: Responses	56	57	73	83

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion:

	2017	2018	2019	2020
White: Your org	88.1%	90.2%	90.6%	88.4%
BME: Your org	83.3%	82.9%	82.6%	78.4%
White: Average	89.1%	88.5%	88.4%	88.6%
BME: Average	76.0%	76.1%	75.6%	72.9%
White: Responses	286	285	308	328
BME: Responses	36	35	46	51

Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months:

	2017	2018	2019	2020
White: Your org	5.1%	4.1%	5.8%	5.6%
BME: Your org	16.1%	13.0%	14.5%	23.2%
White: Average	5.9%	6.2%	5.5%	5.7%
BME: Average	14.6%	13.2%	13.0%	15.0%
White: Responses	428	413	482	485
BME: Responses	56	54	69	82

Appendix 4: Workforce Disability Equality Standards (WDES)

This section includes the 2018 and 2019 trust/CCG and benchmarking group median results for q5f, q11e, q13a-d, and q14 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. It also shows results for q26b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation. The WDES breakdowns are based on the responses to q26a Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months:

	2018	2019	2020
Staff with a LTC or illness: Your org	24.7%	31.0%	18.6%
Staff without a LTC or illness: Your org	24.9%	23.8%	16.2%
Staff with a LTC or illness: Average	25.4%	27.8%	21.9%
Staff without a LTC or illness: Average	20.0%	19.0%	16.3%
Staff with a LTC or illness: Responses	89	126	113
Staff without a LTC or illness: Responses	398	437	444

Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months:

	2018	2019	2020
Staff with a LTC or illness: Your org	19.5%	12.8%	20.0%
Staff without a LTC or illness: Your org	10.2%	7.3%	9.9%
Staff with a LTC or illness: Average	22.1%	15.1%	18.7%
Staff without a LTC or illness: Average	11.0%	10.0%	9.8%
Staff with a LTC or illness: Responses	87	125	110
Staff without a LTC or illness: Responses	392	436	443

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months:

	2018	2019	2020
Staff with a LTC or illness: Your org	24.1%	27.2%	21.4%
Staff without a LTC or illness: Your org	16.0%	15.4%	18.5%
Staff with a LTC or illness: Average	30.5%	27.3%	25.4%
Staff without a LTC or illness: Average	16.4%	16.6%	16.6%
Staff with a LTC or illness: Responses	87	125	112
Staff without a LTC or illness: Responses	393	434	443

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it:

	2018	2019	2020
Staff with a LTC or illness: Your org	57.9%	53.4%	53.7%
Staff without a LTC or illness: Your org	59.6%	47.5%	52.1%
Staff with a LTC or illness: Average	54.8%	53.4%	49.3%
Staff without a LTC or illness: Average	46.9%	47.7%	48.4%
Staff with a LTC or illness: Responses	38	58	41
Staff without a LTC or illness: Responses	136	120	117

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion:

	2018	2019	2020
Staff with a LTC or illness: Your org	85.5%	88.4%	84.0%
Staff without a LTC or illness: Your org	90.4%	89.7%	86.7%
Staff with a LTC or illness: Average	80.4%	80.5%	80.3%
Staff without a LTC or illness: Average	87.4%	87.5%	87.4%
Staff with a LTC or illness: Responses	55	86	75
Staff without a LTC or illness: Responses	271	273	309

Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties:

	2018	2019	2020
Staff with a LTC or illness: Your org	29.3%	33.3%	38.0%
Staff without a LTC or illness: Your org	25.3%	27.8%	25.5%
Staff with a LTC or illness: Average	30.8%	26.7%	29.8%
Staff without a LTC or illness: Average	21.7%	20.6%	21.6%
Staff with a LTC or illness: Responses	58	87	71
Staff without a LTC or illness: Responses	178	194	149

Percentage of staff satisfied with the extent to which their organisation values their work:

	2018	2019	2020
Staff with a LTC or illness: Your org	39.3%	43.2%	41.9%
Staff without a LTC or illness: Your org	52.0%	57.1%	55.9%
Staff with a LTC or illness: Average	45.8%	44.3%	44.3%
Staff without a LTC or illness: Average	56.3%	56.1%	55.6%
Staff with a LTC or illness: Responses	89	125	117
Staff without a LTC or illness: Responses	396	436	465

Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work:

	2018	2019	2020
Staff with a LTC or illness: Your org	77.4%	73.7%	82.4%
Staff with a LTC or illness: Average	75.2%	76.5%	77.0%
Staff with a LTC or illness: Responses	53	76	74

Staff engagement score (0-10):

	2018	2019	2020
Organisation average	7.3	7.5	7.4
Staff with a LTC or illness: Your org	6.8	7.3	6.9
Staff without a LTC or illness: Your org	7.4	7.6	7.5
Staff with a LTC or illness: Average	7.2	7.2	7.1
Staff without a LTC or illness: Average	7.5	7.6	7.5
Organisation Responses	496	580	607
Staff with a LTC or illness: Responses	89	126	117
Staff without a LTC or illness: Responses	401	440	465

Queen Victoria Hospital
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All QVH…

Best Place to Work

2020 Staff Survey Results

Workforce and Organisational Development

Top level summary…

Queen Victoria Hospital
NHS Foundation Trust

2020 (vs 2019) NHS Staff Survey Summary Findings

1059 (1032) Invited to complete the survey	**1049** (1009) Eligible at the end of survey	**59%** (58%) Completed the survey 616 (586)	**56%** (58%) Average response rate for similar trusts 14 (13)	**58%** (52%) Our previous response rate 2019 (2018)

Benchmarking…

2020 benchmarking group details

Organisations in group: **14**

Median response rate: **56%**

No. of completed questionnaires:

17,827

2019 vs 2020 Our views…

72% / 71%	Q18c. Would recommend organisation as place to work
92% / 94%	Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation
88% / 87%	Q18a. Care of patients/service users is organisation's top priority

Results include every question where your organisation had the minimum required 11 respondents.

www.qvh.nhs.uk

Summary findings…

Queen Victoria Hospital
NHS Foundation Trust

All QVH 2020 vs 2019...

Response rate:

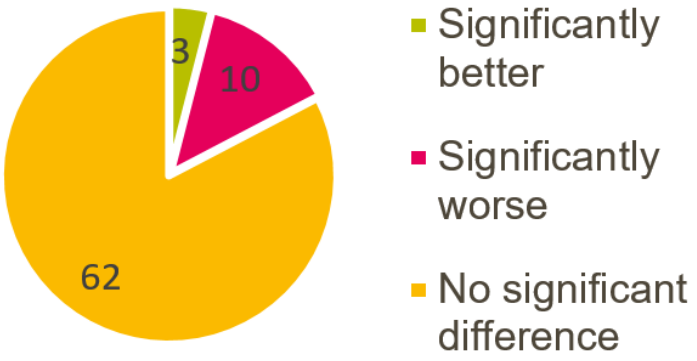
2018	2019	2020
52%	58%	59%

No of questions asked:

2019 – 90 questions
2020 – 78 questions

Out of 75 positive questions asked:

Historical comparison*



No of respondents:

All QVH respondents: **616** (2019 - 586)
Locality 3 areas = 19/22 (2019 – 19/23)

Response rates by…

Queen Victoria Hospital
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Locality 1:	Respondents	Response Rate
Our Organisation	**616**	**58.7%**
276 Corporate (Dir)	20	95.2%
276 Finance & Performance (Dir)	75	59.5%
276 Human Resources & OD (Dir)	24	88.9%
276 Nursing and Access & Outpatients (Dir)	67	69.8%
276 Operations (Dir)	430	55.2%

Staff groups:								
Comparator (Organisation Overall)	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
n = 616	n = 49	n = 90	n = 211	n = 35	n = 26	n = 7	n = 72	n = 126
100%	8.0%	14.6%	34.5%	5.7%	4.2%	1.1%	11.7%	20.4%

2020 locality groups…

Queen Victoria Hospital
NHS Foundation Trust

2020 Staff Survey - Locality Groupings (n=616)		
Locality 1	**Locality 2**	**Locality 3**
Corporate (n=20)	Corporate (n=20)	Corporate Affairs (n=20)
Finance & Performance (n=75)	Commerce & Finance (n=44)	Commerce (n=19) Finance (n=25)
	Non Clinical Infrastructure (n=31)	*Estates (n=5)* Hotel Services (n=26)
Human Resources & OD (n=24)	Human Resources (n=24)	Human Resources (n=24)
Nursing & Access & Outpatients (n=67)	Access and Outpatients (n=24)	Appointments & Records (n=24)
	Director of Nursing (n=43)	Corporate Nursing (n=18) Director of Nursing (n=25)
Operations (n=430)	Clinical Support (n=102)	General Specialities (n=17) Imaging (n=21) *Pathology (n=8)* Pharmacy (n=11) *Prosthetics (n=9)* Therapies (n=36)
	Eye (n=15)	Corneoplastic (n=15)
	Operational Nursing (n=100)	Operational Nursing (n=100)
	Oral (n=38)	Head & Neck (n=26) Orthodontics (n=12)
	Perioperative Care (n=111)	Perioperative Care (n=111)
	Plastics (n=40)	Plastics (n=40)
	Sleep (n=24)	Sleep (n=24)

Add Prof Scientific and Technic (n=49)	Estates and Ancillary (n=26)
Additional Clinical Services (n=90)	Healthcare Scientists (n=7)
Administrative and Clerical (n=211)	Medical and Dental (n=72)
Allied Health Professionals (n=35)	Nursing and Midwifery Registered (n=126)

2019 v 2020 Theme results…

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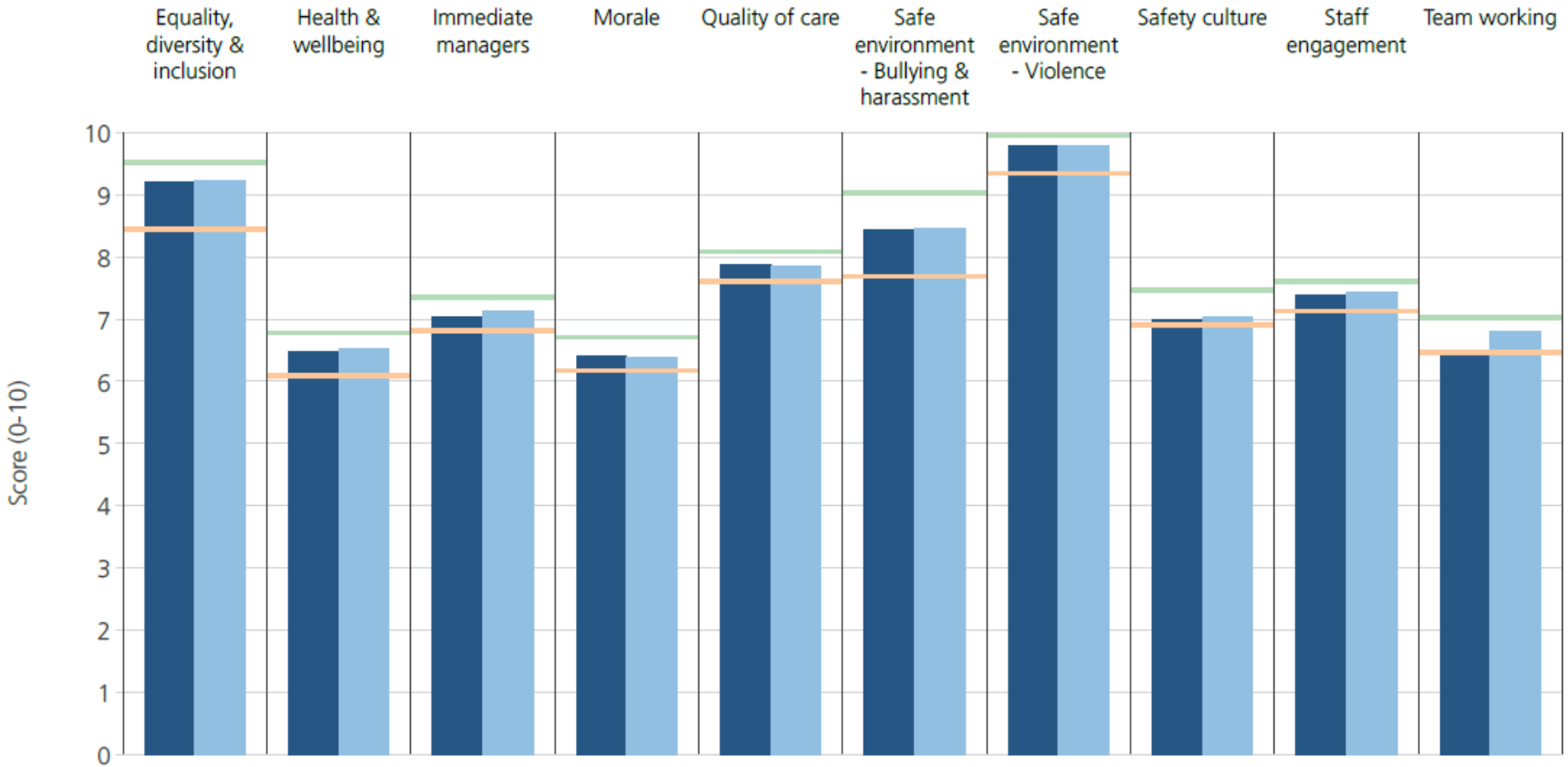
NHS Foundation Trust

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	573	**9.2** ▼	597	Not significant
Health & wellbeing	**6.3**	579	**6.5** ▲	599	Not significant
Immediate managers †	**7.2**	578	**7.0** ▼	601	Not significant
Morale	**6.6**	569	**6.4** ▼	591	Not significant
Quality of care	**7.9**	511	**7.9**	531	Not significant
Safe environment - Bullying & harassment	**8.2**	575	**8.4** ▲	569	Not significant
Safe environment - Violence	**9.8**	577	**9.8**	597	Not significant
Safety culture	**7.0**	573	**7.0**	594	Not significant
Staff engagement	**7.5**	580	**7.4** ▼	607	Not significant
Team working	**7.0**	572	**6.5** ▼	602	↓



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.8	7.3	6.7	8.1	9.0	9.9	7.5	7.6	7.0
Your org	9.2	6.5	7.0	6.4	7.9	8.4	9.8	7.0	7.4	6.5
Average	9.2	6.5	7.1	6.4	7.9	8.4	9.8	7.0	7.4	6.8
Worst	8.4	6.1	6.8	6.2	7.6	7.7	9.3	6.9	7.1	6.5
Responses	597	599	601	591	531	569	597	594	607	602

High level key themes…

Queen Victoria Hospital NHS Foundation Trust

Theme 1: Equality, Diversity & Inclusion

Q	Description	All QVH 2019	All QVH 2020	
Q14	Organisation acts fairly: career progression	89%	86%	▼
Q15a	Not experienced discrimination from patients/service users, their relatives or other members of the public	96%	96%	
Q15b	Not experienced discrimination from manager/team leader or other colleagues	93%	92%	▼
Q26b	Disability: organisation made adequate adjustment(s) to enable me to carry out work	73%	82%	▲

Theme 2: Health & Well-being

Q	Description	All QVH 2019	All QVH 2020	
Q5h	Satisfied with opportunities for flexible working patterns	56%	60%	▲
Q11a	Organisation definitely takes positive action on health and well-being	36%	41%	▲
Q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	70%	69%	▼
Q11c	In last 12 months, have not felt unwell due to work related stress	71%	61%	▼
Q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	37%	59%	▲

Positive score of 100%
Score > 3 % above benchmark
Score < 3 % above benchmark
Scores in between

Theme 3: Immediate Managers

Q	Description	All QVH 2019	All QVH 2020	
Q5b	Satisfied with support from immediate manager	76%	73%	▼
Q8c	Immediate manager gives clear feedback on my work	66%	62%	▼
Q8d	Immediate manager asks for my opinion before making decisions that affect my work	60%	55%	▼
Q8f	Immediate manager takes a positive interest in my health & well-being	76%	74%	▼
Q8g	Immediate manager values my work	75%	74%	▼
N/A	Supported by manager to receive training, learning or development definitely identified in appraisal (removed for 2020)	61%	N/A	

Theme 4: Morale

Q	Description	All QVH 2019	All QVH 2020	
Q4c	Involved in deciding changes that affect work	56%	50%	▼
Q4j	I receive the respect I deserve from my colleagues at work	76%	70%	▼
Q6a	I have realistic time pressures	28%	27%	▼
Q6b	I have a choice in deciding how to do my work	63%	56%	▼
Q6c	Relationships at work are unstrained	54%	46%	▼
Q8a	My immediate manager encourages me at work	72%	70%	▼
Q19a	I don't often think about leaving this organisation	54%	52%	▼
Q19b	I am unlikely to look for a job at a new organisation in the next 12 months	60%	59%	▼
Q19c	I am not planning on leaving this organisation.	68%	65%	▼

Quality of Appraisals (removed for 2020)

Q	Description	All QVH 2019	All QVH 2020
N/A	Appraisal/review definitely helped me improve how I do my job	24%	N/A
N/A	Clear work objectives definitely agreed during appraisal	41%	N/A
N/A	Appraisal/performance review: definitely left feeling work is valued	40%	N/A
N/A	Appraisal/performance review: organisational values definitely discussed	41%	N/A

Theme 5: Quality of Care

Q	Description	All QVH 2019	All QVH 2020	
Q7a	Satisfied with quality of care I give to patients/service users	88%	92%	▲
Q7b	Feel my role makes a difference to patients/service users	93%	91%	▼
Q7c	Able to provide the care I aspire to	78%	78%	

Theme 6: Safe Environment – Bullying & Harassment

Q	Description	All QVH 2019	All QVH 2020	
Q13a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	74%	84%	▲
Q13b	Not experienced harassment, bullying or abuse from managers	91%	88%	▼
Q13c	Not experienced harassment, bullying or abuse from other colleagues	82%	81%	▼

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Theme 7: Safe Environment – Violence

Q	Description	All QVH 2019	All QVH 2020	
Q12a	Not experienced physical violence from patients/service users, their relatives or other members of the public	95%	96%	▲
Q12b	Not experienced physical violence from managers	100%	99%	▼
Q12c	Not experienced physical violence from other colleagues	99%	98%	▼

Theme 8: Safety Culture

Q	Description	All QVH 2019	All QVH 2020	
Q16a	Organisation treats staff involved in errors/near misses/incidents fairly	58%	60%	▲
Q16c	Organisation takes action to ensure errors/near misses/incidents are not repeated	71%	73%	▲
Q16d	Staff given feedback about changes made in response to reported errors/near misses/incidents	58%	54%	▼
Q17b	Would feel secure raising concerns about unsafe clinical practice	70%	77%	▲
Q17c	Would feel confident that org would address concerns about unsafe clinical practice	62%	64%	▲
Q18b	Organisation acts on concerns raised by patients/service users	79%	81%	▲

Theme 9: Staff Engagement

Q	Description	All QVH 2019	All QVH 2020	
Q2a	Often/always look forward to going to work	65%	62%	▼
Q2b	Often/always enthusiastic about my job	77%	75%	▼
Q2c	Time often/always passes quickly when I am working	79%	78%	▼
Q4a	Opportunities to show initiative frequently in my role	76%	74%	▼
Q4b	Able to make suggestions to improve the work of my team/dept	79%	76%	▼
Q4d	Able to make improvements happen in my area of work	61%	59%	▼
Q18a	Care of patients/service users is organisation's top priority	88%	87%	▼
Q18c	Would recommend organisation as place to work	72%	71%	▼
Q18d	If friend/relative needed treatment would be happy with standard of care provided by org	92%	94%	▲

Theme 10: Team Working

Q	Description	All QVH 2019	All QVH 2020	
Q4h	Team members have a set of shared objectives	75%	69%	▼
Q4i	Team members often meet to discuss the team's effectiveness	67%	56%	▼

*Locality 3 changes…

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Locality	2019	Locality	2019
Appointments & Records	▼	Imaging	▲
Commerce	▼	Operational Nursing	▲
Corneoplastics	▼	Orthodontics	N/A
Corporate Affairs	▬	Pathology	N/A
Corporate Nursing	▼	Perioperative Care	▲
Director of Nursing	▲	Pharmacy	▼
Estates	N/A	Plastics	▲
Finance	▲	Prosthetics	N/A
General Specialities	▲	Sleep	▼
Head & Neck	▼	Therapies	▼
Hotel Services	▼		
Human Resources	▲	* Less than 11 respondents	

***No of questions asked: 2019 vs 2020**
78 questions (2019 – 90 questions)

Overall increases over 3%…

Queen Victoria Hospital NHS Foundation Trust

Theme	Q	Description	2019	2020
N/A	Q4f	Have adequate materials, supplies and equipment to do my work	61%	67%
2	Q5h	Satisfied with opportunities for flexible working patterns	56%	60%
5	Q7a	Satisfied with quality of care I give to patients/service users	88%	92%
2	Q11a	Organisation definitely takes positive action on health and well-being	36%	41%
2	**Q11d**	**In last 3 months, have not come to work when not feeling well enough to perform duties**	37%	*59%
6	**Q13a**	**Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public**	74%	*84%
8	Q17b	Would feel secure raising concerns about unsafe clinical practice	70%	77%
1	**Q26b**	**Disability: organisation made adequate adjustment(s) to enable me to carry out work**	73%	*82%

*Top 3 biggest increases

Overall decreases over 3%…

Queen Victoria Hospital NHS Foundation Trust

Theme	Q	Description	2019	2020
4	Q4c	Involved in deciding changes that affect work	56%	50%
10	Q4h	Team members have a set of shared objectives	75%	69%
10	**Q4i**	**Team members often meet to discuss the team's effectiveness**	67%	*56%
4	Q4j	I receive the respect I deserve from my colleagues at work	76%	70%
N/A	Q5d	Satisfied with amount of responsibility given	79%	74%
4	Q6b	I have a choice in deciding how to do my work	63%	56%
4	**Q6c**	**Relationships at work are unstrained**	54%	*46%
3	Q8b	Immediate manager can be counted on to help with difficult tasks	76%	70%
3	Q8c	Immediate manager gives clear feedback on my work	66%	62%
3	Q8d	Immediate manager asks for my opinion before making decisions that affect my work	60%	55%
3	Q8e	Immediate manager supportive in personal crisis	81%	77%
3	Q9b	Communication between senior management and staff is effective	43%	36%
2	**Q11c**	**In last 12 months, have not felt unwell due to work related stress**	71%	*61%
8	Q16d	Staff given feedback about changes made in response to reported errors/near misses/incidents	58%	54%

*Top 3 biggest decreases

All QVH Key themes…

Queen Victoria Hospital
NHS Foundation Trust

Most improved for 2020:

- Health & Wellbeing
- Safe Environment – Bullying & Harrasment

Key focus for 2021:

- Team Working

Other areas to consider in 2021:

- Immediate Managers
- Morale
- Staff Engagement

Covid impact…

Queen Victoria Hospital
NHS Foundation Trust

Looking at the overall results, there may be a correlation between the impact of Covid and the responses to some of the themes in the 2020 survey:

Most improved for 2020:

- Health & Wellbeing (work to continue in 2021)
  - StayWell work
  - Additional Covid support

Key focus for 2021:

- Team Working

  - remote working, virtual working, social distancing, self-isolation, relationships, collaboration, etc

Other areas to consider in 2021:

- Immediate Managers, Morale, Staff Engagement

  - remote working, virtual working, social distancing, self-isolation, relationships, collaboration, etc

Comments…

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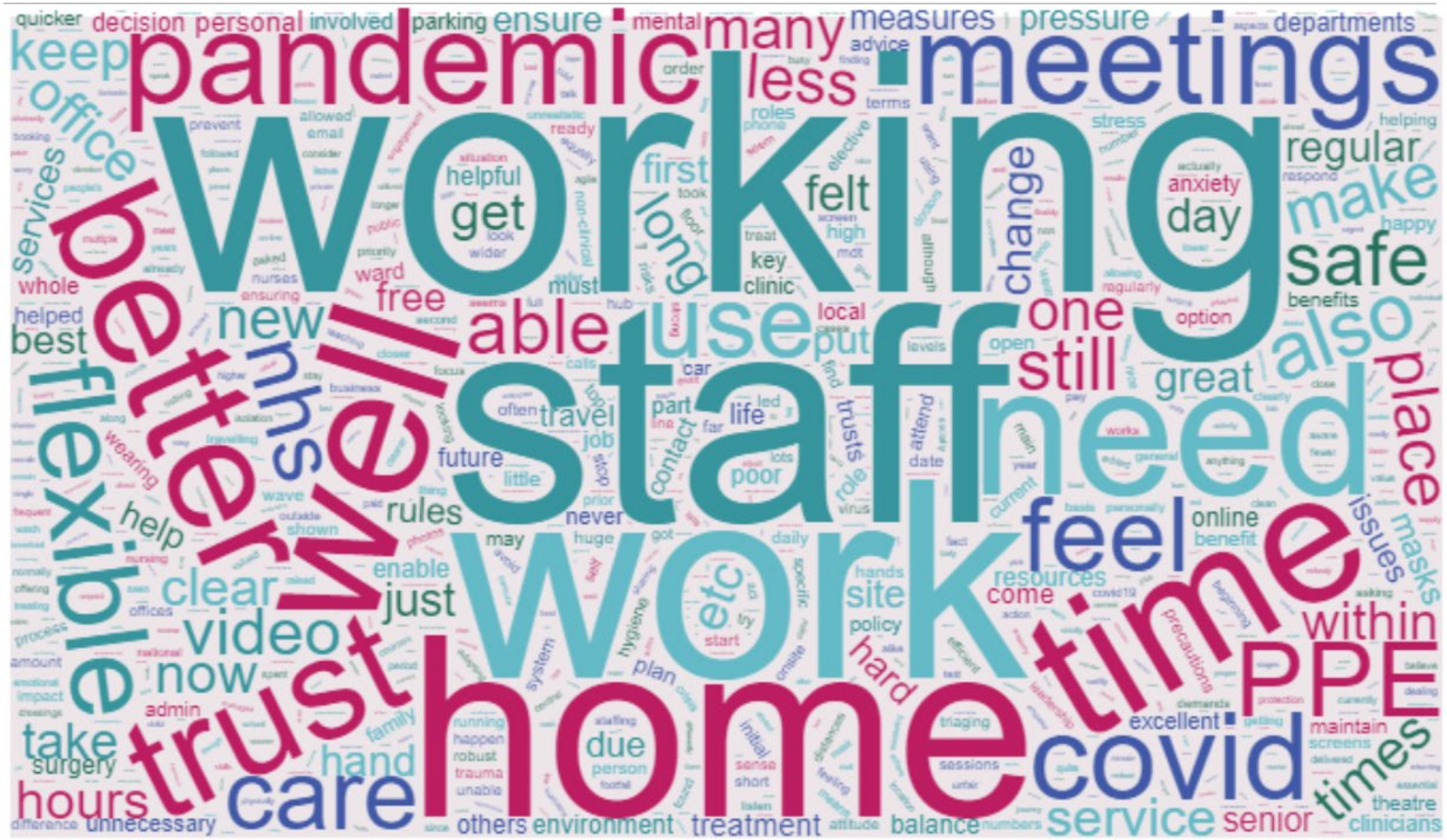
NHS Foundation Trust



Covid-19 comments…

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NHS Foundation Trust

- **60%** of staff members provided comments (372 out of 616)

- Comments are grouped into the top 5 most frequently mentioned themes, these are:
    - ***Remote Working***
    - ***Health & Wellbeing***
    - ***Communication***
    - ***Virtual Working***
    - ***PPE/Infection Control***

- Majority of comments indicate that remote/flexible working and the introduction of virtual clinics have had a positive impact
- On the flipside, it has also shown that relationships and teamwork have deteriorated

2020 Staff Engagement…

Queen Victoria Hospital
NHS Foundation Trust

Comparisons with the Organisation average	Number of respondents	Staff Engagement Score	Would recommend organisation as place to work	If friend/relative needed treatment would be happy with standard of care provided by organisation	Care of patients/service users is organisation's top priority	Able to make suggestions to improve the work of my team/department	Opportunities to show initiative frequently in my role	Able to make improvements happen in my area of work	Often/always look forward to going to work	Often/always enthusiastic about my job	Time often/always passes quickly when I am working
			Advocacy overall 7.9			Involvement overall 6.9			Motivation overall 7.4		
2020 Organisation Average	616	7.4	7.2	8.5	8.1	7.3	7.1	6.4	6.8	7.5	7.8
2019 Organisation Average	586	7.5	7.2	8.4	8.1	7.5	7.3	6.5	6.9	7.7	7.9
2018 Organisation Average	501	7.3	6.7	8.3	7.9	7.3	7.1	6.3	6.7	7.5	7.8

All staff engagement results are within a 0.4% range of the 2019 results:

Key:

10.0
>0.4 pts above
<0.4 pts below
In between

2020 Staff Engagement…

Queen Victoria Hospital
NHS Foundation Trust

Some high level staff engagement results from protected groups:

Staff groups: Additional Professional Scientific and Technical Staff are less engaged than other staff groups (6.9 vs 7.4 organisation average).

Age: 21–30 remain significantly less engaged than other groups (6.9 vs organisation average of 7.4).

Disability: Respondents with a disclosed disability are less engaged than those without (6.9 vs 7.5).

Ethnicity: Those from an African, Indian or any other Asian background are more engaged than those from a White background.

BME: BME staff are more engaged than white staff members (7.7 vs 7.1)
Gender: Males are slightly more engaged than females or those who prefer not to say (7.7 vs 7.4).

Religion: Hindu staff members are more engaged than staff who identify as Christian (8.3 vs 7.5). Those with no religion or would not prefer to say (7.3 vs 6.9) are also lower than the organisation average.

What next…

Queen Victoria Hospital
NHS Foundation Trust

Corporate initiatives:

- Reviewing our approach to agile working on a longer term basis
- Reviewing staff survey data in relation to Equality, Diversity and Inclusion and update action plan
- Involving the Freedom to Speak up Guardian and BAME network co-chairs by sharing relevant and appropriate narrative to support their programmes of work
- Working with key theme trust leads on implementation of strategy/communications

Local level - what next…

Queen Victoria Hospital
NHS Foundation Trust

Engage with senior managers to consider:

- Where are we now?
  - *Review findings*
- Where do we want to be?
  - *How can we improve?*
- How are we going to get there?
  - *What can we do?*

Senior managers must:

- Review comparative data for 2019/2020 to identify improvements and areas to focus on
- Share results with managers/teams within their localities
- Seek ideas to inform improvements
- Develop and implement a joint/agreed action plan
- Share regular updates/outcomes with teams and EMT on progress

Appendices…

1. All QVH responses

2. All QVH responses by staff group

Question topic	Q	Description	All QVH 2019	All QVH 2020
Your job	Q2a	Often/always look forward to going to work	65%	62%
	Q2b	Often/always enthusiastic about my job	77%	75%
	Q2c	Time often/always passes quickly when I am working	79%	78%
	Q3a	Always know what work responsibilities are	89%	88%
	Q3b	Feel trusted to do my job	93%	91%
	Q3c	Able to do my job to a standard I am pleased with	84%	84%
	Q4a	Opportunities to show initiative frequently in my role	76%	74%
	Q4b	Able to make suggestions to improve the work of my team/dept	79%	76%
	Q4c	Involved in deciding changes that affect work	56%	50%
	Q4d	Able to make improvements happen in my area of work	61%	59%
	Q4e	Able to meet conflicting demands on my time at work	46%	49%
	Q4f	Have adequate materials, supplies and equipment to do my work	61%	67%
	Q4g	Enough staff at organisation to do my job properly	42%	45%
	Q4h	Team members have a set of shared objectives	75%	69%
	Q4i	Team members often meet to discuss the team's effectiveness	67%	56%
	Q4j	I receive the respect I deserve from my colleagues at work	76%	70%
	Q5a	Satisfied with recognition for good work	63%	64%
	Q5b	Satisfied with support from immediate manager	76%	73%
	Q5c	Satisfied with support from colleagues	83%	82%
	Q5d	Satisfied with amount of responsibility given	79%	74%
	Q5e	Satisfied with opportunities to use skills	76%	73%
	Q5f	Satisfied with extent organisation values my work	54%	53%
	Q5g	Satisfied with level of pay	36%	34%
	Q5h	Satisfied with opportunities for flexible working patterns	56%	60%
	Q6a	I have realistic time pressures	28%	27%
	Q6b	I have a choice in deciding how to do my work	63%	56%
	Q6c	Relationships at work are unstrained	54%	46%
	Q7a	Satisfied with quality of care I give to patients/service users	88%	92%
	Q7b	Feel my role makes a difference to patients/service users	93%	91%
	Q7c	Able to provide the care I aspire to	78%	78%
Your managers	Q8a	My immediate manager encourages me at work	72%	70%
	Q8b	Immediate manager can be counted on to help with difficult tasks	76%	70%
	Q8c	Immediate manager gives clear feedback on my work	66%	62%
	Q8d	Immediate manager asks for my opinion before making decisions that affect my work	60%	55%
	Q8e	Immediate manager supportive in personal crisis	81%	77%
	Q8f	Immediate manager takes a positive interest in my health & well-being	76%	74%
	Q8g	Immediate manager values my work	75%	74%
	Q9a	I know who senior managers are	84%	83%
	Q9b	Communication between senior management and staff is effective	43%	36%
	Q9c	Senior managers try to involve staff in important decisions	36%	36%
	Q9d	Senior managers act on staff feedback	36%	33%

Question topic	Q	Description	All QVH 2019	All QVH 2020
Your health, well-being and safety at work	Q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	62%	64%
	Q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	45%	43%
	Q11a	Organisation definitely takes positive action on health and well-being	36%	41%
	Q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	70%	69%
	Q11c	In last 12 months, have not felt unwell due to work related stress	71%	61%
	Q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	37%	59%
	Q11e	Not felt pressure from manager to come to work when not feeling well enough	70%	71%
	Q11f	Not felt pressure from colleagues to come to work when not feeling well enough	76%	75%
	Q11g	Not put myself under pressure to come to work when not feeling well enough	6%	7%
	Q12a	Not experienced physical violence from patients/service users, their relatives or other members of the public	95%	96%
	Q12b	Not experienced physical violence from managers	100%	99%
	Q12c	Not experienced physical violence from other colleagues	99%	98%
	Q12d	Last experience of physical violence reported	52%	55%
	Q13a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	74%	84%
	Q13b	Not experienced harassment, bullying or abuse from managers	91%	88%
	Q13c	Not experienced harassment, bullying or abuse from other colleagues	82%	81%
	Q13d	Last experience of harassment/bullying/abuse reported	49%	52%
	Q14	Organisation acts fairly: career progression	89%	86%
	Q15a	Not experienced discrimination from patients/service users, their relatives or other members of the public	96%	96%
	Q15b	Not experienced discrimination from manager/team leader or other colleagues	93%	92%
	Q16a	Organisation treats staff involved in errors/near misses/incidents fairly	58%	60%
	Q16b	Organisation encourages reporting of errors/near misses/incidents	91%	90%
	Q16c	Organisation takes action to ensure errors/near misses/incidents are not repeated	71%	73%
	Q16d	Staff given feedback about changes made in response to reported errors/near misses/incidents	58%	54%
	Q17a	Know how to report unsafe clinical practice	96%	98%
	Q17b	Would feel secure raising concerns about unsafe clinical practice	70%	77%
	Q17c	Would feel confident that organisation would address concerns about unsafe clinical practice	62%	64%
Your organisation	Q18a	Care of patients/service users is organisation's top priority	88%	87%
	Q18b	Organisation acts on concerns raised by patients/service users	79%	81%
	Q18c	Would recommend organisation as place to work	72%	71%
	Q18d	If friend/relative needed treatment would be happy with standard of care provided by organisation	92%	94%
	Q18e	Feel safe in my work.	N/A	88%
	Q18f	Feel safe to speak up about anything that concerns me in this organisation.	N/A	72%
	Q19a	I don't often think about leaving this organisation	54%	52%
	Q19b	I am unlikely to look for a job at a new organisation in the next 12 months	60%	59%
	Q19c	I am not planning on leaving this organisation.	68%	65%
Background information	Q26b	Disability: organisation made adequate adjustment(s) to enable me to carry out work	73%	82%

ALL QUESTION RESPONSES BASED ON STAFF GROUPS		Comparator (Organisation Overall)	Add Prof Scientific and Technic	Add. Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Medical and Dental	Nursing and Midwifery Registered
Q	Description	n = 616	n = 49	n = 90	n = 211	n = 35	n = 26	n = 72	n = 126
Q2a	Often/always look forward to going to work	62%	55%	64%	55%	69%	64%	73%	65%
Q2b	Often/always enthusiastic about my job	75%	67%	80%	70%	77%	74%	83%	79%
Q2c	Time often/always passes quickly when I am working	78%	69%	73%	80%	83%	75%	89%	79%
Q3a	Always know what work responsibilities are	88%	82%	86%	85%	94%	88%	94%	92%
Q3b	Feel trusted to do my job	91%	92%	90%	88%	97%	92%	89%	95%
Q3c	Able to do my job to a standard I am pleased with	84%	84%	88%	77%	80%	84%	90%	90%
Q4a	Opportunities to show initiative frequently in my role	74%	71%	76%	70%	80%	44%	76%	82%
Q4b	Able to make suggestions to improve the work of my team/dept	76%	76%	64%	75%	89%	56%	81%	84%
Q4c	Involved in deciding changes that affect work	50%	49%	40%	49%	71%	19%	53%	58%
Q4d	Able to make improvements happen in my area of work	59%	59%	48%	58%	77%	60%	60%	62%
Q4e	Able to meet conflicting demands on my time at work	49%	49%	55%	44%	51%	64%	45%	52%
Q4f	Have adequate materials, supplies & equipment to do my work	67%	65%	73%	63%	62%	64%	72%	70%
Q4g	Enough staff at organisation to do my job properly	45%	43%	38%	39%	51%	52%	53%	54%
Q4h	Team members have a set of shared objectives	69%	55%	64%	64%	89%	44%	75%	83%
Q4i	Team members often meet to discuss the team's effectiveness	56%	45%	49%	57%	63%	16%	57%	68%
Q4j	I receive the respect I deserve from my colleagues at work	70%	55%	66%	70%	80%	56%	78%	76%
Q5a	Satisfied with recognition for good work	64%	59%	64%	62%	74%	58%	59%	69%
Q5b	Satisfied with support from immediate manager	73%	76%	77%	70%	79%	52%	68%	80%
Q5c	Satisfied with support from colleagues	82%	88%	78%	77%	82%	68%	91%	88%
Q5d	Satisfied with amount of responsibility given	74%	82%	67%	68%	82%	60%	81%	85%
Q5e	Satisfied with opportunities to use skills	73%	80%	64%	68%	82%	48%	85%	83%
Q5f	Satisfied with extent organisation values my work	53%	51%	49%	51%	62%	52%	56%	56%
Q5g	Satisfied with level of pay	34%	41%	14%	32%	38%	56%	43%	37%
Q5h	Satisfied with opportunities for flexible working patterns	60%	55%	55%	67%	47%	56%	46%	68%
Q6a	I have realistic time pressures	27%	33%	30%	26%	47%	31%	24%	22%
Q6b	I have a choice in deciding how to do my work	56%	55%	46%	63%	62%	40%	40%	61%
Q6c	Relationships at work are unstrained	46%	27%	41%	46%	71%	48%	53%	47%
Q7a	Satisfied with quality of care I give to patients/service users	92%	98%	99%	83%	91%	80%	99%	93%
Q7b	Feel my role makes a difference to patients/service users	91%	94%	94%	83%	94%	86%	99%	97%
Q7c	Able to provide the care I aspire to	78%	78%	88%	61%	82%	69%	88%	85%
Q8a	My immediate manager encourages me at work	70%	77%	71%	69%	82%	54%	56%	78%
Q8b	Imediate manager can be counted on to help with difficult tasks	70%	73%	68%	69%	79%	52%	65%	76%
Q8c	Immediate manager gives clear feedback on my work	62%	57%	62%	62%	79%	44%	35%	76%
Q8d	Immediate manager asks for my opinion before making decisions that affect my work	55%	56%	52%	54%	74%	28%	50%	62%
Q8e	Immediate manager supportive in personal crisis	77%	80%	80%	78%	82%	64%	56%	84%
Q8f	Immediate manager takes a positive interest in my health & well-being	74%	78%	71%	75%	91%	60%	54%	79%
Q8g	Immediate manager values my work	74%	82%	70%	73%	88%	52%	68%	78%
Q9a	I know who senior managers are	83%	77%	82%	84%	91%	62%	87%	85%
Q9b	Communication between senior management & staff is effective	36%	44%	30%	37%	59%	24%	28%	37%
Q9c	Senior managers try to involve staff in important decisions	36%	42%	32%	35%	68%	16%	35%	33%
Q9d	Senior managers act on staff feedback	33%	35%	24%	33%	65%	20%	28%	34%

ALL QUESTION RESPONSES BASED ON STAFF GROUPS		Comparator (Organisation Overall)	Add Prof Scientific and Technic	Add. Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Medical and Dental	Nursing and Midwifery Registered
Q	Description	n = 616	n = 49	n = 90	n = 211	n = 35	n = 26	n = 72	n = 126
Q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	64%	60%	73%	84%	56%	52%	59%	34%
Q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	43%	40%	54%	40%	29%	77%	24%	48%
Q11a	Organisation definitely takes positive action on health & well-being	41%	31%	36%	44%	61%	44%	29%	45%
Q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	69%	67%	64%	73%	76%	71%	63%	66%
Q11c	In last 12 months, have not felt unwell due to work related stress	61%	55%	64%	62%	62%	58%	65%	60%
Q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	59%	61%	47%	59%	71%	35%	75%	60%
Q11e	Not felt pressure from manager to come to work when not feeling well enough	71%	53%	63%	75%	*	73%	65%	78%
Q11f	Not felt pressure from colleagues to come to work when not feeling well enough	75%	53%	73%	86%	*	55%	76%	74%
Q11g	Not put myself under pressure to come to work when not feeling well enough	7%	6%	10%	4%	*	18%	0%	11%
Q12a	Not experienced physical violence from patients/service users, their relatives or other members of the public	96%	88%	94%	99%	100%	100%	96%	95%
Q12b	Not experienced physical violence from managers	99%	100%	100%	100%	100%	96%	100%	98%
Q12c	Not experienced physical violence from other colleagues	98%	100%	99%	100%	100%	96%	100%	94%
Q12d	Last experience of physical violence reported	55%	*	*	*	*	*	*	*
Q13a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	84%	83%	84%	88%	84%	88%	85%	76%
Q13b	Not experienced harassment, bullying or abuse from managers	88%	84%	89%	89%	94%	87%	82%	89%
Q13c	Not experienced harassment, bullying or abuse from other colleagues	81%	78%	75%	85%	100%	70%	83%	78%
Q13d	Last experience of harassment/bullying/abuse reported	52%	29%	75%	52%	*	*	43%	58%
Q14	Organisation acts fairly: career progression	86%	83%	82%	87%	95%	76%	82%	90%
Q15a	Not experienced discrimination from patients/service users, their relatives or other members of the public	96%	98%	97%	100%	94%	96%	88%	95%
Q15b	Not experienced discrimination from manager/team leader or other colleagues	92%	92%	92%	93%	100%	79%	88%	92%
Q16a	Organisation treats staff involved in errors/near misses/incidents fairly	60%	56%	52%	55%	79%	58%	57%	69%
Q16b	Organisation encourages reporting of errors/near misses/incidents	90%	98%	91%	88%	88%	82%	87%	96%
Q16c	Organisation takes action to ensure errors/near misses/incidents are not repeated	73%	71%	76%	65%	81%	56%	75%	82%
Q16d	Staff given feedback about changes made in response to reported errors/near misses/incidents	54%	58%	53%	42%	78%	42%	61%	62%
Q17a	Know how to report unsafe clinical practice	98%	98%	99%	96%	100%	89%	98%	100%
Q17b	Would feel secure raising concerns about unsafe clinical practice	77%	84%	76%	71%	91%	64%	87%	78%
Q17c	Would feel confident that organisation would address concerns about unsafe clinical practice	64%	69%	64%	61%	84%	45%	66%	64%
Q18a	Care of patients/service users is organisation's top priority	87%	90%	91%	86%	94%	85%	84%	87%
Q18b	Organisation acts on concerns raised by patients/service users	81%	82%	86%	75%	88%	67%	88%	84%
Q18c	Would recommend organisation as place to work	71%	67%	62%	69%	91%	60%	78%	78%
Q18d	If friend/relative needed treatment would be happy with standard of care provided by organisation	94%	92%	91%	97%	97%	84%	94%	92%
Q18e	Feel safe in my work.	88%	84%	81%	91%	91%	80%	93%	88%
Q18f	Feel safe to speak up about anything that concerns me in this organisation.	72%	80%	68%	67%	88%	64%	78%	73%
Q19a	I don't often think about leaving this organisation	52%	44%	56%	51%	58%	52%	59%	52%
Q19b	I am unlikely to look for a job at a new organisation in the next 12 months	59%	60%	63%	53%	58%	63%	69%	61%
Q19c	I am not planning on leaving this organisation.	65%	63%	69%	60%	82%	58%	71%	65%
Q26b	Disability: organisation made adequate adjustment(s) to enable me to carry out work	82%	*	81%	81%	*	*	*	*

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/05/2021	**Agenda reference:**	**80-21**		
Report title:	**QVH governor representative roles**				
Sponsor:	Clare Pirie, director of communications and corporate affairs (Company Secretary)				
Author:	Clare Pirie, director of communications and corporate affairs				
Appendices:	A: Board level engagement agreement B: NHS Providers: Governors attending board committees, July 2018 report				
Executive summary					
Purpose of report:	Through council of governors meetings QVH fully delivers the requirements for governors to hold NEDs to account. In addition, the Trust currently has in place arrangements for governors to observe Board sub-committees. This report reviews the current arrangement and asks the Board to consider whether it should continue.				
Summary of key issues	• Statement from NHS Providers: *in terms of what constitutes good practice we have a clear view that board committees should not be open to governors* • QVH has an agenda structure for the council of governors that facilitates governors to hold NEDs to account within the council of governor meetings • Advantages and disadvantages of the QVH governor representative roles are set out for consideration				
Recommendation:	The Board is asked to • **NOTE** that QVH fully delivers the requirements for governors to hold NEDs to account without the need for governors observing sub-committees • **AGREE** whether or not to continue to invite governor representatives to attend sub-committees of the Board				
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 – QVH meets regulatory requirements and guidance through council of governor meetings				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		

Report to:	Board Directors
Agenda item:	80-21
Date of meeting:	06 May 2021
Report from:	Clare Pirie, director of communications and corporate affairs (Company Secretary)
Report author:	Clare Pirie, director of communications and corporate affairs
Date of report:	29 April 2021
Appendices:	A: Board level engagement agreement B: NHS Providers: Governors attending board committees, July 2018 report

QVH governor representative roles

Current situation

The governor representative arrangement, with a governor attending each of the three sub-committees of the Board, was last reviewed in July 2018 through the well-led review described below.

Governor representative roles were established as a means of engagement between governors and the Board, and have previously been described by the Trust as playing an important part in enabling governors to carry out their duty to hold non-executive directors (NEDs) to account for the performance of the Board.

As stated in previous reviews of the role, all governor representative positions are by invitation of the Board and are not defined or protected by statute. Neither are they defined in the NHS FT Code of Governance nor the Trust's constitution. The Trust should continue to review the effectiveness of this model in the context of routine annual effectiveness reviews, periodic independent reviews, and as required by the NHS Improvement well-led framework for governance reviews.

Well-led review, 2018 report

In 2018 the QVH external well-led review recommended that the Trust should review the role of governors on committees. This report was prepared after extensive review of documents, meeting with a governor focus group, observation of council of governors meeting, observation of quality and governance sub-committee and finance and performance sub-committee.

Good practice was highlighted in relation to governors as follows:

- The structure of the agenda of the Council of Governors helps embed their understanding of their role, which was observed in practice.

- Review of documentation and observations demonstrate that Governors are enabled to hold the non-executive directors individually and collectively to account for the performance of the board and to represent the interests of NHS foundation trust members and of the public.

The report also stated:

- We note the current practice of Governors sitting on, and actively contributing to, committees. We feel that such contribution can lead to a confusion of roles and possible conflict of interest in the Governors' role of holding NEDs to account for their performance.

At the time of the review the Trust view was that governor representatives on sub-committees promoted governor engagement, in a context of motivated and supportive governors. Action was taken to ensure the minutes of meetings and terms of reference were clear about the status of governors as observers. The Board level engagement agreement (Appendix A) was revised as follows:

- Section 3.3: *Governors may be invited to give their views at a committee meeting, and are welcome to ask questions of clarification. However, they should not be considered as partners in debate and challenge, and are reminded that they do not share the duties, powers and liabilities of directors.*

- Section 4.1: Reference to 'actively engaging in debate and challenge' removed and amended to read *Giving their views when invited to do so and to ask questions of clarification as appropriate*

Best practice and current position of other FTs
In July 2018 NHS Providers published a report (Appendix B) stating:

"*Foundation trusts are free to allow whoever they choose to attend their board committees and we would not in any way wish to infringe up this freedom. However in terms of what constitutes good practice we have a clear view that board committees should not be open to governors. Governors do have the right to attend the open session at board meetings. However the forum at which governors should interact with NEDs and examine the performance of the board is the meeting of the council of governors*."

In April 2021 the question of governor representatives at Board sub-committees was raised within the NHS Company Secretary network with almost 30 trusts contributing views. An almost equal number of these trusts currently have/do not have governor observers at board committees.

Four of those with governor reps currently commented that it is problematic, with challenges including governors becoming too close to operational teams, the added time needed to ensure observers understand the matters discussed, additional time taken for committee chairs or trust staff to agree with governor what can and cannot be shared with the wider council of governors, and confidentiality issues.

Of the trusts which do not currently have governor reps, four used to have them and removed them for reasons including governors seeking assurance at an operational level, executives and NEDs feeling unable to have fully open discussions while being observed, the difficulty of acting on any breach of confidentiality.

Discussion included introducing sub-committee updates from NEDs in council of governors meetings so that governors can appropriately hold NEDs to account; this is already a core part of QVH governance. There was also discussion of introducing an additional signed confidentiality agreement for any observer role. It was generally noted that the NHS Providers document (see above) set out best practice.

Requirement for the council of governors to hold NEDs to account
Your Statutory Duties, 2013 guide for governors summarises the role of governors in holding NEDs to account as follows; "holding the non-executive directors to account requires governors to scrutinise how well the board is working, challenge the board in respect of its effectiveness, and ask the board to demonstrate that it has sufficient

quality assurance in respect of the overall performance of the trust.
This is likely to involve questioning non-executive directors about the performance of the board and of the trust and making sure to represent the interests of the trust's members and of the public in doing so. In performing this duty, governors should keep in mind that the board of directors continues to bear ultimate responsibility for the trust's strategic planning and performance."

Specific suggested ways of doing this include:

- Receive the quality report and accounts and question the non-executives on their content. Ask about the CQC's judgements on the quality of care provided by the trust.
- Receive in-year information updates from the board of directors and question the non-executives on their content, including the performance of the trust against the goals of the forward plan.
- Invite the chief executive or other executive and non-executive directors to attend council of governors meetings as appropriate and use these opportunities to ask them questions.

These are all ways that QVH governors currently carry out their duties, and will remain in place ensuring governors remain able to fulfil their statutory role whether or not the Board decides to retain governor representatives observing Board sub-committees.

As noted in the well-led review and in discussion with other trusts, QVH already has an agenda structure for the council of governors that facilitates governors to hold NEDs to account within the council of governor meetings.

To date the governors elected in winter 2020/21 have only attended one public council of governors meeting and due to other issues raised were not able to work through the usual agenda.

QVH governor representative system

Advantages

- Enables governors to see NEDs at work and thus more fully discharge their responsibilities around holding NEDs to account.
- Engages governors in the work of the organisation.
- May build trust and relationships between governors and members of the Board.
- May foster closer working relationships between governors and NEDs.
- Governor representatives submit a report to all governors on the degree to which they see the NEDs securing assurance on matters of performance, the degree of detail and assurance taken from papers submitted and the scope of the agenda; this may facilitate more focussed questioning at council of governor meetings.
- Governor representatives are able to give assurance to the wider council on matters which for reasons of patient or commercial confidentiality may not be in the public domain.

Disadvantages

- An interest in "seeing NEDs in action" may lead to misunderstanding of the governor role, which is not to assess performance of NEDs in sub-committees but to form a view on the performance of the board of directors and to hold the NEDs to account for this performance.

- The primary function of board committees is to help the board obtain assurance. The presence of an observer may change the nature of the discussion, and could lead to restraint in challenge and less robust assurance.
- It is not the role of governors to engage in operational decision making; "the council should not seek to become involved in running the trust" (*Your Statutory Duties*, 2013).
- Observer status leads to quasi membership of the committee, with governors asking questions and making comments in committee meetings, which may impact on the ability of governors to carry out their accountability role.
- Governors have a joint, not singular, responsibility. That some individual governors are privy to sensitive information which they cannot share with fellow governors can be divisive, and is a concern reflected in recent comments from newer governors about the lead governor.
- The anti-merger campaign has named individual Board members and suggested mismanagement. It would be difficult to engage fully in the work done in sub-committee and the difficult decisions that need to be discussed, while aware of this potential level of personal reputational risk.
- Sub-committee meetings consider information not in the public domain. There is not currently a confident shared understanding of confidentiality. Additional assurances may be sought in this matter, whilst recognising it would be burdensome for the Trust to monitor whether this is successful.

Governor steering group

The current governor steering group, which is responsible for supporting and facilitating the work of the Council of Governors through forward planning and helping to set agendas for council meetings, is currently made up of governor representatives as well as the lead governor and chair of the appointments committee. An alternative way of selecting governors for this group would need to be established if the governor representative model comes to an end. The views of council would be sought on this; one option would be for council members to directly elect governors to the steering group.

Recommendation

The Board is asked to

- **NOTE** that QVH fully delivers the requirements for governors to hold NEDs to account, as described above, without the need for governors observing sub-committees
- **AGREE** whether or not to continue to invite governor representatives to attend sub-committees of the Board

Board-level governance: engagement with governors

1. Status

1.1. The principles of engagement between governor representatives and the Trust's board-level structures and mechanisms were agreed by both the Council of Governors and Board of Directors in 2016 and are reviewed annually. This document has been updated to include the process which has been in place for a number of years for appointment of the lead governor and governor representatives.

2. Background

2.1. **Lead governor** – When FTs were originally set up, the regulator asked all NHS foundation trusts to nominate a lead governor to act as a contact between themselves and Council. The role of lead governor does not assume greater power or responsibility than other governors; it is the council of governors as a whole which has the responsibilities and powers in statute, and not any individual governor. At QVH it has been our practice for the lead governor to also be the governor representative to the Board and we have developed a role description to reflect this.

2.2. **Governor representatives to sub-committees of the Board** - QVH extended this practice to establish governor representatives to the main committees of the Board, who are elected to the role by the Council of Governors.

2.3. The role of governor representatives, pioneered by QVH, is appreciated by the Trust as an established and effective means of open and honest engagement between governors and the Board.

2.4. Since the Health and Social Care Act 2012, the governor representative roles have become particularly significant as they play an important part in governors' duty to hold non-executive directors (NEDs) to account for the performance of the Board.

2.5. The roles foster closer working relationships between governors and NEDs and provide more opportunities for governors to see NEDs at work on a regular basis. As a result, governors are better able to appraise the performance of the NEDs and hold them to account.

3. Guiding principles of engagement

3.1. All governor representative positions are available by invitation of the Board of Directors and are not defined or protected by statute. Neither are they defined in the NHS FT *Code of Governance* nor the Trust's constitution, (with the exception of the Lead Governor role).

3.2. The Trust is committed to its governor representative model and will continue to review its effectiveness in the context of routine annual effectiveness reviews, periodic independent reviews as required by the NHS improvement *Well-Led Framework for Governance Reviews* or any other circumstances that make it necessary to do so.

3.3. Governor representatives to the Board of Directors and its committees may be invited to give their views at a committee meeting, and are welcome to ask questions of clarification. However, they should not be considered as partners in debate and challenge, and are reminded that they do not share the duties, powers and liabilities of directors.

3.4. Governor representatives must observe and maintain confidentiality as directed by the Board of Directors. This will include information that may not be disclosed to other governors and/or to trust staff, foundation trust members and members of the public and press. Advice and support regarding confidentiality can be sought at any time from the Trust Chair/ committee chair(s) and corporate affairs team.

3.5. Governor representative roles are a significant commitment for individual governors who volunteer their time and expertise. Therefore:

3.5.1. The Chair should consider, when requested, opportunities for governors to share roles, establish deputies and shadow one-another as a means to share responsibilities and plan for succession.

3.5.2. The Council of Governors should support individual governors to fulfil their duties as representatives and encourage all governors to understand and engage with the representative roles and consider themselves for nomination.

3.5.3. Governors who nominate themselves for governor representative roles should be able to commit to prepare for and attend routine meetings and to engage with fellow governors to represent them and provide feedback.

3.5.4. When requesting additional support from governor representatives, the Trust Chair, committee chairs and the executive and corporate affairs teams should be mindful of the significant commitments inherent in the role and keep additional requests clear and focused.

3.5.5. Methods to help representatives to feedback to governor colleagues will be facilitated by the corporate affairs team and include less formal methods such as the 'Governor Monthly Update' bulletin and formal methods such as reports to Council meetings.

4. Engagement with the Board: principles for governor representatives

4.1. Governor representatives are expected to engage with the Board according to the following principles:

- By committing to the role for the appointed term and attending as many routine meetings of the Board/sub-committee as possible.
- Giving their views when invited to do so and to ask questions of clarification as appropriate.
- Acting professionally, collaboratively and in a way which is consistent with the Trust's values and the Council of Governors' code of conduct.

5. Engagement with the Council: principles for governor representatives

5.1. Governor representatives are expected to engage with the Council according to the following principles:

- By representing the interests of the Council of Governors and members of the Trust faithfully and proportionately

- Feeding back to governor colleagues openly, honestly and regularly to:
  - Inform them of important decisions and developments.
  - Complete the loop of information on matters governors have raised with them as their representatives.
  - Share observations about the effectiveness of the Board and its sub-committees and the performance of the non-executive directors and the Board in order to inform the Council's statutory duties.

6. Engagement with governor representatives: principles for the Board

6.1. The Board of Directors, particularly the Chair and non-executive directors, is expected to engage with governor representatives according to the following principles:

- By engaging openly and honestly.
- Chairing meetings and / or participating in them in ways which are inclusive of and respectful to lay representatives.
- Including governor representatives in all aspects of Board/committee work including Board/committee development and informal or seminar meetings. Exclusion of the governor representative should be by exception.
- Encouraging and supporting governor representatives to share feedback with the Council on the effectiveness of the Board and its sub-committees and the performance of non-executive directors.

7. Process of appointing governor representatives and appointments committee members

7.1. Appointments are for a twelve-month period, from the date of appointment.
7.2. Governors who hold any of these roles can nominate themselves again if they wish to continue in role
7.3. Where more than one governor is nominated for a role all governors, including those due to stand down, will be able to vote. Voting will be organised by the deputy company secretary and will take place by email. Nominees can, if they wish, provide a written statement.
7.4. Newly elected / appointed governors are not considered for the governor representative roles in their first year, but can be elected to the appointments committee.
7.5. There are no formal prerequisites for any of the roles apart from time commitment.

8. Process of appointing the Lead Governor

8.1. This role is the governor representative to the Board, facilitating communication and decision making at a strategic level and ensuring integrated and effective governance. The role description was last reviewed and approved by Council of Governors at its meeting on 19 January 2017* (Appendix 1).
8.2. This role can only be filled by a public governor, not a staff or stakeholder governor. Newly elected / appointed governors are not considered for the lead governor role in their first year.

8.3. This position is reviewed annually, at the time of election of governor representatives to Board sub-committees and the appointments committee. Governors with at least one year's experience are invited to nominate themselves to be considered for this role.

8.4. The Chair will speak to any governor on an individual basis who puts him/herself forward for the role of Lead Governor, and make a recommendation for approval to the Council of Governors.

9. Review

9.1. This document shall be reviewed by the Council of Governors and Board of Directors annually or more frequently if necessary.

10. Proposed variation to reflect the exceptional circumstances in 2021 only

10.1. From February 2021 we will have an unusually small number of public governors with one year's experience as a governor, as required to fill the governor representative roles. It is proposed that for the June 2021 elections, the requirement for a year's service is waived for the governor representative roles. This means the new public governors joining in February 2021 would be eligible to nominate themselves for election to these roles. The roles of lead governor and chair of appointments committee would retain the requirement for one year's service to maintain the level of understanding and experience needed.

10.2. This proposed waiver is for the June elections only; the expectation is that there will be sufficient more experienced governors at any future governor representative elections.

10.3. Should any of the current governor representatives not be re-elected as governors in January 2021, the process of election to those governor representative roles will take place immediately ensuring governor representation at committees through to end of June 2021.

Appendix B: QVH BoD May 2021

Governors attending board committees

We are aware that it is the practice in some foundation trusts to allow governors to attend and sometimes to participate in the work of board committees. Other foundation trusts hold the line that board committees should be for their board members only to attend with employees who are not on the committee being present only for the item they are involved with.

We are frequently asked what foundation trusts should do when faced with requests from governors to attend board committees. Foundation trusts are free to allow whoever they choose to attend their board committees and we would not in any way wish to infringe up this freedom. However in terms of what constitutes good practice we have a clear view that board committees should not be open to governors. Governors do have the right to attend the open session at board meetings. However the forum at which governors should interact with NEDs and examine the performance of the board is the meeting of the council of governors.

The rationale that governors often put forward for attending committees is that they need to see NEDs in action in order to hold them to account for the performance for the board. We believe this is based on a misunderstanding of the governors' role. It is not the governor role to assess how good their NEDs are, though chairs may ask governors to play a part in NED appraisals. It is the governor role to form a view on the performance of the board of directors and to hold the NEDs to account for this performance, so it is the board's performance not the NEDs' performance with which governors need to concern themselves, so there is no need for governors to 'see NEDs in action' at board committees for them to carry out their accountability function.

This in itself may not be sufficient reason for denying governors the right to observe at board committees. One needs to go into the reason that board committees exist to understand why their needs to be private space for committees to carry out their role. The primary function of board committees is to help the board obtain assurance. They are the fora where NEDs carry out their challenge function in detail. They are, in the words of a former chair, where NEDs and executives 'go eyeball to eyeball' and have sometimes difficult and uncomfortable discussions on performance, the implementation of strategy and the viability of plans for the future. We would argue that an element

of privacy is absolutely necessary if these discussions are to be sufficiently robust, while being contained within the confines of the committee room, with harmonious relationships being maintained once the meeting is over. The presence of an audience is likely to make this much more difficult and may lead to restraint in challenge and the assurance sought by the committee not being as robust as it might have been.

The second significant reason why inviting governors to observe meetings should be treated with caution is that attendance has the tendency to morph over time, particularly when the parties in question know one another. So attendance becomes attendance plus a question and answer session; which becomes asking questions during the course of the meeting; which then becomes governors being quasi members of the committee. This not only has the probable effect of impairing the impact of challenge and the committee obtaining proper assurance. It also has an impact on the ability of governors to carry out their accountability role. How can governors form an independent view on the performance of the board when they have been party to at least an element of board decision making? Furthermore for foundation trusts the law is clear that board committees must be populated by board directors and only board directors in dealing with delegations from the board.

In practice foundations trusts make all sorts of arrangements work for them. But the fact that governors may wish to involve themselves in an area of activity, however well meaning they may be, should not be sufficient reason for them to do so. It is what adds value and does not detract from the organisation's work that counts So, for the reasons we give above, we advise a clear separation between the role of the board and that of the council of governors, with the meeting of the council being where governors hold the NEDS to account for the performance of the board and for board committees to remain meetings of board members.

Contact: Name Person, Does This Job name.person@nhsproviders.org

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	06/05/2021		**Agenda reference:**	81-21	
Report title:	**NHS Provider Licence Conditions**				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Authors:	• Clare Pirie, Director of communications and corporate affairs • Michelle Miles, Director of finance and performance • Hilary Saunders, Deputy company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	The Board is required to self-certify that it is assured that it has complied with the NHS Provider Licence and NHS Acts, and has had regard to the NHS Constitution.				
Summary of key issues	The Board is asked to **CONFIRM** that: • It has complied with the NHS provider licence condition • It has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • It has complied with required governance arrangements (Condition FT4(8)) • It has a reasonable expectation that required resources will be available to deliver the designated Commissioner Requested Services (Condition CoS7(3) over the next financial year but specific factors may cast may doubt on this				
Recommendation:	The Board is asked to **approve** the Trust's self-certification statement				
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:	• NHS Provider Licence • NHS Acts • NHS Constitution.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
Next steps:	Publication of self-certification statement to QVH website • G6/CoS7 before 31 May 2021 • FT4 before 30 June 2021				

Report to:	Board of Directors
Meeting date:	06 May 2021
Reference number:	81-21
Report from:	Clare Pirie, Director of communications and corporate affairs
Authors:	Clare Pirie, Director of communications and corporate affairs Michelle Miles, Director of finance and performance Hilary Saunders, Deputy Company secretary
Appendices:	N/A
Report date:	28 April 2021

Self-certification of NHS Provider licence conditions

1. Introduction

NHSEI requires trusts to consider and self-certify whether or not they have:

- complied with the NHS provider licence condition
- taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
- complied with required governance arrangements (Condition FT4(8))
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3))

These self-certifications need to be made by 31 May for Condition G6(3) and 30 June for Condition FT4(8).

It is up to providers how they carry out this process. Any process should ensure that the provider's board understands clearly whether or not the provider can confirm compliance.

2. Requirements for compliance

The standard NHS licence conditions can be found online here and cover essential requirements such as registration with the Care Quality Commission, financial reporting and good governance processes.

Condition G6 requires NHS foundation trusts to have processes and systems that identify risks to compliance, and to take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

Condition FT4 requires that NHS foundation trusts certify compliance with required governance standards and objectives.

3. Evidence of compliance

Evidence to support Trust compliance with the above conditions includes:

- Board Reports include accurate, comprehensive, timely and up to date information to support decision-making and consideration of issues

- Regular sub-committee meetings covering quality, performance, finance and workforce monitor compliance against relevant legal and regulatory requirements and include consideration of risks and issues
- The Board Assurance Framework identifies risks against the delivery of the Trust's strategic objectives
- Most recent CQC inspection report and well-led inspection report
- The Trust's underlying deficit is well understood by regulators and commissioners, and the Trust is engaged in system working to secure the long-term sustainable future of QVH.

Providers must also review whether their governors have received enough training and guidance to carry out their roles. There is no set requirement for this, it is left to the discretion of the trust how this is delivered.

The agenda of council of governor meetings is designed to support governors in fulfilling their duties; *Governors' Monthly Update* publication for governors and the AGM/AMM also contribute to this.

Elections in the winter of 2020/21 brought 17 new governors into the QVH council of governors, all of whom were briefed on the role of the governor and given information about the Trust in both pre-election events and post-election induction, and given a comprehensive pack of guidance, standing orders and other information related to the governor role. An additional briefing for all governors in March 2021 covered the relationship between Board of Directors and Council of Governors and the role of the governor; business conducted at the previous council meeting; governor responsibilities in terms of confidentiality, media and social media policies, and representing the interests of members and the public; the role of the governor in significant transactions. In April 2021 the head of policy and strategy for NHS Providers kindly attended a virtual seminar to brief governors on the NHS landscape; Christian Dingwall, Partner Browne Jacobson covered the role and duties of governors in statutory transactions and the QVH burns lead gave an update on plans for the burns service. Council also received a presentation by the Chief Executive which outlined 2021/22 priorities and operational planning guidance, support for staff, the covid vaccination programme and system-wide plans for service recovery.

4. Commissioner requested services

Condition CoS7 only applies to NHS foundation trusts designated as providing commissioner requested services; this includes QVH. Commissioner requested services are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHS Improvement.

Providers can be designated as providing commissioner requested services because there is no alternative provider close enough; removing the services would increase health inequalities or removing the services would make other related services unviable.

QVH is commissioned by NHS England to provide the following specialised services which have commissioner requested service designation:

Trauma and Head

- D/06/S/a Specialised Burns Care
- D/10/S/a Specialised Orthopaedics (Adult)
- D/12/S/a Specialised Ophthalmology (Adult)
- D/12/S/b Specialised Ophthalmology (Paediatrics)

Women and Children

- E/02/S/a Paediatric Surgery: Surgery (and Surgical Pathology, Anaesthesia and Pain)

The template requires the Trust to select 'confirmed' for one of three declarations about the resources required to provide these designated services:

a) the required resources will be available over the next financial year
b) the required resources will be available over the next financial year but specific factors may cast may doubt on this
c) the required resources will not be available over the next financial year.

Required resources include: management resources, financial resources and facilities, personnel, physical and other assets. Only one declaration should be confirmed with the reasons for the chosen declaration in the free text box provided.

The Director of Finance has recommended that QVH should confirm option b, that is that the required resources will be available over the next financial year but specific factors may cast may doubt on this. The reason for this is that the QVH burns service does not meet the national specification and the trust has a significant underlying deficit; both these factors are well understood by commissioners and regulators.

5. Recommendation

The Board is asked to **CONFIRM** that:

4.1 It has complied with the NHS provider licence condition

4.2 It has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))

4.3 It has complied with required governance arrangements (Condition FT4(8))

4.4 It has a reasonable expectation that required resources will be available to deliver the designated Commissioner Requested Services (Condition CoS7(3)) over the next financial year but specific factors may cast may doubt on this.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**06/05/2021**		**Agenda ref:**	**82-21**	
Report title:	Update to QVH Board of Directors effectiveness review: Q&GC self-effectiveness review and ToRs for approval				
Sponsor:	Clare Pirie, Director of communications & corporate affairs (company secretary)				
Author:	Clare Pirie, Director of communications & corporate affairs (company secretary)				
Appendices:	Quality and governance ToRs (for approval)				
Executive summary					
Purpose of report:	For the Board to be assured that the quality and governance committee evaluation process has been undertaken as part of the 2020/21 board effectiveness review. The committee terms of reference have also been reviewed and are presented for board approval.				
Summary of key issues	The quality and governance committee evaluation process was underway at the time of the March board and it was noted that an update, together with the latest copy of the committee terms of reference for approval, would be presented to the board in May.				
Recommendation:	• The board is asked to **NOTE** this report as an addition to the information contained in the March 2021 QVH Board of Directors effectiveness review report. • The Board is asked to **APPROVE** the Q&GC terms of reference for the next 12 months.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	KSO4:	KSO5:
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	*Financial sustainability*	***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	This is an addition to the information contained in the March 2021 QVH Board of Directors effectiveness review report which 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:	Quality and governance committee				
	Date:	26/04/2021	Decision:	Noted	
Next steps:	Assuming the ToRs are approved, these will be published to the QVH website and Qnet and take immediate effect.				

Report to:	Board of Directors
Meeting date:	6 May 2021
Reference no:	82-21
Report from:	Clare Pirie, Director of communications & corporate affairs (Company Secretary)
Report date:	28 April 2021

Update to QVH Board of Directors effectiveness review: Q&GC self-effectiveness review and ToRs for approval

As reported in the March 2021 *QVH Board of Directors effectiveness review*, 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. The quality and governance committee evaluation process was underway at the time of the March board and it was noted that an update, together with the latest copy of the committee terms of reference for approval, would be presented to the board in May.

The quality and governance sub-committee reviewed committee effectiveness at the April 2021 meeting, noting that the committee had also agreed recommendations to improve effectiveness through a seminar format in December 2020. The matters noted by the committee included the time needed to cover the significant agenda and that rotating the order of the agenda would support assurance; the value of commissioning 'deep dive' reviews and task and finish groups on priority matters; the offer of induction for new committee members. While infection control restrictions remain on site and 'compliance in practice' visits are not appropriate, non-executive directors are seeking additional assurance and triangulating information in other ways including attending matron's meetings and wider staff meetings.

Recommendation:

- The board are asked to **NOTE** this as an addition to the information contained in the March 2021 *QVH Board of Directors effectiveness review* report.
- The board is asked to **APPROVE** the Quality and governance terms of reference for the next 12 months.

Terms of Reference

Name of governance body

Quality & Governance (Q&G) Committee

Constitution

The Quality and Governance 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. Delegated authority includes:

- Approval of specific policies and procedures relevant to the Committee's purpose, responsibilities and duties.
- Engagement with Trust auditors in cooperation with the Audit Committee.
- Seeking information from within the Trust and commission internal or independent investigations or any activity within its terms of reference if further assurance is required, .

Purpose

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

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

In order to provide this assurance the Committee will maintain a detailed overview of:

- Health and safety
- Clinical Governance
- Information Governance (IG)
- Management of medicines and clinical devices
- Safeguarding
- Patient experience
- Infection control
- Research and development governance
- All associated policies and procedures.

To fulfil its purpose, the committee will also:

- Identify the key issues and risks requiring discussion or decision by the Board of Directors and advise on appropriate mitigating actions.
- Make recommendations to the Board about the amendment of modification of the Trust's strategic initiatives in the light of changing circumstances or issues arising from implementation.
- Work closely with the Audit and Finance & Performance committees as necessary.

Duties and Responsibilities

Duties

- Support the compilation of the Trust's annual quality accounts and recommend to the Board of Directors its submission to the Care Quality Commission.
- Approve quality priorities recommended by Clinical Governance Group for the Board of Directors.

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

Responsibilities

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

- The Trust's performance against the three domains of quality, safety, effectiveness and patient experience.
- Review all serious incident and never event root cause analysis investigations, (ideally prior to external submission) to ensure assurance about the governance of the process and the appropriateness of actions and improvements identified. If timescales do not allow this, the investigation report may be sent externally provided it has been signed off by the Clinical Governance Group and reviewed by the Chair of the Quality & Governance Committee.
- Compliance with essential professional standards, established good practice and mandatory guidance including but not restricted to:
  - Care Quality Commission national standards of quality and safety
  - National Institute for Care Excellence (NICE) guidance
  - National Audit Office (NAO) recommendations.
  - Relevant professional bodies (e.g. Royal colleges) guidance.
- Delivery of national, regional, local and specialist care quality (CQuIN) targets.

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 every two months in the calendar month before a Board business meeting. During the month where there is no formal Committee meeting, members will instead attend local governance and departmental meetings of the key business units and clinical infrastructure in order to assess the clinical governance processes in place and to gain a deeper understanding of quality in the local services and departments. Members will provide formal feedback to the Committee on their observations of these meetings.

The Committee will have an additional meeting in July to receive the annual reports from the clinical groups which report to the Committee.

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.

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.

Secretariat

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

Membership

Members with voting rights

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

- X2 non-executive directors
- Chief Executive
- Director of Nursing and Quality
- Medical Director
- Director of Finance & Performance
- Director of Operations
- Director of Workforce and Organisational Development
- X2 Head of Nursing
- Head of Risk and Patient Safety

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

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 not be a member or have voting rights:

- The secretary to the Committee (for the purposes described above)
- General managers
- Allied Health Professional lead
- Infection control lead
- Head of quality and compliance
- Patient experience lead
- Chief Pharmacist
- Director of communications & corporate affairs
- Clinical Director of Research & Innovation
- Chair of the Board
- Audit and outcomes lead
- Representative of the QVH Council of Governors
- The Trust's internal auditor
- Clinical Commissioning Group (CCG) – principle commissioner of the Trust's services.

The chair, members of the Committee and 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, the following combination of members must be present:

- Two non-executive director (incl. chair)
- Either the director of nursing or a Head of Nursing
- One other director with voting rights
- Four other members

Attendance

Members 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. A suitable deputy should be sent to cover any absence. Furthermore, members need to advise the chair in advance if they have to leave the meeting early or are planning to arrive late.

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 the behalf of the Committee member.

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 meeting 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.

Papers will be circulated to all non-executive directors to provide additional assurance.

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

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

Final and approved minutes of Committee meetings shall be circulated to the clinical cabinet and non-executive directors. The Committee chair shall provide an update to the Audit Committee.

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 2022 in anticipation of approval by the Board of Directors at its meeting in March 2022.

Definitions

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**6 May 2021**		**Agenda reference:**	**84-21**	
Report title:	**Audit Committee Assurance update**				
Sponsor:	Kevin Gould, Audit Committee Chair				
Author:	Kevin Gould, Audit Committee Chair				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide assurance to the board in relation to matters discussed at the Audit Committee meeting on 17 March 2021				
Summary of key issues	The Committee received updates on Internal Audit and Counter Fraud, as well as draft annual reports. A progress report from KPMG on the external audit was also received.				
Recommendation:	The Board is asked to **NOTE** the contents of this report.				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience* √	KSO2: *World-class clinical services* √	KSO3: *Operational excellence* √	KSO4: *Financial sustainability* √	KSO5: *Organisational excellence* √
Implications					
Board assurance framework:	Internal audit report on risk management was received				
Corporate risk register:	Internal audit report on risk management was received				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	None				

Report to: Board of Directors
Meeting date: 6 May 2021
Author: Kevin Gould, Chair
Appendices: N/A
Report date: 27 April 2021

Audit Committee report
Meeting held on 17 March 2021

1. The Committee reviewed and approved its workplan for 2021/22.

2. RSM presented an update on the Internal Audit plan. Three reports had been completed since the previous meeting:
   - Staff Retention (reasonable assurance, no High priority actions)
   - Risk Management (substantial assurance, no High priority actions)
   - Conflicts of Interest (reasonable assurance, no High priority actions)

   The Committee reviewed and discussed the outstanding management actions in some detail, focussing on those where target dates have been extended. It asked for a further, more detailed, update at the next meeting.

3. RSM presented the draft Internal Audit annual report and Head of Internal Audit opinion. This will be finalised after the year-end.

4. The Internal Audit Plan for 2021/22 was considered. This reflected the comments made by board members in advance. With some additional clarification, this was approved.

5. The Committee received a report on the progress of Counter Fraud activity and a draft annual report.

6. The Counter Fraud work plan for 2021/22 was considered and approved.

7. KPMG provided its update and progress report for the 2021/22 audit. No significant issues have been raised to date during the interim audit. As in the previous year, work on Going Concern and the VfM report will be a priority. There is a new requirement for auditors to provide a commentary on VfM which expands on the information provided in the past. The Committee will meet with KPMG to discuss this in more detail as the work progresses. The overall timetable was discussed and agreed.

8. The Committee received a report providing an overview of the single-tender waivers submitted during the financial year to date. The pandemic has provided additional challenges, such as the ability of potential new suppliers to come onsite. A more in-depth review of controls around waivers will be brought to the next meeting.

9. The Committee received and considered the annual review of Whistle Blowing arrangements.

There were no other items requiring the attention of the Board.