NHS
Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 2 September 2021

Session in public
11:00 – 13:00

MEMBERSHIP: MEETINGS OF THE BOARD OF DIRECTORS September 2021

Members (voting):

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

In full attendance (non-voting):

Director of Operations	-	Abigail Jago
Director of Communications and Corporate Affairs	-	Clare Pirie
Deputy Company Secretary (minutes)	-	Hilary Saunders
Director of Workforce (interim)	-	Lawrence Anderson
Lead governor	-	Peter Shore

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 declarations 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 operating game, HFMA Academy and coaching and training)	Chair of the Audit, Risk and Assurance Committee for one of the organisations within the MoD Non-executive member of the ARAC for Rural Payments Agency, and for Defra. Non-trustee member of Finance Risk and Audit Committee of Farm Africa Governor at Hurstpierpoint College and trustee of the Association of Governing Bodies of Independent Schools.

							Churchwarden for Parish of Buxted & Hadlow Down, trustee of Friends of St Margaret, and St Marks House School trust
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 Medical Director	MaxFacs Medical Limited	Nil	Nil	Nil	Nil	Nil	Nil
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
Lawrence Anderson 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
Lawrence Anderson 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

NHS
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Business meeting of the Board of Directors
Thursday 02 September 2021
11:00 – 13:00

Agenda: session held in public			
Welcome			
124-21	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**page**
125-21	**Patient story**	*Assurance*	-
126-21	**Draft minutes of the meeting held on 5 August 2021** *Beryl Hobson, Chair*	*approval*	1
127-21	**Matters arising and actions pending** *Beryl Hobson, Chair*	*review*	12
128-21	**Chair's report** *Beryl Hobson, Chair*	*to note*	13
129-21	**Chief executive's report** *Steve Jenkin, Chief executive*	*assurance*	16
Key strategic objective 5: organisational excellence			
130-21	**Board assurance framework** *Lawrence Anderson, Interim director of workforce and OD*	*assurance*	23
131-21	**Financial, operational and workforce performance assurance** *Paul Dillon-Robinson, Committee chair*	*assurance*	24
132-21	**Workforce monthly report, including annual workforce race equality standard and workforce disability equality standard** *Lawrence Anderson, Interim director of workforce and OD*	*assurance*	27
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
133-21	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*assurance*	39
134-21	**Financial performance** *Michelle Miles, Director of finance*	*assurance*	40
135-21	**Operational performance** *Abigail Jago, Director of operations*	*assurance*	52
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			

136-21	**Board Assurance Framework** *Nicky Reeves, interim Director of nursing, and* *Keith Altman, Medical director*	*assurance*	61
137-21	**Quality and governance assurance** *Karen Norman, Non-executive director*	*assurance*	63
138-21	**Corporate risk register (CRR)** *Nicky Reeves, interim Director of nursing*	*review*	66
139-21	**Quality and safety report** *Nicky Reeves, interim Director of nursing, and* *Keith Altman, Medical director*	*assurance*	106
140-21	**Annual reports** a) Safeguarding b) Infection, prevention & control c) Patient experience d) Emergency preparedness, resilience and response, and business continuity e) Medical Appraisal and Revalidation Annual Report f) Research and Innovation Annual Report *Nicky Reeves, interim Director of nursing* *Keith Altman, Medical director*	*to note*	139
Any other business (by application to the Chair)			
141-21	*Beryl Hobson, Chair*	*discussion*	-
Members of the public			
142-21	*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*	-
143-21	*Further to paragraph 39.1 and annex 6 of the Trust's Constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the board to discuss issues of a commercially sensitive nature.* *Beryl Hobson, Chair*	*approval*	

Document:	Minutes (Draft & Unconfirmed)	
Meeting:	**Board of Directors (session in public)** **Thursday 5 August 2021, 14:00 via videoconference**	
Present:	Beryl Hobson (BH)	Trust Chair (voting)
	Keith Altman, (KA)	Medical Director (voting)
	Lawrence Anderson (LA)	Interim Director of workforce (non-voting)
	Paul Dillon-Robinson (PD-R)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Gary Needle (GN)	Senior independent director (voting)
	Karen Norman (KN)	Non-executive director (voting)
	Steve Jenkin (SJ)	Chief executive (voting)
	Michelle Miles (MM)	Director of finance (voting)
	Nicky Reeves (NR)	Interim Director of nursing (voting)
In attendance:	Hilary Saunders (HS)	Deputy company secretary (minutes)
	Peter Shore (PS)	Lead governor
	Ian Francis (IF)	Director of clinical strategy **[item: 110-21]**
Apologies:	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
	Abigail Jago (AJ)	Director of operations (non-voting)
Members of the public:	22 members of the public	

Welcome	
93-21	**Welcome, apologies and declarations of interest** The Chair opened the meeting. There were no new declarations of interest although the Chair noted that the majority of board members would have a personal interest in item 99-21. Apologies were noted as above The Chair welcomed LA to his first meeting since being appointed interim Director of Workforce. It was assumed that covering reports and papers were taken as read. Since moving to online meetings and in order to make most efficient use of the time available, the Board now submitted questions in advance. The Chair went on to welcome those members of the public in attendance today, reminding them that as this was a meeting in public, not a public meeting they would be unable to take part in discussions. Some questions had been raised in advance and these would be addressed at the end, with responses recorded in the minutes.
Standing items	
94-21	**Patient story** The Board was advised that the patient scheduled had been unable to attend today's meeting.
95-21	**Draft minutes of the meetings held on 06 May** The minutes of the meeting held on 6 May were **approved** as a correct record, subject to the second bullet point of item 80-21 being amended to make it clear that bullying referred to was between governors.
96-21	**Matters arising and actions pending** The Board received the latest matters arising update.
97-21	**Chair's report** The Board noted the contents of the Chair's report.
98-21	**Chief executive's report** SJ opened by paying tribute to Sir Simon Stevens, the former CEO of NHSEI. He commended the appointment of Amanda Pritchard as his replacement, noting her unique skills and experience, and that she is the first woman to head up the NHS in England in its 73 year history.

	The Board received the CEO's latest report comprising overall board assurance framework, main report, dashboard and media coverage and sought additional clarification as follows: • The Trust was still awaiting confirmation as to whether the 3% pay award (including pension contribution) would be fully funded by the government. • The Sussex ICS quarterly system assurance process ran alongside NHSEI. QVH had attended the first meeting and the governance structure would develop further once the new ICS Chair and CEO had been appointed. The Trust had previously benefitted from support (from the intensive support unit, for example) which had provided reassurance of our systems and processes. • Assurance that the final memorandum of understanding being developed for the ICS framework would come to individual boards for sign off. • The Board commended the Integrated Performance Dashboard which had been updated to reflect new planning guidance around recovery. SJ noted the consistency shown across all KSOs. • The Board noted outstanding feedback regarding staff across a wide variety of roles, including the achievements of three staff set out in the report. SJ highlighted: • The remarkable work undertaken by teams as the Trust adapted as a surgical hub; • The level of Trust support provided to staff during the pandemic; • Maintenance of strong rates of staff appraisals; • Introduction of 'virtual' appointments, welcomed by patients. Areas of particular concern included: • Late referrals from other trusts and patients with long waits; whilst the number of long waiters was currently reducing it was likely to increase again in the autumn with the position exacerbated by the impact of workforce challenges. Work was underway to manage the position, and SJ expressed his thanks to the independent sector, in particular the McIndoe Surgical Centre who had worked closely with the Trust in identifying additional capacity. Noting, that the independent sector had its own challenges, SJ reminded the Board that this was a system-wide problem with challenges across the south coast. There was a likelihood that QVH would be asked to step up again as a regional cancer hub as autumn/winter approached. • Finance remained a concern, with implications around the pay award and the Elective Recovery Fund (ERF). A reminder that the efficiencies required in the second half of the year would be challenging. • The comments on social media by some of our external stakeholders which were impacting negatively on all staff who were committed to delivering compassionate care and were deserving of support. There were no further comments and the Board **noted** the contents of the update.
Strategy	
99-21	The Chair commented that whilst this might be considered the most important item on today's agenda, the work of serving our patients - as covered throughout the agenda - was actually the most important work we do. Nevertheless, she recognised that this matter was a significant decision for this Board. As outlined previously, the Board would discuss as much as possible in public, but there were some commercially sensitive elements of the strategic case, which would be reviewed in the private part of the meeting when the Board would also make a decision on the recommendations. For clarity, Board was being asked today to decide whether to continue to work to develop a full business case; this was not a final decision to merge as more detailed work would be required in the months ahead should we proceed to full business case (FBC). This work would include a proactive programme of listening to staff, patients and other key stakeholders, developing a common vision, values and culture and supporting staff of both organisations to shape the merger and the associated benefits. SJ reiterated that there was currently no operating model for QVH as part of a merged organisation; progressing to FBC stage would provide the opportunity to develop and consider this with our staff and other stakeholders. He went on to explain the rationale for his recommendation to move to the next stage of developing the FBC, highlighting in particular:

- That QVH was an excellent hospital, with dedicated and skilled staff, and patient feedback amongst the best in the country. Partners and patients had commended the level of care delivered for cancer patients through the pandemic.
- QVH is a very small organisation which brings significant challenges including issues of compliance with national specifications and bureaucracy of service agreements for services we are unable to provide ourselves. In a number of areas there is just one person who is responsible for a role in the organisation, which means work pressure and difficulties taking annual leave, as well as a lack of career progression. There is also the significant underlying financial deficit which is not a new problem; for a number of years before going into deficit in 2018/19 the Trust had relied in non-recurrent funds and accounting treatments to break even.
- The Board had continued to evaluate the benefits and risks of remaining a stand-alone organisation and concluded that it was in the best interests of patients and staff to look closely now at options for formal partnership with another organisation. QVH was already an exceptionally networked organisation. The Board had of course already thought about all its partners in this process, and had chosen to develop a strategic case with UHSussex with which QVH already had strong clinical links.
- Reassuring feedback had been received from staff who had worked at BSUH prior to the management agreement with WSHFT, noting the significant improvements in stability and leadership as a result of this.

SJ provided the following additional context around the options:

- Trust clinicians had asked the Board to include an option for clinical collaboration; this was set out in Option 3.
- That the option of 'do nothing' was not feasible because QVH was unsustainable in its current form. This option would result in continued uncertainty whilst the Board went back to square one to try to find an alternative.
- The options appraisal had been undertaken by the full executive teams of both organisations, (the process was described in the report).
- QVH clinical directors and leads will work with their equivalents at UHSx to undertake joint reviews of specific clinical services; this is based on the premise that there is work the Trust could do now to see how closer collaboration with UHSx might support fragile services. The Sussex Acute Review contributes to this, and the Trust is speaking directly with UHSx on this because QVH and UHSx are the two providers of specialist services in the area and looking to collaborate to develop a clinically sustainable model for these services. It was likely that this work would inform the FBC but also continue beyond that timescale. Should this clinically-led work propose any service change, this would of course be subject to patient engagement and public consultation.

The Chair invited all members of the Board to contribute their views and in discussion it was noted:

- That a merged organisation would provide access to the "Patient First" quality improvement programme resulting in some real improvements to patient care and experience through a proven methodology.
- That services which do not meet all elements of national standards need a long term plan to ensure patient safety, quality and experience are maintained. Commissioners are clear in their expectation that the Trust needs to have in place robust plans to address areas of non-compliance.
- Whilst some staff were understandably anxious about the negative impacts of a merger, other staff were expressing positive views regarding potential career development potential, educational opportunities and the benefits of being part of a University hospital.
- A merger would provide QVH with access to a range of specialist nursing roles which it would otherwise not be able to support; the Trust would also benefit from access to a range of support staff such as safeguarding nurses, mental capacity experts and patient experience leads.
- Risks to the organisation may be greater by not merging, particularly with regard to future provision of specialist services.
- Whilst merger itself would not necessarily resolve challenges related to delivering some clinical services on the QVH site, there was a significant cultural difference between a service level agreement (SLA) and being part of the same organisation. QVH currently has many SLAs with partner organisations, but it is far easier to call for assistance when part of the same team.
- Surpluses generated before the Trust went into deficit in 2018/19 were too small to result in meaningful reinvestment, hence current issues with backlog maintenance and IM&T.
- Investment in more recent years had included filling clinical vacancies to maintain a safe hospital and high quality care and clinical outcomes. In terms of efficiencies, a 5.5% reduction in 2023/24 would equate to a reduction of over 80 nurses (ie. 20% of the nursing establishment) which

demonstrated the scale of the challenges. Corporate service benchmarking also evidenced the high costs QVH incurs in providing its corporate functions. A merger could:

- help improve the efficiency of corporate services through greater economies of scale;
- facilitate greater clinical alignment, making services more financially sustainable;
- eliminate the need for Service Level Agreements, which are expensive and inefficient;
- facilitate access to investment for specialist services and associated research and development.

- The pandemic has shown that people don't need to be in the same place to work as a cohesive team.
- There is a very real impact on people's wellbeing if they are the only person carrying out a function; a merger would help to build a more resilient workforce and protect their wellbeing.
- UHSx has an excellent organisational development (OD) team which would work closely with our own OD team to bring together the two organisations whilst retaining specialist, skilled staff. It was also noted that whilst investing in support teams might be unpopular, our clinical teams are unable to work without them.
- The current financial position is an anomaly and future funding for QVH is uncertain with no indication that the Trust would receive more income for the same level of activity.
- The recommendation of the Strategic Case is to move to the next stage; the Board should consider today whether there is a strong argument that warrants the detailed work; if so the boards of both organisations will need to ensure that the FBC answers the more detailed questions.
- That a key responsibility of the board is to create the conditions under which staff can deliver the best possible treatment and patient care; the strategic case provides a clear explanation as to why it has been difficult to achieve this in recent years and change is needed to ensure long term sustainability for the hospital and its services.
- The preferred option presents the best possible opportunity to shape the better future that everyone wants.

The Board sought and received the following additional clarification:

- Due to the national nursing recruitment challenges we had a significant number of unfilled vacancies in theatres and our Critical Care Unit (CCU). At the time, in order to mitigate the risk the Trust had to close theatre capacity on a daily basis and cancel CCU admissions at short notice to maintain safety and quality. A decision was made to carry out a robust international recruitment campaign and a social media recruitment campaign to address these challenges; this successfully attracted a number of staff enabling us to maintain activity.
- The Trust has been clear that it is not prepared to compromise safety or quality in addressing the financial challenge. Whilst it will continue to explore every opportunity to reduce expenditure or increase income, there are no further significant untapped sources of income or cost savings.
- It is not possible to predict now what might be on the QVH site in the future. Today's decision was about proceeding to FBC not about deciding whether or not to merge; as the FBC develops the Board's role would be to ensure that the preferred option would ensure that in three years' time our patients are still receiving expert, compassionate care from highly skilled, motivated teams.
- During FBC development, consideration would be given as to whether the preferred option would help:
  - Further development and investment in services;
  - Maintain and build on QVH's record for patient experience, clinical outcomes and safety;
  - Continue to provide services to patients from the wider area currently covered (including Kent and Surrey).
  - Continue to deliver world class research and innovation;
  - Secure the future of the hospital on the East Grinstead site.
- Relationships between clinicians, executives, operational leads and clinical directors had developed and matured over the pandemic. Both clinical and non-clinical staff will be engaged in setting out clear expectations for the FBC. There was also good clinical engagement with KPMG over the acute services review. Key means of engagement will be through Hospital management team (HMT), Executive management team (EMT), Clinical Directors, Joint Local Negotiating Committee (JLNC), Joint Consultation and Negotiating Committee (JCNC) and Team Brief. East Sussex Hospital Trust, UHSx and commissioners were part of the acute collaborative network and already looking at fragile services - not just those that impact QVH. Governance would be managed through the Joint Executive Group (JEG) and Joint Oversight Group (JOG).
- Whilst not possible to put an estimate on the time invested in this process, securing the long term future of the hospital and the development of the FBC would need dedicated resources. Main costs

	to date had been consultancy costs funded by Sussex Health and Care Partnership in recognition of the need to secure a long term sustainable solution for QVH. There have also been legal costs, largely related to work with our governors, of c.£5,200 to date. The Chair stated that joining a larger organisation could provide significant opportunities including access to Patient First quality improvement, greater collaboration on research, connections to a university teaching hospital and greater development opportunities for staff. It would also enable QVH to reduce fragility in both clinical and administration services. Whilst recognising that some questions remained unanswered, approval of the strategic case today would provide a basis to work with UHSx to address some of these. The Board would move into a private session later to examine some elements in more detail and arrive at a final decision. There were no further comments and the Board **noted** the contents of the report.
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services	
100-21	**Board Assurance Framework** KA advised that following publication of board papers, an updated version of KSO2 BAF was circulated to the Board which now included reference to antibiotic prescribing. The Board was cognisant of both national and World Health Organisation (WHO) focus on improving compliance in this area. NR confirmed this was now also included as a risk on the corporate risk register but didn't appear in today's reports due to the reporting time lag. The Board expressed thanks to the Head of risk and patient safety for her work in this area.
101-21	**Quality and governance assurance** The Board received the latest Quality and governance assurance report, noting that annual quality reports would be presented for approval next month. The Board asked about the feasibility of accessing the UHSx Patient First methodology in advance of any formal merger. SJ stated that this had already been discussed at the Joint Executive Group and whilst noting that both organisations would be under considerable pressure in the coming months he agreed to follow up with Marianne Griffiths at UHSx and report back. **[Action: SJ]** The Board went on to discuss the issue of non-compliance with antibiotic prescribing, seeking assurance as to how the Trust was working to improve compliance. This would be a complex matter to resolve and require behavioural change from prescribing clinicians. A task and finish group, (chaired by the medical director) had been established to manage this; audits had identified areas of concern and a ward round check list developed which would include antibiotics/prescription checks. It was hoped that these changes would go some way to improving antimicrobial stewardship. There were no further comments and the Board **noted** the contents of the update.
102-21	**Corporate risk register (CRR)** The Board **received** the latest CRR. Additional clarification was sought in respect of two COVID related risks; ID 1218 relating to the impact of COVID on service delivery, recovery and performance and long waits, and ID 1210 relating to the adverse impact on patient experience as staff were required to isolate as a result of the increase in test and trace tracking. NR confirmed that the Trust had introduced the national risk assessment process to consider safe return to work of essential staff. There were no further comments and the Board **noted** the contents of the update.
103-21	**Quality and safety report** The Board received the latest Quality and safety report seeking examples of the measures implemented by the working group set up to consider the cluster of falls. NR advised that a number of actions were currently in progress including screening tool review, development of post fall reporting, patient education programmes and individual care plans for those considered high risk. There were no further comments and the Board **noted** the contents of the update.

104-21	**6-monthly nursing workforce review** The Chair highlighted the importance of this report which reviewed nurse staffing levels as required by the National Quality Board. The paper evidenced safe provision of care, identified vacancy rates in individual clinical areas, and benchmarked care hours per patient day against 'model hospital' data; for context this also included the potential number of retirees per clinical area. Noting that the chart of Care Hours per Patient Day showed QVH to be significantly above the national median and peers the Board sought assurance that this was the right balance of effectiveness and economy. NR explained that the chart had been designed to review a number of trusts but that QVH skewed the data because of the different number of staff/patient ratios due to our specialisms (eg. the Burns Unit operates on a high patient/nurse ratio). Moreover, QVH is unable to benefit from the usual economies of scale from ward sizes; whilst the Trust is keen to benchmark, a more meaningful comparison would be against a similar sized specialist unit. NR assured the Board that the Trust did not operate with a surplus of staff, but that there were challenges related to having small numbers of patients in multiple speciality locations meaning the Trust was unable to benefit from economies of scale. There were no further comments and the Board **noted** the contents of the update.
105-21	**Research and innovation strategy** The Board **received** the Trust's new Research and Innovation Strategy noting the high calibre of the content and major progress made; KA paid tribute to those involved in its development. The strategy had previously been considered in detail by the Quality and governance committee. The Board discussed how the Trust might encourage more patients to engage in clinical trials; it also considered how easy it would be to address some of the challenges described in the report. Dialogue with key partners would be required and a formal collaboration would help with progress. The Board also noted the benefits of working with the Brighton and Sussex Medical School. Whilst at this stage aims and objectives were largely aspirational, they were hopefully achievable. The Research and Development group would agree objectives to be monitored through the Quality and governance committee. The Board will retain oversight through regular Quality and governance assurance updates. KN confirmed that the 2019/20 data contained within the strategy would be updated in the next annual report. There were no further comments and the Board **noted** the contents of the strategy.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
106-21	**Board Assurance Framework** The board **received** the latest BAFs for KSOs 3 and 4, noting changes since the last update.
107-21	**Financial, operational and workforce performance assurance** The Board received a report from the Committee chair. Noting concerns around the required level of efficiencies in the second half of the year, the Board sought clarification as to whether there was anything that could be reasonably delivered without compromising patient or staff safety. PD-R confirmed that the Committee's focus was on what action was feasible, and that the committee would not support anything that might compromise patient safety or quality. There were no further comments and the Board **noted** the contents of the update.
108-21	**Financial performance** The Board received the latest report on financial performance noting that the Trust was still awaiting clarity around the financial regime for H2 (the second half of the financial year). It may be necessary to convene an additional F&PC meeting at the beginning of September once the Trust has a better understanding of the implications of H2 funding.

	There were no further comments and the Board **noted** the contents of the update.
109-21	**Operational performance** The Board **received** the latest operational performance report noting progress made against most of the recovery plan targets. 2-week wait performance had been affected as a result of patients choosing to delay treatment. The Board sought clarification as to what choice patients had and how this might impact on service provision. SJ explained the principles of patient choice, noting that some patients were choosing not to attend appointments as a result of COVID but also because of holiday arrangements. Consultants had oversight of individual cases and the expectation was that an alternative date would be found as soon as possible.
110-21	**Radiology PACS procurement** The Board received a report requesting authority to appoint Sectra as the PACS and VNA supplier, it was also asked to approve the project funding required for implementation. This report had been reviewed previously in depth by the Finance and performance committee. BH welcomed IF to the meeting who advised that the Trust had been part of the imaging network consortium since 2011 and today's proposal was part of a refresh. This contract was fundamental to the imaging department. The Board sought assurance that the capital and revenue funding requirements were affordable. MM confirmed this was included in this year's capital plan; the Trust would need to manage the impact of depreciation. IF added that revenue was on a pro-rata basis which reflected QVH activity. There were no further comments and the Board unanimously **approved** the business case and associated funding.
Key strategic objective 5: organisational excellence	
111-21	**Board assurance framework** The Board **noted** the contents of the BAF for KSO5.
112-21	**Workforce monthly report** The Board received the latest workforce report, noting in particular: • That KPIs continued to demonstrate workforce stability; • The slight increase in turnover and a slight increase in sickness this month compared to last month. • That appraisal rates remained at over 90%, and 12-month rolling stability at over 85%. There were no questions and the Board **noted** the contents of the update.
Governance	
113-21	**Annual review of SFIs, SOs and Scheme of Delegation** The Board undertook an annual review of the Standing Financial Instructions, Standing Orders and Reservation of Powers/Scheme of Delegation. These had previously been reviewed by the Audit committee, with changes to the Standing Financial Instructions and Reservation of Powers/Scheme of Delegation recommended. Subsequent to circulation of the reports, it was also noted that as the UK was no longer under the OJEU thresholds, the SFIs should be updated to read *World Trade Organisation Government Procurement Agreement (WTO GPA)* There were no further comments and the Board unanimously **approved** the SFIs, SOs and RoP/SoD for 2021/22.
114-21	**Motion to rescind changes to Governor Steering Group ToRs** The Board considered a motion brought by a governor to rescind changes to the Governor Steering Group (GSG) Terms of Reference (ToRs) which were proposed as part of their routine annual review. These had been approved by Council in January 2021 to reflect the work done by the GSG and the role of governors in holding NEDs to account (not advising executives).

	A public governor who had joined Council after January 2021 felt the change of wording removed an avenue of communication between the Board and Council; she had therefore brought a motion to rescind to the Council of Governors in May which was carried by majority vote. As the wording around the GSG ToRs is incorporated into the Trust Constitution any changes proposed by Council also required Board consideration. Having taken the governors' statutory role into account the paper suggested that moving back to an earlier, less relevant and inaccurate wording was not appropriate and proposed that the current ToRs remain in place to be reviewed by the GSG as part of its work programme in December 2021. The Board considered the implications of rescinding, in particular the impact on the executive team in terms of workload. The CEO reminded the Board that it was not the task of governors to 'advise the CEO' as stated in the previous version; given the particularly challenging conditions the team were working under, SJ expressed concern that this might impact on him and the executives if today's motion was supported. The Board were clear that if rescinding the ToRs today resulted in an increased burden for the Trust, this would be revisited. It was not possible to achieve consensus so the Chair asked the Board to vote. The result was tied, requiring the Chair to take the casting vote. The Chair **agreed** to support the motion; however, she reminded governors that this matter should have been managed through the standard CoG work programme set up for this purpose. This issue had created an enormous amount of additional work for the very small Corporate Affairs team and the Chair warned that the more their time was diverted in this way, the less able they would be to carry out their core work. She also recognised that the additional pressure this had created for the team was a good example of the need for the case for change, as described in the Strategic Case.
115-21	**Audit committee** The Board **noted** the contents of the report.
Any other business (by application to the Chair)	
116-21	There was none.
Members of the public	
117-21	**Questions from members of the public** **Caroline Migo, public governor:** ***'Does the board consider that there is majority support amongst QVH staff groups for the acquisition and, if so, what is the basis for this?'*** SJ responded *'the Director of Nursing gave a clear perspective on this earlier in the meeting. We will of course continue to engage with staff in the months ahead around their hopes and concerns. I believe that when BSUH and Western were looking at coming together they carried out a survey to gather those staff views and we will have a look at whether that sort of approach would be helpful at QVH.'* **Caroline Migo, public governor:** ***'Breast cancer reconstruction is one of the principle workstreams for the trust and it is one of the largest centres for this procedure in Europe. It is paid approximately £9000 for each of these procedures. Can the board explain why, for years and years, it has failed to negotiate an appropriate level of remuneration for this procedure whilst nearby units (Marsden and St Thomas') are paid 80-90% more for these procedures.*** *SJ responded: 'There are two data source that could be used for procedure costs – national tariff or reference cost. And one important factor in this may be length of stay. The national Getting It Right First Time (GIRFT) Breast Surgery Review of QVH reported on in April 2019 and states "If, for the same procedure, the Trust's reference cost value is higher than the national average then length of stay (and/or procedure/patient complexity) is likely to be the main contributor to the cost variation." The GIRFT report also states "Rather than look at individual procedure types, we suggest you consider your service as a whole". I see that this question is from a governor and we would be happy to explain this in more detail at a council of governors meeting if that would be helpful. Data shows QVH to be more efficient than the national average, with an improved length of stay. I cannot comment on London trusts commanding or*

negotiating fees almost double what we are receiving and would welcome our breast consultants being able to confirm the veracity of this'

Caroline Migo, public governor:

There are 2 other options which have not been included in the strategic case options exercise, each of which would be less disruptive, risky and wasteful of time and resources:

1. ***Fixing the recent financial problems by spending less and negotiating better remuneration.***
2. ***Change of leadership.***

Can the board explain why neither of these obvious options has been considered?

1. SJ responded: *'The issue of finances has been covered in the Board paper and discussion earlier in this meeting'.*
2. *BH responded 'No we have not considered this and neither have we had any indications from our regulators that we should consider this. In fact the CQC rated leadership as 'good' at our last inspection and stated that ''the Trust's leadership team had the skills, knowledge, experience and integrity that they needed to lead the trust…. The different levels of governance and management functioned effectively to provide assurance." In addition our performance throughout the pandemic is widely regarded as being of a very high standard'.*

John Gooderham, public member:

Will the Board consider holding a ballot of members on the merger with University Hospitals Sussex at some stage in the process?

SJ responded: 'If the two trusts proceed to develop a full business case then there will be further work including listening to the hopes and concerns of staff, patients and other key stakeholders. I believe that the trusts that came together to form UHSx carried out some kind of survey of members in that context and we may wish to look at that approach'

Roger Smith, public governor:

The Board would be regarded as having failed in the process of undertaking Due Diligence into the merger proposal if it does not undertake an independent investigation into the performance, both managerial and clinical, of the Regional Neurosciences Service previously based at Hurstwood Park, since the time of their take over by the UHS and the body preceding it, and demand and have granted full and unredacted sight of any confidential studies and reports carried out for the Brighton organisation into these services

SJ responded: *'I think this refers to an internal service move at BSUH in 2015, well before the current leadership, and which now provides the neurological expertise essential to patients who experience major trauma in the same place as the other care those patients need. As stated in the Board paper, QVH will seek assurance regarding the position of UHSussex in relation to operational performance, clinical safety, quality and finances. The purpose of this is to provide assurance that QVH staff and services would be joining a sustainable and high quality organisation. I would not expect it to include a review of a specific past service move'.*

Peter Ward Booth, public governor:

The Trust was financially in good health, profitable, for the years prior to FYE 2019. During FYE 2019 and 2020, the Trust accounts show that Trust expenditure including Staff increased by 22%, whilst in the same period income increased by about 10%. Does the Board consider that this increase in staff accounts for the recent deficit? If it does, what has been done to correct this self-imposed loss? If not where has the loss appeared from in the last couple of years?

SJ noted that this question had been covered in the Board paper and discussion earlier in this meeting.

Tim Butler, public governor

Directors of the Trust stated clearly in the recent Council of Governors meeting that if the Governors passed the motion pausing acquisition activity would prevent them from continuing to work on the merger with the risk that the hospital would be put into special measures and / or the control of the hospital could be taken away from the current management and governors. What has changed that now allows the Board to proceed

	given the motion was passed and the opinions of the Directors expressed on the 19th July? *SJ responded: 'I was clear at the council of governors meeting that we could not be bound by this motion. The suggestion of special measures was made by a governor not a Board member. The email sent to all governors after the meeting stated "We believe that acting in line with the motion would place us in dereliction of our duties as directors of the Trust. As directors we are required to 'act to promote the success of the organisation including designing and then implementing the agreed priorities, objectives and the overall strategy of the NHS Foundation Trust'. To have our hands tied for two years regarding discussions on the clinical and financial sustainability of QVH would put us in breach of this duty." I did not refer to special measures but said that doing nothing for two years would be unacceptable and that we could face intervention from NHSEI'* **Tim Butler, public governor** ***When was the Strategic Case Document completed?*** SJ: *'The document has been under development for some months, as governors are aware, and as is often the case with such documents was completed in time for the planned August meeting'*. **Tim Butler, public governor** ***Why has the Strategic Case Document not been provided to the Governors of the Trust at all?*** *SJ: 'As there are elements of the strategic case that are commercially sensitive, the full Strategic Case will be considered in private'.* **Tim Butler, public governor** ***Given the complexity of scheduling a meeting between so many senior people, when was the date of this meeting agreed by QVH Management? Specifically was this meeting date set on or before 19th July 2021?*** SJ: *There has been no secret about our Board timetable, we usually plan meetings for a full year at a time. This Board meeting has been on the schedules for several months and listed on our public website since 15 April.* **Oliver Harley, public governor** ***What measures has the board taken to control the excessive spending (22% increase) which started to occur in FYE 2019 and why hasn't 'control of spending in line with pre 2019 levels' been included in the list of options for the strategic options?*** *SJ noted that this question had been covered in the Board paper and discussion earlier in this meeting.* **Caroline Migo, public governor** ***The governors' motion to rescind the changes to the terms of reference of the GSG was passed by a majority vote. The legal definition of rescind is "The act of revoking, voiding an order, agreement, or contract to rescind something in law means to invalidate it, putting the parties back to the position as if the agreement had not existed, to start over with a clean slate, to allow the parties to return to the status quo that existed before the agreement was made. It therefore does not follow that board approval is required or valid as if it reverts back to before changes were made. Nothing has happened so no approval is necessary***. BH responded: *'In January 2021 the Council of Governors and the Board of Directors agreed to an update to the terms of reference of the governors steering group in order to properly reflect the statutory role of governors, which is also in line with what the steering group have been doing to shape council agendas etc over the past few years at least. The Trust Constitution has been updated to reflect this. As was explained in the recent CoG meeting, the governor motion would require a further change to the Constitution, so is also a matter not just for council of governor decision making but also Board review and approval.'*
118-21	**Exclusion of members of the public** Aligned to paragraph 39.1 and annex 6 of the Trust's Constitution, the Board agreed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the board to discuss issues of a commercially sensitive nature.

	There were no further comments and the Chair closed the public session of the meeting.

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**
	Aug 2021	101-21	Q&GC assurance	KSO1	Update on feasibilty of access to UHSussex Patient First methodology	**SJ**	**Sept**		**Pending**
	May 2021	75-21	CSSD procurement of outsourced service	KSO4	Additional information to be circulated prior to final decision to be deferred to May F&PC, with input from all board members.	**MM**	**End May**	Approved at May F&PC meeting at which all board members were invited to attend.	**Closed**

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/09/21**		**Agenda reference:**	**128-21**	
Report title:	**Chair's report**				
Sponsor:	Beryl Hobson, Chair				
Author:	Beryl Hobson, Chair				
Appendices:	None				
Executive summary					
Purpose of report:	Chair's valedictory report				
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:	2 September 2021
Agenda item reference no:	128-21
Report from:	Beryl Hobson, Chair
Date of report:	23 August 2021

Chair's Report

'It's not difficult to make decisions when you know what your values are'
Roy E Disney

This is my final report as Chair of QVH. I joined as Chair designate in July 2014 and became Chair in April 2015. During the last 7 years I have worked with the most amazing people across the whole hospital. I have watched complex surgical procedures and been in awe of the skills of our specialist surgeons and nurses. Every procedure I have observed has been prefaced by the comment 'you are not squeamish are you?' I am pleased to say I have never given my colleagues the pleasure of seeing me faint! The work we do really does help people rebuild their lives.

The surgeons are of course supported by a whole range of other colleagues both clinical and non-clinical. No hospital can operate without the wide range of support staff – including the people who work in the kitchens, the gardens, maintenance, the domestic team, and all the admin and business management teams. Every single person plays an important role in ensuring that our patients receive the best possible care. This is witnessed by the astonishing patient feedback we receive which is amongst the best in the country, and evidenced by our 'outstanding' for care in both our CQC reports over the last six years.

We have of course faced many challenges along the way – the older parts of our estate being the source of quite a few of them. In whatever circumstances, QVH people have risen to the occasion with their customary good cheer and got it sorted.

The main challenge has of course been the need to ensure a sustainable future for QVH. We are not currently sustainable in terms of some clinical services, financially or in terms of some of our fragile support teams. As the second smallest trust in the country, we still (rightly) have the same regulatory requirements as much larger trusts. Unlike small businesses we aren't able to determine our prices, cut our costs in certain ways or target a large share of a niche market. To think that it is that simple would be naïve. As a result I believe that the decision made by the board last month to proceed to develop a full business case for merger with University Hospitals Sussex is the right one. It will enable QVH to develop on this site, secure specialist services, and ensure development opportunities for colleagues who otherwise may feel the need to look elsewhere for career development.

I would like to thank both the CEOs I have worked with during my time here – Richard Tyler and most recently Steve Jenkin. The Chair/ CEO relationship is important for a highly functional board and organisation. I have tried to provide both challenge and support in equal measure, and I have learnt so much from both of them.

I have also enjoyed working with all my board colleagues, both executive and non-executive. I can honestly say that every single one of them has had the best interests of patients at heart, and this been the basis for our decision making. At times it has been difficult to balance competing demands, but as my favourite quote at the top of this report points out we have always focussed on our values. We have endeavoured to

make decisions in line with the Nolan principles of public life – selflessness, integrity, objectivity, accountability, openness, honesty and leadership. Above all we have ensured we put the patient at the centre of all our thinking.

I have calculated that I have probably worked with over 60 governors as Chair of the Council of Governors. On the whole these have been enjoyable experiences, with governors who have been good ambassadors for the Trust and have provided a helpful perspective and sound judgment on the Trust's performance. At the same time they have challenged us on every aspect of the board's work. I am very sad that many of the most recent governor meetings have focussed on a single issue, with little mention of patient care or staff wellbeing. This has significantly undermined the valuable role that governors can play in foundation trusts. Ironically what we have in common is our shared passion for QVH and our desire to ensure it has a sustainable future.

Finally I want to send my best wishes to my successor, Dr Peter Carter. I hope he will enjoy his time at QVH, working with some of the very best colleagues in the country.

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, 23/08/2021. KSO 3, 4 and 5 were reviewed at the Finance and Performance Committee 26/07/2021. The trust finances continue to be 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 BAFs. 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 August trust board .

	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	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	20	20	20	16
KSO 5	16	16	16	16	9

NHS
Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/09/2021**		**Agenda reference:**	**129-21**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	1) Integrated Dashboard 2) QVH media update				
Executive summary					
Purpose of report:	To update the Board on key Trust issues, and external issues that may have an impact on the Trust's ability to achieve its internal targets.				
Summary of key issues	• Strategic case approved by UHSussex and QVH Boards • QVH senior nurse leading nursing team at Paralympics • Sussex ICS shortlisted for HSJ awards				
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:	16/08/21	Decision:		
Next steps:					

CHIEF EXECUTIVE'S REPORT
SEPTEMBER 2021

TRUST ISSUES

Possible merger University Hospitals Sussex and QVH - strategic case approved

On 5 August the boards of Queen Victoria Hospital NHS Foundation Trust and University Hospitals Sussex NHS Foundation Trust agreed to work together to develop a full business case for merger. Detailed work on the operational, clinical and financial aspects of two organisations considering merger is likely to take around six months. This will provide the information needed before the boards of both organisations are asked to take a further decision on whether or not the possible merger should go ahead.

In the coming months there will be a focus on engagement with the staff of both organisations, people who use our services, our commissioners, other healthcare providers, and other stakeholders such as charities closely linked to our work. We will be explaining what merger would look like, and seeking views on what improvements we should seek to achieve and what concerns we need to address.

No changes to services are planned at this stage. We plan to jointly review specific clinical services across QVH and UHSussex where there are either opportunities to collaborate or fragilities of service to address. If in the future we develop plans to make changes for the benefit of patients, those proposals would be shaped by the expertise of our clinicians and we would also seek the views of the people who use those services before making any decisions.

Our People – congratulations to:

Kim Brinkworth

Kim Brinkworth, senior nurse on Canadian Wing, has flown out to Tokyo to take on a very special role – leading a team of nurses supporting the ParalympicsGB athletes. She is one of five nurses who are part of the sport and medicine team, working alongside doctors, physiotherapists, nutritionists, sports psychologists and other professionals. Together they are running a performance centre for GB athletes, as well as providing support at the preparation camps, in the Paralympic village and virtually via PC or phone. Kim talked before she left about the excitement and privilege of being involved and from Tokyo, as lead of Paralympic nurse team, Kim has thanked colleagues back in the UK for backfilling their work and making this possible

Samantha Hunter

Samantha Hunter, our advanced speech and language therapist, who was a case reviewer for the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Dysphagia in Parkinson's Disease study. NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children and making its results available.

Integrated Performance Dashboard Summary

Our Integrated Performance Dashboard (Appendix 1) has been slightly changed to reflect the new planning guidance around recovery plans. A revised Staff Friends and Family Test incorporating nine questions was introduced nationally from 1 July, and will be included in future dashboards.

Board Assurance Framework (BAF)

The entire BAF was reviewed at executive management meeting (16/08/2021) alongside the corporate risk register. KSO 1 and 2 were reviewed at the Quality and Governance Committee, 23/08/2021. KSO 3, 4 and 5 were reviewed 26/07/21 at the Finance and Performance Committee. Changes since the last report are shown in underlined type on the individual KSO sheets.

Media

A summary of QVH media activity (Appendix 2) during July 2021, reflecting particular interest around the appointment of Dr Peter Carter OBE, former CEO of the Royal College of Nursing, as new Chair of Queen Victoria Hospital NHS Foundation Trust from 1 October.

SUSSEX UPDATE

HSJ Awards 2021

Sussex Health and Care Partnership (SHCP) has been shortlisted for 'Integrated Care System of the Year' in this year's prestigious HSJ Awards. This is recognition for the work carried out by partners during the pandemic. In addition SHCP has also been nominated twice in the NHS Race Equality Award category for the BAME Disparity Response Programme and the BAME Locally Commissioned Service (LCS).

Sussex Integrated Care System (ICS) - Chair recruitment

A national recruitment process has been taking place over the summer months to ensure all 42 ICSs will have a chair. For Sussex interviews are due to take place over 9/10 September.

Steve Jenkin
Chief Executive

Appendix 1

Integrated Dashboard Summary
Key indictators at a glance - September 2021 (reporting M4)

Queen Victoria Hospital
NHS Foundation Trust

KSO1 Outstanding Patient Experience & KSO2 World Class Clinical Services

C-Diff	0
MRSA	0
E-coli	0
Gram-negative BSIs	0
Serious Incidents	0
Never Events	0
No of QVH deaths	0
No of off-site deaths (within 30 days)	0
Complaints	1
Closed <30 days	8
FFT	
In patients	100%
Outpatients	95%
MIU	93%
Day surgery	98%
Hand trauma	96%

KSO 3 Operational Excellence

MIU <4hrs	99.90%
RTT 18 weeks	76.08%
Cancer 2ww	97.00%
Cancer 62 day	89.30%
Diagnsotics <6weeks	90.76%
52ww	310
Recovery activity	
Day case	89.00%
Elective inpatient	89.00%
First outpatients	98.00%
Follow-up outpatients	97.00%
Outpatient therapies	113.00%
Non-elective	105.00%

Key	Improved Performance	Deteriorating Performance	Remains the same

KSO4 Financial Sustainability (YTD)

Income	29,190k
Pay expenditure	17,980k
Non-pay expenditure	10,730k
Surplus/Deficit	480k

The financial position reflects the trust internally reported position. Monthly phasing of the plan is misaligned to the Provider Finance Return (PFR), with plan alignment reached at M6.

Block regime in H1, ERF estimated income £2.2m is within the position/ The trust is awaiting agreement and confirmation on actual performance, no clawback has been assumed in the YTD position.

Guidance for H2 will be published in September. Indicative efficiency target of 3%.

KSO5 Organisational Excellence

Vacancy rate	9.89%
Turnover rate	12.20%
Sickness rate	3.04%
Appraisal rate	83.72%
MAST	92.35%
Q2 Staff FFT (work at QVH)	
Q2 Staff FFT (care at QVH)	

Queen Victoria Hospital
NHS Foundation Trust

QVH media update – July 2021

Sunglasses stop sunburn to your eyes
Samer Hamada, consultant ophthalmic surgeon and clinical director of our corneoplastics service, was quoted in a series of national media articles about eye sun safety. It follows research by the Australian Skin Cancer Foundation which found that eyes are ten times more sensitive to the sun's invisible ultraviolet (UV) rays than the skin.

The coverage, initiated by the Daily Mail and featured in its newspaper and website, quotes Samer explaining how UVB rays can damage the cornea itself, known as photokeratitis, which is like sunburn of the eye. It was also featured along with sun safety tips in The Sun; The Scottish Sun; The Irish Sun; The American Sun; and the nation.lk website.

QVH appoints new Chair
The appointment of Dr Peter Carter OBE, former CEO of the Royal College of Nursing, as new Chair of Queen Victoria Hospital NHS Foundation Trust received a series of media mentions. He will take up the role in October following the retirement of current Chair, Beryl Hobson. Publications to feature the news included the HSJ (behind paywall); Nursing Times, the Mid Sussex Times; and the Crawley Observer.

The HSJ also ran an article at the end of the month about how our council of governors has asked for activity relating a possible merger of our hospital with University Hospitals Sussex to be paused. The piece (behind the paywall) explains how the Board will continue to engage with governors around the long-term sustainability of the hospital.

COVID and the NHS
The Daily Mail ran two stories this month about the impact of COVID-19 admissions on the NHS. One article talks about admissions of over 65s being a third lower due to the COVID vaccine, and the other about the impact of a third wave. In both Queen Victoria Hospital is mentioned in relation to figures from a Public Health England report which said we were one of two trusts in England with no COVID admissions.

Representing QVH at NHS birthday celebration service
News that Kokila Ramalingam, our specialty team lead for plastic and reconstructive surgery, was chosen to attend a special event at St Paul's Cathedral to mark the NHS' birthday, was featured on the InYourArea website. Kokila joined staff from across the NHS at the event, as well as The Duke of Cambridge, NHS Chief Executive Sir Simon Stevens, NHS Medical Director Professor Stephen Powis, and England's Chief Nurse Ruth May.

Remembering Sir Archibald McIndoe
Jim Marshall, one of the few remaining members of a club for seriously burned Second World War airmen, fondly remembered pioneering surgeon Sir Archibald McIndoe who rebuilt his life – 80 years after the formation of the trailblazing society known as the Guinea Pig Club. The Club was officially

formed on 20 July 1946 at our hospital. Queen Victoria Hospital is mentioned as the place where airmen like Jim were treated.

Jim's story received a tremendous amount of coverage including ITV; The Standard; The Times; MSN news and Yahoo news (both citing the Evening Standard); The National; The Argus; Bicester Advertiser; Express and Star; Guernsey Press; Malvern Gazette; Darlington and Stockton Times; and Shropshire Star.

The piece in The National also generated a contribution to its letters page about Dick Worn who was also treated by Sir Archibald McIndoe. We are referred to as "East Grinstead".

Glaucoma awareness week

To mark glaucoma awareness week (28 June-4 July), Gok Ratnarajan, consultant ophthalmic and glaucoma surgeon, helped us create a short information video explaining what glaucoma is, the symptoms and how we are supporting our patients. We ran shorter segments of the video across our social media channels throughout the week, with the full length version available on our YouTube. It was part of a week-long takeover of our social media to raise awareness of the condition known as the silent thief of sight and the importance of early diagnosis.

Gok was also interviewed about glaucoma by West Kent Radio.

Ad hoc media

Queen Victoria Hospital was mentioned in a piece on the InYourArea website about how Crowborough's Horder Centre has been presented with a Wealden Hero Award to mark their contribution to NHS services during the pandemic.

Press releases

We issued the following press releases this month which you can read via the links below.

- QVH nurse attends special NHS commemoration service
- Dr Peter Carter appointed as new Chair of QVH

We also published the following information on our website:

- Queen Victoria Hospital NHS Foundation Trust AGM 2021
- Coronavirus information and advice for our patients and visitors – updated standing item
- Visiting patients on our wards during the COVID-19 pandemic – updated standing item
- NHS patients, staff and visitors must continue to wear face coverings in healthcare settings
- Roadworks on Holtye Road 2-9 August 2021

KSO5 – Organisational Excellence

Risk Owner: Interim Director of Workforce & OD
Date: 12th August 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, and the 2020 outcome remained stable through COVID
- 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
- Concerns regarding staff availability owing to isolation requirements

Initial Risk 3(C)x 5(L)=15, moderate
Current Risk Rating 4(C)x 4(L)=16, high
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 including monthly Workforce Establishment reconciliation
- 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 including succession 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:	**2 September 2021**		**Agenda reference:**	**131-21**	
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, by the committee chair, at an informal meeting with executive leads on 23rd August.				
Summary of key issues	Operational performance. Generally positive results to date, but challenges for the future Workforce indicators. Some increase in sickness and turnover to monitor, but generally stable, if some upward trends emerging. Financial results. Year to date looking to break-even, but based on current funding framework and assumptions.				
Recommendation:	The Board is asked to **NOTE** the contents of the report, the **ASSURANCE** (where given), and the uncertainty and challenges in the near future.				
Action required	~~Approval~~	~~Information~~	**Assurance**	**Assurance**	**Assurance**
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: x *Operational excellence*	KSO4: x *Financial sustainability*	KSO5: x *Organisational excellence*
Implications					
Board assurance framework:	KS05 – Organisational Excellence – strong indicators of successful management, but aware of critical dependencies KS04 – Financial Sustainability – short-term break-even is the result of national funding, longer-term is not resolved KS03 – Operational Excellence – risk remains high as growth in waiting lists and times				
Corporate risk register:	Reflected in BAF scores. Committee will look 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:	2 September 2021
Reference no:	131-21
Report from:	Paul Dillon-Robinson, Committee Chair
Report date:	24 August 2021

Financial, operational and workforce performance assurance

Introduction

The finance and performance committee did not meet during August, but – as chair – I met with the director of operations, director of finance and a senior member of the workforce team, using the draft board papers as background.

The paper below highlights issues that were discussed and therefore the assurance that management are aware of, and working on.

1. Operational performance

The Trust continues to make impressive progress in addressing waiting lists and seeking to work to targets; both standard national and as part of restoration and recovery. Performance figures are adversely impacted by ongoing staffing issues within the Sleep disorders team; some late referrals and patient cancellations.

Staffing issues are a critical factor in delivering operational performance. The small size of the Trust makes this difficult to manage and the pressures on the wider healthcare system do not create capacity for other trusts to support QVH staffing. Whilst there is an increase in bank (primarily) and agency staff, even these sources are limited.

Access to independent sector capacity is patchy, both in terms of availability and what activity might be most appropriate to be undertaken.

The wider Sussex system is facing operational pressures through increased A&E activity and delayed discharges.

2. Workforce performance

Whilst workforce indicators remain broadly positive, there continues to be a slight increase in sickness (long-term) and turnover indicators.

3. Financial performance

The Trust continues to forecast break-even for the first half of the year, but based on receiving £2.7m from the elective recovery fund (ERF). However, changes to the ERF requirements do not guarantee this income.

Planning for H2 is due to start in September and indications are for significant efficiencies to be required and potential block contract arrangements that are unlikely to be as generous to the Trust as those in place in H1. Cash flow may therefore become more challenging in H2.

The meeting also discussed the reduction in capital spending, as well as the need to improve the number of invoices being paid to suppliers within the better payment practice code.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02 September 2021		**Agenda reference:**	**132-21**	
Report title:	**Workforce Report: September 2021**				
Sponsor:	Lawrence Anderson, Interim Director of Workforce & Organisational Development				
Authors:	Lawrence Anderson, Interim Director of Workforce & Organisational Development				
Appendices:	NA				
Executive summary					
Purpose of report:	The Workforce and OD Report for September 2021 is provided in the format consistent with the Trust Workforce Strategy and NHS Staff Survey Themes				
Summary of key issues	• Corporate induction has recommenced on site face to face with positive feedback • Staff friends and family test was reintroduced in line with national guidance with 9 new questions linked to staff engagement • WRES and WDES returns submitted				
Recommendation:	The Board is asked to **note** the 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:	• KSO5. Trust reputation as a good employer and ensuring 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:	None				
Resources:	Managed by HR and OD with support from Finance, operations and nursing				
Assurance route					
Previously considered by:					
	Date:		Decision:	Noted	
Previously considered by:					
	Date:		Decision:		
Next steps:					

NHS
Queen Victoria Hospital
NHS Foundation Trust

Workforce and Organisational Development Report

Lawrence Anderson, Interim Director of Workforce & Organisational Development

August 2021 (July 2021 Data)

Contents

Headlines

Engagement & Communication:

- National WRES and WDES returns were reviewed by F&P and submitted on the National portals as required. The reports will be published on our website.
- Staff Friends and Family Test (SFFT) recommenced this quarter with 9 mandatory questions around staff engagement
- Regular communications sent to heads of department and all QVH staff on available development and apprenticeships

Attraction & Retention:

- Another rise in number of adverts placed with 38 in July compared to 26 in June. July shows a total of 87.08 WTE advertised.
- 30 new starters in July (a drop of 1 compared to June); the average time from conditional offer to start date was 85.83 days and this increase was due to staff absence within the resourcing team and takes into account notice periods, without notice periods the average time taken was 53.3 days for external starters and 24.69 for internal.
- Overall average time taken from when an advert was approved to a new starter in post was 86.68 days, a reduction of 32.32 (1 month) days.
- Work towards Disability Confident Leader employer status.
- Building of a network of BAME network interview panel participants.

Health & Wellbeing:

- Mental Health First Aider training programmes have been confirmed to staff virtually (Rethink) x16 and face to face (St John Ambulance) x15. Bite-size sessions for all staff will be offered in August for September/ October dates
- July's focus was getting outdoors and being active

Learning & Education:

- Overall Stat & Mand compliance is **90.29%** across QVH – slight decrease by 0.57% from last month 90.86% (includes non perm and perm staff)
- Appraisals compliance is **85.07%** across QVH – increased by 1.35% from last month 83.72%. 33 GMC and GDC registrants have Covid PDR exemptions.
- This month the new Corporate Induction programme commenced and initial feedback has been positive.
- In August Medical Education received excellent feedback and plans are in place for September and October

Talent & Leadership

- A quarterly update of the apprenticeship activity
- The Admin & Clerical programme (Skills for Success) continues to be offered across QVH

Workforce KPI Summary

Queen Victoria Hospital NHS Foundation Trust

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2020/21 & 2021/22			Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Compared to Previous Month
Establishment WTE *Note 1				1028.14	1028.14	1030.33	1030.18	1036.20	1037.20	1035.09	1042.49	1042.49	1031.34	1031.34	1032.34	**1032.34**	◄►
Staff In Post WTE				922.58	920.90	922.67	923.09	933.53	928.06	927.02	932.50	934.23	931.78	930.44	930.22	**922.66**	▼
Vacancies WTE				105.56	107.24	107.66	107.09	102.67	109.14	108.07	109.99	108.26	99.58	100.90	102.12	**109.68**	▲
Vacancies %	>12%	8%<>12%	<8%	10.27%	10.43%	10.45%	10.40%	9.91%	10.52%	10.44%	10.55%	10.38%	9.65%	9.78%	9.89%	**10.62%**	▲
Agency WTE				5.70	6.82	11.12	10.10	11.95	10.80	10.83	9.78	10.55	7.46	11.06	12.11	**12.89**	▲
Bank WTE *Note 2				47.47	59.00	57.61	64.72	66.60	65.44	76.20	66.31	87.81	64.81	64.22	72.64	**78.37**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	11.74%	11.22%	10.65%	10.05%	10.49%	10.60%	10.63%	10.25%	10.76%	11.55%	10.94%	12.20%	**13.15%**	▲
Monthly Turnover				0.75%	1.05%	0.70%	0.70%	0.84%	0.99%	1.66%	0.20%	1.45%	1.34%	0.33%	2.03%	**1.49%**	▼
12 Month Rolling Stability % *Note 3	<70%	70%<>85%	>=85%	86.25%	87.08%	89.12%	89.44%	89.11%	89.07%	88.87%	89.06%	88.91%	88.37%	87.84%	87.11%	**85.09%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	2.77%	2.68%	2.88%	2.99%	3.26%	3.20%	3.48%	2.50%	2.75%	2.49%	3.04%	3.63%	***TBC***	▲
% staff appraisal compliant (Permanent & Fixed Term staff) *Note 4	<80%	80%<>95%	>=95%	78.27%	80.86%	80.58%	80.00%	80.60%	84.03%	82.03%	83.69%	86.32%	86.50%	85.23%	83.72%	**85.17%**	▲
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 5	<80%	80%<>90%	>=90%	91.88%	92.58%	90.80%	90.82%	91.02%	91.92%	92.30%	91.47%	91.65%	92.57%	92.34%	92.35%	**91.98%**	▼

		2019-20	2020-21	
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%	**National Survey Of 572 responses: 92% : 2%**	**National Survey Of 594 responses: 94% : 2%**	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%	**National Survey Of 560 responses: 72% : 10%**	**National Survey Of 593 responses: 71% : 11%**	19-20 & 19-21 ▲Responses ▼ Likely ▲Unlikely

*Note 1 -2020/21 establishment updated in September backdated to April 20. From Finance Ledger
*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 to date has been adjusted for GMC medics who are exempt from appraisals due to Covid-19.

GOAL 1: Engagement & Communication

Queen Victoria Hospital NHS Foundation Trust

- Equality & Diversity WRES, WDES reports were submitted to the National portals at the beginning of August and the reports will be available on our website.
- Picker was procured as QVH Staff Survey provider for a further year. We are currently looking at the directorate breakdown and staff lists to send to Picker. This year it will be difficult to do a comparison against 2020 results due to significant changes to QVH business units.
- Staff friends and family test was reintroduced in for Q2 2021 with 9 new questions linked to Staff Engagement. There were 124 respondents to the survey, the results are as follows:

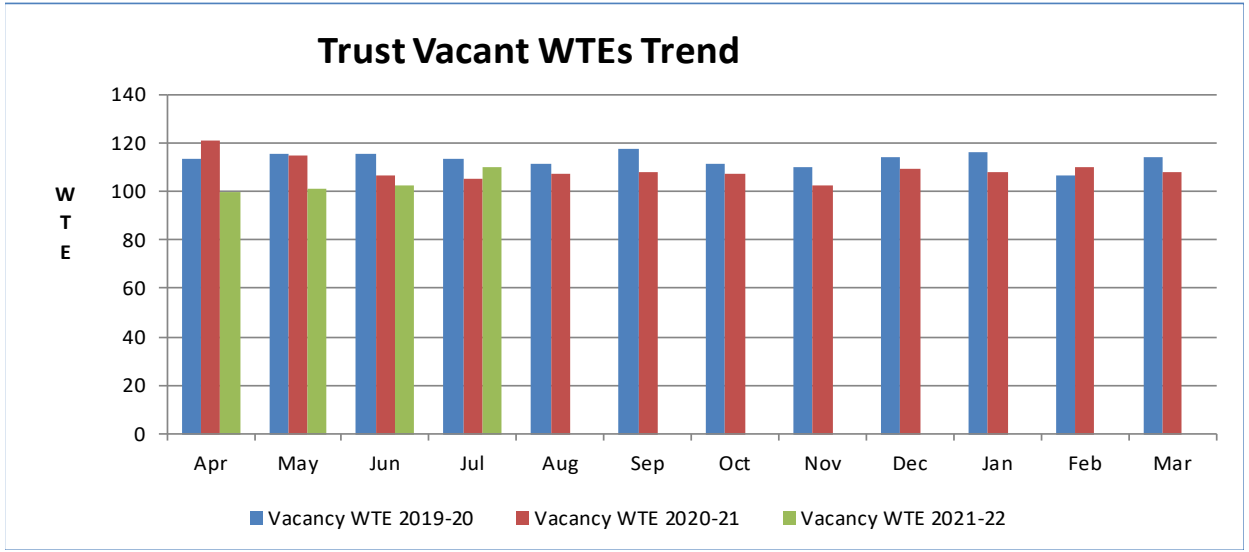
Q	Q2 2021/22 Questions and Results	Strongly Agree/Agree %	Disagree/Strongly disagree %
Q1	There are frequent opportunities for me to show initiative in my role:	62.9	23.39
Q2	I am able to make suggestions to improve the work of my team/department:	66.13	19.35
Q3	I am able to make improvements happen in my area of work:	58.06	25.8
Q4	Care of patients / service users is my organisation's top priority	87.09	4.84
Q5	I would recommend my organisation as a place to work	65.32	16.13
Q6	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	92.75	4.84
Q		**Always/Often Total**	**Rarely/Never Total**
Q7	I often/always look forward to going to work:	54.03	12.1
Q8	I am often/always enthusiastic about my job:	60.48	8.07
Q9	Time often/always passes quickly when I am working:	72.58	4.84

COMMENTARY	FORWARD LOOK / POTENTIAL RISKS
• OD&L will work with communications team in the next few months to promote the 2021 NHS Staff Survey.	• Due to increased no of questions in SFFT the completion rate from QVH staff may decrease • 2021 NHS Staff Survey findings will be difficult to compare against 2020 finding due to significant changes to QVH business unit groupings.

GOAL 2: Attraction & Retention

Vacancies

Queen Victoria Hospital NHS Foundation Trust



	Non Medical		Medical	
	Posts advertised this month	Pipeline	advertised this	Pipeline
Corporate	10.8	8	NA	NA
Eyes	2	2	2	6.83
Sleep	0	0	0	0
Plastics	0	3	5	18
Oral	1	2.2	1	5.38
Periop	8.3	8	2	2.6
Clinical Support	7.2	8.8	0	2.6
Outpatients	0.6	1.6	NA	NA
Director of Nursing	1.8	0	NA	NA
Operational Nursing	20.54	13.51	NA	NA
Community Services	0	0	0	0
QVH Trust Total	**52.24**	**47.11**	**10**	**35.41**

VACANCY PERCENTAGES	May-21	Jun-21	Jul-21	Compared to Previous Month
Corporate	9.95%	7.88%	8.40%	▲
Eyes	9.22%	15.69%	18.63%	▲
Sleep	14.10%	14.10%	14.94%	▲
Plastics	4.19%	4.61%	4.61%	◄►
Oral	1.16%	2.60%	2.70%	▲
Periop	12.58%	12.73%	13.43%	▲
Clinical Support	16.02%	15.14%	14.15%	▼
Outpatients	29.74%	29.51%	34.93%	▲
Director of Nursing	7.28%	7.28%	3.44%	▼
Operational Nursing	4.65%	5.90%	8.30%	▲
Community Services	32.33%	32.33%	35.61%	▲
QVH Trust Total	9.78%	9.89%	10.62%	▲

COMMENTARY

- Increase in Vacancy rate from June of 0.73% with highest in Community Services and Outpatients at 35.61% and 34.93% respectively.
- Highest volume of WTE recruited again in Operational Nursing at 20.54 for July.
- QVH received 426 applications in July with 111 interviewed and 47 offered.
- Our Bank recruitment continues to increase with 46 new bank workers appointed (19 of which are HCA's and 12 Admin)

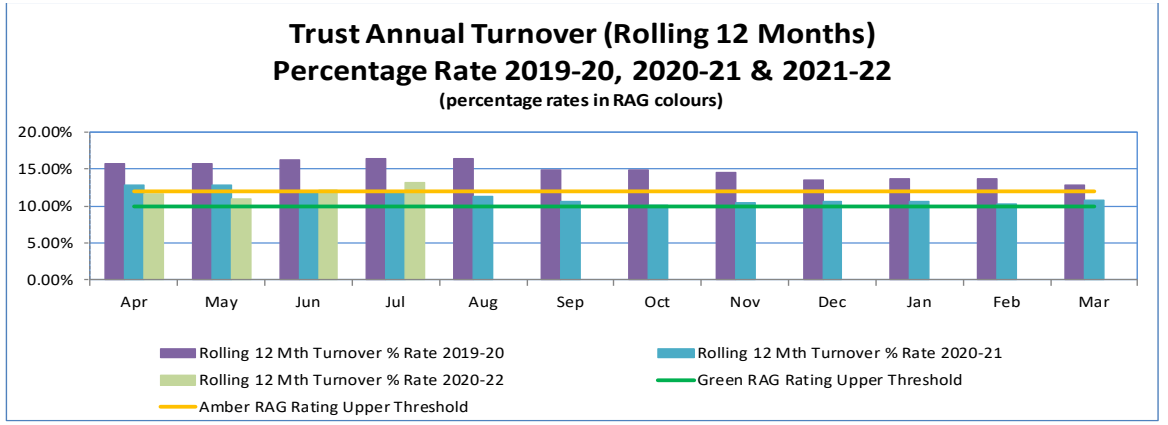
FORWARD LOOK / POTENTIAL RISKS

- Look at attracting Agency staff to move over to Bank (in line with recent work carried out at Croydon NHS)
- Review how and where we advertise hard to fill vacancies to attract from different pool of potential applicants.
- Monthly roster review meetings with managers to ensure correct and full utilisation of rostering system to reduce need for bank/agency usage

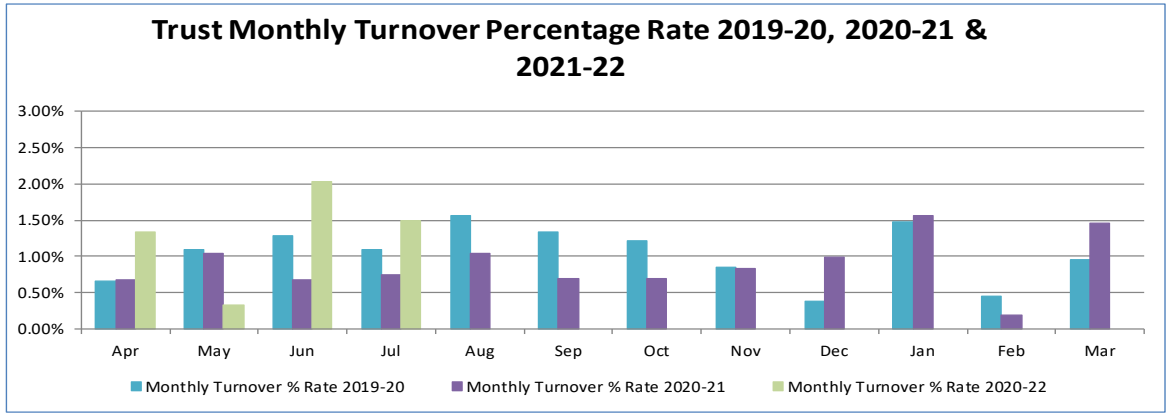
Turnover, New Hires and Leavers

Queen Victoria Hospital NHS Foundation Trust

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	May-21	Jun-21	Jul-21	Compared to Previous Month
Corporate %	11.45%	11.66%	13.29%	▲
Eyes %	33.94%	33.52%	35.27%	▲
Sleep %	16.83%	16.44%	12.99%	▼
Plastics %	6.35%	8.94%	12.24%	▲
Oral %	11.17%	11.69%	11.70%	▲
Peri Op %	10.46%	12.77%	13.16%	▲
Clinical Support %	9.74%	10.08%	12.31%	▲
Outpatients %	23.95%	21.45%	18.14%	▼
Director of Nursing %	3.65%	3.60%	3.04%	▼
Operational Nursing %	7.34%	10.38%	11.13%	▲
Community Services %	23.96%	23.51%	25.52%	▲
QVH Trust Total %	10.94%	12.20%	13.15%	▲



MONTHLY TURNOVER excl. Trainee Doctors	May-21	Jun-21	Jul-21	Compared to Previous Month
Corporate %	0.00%	1.90%	1.66%	▼
Eyes %	1.73%	6.62%	3.61%	▼
Sleep %	0.00%	0.00%	0.00%	◄►
Plastics %	0.00%	2.67%	3.17%	▲
Oral %	0.00%	1.63%	0.00%	▼
Peri Op %	0.56%	2.30%	3.40%	▲
Clinical Support %	1.56%	0.45%	2.22%	▲
Outpatients %	0.00%	0.00%	3.03%	▲
Director of Nursing %	0.00%	0.00%	1.95%	▲
Operational Nursing %	0.00%	2.97%	1.30%	▼
Community Services %	0.00%	0.00%	4.97%	▲
QVH Trust Total %	0.33%	2.03%	1.49%	▼



COMMENTARY

- Turnover has decreased in July, most significantly in Eyes as there were new starters in month
- The Trust annual turnover remains high and above 2020/21, although greatly improved from 2019/20. Most areas saw an increase in leavers in month.

FORWARD LOOK / POTENTIAL RISKS

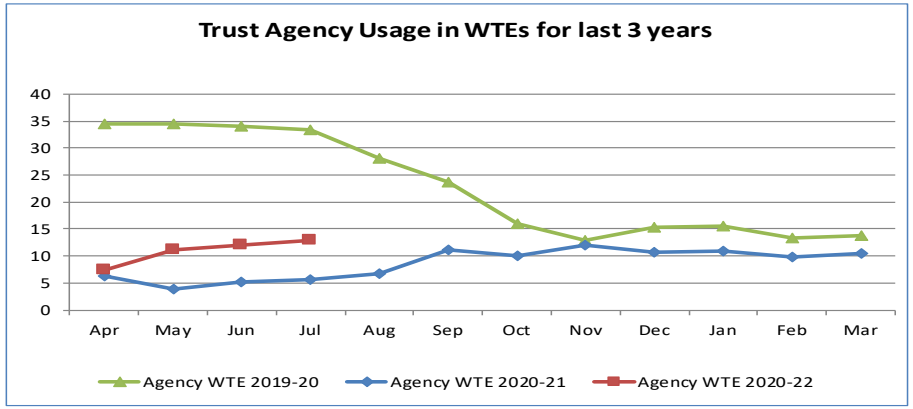
- Work ongoing to refresh the current process for leavers' conversations and a project to engage with staff through stay conversations, to then look at any trends to enable change and improve retention.

Temporary Workforce

Queen Victoria Hospital NHS Foundation Trust

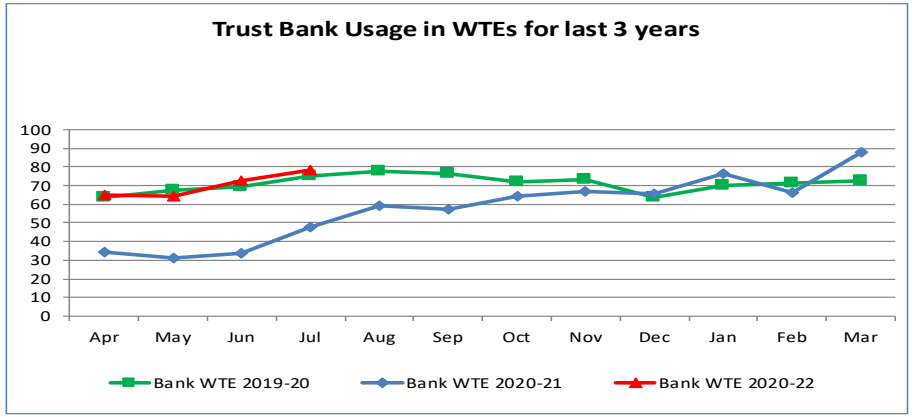
Agency				
BUSINESS UNIT (WTE)	May-21	Jun-21	Jul-21	Compared to Previous Month
Corporate	1.56	1.84	1.80	▼
Eyes	0.00	0.00	0.00	◄►
Sleep	0.00	0.23	0.26	▲
Plastics	0.00	0.00	0.00	◄►
Oral	0.00	0.00	0.00	◄►
Periop	3.31	3.95	4.65	▲
Clinical Support	2.81	1.31	1.00	▼
Outpatients	0.00	0.00	0.00	◄►
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	3.38	4.77	5.19	▲
Community Services	0.00	0.00	0.00	◄►
QVH Trust Total	11.06	12.11	12.89	▲

Bank				
BUSINESS UNIT (WTE)	May-21	Jun-21	Jul-21	Compared to Previous Month
Corporate	10.45	11.00	10.41	▼
Eyes	1.55	1.44	1.65	▲
Sleep	2.84	2.98	3.76	▲
Plastics	1.95	2.23	3.86	▲
Oral	2.84	3.50	2.84	▼
Periop	16.81	17.26	20.95	▲
Clinical Support	6.84	7.75	8.75	▲
Outpatients	1.54	1.60	1.63	▲
Director of Nursing	1.83	2.93	2.21	▼
Operational Nursing	16.36	20.40	20.57	▲
Community Services	1.19	1.57	1.75	▲
QVH Trust Total	64.22	72.64	78.37	▲



Agency				
STAFF GROUP (WTE)	May-21	Jun-21	Jul-21	Compared to Previous Month
Qualified Nursing	5.91	7.66	8.35	▲
HCAs	0.78	1.06	1.48	▲
Medical and Dental	0.98	1.27	1.07	▼
Other AHP's & ST&T	1.83	0.28	0.19	▼
Non-Clinical	1.56	1.84	1.80	▼
QVH Trust Total	11.06	12.11	12.89	▲

Bank				
STAFF GROUP (WTE)	May-21	Jun-21	Jul-21	Compared to Previous Month
Qualified Nursing	22.71	26.06	26.77	▲
HCAs	7.47	8.36	11.27	▲
Medical and Dental	5.24	5.72	8.53	▲
Other AHP's & ST&T	2.82	3.43	3.42	▼
Non-Clinical	25.99	29.07	28.37	▼
QVH Trust Total	64.22	72.64	78.37	▲



COMMENTARY

- Increases in both Bank and Agency usage in July with 12.89 Agency and 78.37 bank.
- Operational Nursing with the highest agency usage of 5.19 and bank at 20.57.
- Corporate and Clinical Support showed a drop in agency usage and bank reduced in Corporate, Oral and Director of Nursing

FORWARD LOOK / POTENTIAL RISKS

- Continue to work with finance and general/local managers to ensure establishment data is correct and staff in in correct establishment lines.
- Work with the ICS on the agency use process and to look at collaborative bank working across trusts with the use of the Digital Staff Passport

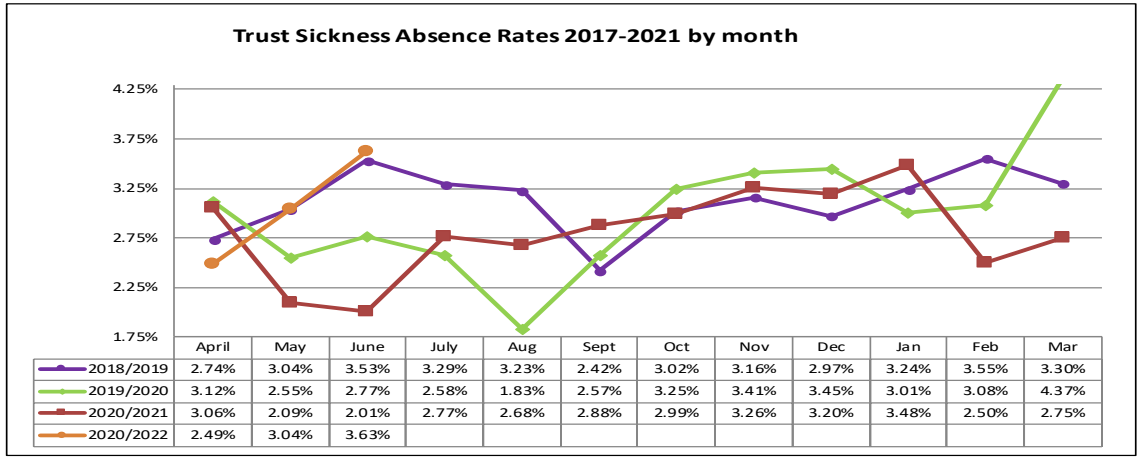
GOAL 3: Health and Well-being

Queen Victoria Hospital NHS Foundation Trust

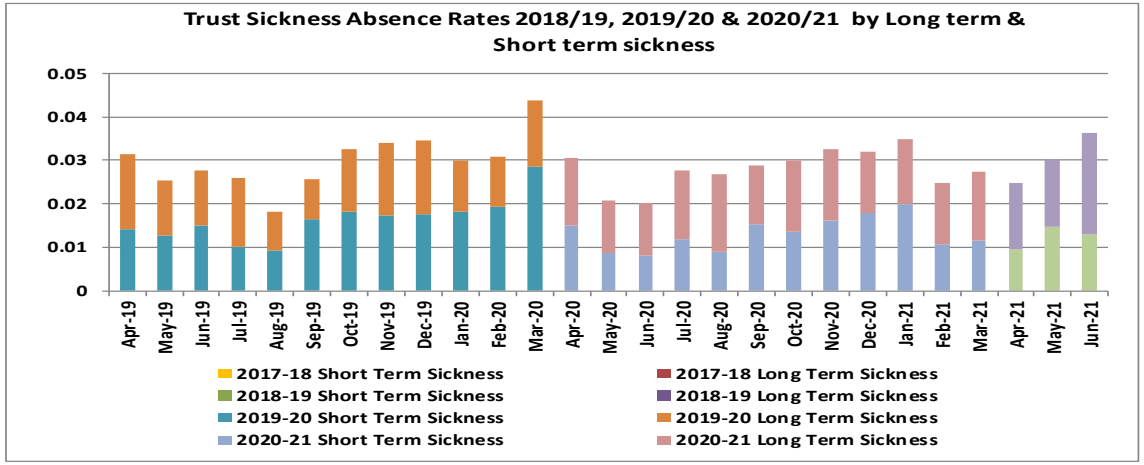
SHORT TERM SICKNESS	Apr-21	May-21	Jun-21	Compared to Previous Month
Corporate	1.21%	1.10%	1.05%	▼
Clinical Support	1.01%	0.43%	0.99%	▲
Plastics	1.23%	0.56%	0.28%	▼
Eyes	0.78%	2.03%	0.00%	▼
Sleep	1.21%	3.98%	2.81%	▼
Oral	0.21%	0.21%	0.58%	▲
Periop	0.56%	2.04%	1.95%	▼
Outpatients	0.98%	0.88%	0.68%	▼
Director of Nursing	0.15%	0.26%	0.38%	▲
Operational Nursing	1.49%	2.47%	2.31%	▼
Community Services	0.53%	0.53%	0.00%	▼
QVH Trust Total	1.53%	1.47%	1.30%	▼

LONG TERM SICKNESS	Apr-21	May-21	Jun-21	Compared to Previous Month
Corporate	2.02%	1.41%	1.63%	▲
Clinical Support	1.88%	1.40%	3.33%	▲
Plastics	0.71%	0.16%	0.82%	▲
Eyes	0.00%	0.00%	0.00%	◄►
Sleep	7.65%	6.30%	15.06%	▲
Oral	2.08%	2.10%	0.43%	▼
Periop	0.69%	1.16%	2.40%	▲
Outpatients	0.00%	4.87%	4.86%	▼
Director of Nursing	0.00%	0.00%	1.31%	▲
Operational Nursing	1.79%	2.36%	2.24%	▼
Community Services	0.00%	0.00%	8.40%	▲
QVH Trust Total	0.96%	1.57%	2.33%	▲

ALL SICKNESS (with RAG)	Apr-21	May-21	Jun-21	Compared to Previous Month
QVH Trust Total	2.49%	3.04%	3.63%	▲



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
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%	2.75%
2020/2022	2.49%	3.04%	3.63%									



COMMENTARY

- The Trust's total absence in June 2021 has increased by 0.59% to 3.63%
- The rise of total sickness in June 2021 is due to an increase in long term cases
- There is a slight decrease in short term sickness across the Trust in June 2021

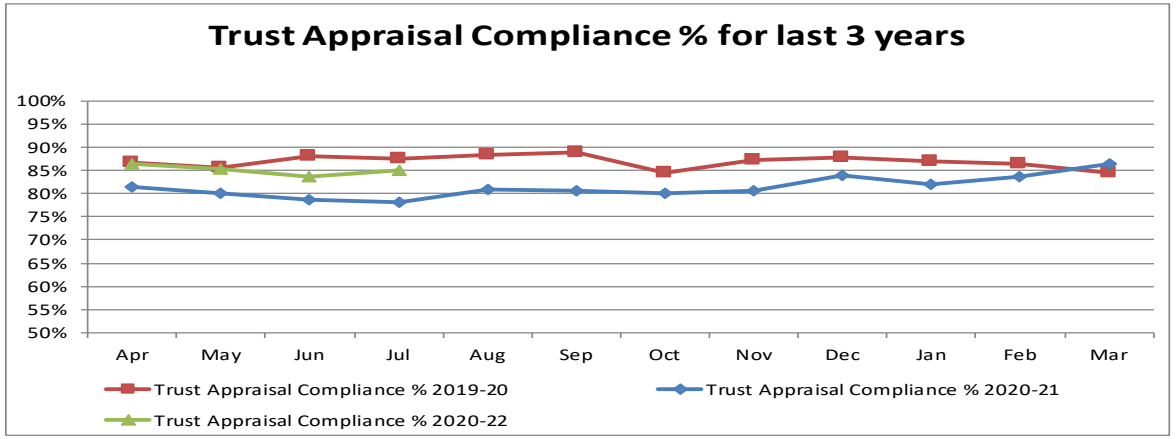
FORWARD LOOK / POTENTIAL RISKS

- With national restrictions having been lifted there was an increase in staff being required to self-isolate and along with the increase in long term sickness cases how will services continue to ensure safe staffing levels

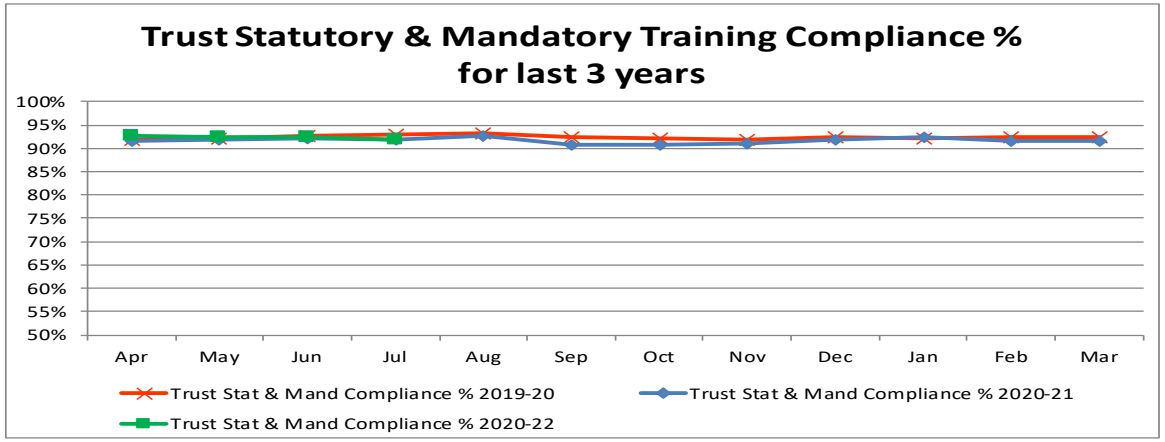
GOAL 4: Learning and Education

Queen Victoria Hospital NHS Foundation Trust

APPRAISALS	May-21	Jun-21	Jul-21	Compared to Previous Month
Corporate	79.59%	79.19%	80.20%	▲
Eyes	67.86%	65.52%	75.00%	▲
Sleep	83.87%	80.65%	73.33%	▼
Plastics	79.01%	75.90%	79.52%	▲
Oral	79.76%	82.56%	82.56%	◄►
Peri Op	84.85%	84.05%	85.12%	▲
Clinical Support	96.36%	90.91%	90.00%	▼
Outpatients	92.00%	88.00%	75.00%	▼
Director of Nursing	88.46%	92.31%	96.23%	▲
Operational Nursing	90.78%	87.74%	92.82%	▲
Community Services	76.92%	84.62%	75.00%	▼
QVH Trust Total	85.23%	83.72%	85.17%	▲



MANDATORY AND STATUTORY TRAINING	May-21	Jun-21	Jul-21	Compared to Previous Month
Corporate	93.31%	93.58%	92.59%	▼
Eyes	94.32%	94.26%	96.39%	▲
Sleep	88.64%	90.30%	88.51%	▼
Plastics	80.81%	80.18%	78.22%	▼
Oral	92.43%	92.16%	91.56%	▼
Peri Op	91.83%	91.83%	90.93%	▼
Clinical Support	96.43%	96.60%	95.10%	▼
Outpatients	96.68%	95.73%	97.41%	▲
Director of Nursing	94.93%	95.10%	95.49%	▲
Operational Nursing	94.20%	94.21%	95.54%	▲
Community Services	94.87%	91.67%	90.28%	▼
QVH Trust Total	92.34%	92.35%	91.98%	▼



COMMENTARY

- Corporate and doctors inductions have been redesigned to return to a fuller programme from August 2021 with a mix of face-to-face, eLearning, and online activity. This is the first phase of the changes and OD&L and MedEd will monitor COVID situation to make necessary adjustments.

FORWARD LOOK / POTENTIAL RISKS

- As doctors' exemptions for appraisals end, it means appraisal rates could drop unless they actively seek to renew their appraisal compliance.

GOAL 5: Talent & Leadership

Including OD&L and Medical Education activity

Queen Victoria Hospital NHS Foundation Trust

Apprenticeships:

This month we are procuring training providers for L3/L5 management at QVH. In Q1 we have the following numbers of people at QVH involved with apprenticeships:

Apprenticeship metrics April - June 2021				
Month	**Apprentices in training**	**New starts**	**Completed**	**Withdrawn**
April	23	0	1	1
May	23	0	0	0
June	21	0	2	0
Position at end of April - June 2021 quarter	**21**	**0**	**3**	**1**

In terms of Levy spend, at the end of Q1 we have used **50.91%** of the levy pot.

A&C Programme:

This programme continues to be advertised across QVH and only a few dates for Admin & Clerical staff to take up this opportunity remain.

Workshop	Date	Time
Working with self and others	Wed 11th August	9.30 – 12
Developing yourself	Thurs 19th August	10 – 11
Stepping into management	Wed 15th Sept	9.30 – 12
Getting the most out of your appraisal	Wed 22nd Sept	2 – 3.30
Basic project management	Wed 29 September	1:30 - 4
Working in teams	Tues 12th October	9.30 - 12
Personal resilience	Thurs 21st October	2 – 4.30

SHCP – Leadership, OD and Talent Group activity:

No further activity to report in this area but we are scoping out coaching activity for the Autumn schedule.

Other activities:

- Bespoke team development session currently being developed for Operations and Finance department.

Medical Education activity

August junior doctors' induction was very well received with excellent feedback from the new starters across all specialties.

Timetables are also in place for the September and October doctors' inductions. In September QVH will be welcoming new Dental Core Trainees, who are the most junior trainees working in the Trust, and are therefore offered an extended induction incorporating simulation training.

The newly refurbished relaxation area in the Surgeons' Mess is ready for use, and the furniture will be replaced shortly.

The plans for additional funding received from HEE relating to PGME Training Recovery have been submitted to HEE and work has started to gather quotes for the areas identified.

Dental foundation training will start in September in the Dental Skills Lab.

Invitations have been sent out for the doctors' mandatory training update webinars in September; these webinars are run twice yearly to maintain the compliance rate for all substantive and fixed term medical and dental staff.

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed : 22 August 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, moderate
Current Risk Rating 4(C) x 4 (L) = 16
Target Risk Rating 3 (C) x 3 (L) = 9, low

Risk
Sustained delivery of constitutional access standards

Patients & Commissioners lose confidence in our ability to provide timely and effective treatment due to an increase in waiting times and a fall in productivity.

Rationale for current score

- Increase of RTT waiting list and patients waiting >52 weeks / > 78 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
- Increasing staff gaps 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]
- Medical capacity in sleep
- Specialist nature / complexity of some activity
- Sentinel Lymph Node demand [CRR 1122]
- Capacity to deliver NHSE, system and QVH recovery and transformation requirements
- Anaesthetic gaps

Future risks

- Further COVID-19 surge
- National Policy changes to access and targets
- NHS funding and fines changes & volatility
- Reputation as a consequence of recovery
- Workforce morale and potential retention impact due to merger considerations
- System service review recommendations and potential risks to services

Future Opportunities

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

Controls / Assurance

- Mobilising of virtual outpatient opportunities to support activity during COVID-19
- Outpatient improvement programme
- Additional reporting to monitor COVID-19 impact
- Recovery planning and implementation underway
- Weekly RTT and cancer PTL meetings ongoing
- Additional cancer escalation meetings initiated where required to maximise daily grip
- Development of revised operational processes underway to enhance assurance and grip
- Additional fixed term anaesthetist posts out to advert
- Locum staff identified to support sleep position
- Theatre productivity work programme in place
- Programme of waiting list validation

Gaps in controls / assurance

- 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 RTT 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
- Theatre capacity due to Rowntree theatre procedure limits

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance | **Committee: Finance & Performance** | **Date last reviewed 24th August 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 4)

- The Trust submitted a breakeven plan for H1 in line with ICS. As at month 4 the Trust has delivered a surplus of £0.5m. This surplus is due to the activity being above the required thresholds in planning. This additional activity will be funded, if all gateways are achieved, through the elective recovery fund (ERF)
- ERF guidance changed at month 3 increasing the required activity threshold to 95% instead from 85% of achievement of 19/20 activity levels.
- Guidance is anticipated for H2 in mid September with two planning rounds, the final submission likely in December.
- 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
- 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 until September for H2 and later in the calendar year for 22/23, 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 2023/24 ~~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 FBC
- 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 potential merger to include greater economies of scale and efficiencies for work load and also potential cash savings in the longer term
- Development of the Green plan in line with national requirements
- ICS Quarterly Provider Assurance Meetings now commenced

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 H1 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:	**03/09/21**		**Agenda reference:**	**134-21**	
Report title:	**Financial Performance**				
Sponsor:	Michelle Miles, Director of finance and performance				
Author:	Michelle Miles, Director of finance and performance				
Appendices:					
Executive summary					
Purpose of report:	To provide the Board with an overview of the Trust's financial performance.				
Summary of key issues	The Trust I&E position is £199k surplus against the YTD plan at M4. The trust in line with national requirements is operating under block income regime with a plan set for H1 (M1-6) 2021-22, further guidance on H2 planning will be issued in September. Overall surplus position year to date driven by trust hitting above threshold activity targets for Q1, however ERF guidance has changed for Q2 leading to a shortfall in planned income. Expenditure run rate (both Pay and Non-Pay) broadly in line with last 12 months averages. Services across the trust are currently carrying vacancies that are not fully backfilled and therefore resulting into a year to date underspend (£835k) for pay lines. Non-Pay in contrast overspending where budget has been flexed to reflect the threshold activity targets (-£173k). The cash position for the Trust continues to remain favourable due to the level and timing of the block payments arrangement this year which for the very least will continue during H1 2021-22. Due to the delay in guidance for H2 the cash position is being assumed that no ERF support is available.				
Recommendation:	To **note** the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):			KSO3:	**KSO4:**	KSO5:
			Operational excellence	***Financial sustainability***	*Organisational excellence*
Implications					
Board assurance framework:	KS04 – Financial Sustainability				
Corporate risk register:	KS04 – Financial Sustainability				
Regulation:	NHSI Financial Submission				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:	N/A	
Previously considered by:					
	Date:		Decision:		
Next steps:					

NHS
Queen Victoria Hospital
NHS Foundation Trust

Financial Performance Report

Michelle Miles, Director of Finance & Performance

BoD September 2021

Finance & Performance Committee

Headline Financial performance Month 04

Queen Victoria Hospital NHS Foundation Trust

Performance YTD Month 04

Income

- Block regime in H1, ERF estimate income £2.3m is within the position. The Trust is awaiting agreement and confirmation on M1 and M2 actual performance, no clawback has been assumed in the YTD position.

Expenditure

- YTD under performance to plan of £0.6m, mainly within Pay, due to current vacancies and staffing challenges.

Activity

- Trust's activity threshold for July 21 was 95%, measured against 19/20 activity levels, achievement against this DC 96% , EL 73%, OP New 93% and OP Follow up at 98%. June achievement against the Trust plan DC 89% , EL 89%, OP New 98% and OP Follow up at 97%.

Efficiencies

- The target efficiencies for H1 is £812k, identified and risk assessed schemes for H1 is £141k, shortfall of £671k against the H1 target. YTD actual achievement is £66k. Following establishment reviews in M4, efficiencies identified will be validated and reflected from M5.

Balance sheet

- Trade Receivables have increased by £2.5m primarily due to accrual of ERF funding April to July £2.3m
- Trade payables have increased by £1.9m due to PDC dividend accrual April – July to be paid in September £0.6m, and other accrued services
- Better Payment Practice Code (BPPC) performance continues to be a focus for NHSI/E, Trust YTD performance is compliance, but there are historic issues to be resolved.

Capital

- The Trust capital forecast been revised from £5.7m to £4m following the removal of the assumption of £1.7m ICS capital funding. Many of the 2021/22 projects have recently been approved, with the capital spend occurring later in the year.

Financial performance Risks & Mitigations

Trust is forecasting breakeven at the end of H1.

Income: ERF reduction of £1m to estimated ERF income following the revised Q2 threshold to 95%. Trust H1 ERF income estimate is £2.7m. Payment is subject to System meeting the 5 ERF Gateway requirements which yet to be determined.

Expenditure: Trust run rate is underperforming YTD £0.5m, if recruitment and staffing challenges are not met in Q2, the Trust may not achieve a break even position and instead a surplus position, a review of the establishment required for Q2 and H2 planning is ongoing.

Efficiencies: The Trust historically has not been able to deliver cash releasing efficiencies, we continue to work for the identification of further efficiencies, validation of schemes is ongoing and will be reflected in M5. Indicative H2 efficiency target is 3%.

Capital: forecast revised from £5.7m to £4.0m. At this time we are not intending to seek additional cash support and will have discussions on that basis at an ICS level. The Trust will need to review the allocation of funds to "approved" projects in line with the reduced funds available.

Guidance for H2 will be released in September, with H2 planning September – November. The challenge for the trust is how do we reduce our cost base with an indicative efficiency target of 3%, whilst delivering an uplift in activity.

The financial position reflects the Trust internally reported position. Monthly phasing of the plan is misaligned to the Provider finance return (PFR), with plan alignment reached at M6.

Income & Expenditure Month 04

Queen Victoria Hospital NHS
NHS Foundation Trust

Income and Expenditure

	In Month £'000				Year to Date £'000				Forecast Outturn		
	19/20	Plan	Actual	Variance	19/20	Plan	Actual	Variance	Plan	Forecast S/L	Variance
Income											
Patient Activity Income	5,961	6,371	5,842	(529)	21,581	25,484	24,455	(1,029)	38,226	35,073	(3,153)
Other Operating Income	381	232	195	(37)	1,543	928	1,283	356	1,392	1,925	533
Block projected top up	0	810	776	(35)	1	3,242	3,443	201	4,863	5,164	301
Total Income	**6,342**	**7,413**	**6,822**	**(591)**	**23,125**	**29,653**	**29,190**	**(463)**	**44,480**	**42,162**	**(2,318)**
Pay											
Substantive	(3,769)	(4,524)	(4,243)	282	(15,205)	(18,097)	(16,695)	1,402	(27,145)	(25,043)	2,103
Bank	(330)	(169)	(278)	(109)	(1,061)	(676)	(1,001)	(326)	(1,013)	(1,502)	(489)
Agency	(248)	(11)	(68)	(58)	(836)	(43)	(284)	(241)	(64)	(426)	(362)
Total Pay	**(4,347)**	**(4,704)**	**(4,589)**	**115**	**(17,103)**	**(18,815)**	**(17,980)**	**835**	**(28,223)**	**(26,970)**	**1,252**
Non Pay											
Clinical Services & Supplies	(540)	(886)	(797)	89	(2,152)	(3,510)	(2,785)	725	(5,342)	(3,810)	1,532
Clinical Services & Supplies - Med & S	(548)	(549)	(568)	(19)	(2,182)	(2,020)	(2,122)	(102)	(3,118)	(3,184)	(66)
Drugs	(142)	(130)	(123)	7	(496)	(481)	(488)	(6)	(741)	(732)	9
Establishment Expenses	(347)	(244)	(224)	21	(1,077)	(787)	(905)	(118)	(1,216)	(1,358)	(141)
Consultancy	(1)	(16)	(47)	(31)	(4)	(59)	(151)	(92)	(91)	(227)	(136)
Other non pay	(298)	(519)	(627)	(108)	(1,551)	(1,818)	(1,971)	(154)	(2,856)	(2,957)	(101)
Total Non Pay	**(1,876)**	**(2,344)**	**(2,386)**	**(42)**	**(7,462)**	**(8,676)**	**(8,423)**	**253**	**(13,364)**	**(12,267)**	**1,096**
Non Operational Expenditure	(100)	(128)	(148)	(20)	(533)	(466)	(632)	(167)	(721)	(948)	(228)
Non Operating Income	2	0	0	(0)	6	0	0	(0)	0	0	(0)
Depreciation and amortisation	(287)	(378)	(420)	(41)	(1,174)	(1,416)	(1,675)	(259)	(2,173)	(2,062)	111
Total Expenditure	**(6,607)**	**(7,554)**	**(7,543)**	**11**	**(26,265)**	**(29,372)**	**(28,710)**	**662**	**(44,479)**	**(42,248)**	**2,231**
Surplus / (Deficit)	**(265)**	**(140)**	**(721)**	**(581)**	**(3,141)**	**281**	**480**	**199**	**1**	**(86)**	**(87)**

QVH PERFORMANCE COMMENTARY

The financial position reflects the Trust internally reported position. Monthly phasing of the plan is misaligned to the PFR, with alignment reached at M6.
Year to date M4 the Trust is reporting a surplus to plan position of £0.2m driven mainly by Elective recovery expenditure as the trust has been hitting planned activity recovery targets.

Income

- ERF YTD £2.3m, this is the Trust full estimate of ERF income. Income is YTD £463k behind plan due to activity reduction resulting in less ERF income achieved.
- **Expenditure**
- Pay: £835k surplus, mainly due to substantive vacant posts and staffing challenges across services.
- The trust expenditure run rate is line with trends in delivering activity performance.

QVH FORWARD LOOK / PERFORMANCE RISKS

Trust is forecasting breakeven at the end of H1. The block regime is supporting the Trust breakeven position.

Risks

Income

- The impact of the ERF The Trust is reflecting the full planned estimate of ERF income, no provision has been made for a change to this whilst we await conformation of the actuals.

Expenditure

- Staff challenges and vacancies, which will impact service delivery as the Trust work to meet the 95% threshold.

Mitigations

- The Trust has met and is expected to meet the activity thresholds and activity plan in H1, this has been delivered with the current cost base. The Trust will review the establishment required to maintain and deliver performance.
- Review vacancies and establishment for H2.

Balance Sheet Month 04

Queen Victoria Hospital NHS
NHS Foundation Trust

Statement of financial position 2021-22

£000's	Prior Year End March 2021	April	May	June	July	Change In Month	Change In Year
Non Current Assets							
Fixed Assets	54,165	53,857	53,732	53,384	53,316	(68)	(849)
Other Receivables	227	227	227	227	227	0	0
Total Non Current Assets	**54,392**	**54,084**	**53,959**	**53,611**	**53,543**	**(68)**	**(849)**
Current Assets							
Inventories	1,462	1,460	1,442	1,469	1,465	(4)	3
Trade and other Receivables	4,140	3,353	4,544	6,289	6,679	390	2,539
Cash and Cash Equivalents	8,582	9,072	8,933	8,358	8,851	493	269
Total Current Assets	**14,184**	**13,885**	**14,919**	**16,115**	**16,995**	**879**	**2,811**
Current Liabilities							
Trade and other Payables	(10,544)	(9,575)	(10,060)	(10,949)	(12,486)	(1,537)	(1,942)
Borrowings	(893)	(883)	(883)	(857)	(857)	0	37
Provisions	(88)	(88)	(88)	(88)	(87)	1	1
Other Liabilities	(431)	(396)	(337)	(349)	(343)	5	88
Total Current Liabilities	**(11,956)**	**(10,942)**	**(11,368)**	**(12,242)**	**(13,773)**	**(1,531)**	**(1,817)**
Subtotal Net Current Assets	**2,228**	**2,943**	**3,551**	**3,873**	**3,222**	**(651)**	**994**
Total Assets less Current liabilties	**56,620**	**57,027**	**57,510**	**57,484**	**56,765**	**(719)**	**145**
Non Current Liabilties							
Borrowings	(3,653)	(3,653)	(3,653)	(3,266)	(3,266)	0	387
Provisions	(908)	(908)	(908)	(908)	(909)	(1)	(1)
Total Non Current Liabilties	**(4,561)**	**(4,561)**	**(4,561)**	**(4,174)**	**(4,175)**	**(1)**	**386**
Total assets Employed	**52,059**	**52,466**	**52,949**	**53,311**	**52,590**	**(720)**	**531**
Tax Payers Equity							
Public Dividend Capital	21,005	21,005	21,005	21,005	21,005	0	0
Revaluation Reserve	13,943	13,943	13,993	13,993	13,993	0	50
Income and Expenditure Reserve	17,111	17,518	17,951	18,313	17,592	(721)	481
Total Tax Payers Equity	**52,059**	**52,466**	**52,949**	**53,311**	**52,590**	**(721)**	**531**

QVH PERFORMANCE COMMENTARY

- Non current assets have decreased in value reflecting the relatively slow starting rate of in year additions (£0.6m) compared with the depreciation/amortisation costs for the year to date (£-1.4m).
- Trade receivables have increased in year by £2.5m primarily due to an increase in NHS income accruals that includes the elective recovery fund (ERF) estimate for April to July of £2.3m and other covid related funding arrangements.
- The closing cash balance for July has increased from last month by £0.5m reflecting the surplus position, the profile of spend and accruals including capital, and dividends.
- Trade payables have increased in year by £1.9m which reflects the accrual accumulation of dividends and other accrued services costs.
- Borrowings mainly consists of the current liabilities element of the theatre capital loan.
- Other liabilities consists of deferred income items which have remained fairly consistent in-year.
- Non current borrowings consist of the bulk of the theatre loan and longer term finance lease liabilities. Reduced in June for the first half-yearly repayment instalment of the principal.
- Provisions include long term liabilities relating to early retirement pension costs and the clinical pension tax scheme.
- Revaluation reserve has increased by £50k in year to account for a revaluation of assets following a valuation clarification, (Arcomed pumps). This does not affect the income & expenditure position.
- Income and expenditure reserve has increased to reflect the current statement of comprehensive income (SOCI) surplus position.

Cashflow Report Month 04

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance Month 04 2021/22

Cashflow Report

	Actual £'000				Forecast £'000							
	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Opening Balance	**8,577**	**9,067**	**8,928**	**8,358**	**8,851**	**8,148**	**10,194**	**9,541**	**8,089**	**6,192**	**4,740**	**3,288**
Receipts												
Block & System income	6,283	6,283	6,304	6,291	6,283	6,283	6,283	6,283	6,283	6,283	6,283	6,283
Elective Recovery Fund (tbc)	0	0	0	0	0	3,540	0	0	0	0	0	0
Other Core Income incl HEE	1,675	256	211	162	250	250	1,050	250	250	250	250	250
Receipts from other income	109	167	130	163	138	138	138	138	138	138	138	138
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	0
PDC Cash Support Received	0	0	0	0	0	0	0	0	0	0	0	0
Total Receipts	**8,067**	**6,706**	**6,645**	**6,616**	**6,671**	**10,211**	**7,471**	**6,671**	**6,671**	**6,671**	**6,671**	**6,671**
Payments												
Payments to NHS Bodies	(644)	(687)	(364)	(459)	(665)	(665)	(665)	(665)	(665)	(665)	(665)	(665)
Payments to non-NHS bodies	(2,584)	(1,876)	(2,037)	(1,290)	(2,230)	(2,230)	(2,980)	(2,980)	(2,980)	(2,980)	(2,980)	(2,980)
Net Payroll Payment	(2,460)	(2,417)	(2,442)	(2,471)	(2,521)	(2,521)	(2,521)	(2,521)	(2,521)	(2,521)	(2,521)	(2,521)
Payroll Taxes	(1,197)	(1,167)	(1,220)	(1,200)	(1,236)	(1,236)	(1,236)	(1,236)	(1,236)	(1,236)	(1,236)	(1,236)
Pensions Payment	(691)	(697)	(703)	(703)	(721)	(721)	(721)	(721)	(721)	(721)	(721)	(721)
PDC Dividends Payment	-	-	-	-	-	(792)	-	-	-	-	-	(792)
Loan Interest & Repayment	-	-	(449)	-	-	-	-	-	(444)	-	-	-
Total Payments	**(7,577)**	**(6,845)**	**(7,215)**	**(6,123)**	**(7,373)**	**(8,165)**	**(8,123)**	**(8,123)**	**(8,567)**	**(8,123)**	**(8,123)**	**(8,915)**
Net Cash Movement	**490**	**(139)**	**(570)**	**493**	**(702)**	**2,046**	**(652)**	**(1,452)**	**(1,896)**	**(1,452)**	**(1,452)**	**(2,244)**
Closing Balance	**9,067**	**8,928**	**8,358**	**8,851**	**8,148**	**10,194**	**9,541**	**8,089**	**6,192**	**4,740**	**3,288**	**1,043**

QVH PERFORMANCE COMMENTARY

- Cash balances are currently only sustainable in H1 (April-Sept) if ERF income is achieved and an operating surplus achieved. The balance will be reduced in H2 by capital spend and the funding flows and operating plan is not yet available to fully understand the impact of any potential changes.
- There is currently a cash balance which covers a month of average spend, which is sufficient in the short term as block payments are received in month.
- Financial services will work with commissioners and other providers to ensure payments are made in a timely manner and older debts controlled.
- The cash position will continue to be reviewed and managed and any future requirements assessed monthly.

QVH FORWARD LOOK / PERFORMANCE RISKS

- The forecast assumes the current level of funding and spend continues. However should this regime change from block payment or break even funding basis then appropriate cash support would be required should the Trust run at an operating deficit. No H2 forecast of ERF has been made hence the anticipated reduction in cash balances in the second half of the year.
- The revised capital plan is £4.0m from £5.7m (see capital slide) and the cash requirement has been reduced accordingly and is profiled towards the second half of the year.
- The NHS Operating Plan is still in development pending changes in the covid finance regime and so is not available to be included with this table

Debtors Month 04

Queen Victoria Hospital NHS Foundation Trust

Debtors

	Jul 20 £'000	Aug 20 £'000	Sep 20 £'000	Oct 20 £'000	Nov 20 £'000	Dec 20 £'000	Jan 21 £'000	Feb 21 £'000	Mar 21 £'000	Apr 21 £'000	May 21 £'000	Jun 21 £'000	Jul 21 £'000	In Month Change £000
NHS Debtors														
0-30 Days Past Invoice Due Date	221	131	90	182	249	1,189	927	308	803	605	383	53	114	**61**
31-60 Days Past Invoice Due Date	75	62	92	14	68	14	5	743	62	132	239	353	32	**(321)**
61-90 Days Past Invoice Due Date	112	72	63	77	14	68	8	4	743	18	116	231	353	**122**
Over 90 Days Past Invoice Due Date	3,840	2,792	2,321	2,054	1,848	1,619	1,661	796	747	666	650	708	873	**164**
Total NHS Debtors	**4,248**	**3,056**	**2,566**	**2,327**	**2,180**	**2,889**	**2,601**	**1,852**	**2,355**	**1,422**	**1,388**	**1,345**	**1,371**	**26**
Non NHS Debtors														
0-30 Days Past Invoice Due Date	150	55	64	87	43	87	90	70	193	175	34	49	76	**27**
31-60 Days Past Invoice Due Date	16	41	21	7	57	9	24	30	12	12	157	14	22	**8**
61-90 Days Past Invoice Due Date	21	16	38	2	7	57	8	19	9	11	15	139	14	**(125)**
Over 90 Days Past Invoice Due Date	556	590	435	468	361	388	410	391	398	343	335	344	475	**132**
Total Non NHS Debtors	**743**	**702**	**558**	**564**	**468**	**541**	**533**	**510**	**611**	**541**	**540**	**545**	**587**	**42**
Other Debtors Less Than One Year	341	571	592	564	989	(41)	42	(511)	1,566	1,017	2,616	4,399	4,721	
Total Debtors	**5,332**	**4,329**	**3,716**	**3,456**	**3,637**	**3,389**	**3,176**	**1,851**	**4,532**	**2,980**	**4,544**	**6,289**	**6,679**	
NHS : Total NHS & Non NHS ratio	*0.85*	*0.81*	*0.82*	*0.80*	*0.82*	*0.84*	*0.83*	*0.78*	*0.79*	*0.72*	*0.72*	*0.71*	*0.70*	

QVH PERFORMANCE COMMENTARY

The month 04 total debtor balance is £6.7m. This has risen over the last months with the increase of income accruals for current year funding arrangements.

The invoiced NHS debtors balance has decreased by £1.0m since March 2021, mainly reflecting collection and settlement of 2020-21 NHS funding and income allocated at year end.

Financial services will continue to review aged debts with the aim of resolving any disputes and collection of income. It should be noted that the majority of older debtors were provided for in 2020-21.

Other Debtors consists mainly of the net effect of income accruals (ERF and other NHS funding streams), adjustments for receipts in advance and prepayments, provisions and other non-invoiced debtors such as VAT and the injury cost recovery scheme.

QVH FORWARD LOOK / PERFORMANCE RISKS

- Financial Services continue working closely with Business Managers and the Contracting team to ensure billing is accurate, timely and resolutions to queries are being actively pursued.
- Financial services will continue to review Aged Debts with the aim of resolving any disputes and collecting income due.

Creditors Month 04

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 04 2021/22

Trade Creditors

	Aug 20 £'000	Sep 20 £'000	Oct 20 £'000	Nov 20 £'000	Dec 20 £'000	Jan 21 £'000	Feb 21 £'000	Mar 21 £'000	Apr 21 £'000	May 21 £'000	Jun 21 £'000	Jul 21 £'000	In Month Change
NHS Creditors													
0-30 Days Past Invoice Due Date	380	323	302	196	363	278	247	395	131	147	103	93	(10)
31-60 Days Past Invoice Due Date	155	39	9	109	103	117	157	42	85	25	59	28	(31)
61-90 Days Past Invoice Due Date	42	155	19	27	84	90	91	102	35	56	36	25	(11)
Over 90 Days Past Invoice Due Date	1,270	1,111	1,180	665	698	722	774	691	608	645	663	634	(29)
Total NHS Creditors	**1,847**	**1,629**	**1,510**	**996**	**1,248**	**1,207**	**1,269**	**1,230**	**860**	**872**	**862**	**781**	**(81)**
Non NHS Creditors													
0-30 Days Past Invoice Due Date	292	566	342	843	1,138	513	325	1,323	444	423	650	363	(288)
31-60 Days Past Invoice Due Date	43	31	55	37	30	410	91	84	101	49	74	89	16
61-90 Days Past Invoice Due Date	103	12	7	5	31	12	18	44	28	47	35	92	57
Over 90 Days Past Invoice Due Date	160	41	26	20	26	16	60	38	16	69	77	150	73
Total Non NHS Creditors	**597**	**650**	**430**	**905**	**1,224**	**949**	**493**	**1,489**	**588**	**589**	**836**	**694**	**(142)**
Other Creditors Less Than One Year	(366)	(402)	(106)	(15)	(975)	(340)	(149)	(678)	80	(63)	(332)	170	
Total Creditors	**2,078**	**1,877**	**1,834**	**1,886**	**1,497**	**1,816**	**1,613**	**2,041**	**1,528**	**1,398**	**1,366**	**1,644**	
NHS : Non NHS ratio	***0.76***	***0.71***	***0.78***	***0.52***	***0.50***	***0.56***	***0.72***	***0.45***	***0.59***	***0.60***	***0.51***	***0.53***	

QVH PERFORMANCE COMMENTARY

- The trade creditors balance at month 4 is £1.6m compared to a running average of £1.7m.
- NHS and Non NHS balances have both reduced this month compared to last.
- The other creditors balance reflects the adjustment back to the balance sheet value for items within the trade creditors total which have not yet been validated to be accounted for on the general ledger but have been included in the aged creditors balance for completeness, or uncleared payments.

QVH FORWARD LOOK / PERFORMANCE RISKS

- Financial services will continue to review older NHS SLA balances with our key partner Trusts with the aim of resolving any disputes.
- Financial services are continuing to review areas where invoice authorisation is delayed in order to target and support training needs.
- The team are working with all budget holder to process and gain approval for invoice payment as quickly as possible.

Better payment practice code Month 04

Queen Victoria Hospital NHS Foundation Trust

Better payment practice code						
Target: 95% of invoices paid within 30 days of receipt	Current YTD	Current YTD	Previous Month YTD	Previous Month YTD	Current Month	Current Month
	31/07/2021	31/07/2021	30/06/2021	30/06/2021	31/07/2021	31/07/2021
	Invoice Quantity Current YTD	Invoice Value £000 Current YTD	Invoice Quantity Prior YTD	Invoice Value £000 Prior YTD	Invoice Quantity Current Month	Invoice Value £000 Current Month
Non NHS						
Total bills paid in the year	5,712	13,207	4,447	10,120	1,265	3,086
Total bills paid within target	5,167	12,674	4,067	9,739	1,100	2,934
Percentage of bills paid within target	**90.5%**	**96.0%**	**91.5%**	**96.2%**	**87.0%**	**95.1%**
NHS						
Total bills paid in the year	410	2,154	332	1,694	78	460
Total bills paid within target	373	2,115	301	1,663	72	452
Percentage of bills paid within target	**91.0%**	**98.2%**	**90.7%**	**98.2%**	**92.3%**	**98.4%**
Total						
Total bills paid in the year	**6,122**	**15,361**	**4,779**	**11,814**	**1,343**	**3,546**
Total bills paid within target	**5,540**	**14,789**	**4,368**	**11,402**	**1,172**	**3,387**
Percentage of bills paid within target	**90.5%**	**96.3%**	**91.4%**	**96.5%**	**87.3%**	**95.5%**
Compliance target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Above (below) target	(4.5%)	**1.3%**	**(3.6%)**	**1.5%**	**(7.7%)**	**0.5%**

QVH PERFORMANCE COMMENTARY

- NHSI/E will be monitoring BPPC closely during the year The target is 100% of invoices to be paid within 30 days, with compliance at 95%
- Trust performance YTD is
  - Number of invoices 90.5% (4.5% below compliance)
  - Value of invoice 96.3% (compliant)
- NHSI/E have not yet confirmed if performance will be measured against Number of invoices or value of invoices but did indicate that value would be the key indicator.
- The key areas of non compliance are clinical supplies and services and agency staffing for which additional supporting data or detailed checking processes are required before the budget holder can approve.
- As a note QVH does not hold back any payment for an approved invoice for cash flow reasons.

QVH FORWARD LOOK / PERFORMANCE RISKS

- NHSI/E CFO will be writing individually to providers who have a performance at an unacceptable level and appear to have good levels of cash. The CFO will ask for action plans to resolve the poor performance.
- This communication will go to Chief Executives copied to Directors of Finance and Audit Committee Chairs.
- Trust is performing above the 95% £value compliance level but there are historic issues to resolve. The financial services team are continuing review of performance, key factors and reporting analysis which will develop and target the areas of non compliance.
- Financial services are also continuing to review areas where invoice authorisation is delayed in order to target and support training needs with a view of improving performance.

Capital Month 04

Queen Victoria Hospital NHS Foundation Trust

	Year to Date £'000			Forecast Outturn £'000		
	Plan	Actual	Variance	Plan	Actual	Variance
Estates Projects						
Main theatres heating boilers	0	0	0	120	120	0
Eye bank air handling unit	0	0	0	180	180	0
Other	255	263	(8)	1,319	1,319	0
Total Estates Projects	**255**	**263**	**(8)**	**1,619**	**1,619**	**0**
Medical Equipment						
Microvascular/ENT microscope	0	0	0	216	216	0
Patient record system for Ophthalmology	0	0	0	165	165	0
Laser for scar service	0	0	0	150	150	0
Other	200	99	101	532	532	0
Total Medical Equipment	**200**	**99**	**101**	**1,064**	**1,064**	**0**
Information Management & Technology (IM&T)						
Windows 10 / Server 2012 Upgrade	8	8	0	250	250	0
Radiology systems (PACS/RIS) reprovision	39	39	0	200	200	0
EDM scanning solution	26	26	0	175	175	0
Other	234	33	202	577	577	0
Total Information Management & Technology (IM&T)	**308**	**106**	**202**	**1,202**	**1,202**	**0**
Capitalised staff costs	0	92	(92)	350	350	0
Contingency				500	500	0
Not yet allocated				969	(715)	1,684
Total Capital 2021/22 Month 2021/22 Programme	**763**	**560**	**295**	**5,704**	**4,020**	**1,684**

QVH PERFORMANCE COMMENTARY

- QVH's capital allocation for 2021/22, as reported at M03 was £5.7m. At M04 the total has been reduced by £1.7m to £4.0m following the removal of the assumption of ICS capital funding.
- The trust has capital programmes identified of £3.5m and a contingency reserve of £0.5k.
- Approximately half the YTD spend has been on projects continued from 2020/21.
- The authorisation and procurement processes for equipment and IM&T are progressing and a rate of expenditure more in line with plan is expected in the near future. This year's IM&T programme in particular requires a considerable planning phase.

QVH FORWARD LOOK / PERFORMANCE RISKS

- The Trust capital forecast is £4.0m at M04. The £1.7m funding from the ICS has been removed on the basis that it is unlikely to be allocated to the Trust. At this time we are not intending to seek additional cash support and will have discussions on that basis at an ICS level.
- The Trust will need to review the allocation of funds to "approved" projects in line with the reduced funds available.
- Many of the 2021/22 projects have only recently been approved and are in the development phase, with the bulk of the work falling later in the year.

-

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 September 2021**		**Agenda reference:**	**135-21**	
Report title:	**Operational Performance Report**				
Sponsor:	Abigail Jago, Director of Operations				
Authors:	Operations Team				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide an update regarding operational performance and H1 recovery.				
Summary of key issues	Key items to note in the operational report are: • Operational performance in month • Recovery 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:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

NHS
Queen Victoria Hospital
NHS Foundation Trust

Operational Performance Report

Abigail Jago, Director of Operations

August 2021

Trust Board

Contents

Headlines

Queen Victoria Hospital NHS Foundation Trust

Cancer:

- Performance **meeting national / local set standards** for 2WW cancer, 62 day, 31 day, faster diagnosis cancer standard, 104 day waits and 62 day backlog as a % of the PTL.
- Performance **behind plan** for 62 day backlog primarily due to late referrals.

Diagnostics:

- **DMO1** – Continued challenges within the sleep service due to staffing gaps. Radiology only DMO1 performance is **99.7%**.

Waiting Lists and Long Waiters:

- Reduction in patients waiting over **52** weeks.
- Patients waiting more than **78** and **104** weeks have both increased slightly in month. 78 week trajectories revised and submitted to ICS.

Activity Vs Plan:

- **Day case** activity has fallen in month primarily due to workforce and independent sector availability.
- **Elective** activity has reduced in month. Ongoing challenges regarding sleep capacity.
- **First outpatients** and **follow up outpatient** have reduced in month to below plan.

Risk to performance / forward look

- **62D/104D backlog** – ongoing performance risk due to continued high levels of late referrals.
- **2WW** – continuing to see high levels of patient choice delays for the first appointment, which is driving the challenged performance in July and August.
- Staffed theatre capacity
- Sleep staffing position; continued performance risk for **DMO1**.
- Ongoing risk around patients delaying / unable to attend for treatment for Covid and Non-Covid reasons.

Performance Summary

NHS
Queen Victoria Hospital
NHS Foundation Trust

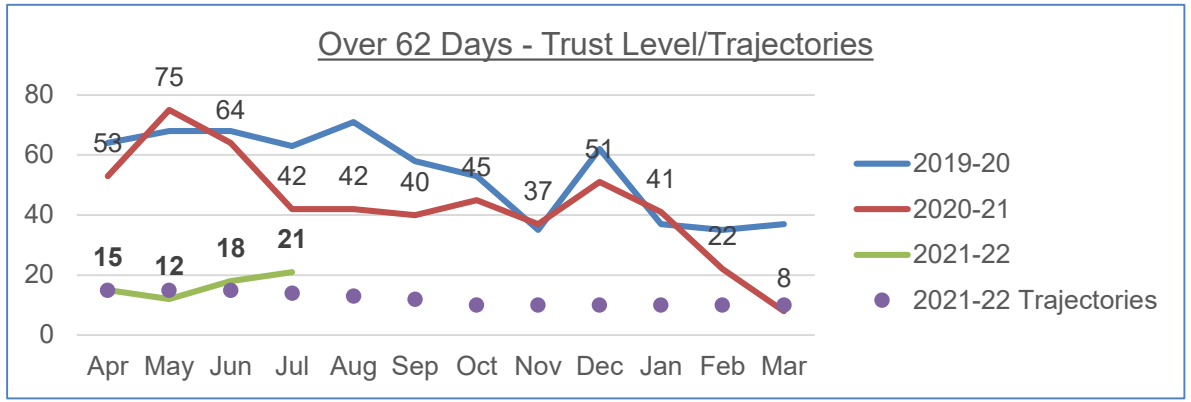
	KPI	TARGET / METRIC	SOURCE	AUG20	SEP20	OCT20	NOV20	DEC20	JAN21	FEB21	MAR21	APR21	MAY21	JUN21	JUL21
CANCER	Cancer 2WW	93%	National	98.4%	99.7%	98.7%	99.4%	98.9%	90.7%	98.2%	98.8%	97.8%	98.5%	97.0%	-
	Cancer 62 day	85%	National	91.3%	85.3%	81.2%	86.6%	85.7%	85.3%	87.5%	87.7%	87.5%	89.2%	89.3%	-
	Cancer 31 day	96%	National	93.9%	89.7%	92.2%	93.3%	92.8%	89.7%	94.8%	94.6%	95.5%	97.3%	98.0%	-
	Faster Diagnosis	75%	National	75.3%	67.8%	82.2%	75.1%	77.1%	73.7%	82.8%	83.2%	84.7%	88.9%	85.4%	-
	Cancer 104 day	Internal trajectory	Local	9	5	6	9	12	20	11	10	5	2	2	2
	Cancer 62 day backlog	Internal trajectory	Local	42	40	45	37	51	41	22	8	15	12	18	21
	Cancer 62 day backlog	<5% of PTL	Local								2.3%	4.6%	2.7%	4.8%	4.3%
DIAGNOSTICS	DMO1 Diagnostic waits	99% <6 weeks	National	86.8%	92.0%	94.9%	98.1%	96.3%	98.80%	99.15%	98.92%	98.88%	97.51%	94.07%	90.76%
	Histology TAT	90% <10 days	Local	92%	95%	95%	98%	96%	88%	94%	94%	95%	97%	91%	97%
	Imaging reporting	% <7 days	N/A	98.6%	98.2%	98.6%	98.5%	98.5%	97.9%	98.4%	97.0%	96.8%	99.1%	97.2%	97.0%
RTT WAITS	RTT52	Phase 3	ICS	461	555	608	563	623	740	907	903	715	534	370	310
	RTT78	N/A	N/A	8	10	16	29	32	43	62	87	126	137	99	103
	RTT104	N/A	N/A	-	-	-	-	-	-	-	2	5	6	4	6
	RTT18	92%	National	47.70%	55.60%	64.20%	69.60%	71.36%	71.06%	69.96%	70.22%	71.20%	74.14%	77.59%	76.08%
RECOVERY ACTIVITY	Day Case	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	100.8%	89%	93%	89%
	Elective	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	92.6%	104%	93%	89%
	First Outpatients	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	103.4%	95%	113%	98%
	Follow Up Outpatients	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	112.8%	103%	102%	97%
	Outpatient Therapies	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	105.9%	108%	111%	113%
	Non Elective	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	103.1%	112%	104%	105%
MIU	MIU	95% discharged <4hrs	National	99.8%	98.5%	100%	100%	99.6%	100%	99.8%	100%	99.9%	99.9%	99.1%	99.9%
RAG	Deteriorating position or plans / cause for concern			Improving position or plans / local trajectories on track						Delivery of national / local standard					

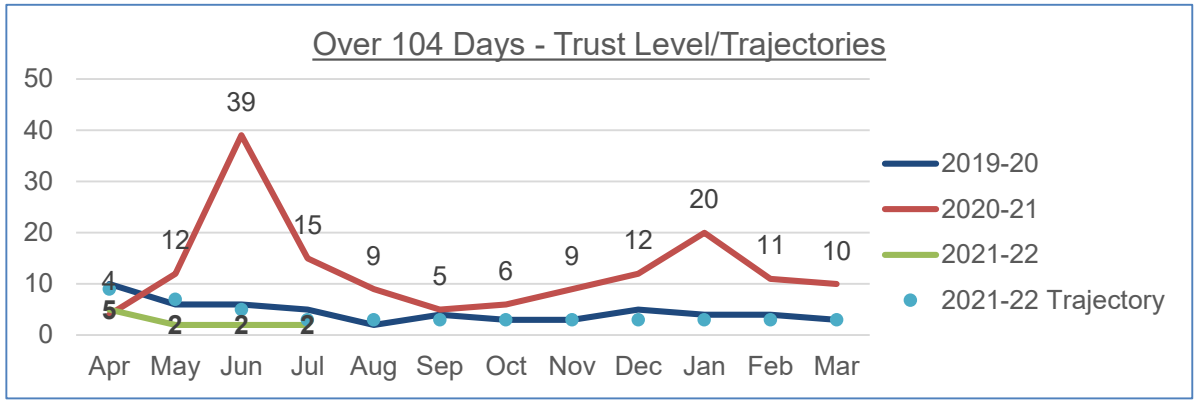
Cancer

Performance Dashboard / 62 days / 104 day backlog / recovery

Queen Victoria Hospital NHS Foundation Trust

Trust Level	2020-21	Q1 2021-22			Q2 2021-22			Q3 2021-22			Q4 2021-22			Change from last month
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	
Two Week Wait	94.0%	97.8%	98.5%	97.0%										↓
62 Day Referral to Treat	86.5%	87.5%	89.2%	89.3%										→
Faster Diagnosis	77.5%	84.7%	88.9%	85.4%										↓
62 Day Con Upgrade	90.1%	90.0%	92.3%	83.9%										↓
31 Day Decision to Treat	93.0%	95.5%	97.3%	98.0%										↑
31 Day Sub Treat	94.0%	94.4%	100%	87.5%										↓





PERFORMANCE COMMENTARY

- QVH were compliant against four key metrics in June 2021.
- **Consultant upgrade** – QVH was below target for June, reporting 2.5 breaches. 1.5 due to late referrals, received on day 57, 58 and 71.
- **31 day subsequent** - QVH was below target for June, reporting 1 breach.
- **Screening** - QVH was below target for June, reporting 1 breast breach.
- **62 day backlog** – QVH did not meet the trajectory for July due to late referrals (11 in month), however the % of waiting list target was met (4.3%).
- **Over 104 day** – QVH met the agreed recovery trajectory for July.

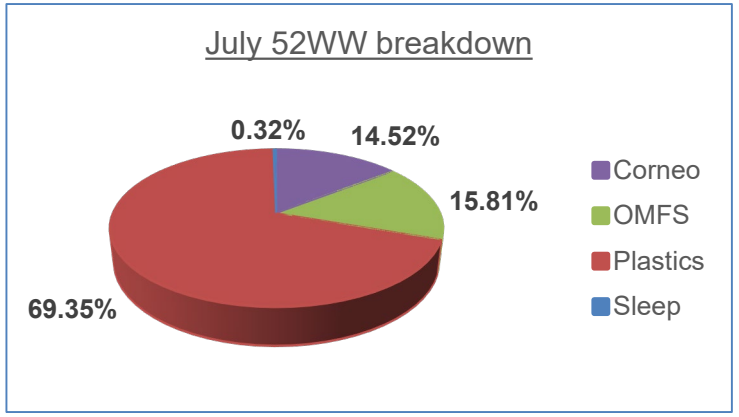
FORWARD LOOK / PERFORMANCE RISKS

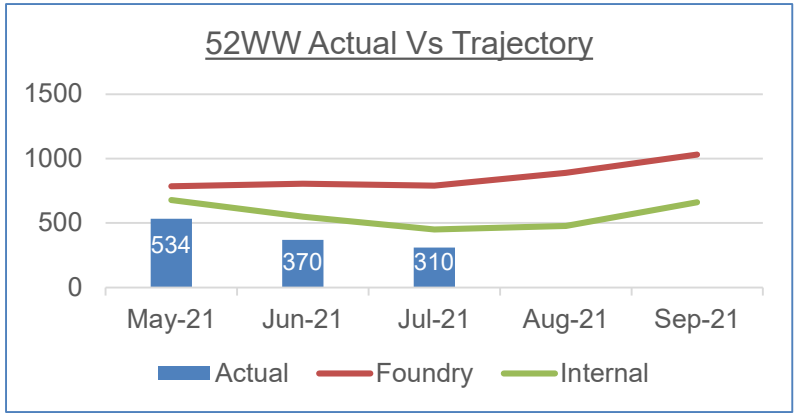
- The unvalidated performance for **31 day, 62 day** and **FDS** for July is above plan.
- As highlighted last month the **2WW** performance is challenged in July and August with a 41% increase in referrals and continued challenges with patient choice delays due to the holiday period.
- **62 day backlog** – ongoing risk around inclusion of late referrals from other trusts. Predicting to not meet the August trajectory; original improvement plans to be updated.
- **Over 104 day** – expected to meet the August trajectory. Ongoing risk around inclusion of late referrals from other trusts. Challenges with patient initiated delays.
- Current delays where surgery is being cancelled due to medical reasons - COVID and non-COVID delays.

RTT Waits

52WW / 78WW / 104WW

Queen Victoria Hospital NHS Foundation Trust



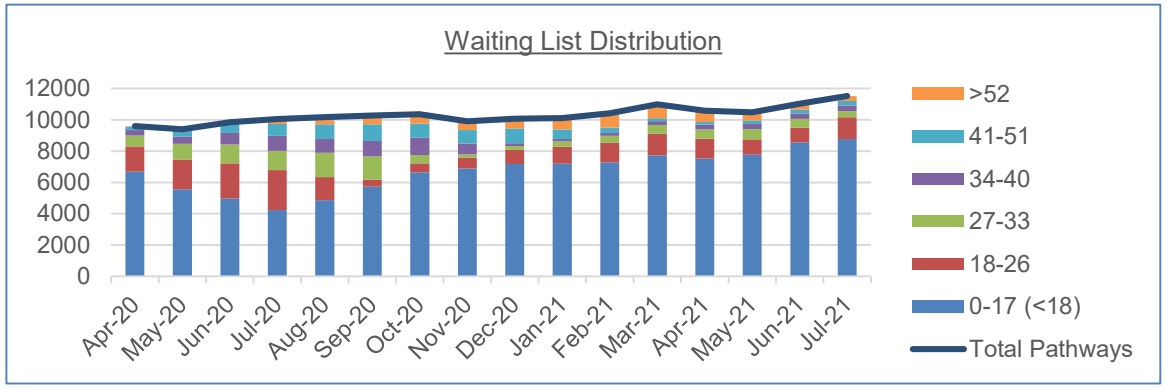


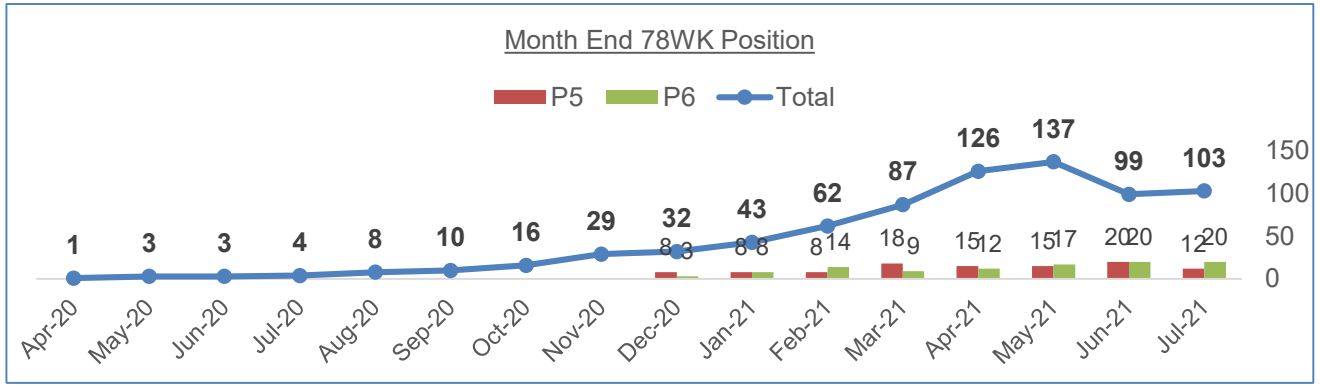
PERFORMANCE COMMENTARY

- **52WW** - In month reduction in number of patients waiting more than 52 weeks. The trust is continuing to meet the system (foundry) modelling and internal trajectory for 52WW. 59 patients waiting over 52 weeks are a P5 or P6 (i.e. patient deferred).
- **78WW** - Slight in month increase in patient waiting over 78 weeks; Corneo - 17, MaxFacs - 13, Plastics - 73. In total; 35 have a To Come In (TCI) date booked, 32 are a P5 or P6.
- In month the Trust reported 6 patients waiting over **104 weeks**; 3 plastics, 2 corneo, 1 OMFS. 2 have a TCI, 1 is a P5.

FORWARD LOOK / PERFORMANCE RISKS

- Increase in 52WW and 78WW patients due to waiting list distribution reflecting 20/21 referral patterns.
- Ongoing risk around patients delaying treatment for Covid and Non-Covid reasons.
- **78WW** trajectory has been agreed from August.





Recovery Activity

QVH Site / Independent Sector

Queen Victoria Hospital NHS Foundation Trust

Point Of Delivery Group	July 2122 Activity	Recovery Plan	2122 Activity Variance against Recovery Plan	2122 Percentage Variance against Recovery Plan	1920 Activity	2122 Activity Variance against 1920 Activity	2122 Percentage Variance against 1920 Activity
Day Case	959	1079	-120	89%	994	-35	96%
Elective	234	264	-30	89%	319	-85	73%
First Outpatients	3204	3267	-63	98%	3427	-223	93%
Follow Up Outpatients	10079	10404	-325	97%	10226	-147	99%
Outpatient Therapies	2508	2225	283	113%	2921	-413	86%
Non Elective	581	553	28	105%	689	-108	84%
Grand Total	**17565**	**17793**	**-228**	**99%**	**18575**	**-1010**	**95%**
RAG RATING		Below 90% of recovery plan		90%-100% of recovery plan		Over 100% of recovery plan	

PERFORMANCE COMMENTARY

- **Day Case** – Main challenge to day case plan is corneo and maxfacs. Corneo is driven by staff shortages, reduced availability for high flow cataract lists at the independent sector and at weekends. Maxfacs is driven by junior staff challenges.
- **Elective** – Sleep continues to drive elective underperformance due to staff shortages.
- **First Outpatients** – Broadly on plan; slight underperformance in corneo due to staffing levels and off site maxfacs.
- **Follow Up Outpatients** – Broadly on plan; underperformance driven by staffing challenges in sleep and corneo.
- Recovery Plan is achieved for **Outpatient Therapies** and **Non Elective**.

FORWARD LOOK / PERFORMANCE RISKS

- **Corneo** – One Fellow vacancy covered, two remaining with planned start dates in September. Recruitment underway for two new Fellow vacancies in November.
- **Plastics** – Forward look expect achievement of in month plan.
- **Sleep** – Elective activity recovering to approximately 50% of plan as predicted. Ongoing technician shortages continue to drive challenges.
- **Spoke site** – Patients converting to maxfacs day cases at Medway are limited.. Capacity and demand is being reviewed.
- **Anaesthetics** – Occasional list cancellation due to anaesthetic capacity
- Ongoing risk around patients delaying treatment for Covid and Non-Covid reasons.
- **Independent sector** – Continued challenge with maintaining sessional arrangements.

Recovery Work Streams

Queen Victoria Hospital NHS Foundation Trust

Virtual Consultations:

Deliver 25% of outpatient appointments remotely by telephone or video consultation.

- Currently achieving the target; 26%.
- Focussed analysis of service utilisation.
- Seeking patient feedback for telephone appointments to shape service improvements.

Patient Initiated Follow Up (PIFU):

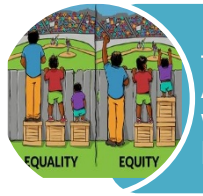
Begin reporting on PIFU activity across the six national metrics from the end of Q2 with a target of 2% of outpatient activity as PIFU.

- Accelerated PIFU target for H2; 2% of outpatient activity now required.
- PIFU reporting process finalised
- Options for further roll out are being explored including facial palsy and other plastic sub specialties.

Advice & Guidance (A&G):

Increase the uptake of A&G to the national ambition of 15% by the end of September 2021.

- A&G target for H2 has increased to 15%.
- Ongoing work to report A&G from DeRS (Dental Electronic Referrals System); internal process change required. Impact being reviewed.
- Limited referrals to A&G services; highlighted at system level.



Health Inequalities:

Address inequalities in access, experience and outcomes, working with local partners across health, social care, and beyond.

- Leadership roles have been identified
- Ethnic coding improvement workstream is underway through Data Quality Group
- Long wait analysis completed for deprivation indices and ethnicity
- Scoping for cancer priorities is underway and will be driven through the Cancer Board

Recovery Work Streams

Queen Victoria Hospital NHS Foundation Trust

Clinical Validation:

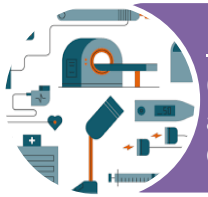
Validate surgical waiting lists to allow operating lists to run effectively.

- QVH diagnostic 'D' code validation is complete in line with system and national deadline.
- Work is underway to ensure upload of clinical national urgency codes (P codes) for off site activity.

Pathway Transformation:

Redesign clinical pathways to increase productivity, and accelerate progress on digitally-enabled care.

- Ophthalmology and ENT identified and system programme delivery has commenced with QVH input. This work includes consideration of a single PTL for general ENT.



Diagnostics:

Community diagnostic hubs (CDH) should be created across the country, away from hospitals, so that patients can receive life-saving checks close to their homes.

- Funding secured, which is primarily for recruitment.
- QVH now live as an early adopter site for diagnostics.
- Work underway to review physiology testing scope within the QVH hub.

System PTL:

System wide management of elective waiting lists to reduce long waiters.

- System tactical PTL meeting has taken place. Initial focus for P2 patients >78 weeks
- System PTL is being developed within the ENT workstream.

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed 23rd August 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 may not be able to recruit or retain a workforce with the right skills and experience due to national staffing challenges impacting and possible 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) Ongoing risk of Covid outbreak impacting on clinical care Risk 1220

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

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
- 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
- Clinical Harm Review process in place

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

Future risks
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility.
- Impact of Sussex partnership plans on QVH clinical and non clinical strategies

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

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 2019 via existing referral pathway. Inpatient paeds on exception basis
- QVH simulation faculty to enhance safety and learning culture in theatres
- Burn Case for Change being developed in collaboration with NHSE
- Amber and green pathways in theatres and wards, asymptomatic staff screening, comprehensive IPC board assurance document, patient screening pathways. New Risk assessment process for staff contacted via "Track and Trace"

Gaps in controls / assurance
- Unknown Specialist commissioning intention for some of QVH services eg inpatient paediatric Sussex based service and head and neck pathway Risks 834, 968, 1226
- Ongoing workforce challenges with recruitment and retention
  Risks 1225, 1199, 1077,

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Date last reviewed: 23rd August 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

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)
- Antimicrobial prescribing (CRR 1221)
- Repeat prescriptions in Sleep (CRR 1164)

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/09/21		**Agenda reference:**	**137-21**	
Report title:	Quality and Governance Assurance				
Sponsor:	Karen Norman, Committee chair				
Author:	Beryl Hobson Trust Chair and 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, clinical harm reviews, clinical risks, patient experience, patient safety and full achievement of 2 of the 3 Q1 quality priorities. The report notes the reintroduction of Compliance in Practice visits and the approval of two policies.				
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 noted the need to extend the scope of the risk relating to staffing.				
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:	137-21
Date of meeting:	02/09/2021
Report from:	Beryl Hobson, Trust chair
Report author:	Beryl Hobson
Date of report:	23 August 2021
Appendices:	NA

Quality and governance committee assurance

The Q&GC wish to bring the following matters from those considered at our meeting on 23 August to the attention of the Board:

1. **Covid 19- update**
   There was significant discussion about the covid vaccination rate amongst staff. The data provided showed 86.2% of all staff had received both vaccines, although this was significantly lower amongst Doctors (76.1%). Further work will be undertaken on understanding this data, including work with individuals to establish why this figure is so low. A further report will be provided to the next Q&G meeting.

2. **Clinical Harm Reviews**
   This item has appeared in previous feedback to the board and the committee was informed again that the 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 informed that the clinicians do have access to support to undertake this process. Those who are struggling to find time will be asked what further support they need.

3. **Corporate Risk Register**
   It was noted that most of the issues on the CRR report had a workforce component. The next meeting will receive a 'deep dive' into the current workforce challenges (this will also be copied to the Finance and Performance committee in view of the overlap between the committees with regard to workforce).

   The committee was reassured that the new antimicrobial steering group has now met and identified various challenges. Some 'small wins' had already been achieved by challenging colleagues with high antibiotic prescribing rates who had subsequently amended their practice. It was agreed that this would become a standing item on the Patient Safety Summary report.

4. **Patient Experience Report**
   Good assurance on patient experience was taken from the most recent results from the "Friends and Family Test" and patient feedback. Thanks were expressed to Nicolle Fergusson who will be leaving the trust before the next committee meeting for her work in this area over many years at QVH.

5. **Quality Priorities Report**
   The committee had a significant discussion on this item and recognised the difficulty in getting engagement on this matter. It also discussed the best way of

presenting data to ensure it is meaningful and how it can turn 'reassurance' into 'assurance'. The committee was asked to record achievement of the Q1 priorities - two were achieved (patients safety and patient experience) and one was partially achieved (clinical effectiveness). Work is ongoing to ensure this last one is met.

6. **Quality and Safety Report**
   The Committee welcomed the news that Ian Francis had been appointed as Deputy Medical Director for Clinical Strategy and Cancer and Sophia Ahmed as Clinical Lead for Governance.

   Discussion about the rise in out of hours surgery highlighted that the regular reviews previously undertaken of OOH surgery are not currently being undertaken. This will be addressed going forward.

   The committee noted that there were 15 occasions when Peanut ward was unable to accept patients due to staffing problems. This was a combination of vacancies, sickness and the unavailability of bank and agency staff during the holiday period. The risk is being managed using onward referral pathways to other hospitals.

7. **Compliance in Practice (CiP) visits.**
   The committee was pleased to see that CiP visits are being reintroduced, albeit in a modified manner initially due to the need to reduce Covid-19 transmission risks.

8. **Policies approved by the committee**
   - Display Screen Equipment policy
   - Management of External Agency visits, Inspections and Accreditations policy

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 September 2021**		**Agenda reference:**	**138-21**	
Report title:	**Corporate Risk Register**				
Sponsor:	Nicky Reeves, Interim Director of Nursing				
Author:	Karen Carter-Woods, Head of Risk, Clinical Quality & Patient Safety				
Appendices:	None				
Executive summary					
Purpose of report:	For assurance that the Trust risk management process is being followed; new risks identified and current risks reviewed and updated in a timely way.				
Summary of key issues	Following the December 2020 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 • No corporate risks closed • No corporate risks rescored				
Recommendation:	The Board is asked to note the Corporate Risk Register information				
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 trust are required to have a corporate risk register and systems in HMT place to identify & manage risk effectively.				
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.				
Resources:	Actions required are currently being delivered within existing trust resources				
Assurance route					
Previously considered by:	Finance and performance committee: all risks except ID1226 (Burns risk – new July) and patient safety risks				
	Date:	26/07/21	Decision:	Noted	
Previously considered by:	Quality and governance committee: all patient safety risks				
	Date:	23/08/21	Decision:	Noted	
Next steps:					

Corporate Risk Register Report
June and July 2021 Data

Key updates

Corporate Risks added between 01/6/2021 and 31/07/2021: 3

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x5=15	1225	Head & Neck Staffing	DoN / HoN
3x5=15	1221	Antimicrobial prescribing	MD / IPCC Lead
4x3=12	1226	Adult Burns - Delivery of commissioned services whilst not meeting all national Standards / criteria	DoN / HoN

Corporate Risks closed this period: nil

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed

Corporate Risks rescored this period: Nil

Risk ID	Service / Directorate	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore

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

Risk Register management

There are 68 risks on the Trust Risk Register as at 3rd August 2021, of which 22 are corporate, with the following modifications occurring during this reporting period (June and July 2021 incl):

- Three new corporate risks added
- No corporate risks closed
- No corporate risks rescored

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

Risk Register Heat Map

The heat map shows the 22 corporate risks open on the trust risk register as at the end of July 2021.
One of the corporate risks remains within the higher grading category: ID877 – Finance risk

	No harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2			**5**	**1**	**9**
Possible 3		**4**	**22**	**9** ID: 834, 968, 1163, 1192, 1210, 1214, 1215, 1218, 1226	**0**
Likely 4		**2**	**5** ID: 1040, 1077, 1136, 1148, 1217	**0**	**0**
Certain 5		**0**	**7** ID1140, 1164, 1189, 1198, 1199, 1221, 1225	**1** ID: 877	**0**

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

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

Link to Key Strategic Objectives

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

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

- Safe
- Effective
- Caring
- Well led
- Responsive

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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
1226	13/07/2021	Adult Burns - Delivery of commissioned services whilst not meeting all national standards/criteria	-Lack of key services and support functions onsite (renal replacement facilities, and other acute medical specialties when needed urgently)□ -Potential increase in the risk to patient safety□ -Potential loss of income if burns derogation lost□	-Operating at Unit+ level□ -Adult Burns inpatient review taking place□ -Strict admission criteria in place, any patient not meeting criteria will be referred on to a Burns Centre□ -Low threshold for transferring out inpatients who deteriorate and require treatment not available at QVH □ -SLA in place with UHS for ITU verbal support	Keith Altman
1225	28/06/2021	Head & Neck Staffing	There is a vacancy of 5.2 WTE on the newly created Head & Neck unit whilst recruitment is taking place. The unit is now open due to demand and is being staffed by 6.82 WTE staff as well as being heavily reliant on bank and agency staff. This poses a risk that the unit is frequently left short staffed which can impact upon patient safety.	- Use of bank staff, an enhanced rate would lead to greater uptake of shifts. □ - Ongoing recruitment, however there have been no suitable applicants in the three adverts that have run so far.□	Nicola Reeves

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
1221	07/06/2021	Antimicrobial prescribing	Audit has shown that there are low levels of compliance with antimicrobial prescribing guidance. Antibiotics are being prescribed inappropriately by being prescribed when there is no indication, they are being prescribed for too long, no indication is being given, no duration is being documented, samples are not being sent for Microbiology analysis and when they are there is often no review of the organism and therefore antibiotic prescription is not altered.	Clear antimicrobial prescribing policy Micro guide available for all staff to download onto their smart devices 24 hours on call Microbiology service Audits of antibiotic prescribing. Infection control guidance and messaging and education of doctors. Indications for antibiotic prescribing mandated on drug charts.	Keith Altman
1218	05/05/2021	Covid-19 Impact on Operational Delivery	Impact of covid-19 on service delivery, recovery and performance.	Suite of SOPs to enable safe service delivery and recovery plans in to support performance requirements.	Abigail Jago

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
1217	30/04/2021	Possible merger	Misinformation from outside the Trust or misinterpretation of information made available by the Trust impacts on confidence in sustainable future of hospital.□ Recruitment and retention issues and concerns from referring clinicians/patients about beginning long term treatment programmes. Increased demands for information through FOI requests and other routes impacts on delivery of core business	Frequent and ongoing staff briefings and engagement. □ Programme of work with governors. □	SJ
1215	08/04/2021	Theatre Surgical Air Systems	Failure of main theatres surgical air systems, this system is for the surgical air tools and theatre pendant brakes.	Temporary air brake system installed using bottled air cylinders; J Cylinder sizes. This is a very limited options to allow the air brakes to operate and to prevent the pendants from rotating during procedures.	Michelle Miles

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
1214	07/04/2021	Theatre Boilers - reduced capacity	Currently there are two heating boilers out of four that have failed serving the main theatres. These boilers operate on demand with only 2 running at any one time, meaning that if a further boiler fails this could cause heating loss to the theatres	Daily checks of plant and operation of heating plant controlled to prevent over working of the remaining boilers	Michelle Miles

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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
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.	Keith Altman

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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	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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
1136	20/12/2018	Evolve: risk analysis has identified current risk within system processes and deployment	There are a significant risk with the current provision of the EDM service within the Trust. The Chief Clinical Information officer has completed a risk analysis which has identified current risk within system processes and deployment.□ There are hazards which remain at level 4 and above using the NHS digital clinical risk management risk matrix indicating the need for: "mandatory elimination or control to reduce risk to an acceptable level".□ Unacceptable level of risk have been identified in the following areas:□ • documentation availability and scanning quality□ • partial rollout of EDM - operating a hybrid model□ • event packs not sent for scanning□ • system speed□ • E form instability□ • incorrect patient data being uploaded to EDM (internal scanning)	A review of clinical risk was undertaken and presented to the Quality & Governance Committee on 21st June.□ The above risks persist, although some improvements in the system and processes have been achieved.□ A number of measures are planned over the next few months to mitigate these risks further and a reduction in the risk rating is anticipated this calendar year.□ 1. A system upgrade is planned to deliver increased performance, reliability and stability. This will also facilitate smoother future upgrades with reduced downtime during the upgrade process. This upgrade will also introduce usability improvements and new features to make document retrieval and editing more efficient.□ 2. A new scanning contract is being negotiated with potential improvements in cost and turnaround time□ 3. We are continuing to develop a solution that automates uploading	Michelle Miles

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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	Abigail Jago

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
968	20/06/2016	Paediatrics: 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	Nicola Reeves

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
877	21/10/2015	Financial sustainability	1) Failure to achieve key financial targets would adversely impact the NHSI "Financial Sustainability Risk rating and breach the Trust's continuity of service licence. 2)Failure to generate surpluses to fund future operational and strategic investment	1) Annual financial and activity plan 2) Standing financial Instructions 3) Contract Management framework 4) Monthly monitoring of financial performance to Board and Finance and Performance committee 5) Performance Management framework including monthly service Performance review meetings 6) Audit Committee reports on internal controls 7) Internal audit plan	Michelle Miles

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead
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	Keith Altman

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
David Johnson	Compliance (Targets / Assessments / Standards)	12	8		KSO1 KSO2 KSO3 KSO5
David Johnson	Patient Safety	15	6	**July** - still awaiting formal upload of budget to allow further recruitment to be undertaken. Flexible workforce being used as available. Activity continues to fluctuate	KSO1 KSO2

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Tania Cubison	Patient Safety	15	9	**July**: anti-microbial stewardship group formed, to meet fortnightly - MD to chair	KSO1 KSO2
Kathy Brasier	Compliance (Targets / Assessments / Standards)	12	8	**July**: recovery implementation ongoing. Patient treatment activity plans broadly on track; some current staffing challenges. June 2021: recovery plans in place, reported through DEC and system reporting requirements.	KSO3

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Claire Pirie	Compliance (Targets / Assessments / Standards)	12	6		KSO3 KSO5
Phil Montague	Estates Infrastructure & Environment	12	8	08/04/2021 Surgical air equipment was reviewed by our incumbents medical air and gas providers and they supplied a replacement costing for this unit for lifecycle earlier in the year, this cost is now being reviewed for the urgent replacement of the equipment.	KSO1 KSO3 KSO5

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Phil Montague	Estates Infrastructure & Environment	12	8	Update 07/04/21 This project has been under review with a M&E designer specialist with full tender documents being drafted and being put together with the tender and replacement imminent. Specific time lines however will be supplied once all the documents have been prepared by the M&E designer and forwarded to the relevant stakeholders.	KSO3 KSO5

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Karen Carter-Woods	Patient Safety	12	8	**July** - Following "freedom day" QVH continues to reinforce mask wearing and social distancing as the rest of the NHS, staff are supported to challenge. Visiting restrictions remain in place at this time. Review of isolation guidance and creation of risk assessment process to support staff returning to work when appropriate June 2021: delay to proposed date for lifting of restrictions; now likely July and not June as was planned □ May 2021: awaiting Government Guidance re last stage of lifting restrictions□ March 2021 R&R Governance meeting fortnightly. CCG support for recent nosocomial issue with C Diff. Updated visitor guidance in place	KSO1 KSO2

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
David Johnson	Patient Safety	15	9	**July** - vacancy reviewed and remains a challenge particularly with band 5 posts May 2021:□ Band 6: 0.14 vacancy □ Band 5: 3.58 WTE vacancy □ Also vacancies on HNU - CCU backfilling□ Unsuccessful recruiting apart from one post CCU□ □ 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
Tania Cubison	Patient Safety	15	9	**July:** Lead consultant for Sleep actively making appointments to recruit□ June: improving situation with proposed new appointments at both consultant and middle grade level□ May 2021: interim CD oversight in place. Action Plan developed and being implemented	KSO3

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Judy Busby	Patient Safety	12	8	**14/7/21** 8b sleep pharmacist interviewing 30 July, antimicrobial pharmacist interviewing 15 July. 0.4wte band 7 did not accept and 1wte that accepted has now declined. Locum left without notice looking for 2 locum pharmacists now without success. Only 60% pharmacist cover with bank and substantive excluding sleep post. 2/7/21 8b sleep pharmacist out to advert. 8a antimicrobial pharmacist left, no applicants first time out but 1 on 2nd advert - interview being set up. B7 pharmacists offered 1wte and accepted hope to start Sep. Looking to offer remaining 0.4wte but days may not suit candidate. Only able to get 0.6wte locum B7 pharmacist not full time. lacking B8a pharmacists. Staff member on long term sick due back on phased return 12th july. 4/6/21 0.6wte band 7 started. new locum has left and no offers of new ones from agencies. Band 8a antimicrobial pharmacist leaves end July. Adverts out for this post and remaining band 7 posts. New sleep band 8b JD awaiting job evaluation. 30/4/21 Appointed 0.6wte band 7 for 2wte vacancy from current locum. New WTE locum starting 5-5-21 to cover remaining vacancy and support sleep work 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	KSO1 KSO2 KSO3 KSO4 KSO5

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Sarah Solanki	Compliance (Targets / Assessments / Standards)	15	9	**29-07-2021** - No progress re the new band 5 recruit. Asked for an update - none received yet. Band 6 roles - interviews on 4th August - 4 candidates all UK. □ □ 20-07-2021 - Band 5 recruit - hoping to onboard prior to HCPC registration and pay top of band 4 - similar approach to nursing. HR supportive. Band 6 job out to advert with amended JD - already more interest than previously. Job advert closes 26th July. Band 7 job advert out at beginning of August. Ongoing work with the AHP faculty to try and increase student intake. Apprenticeships need exec support.□ □ □ 30-06-2021 - Previous band 5 interviewee not suitable. job resubmitted to trac. Band 5 interviews today - 1 good interviewee - graduate student. Offered job - verbally accepted. Band 6 JD - tweaked to training post. JD being consistency checked. Interested party coming to visit on the 8th July. Keen to get apprenticeships etc. approved given the predicted national shortage by 2024.□ □ 04-06-2021 - Workforce difficulties. Rescore considered (DoO & HoR). Band 5 shortlisting complete - interviews on 9th - 1 suitable candidate. Band 6 interviews unsuccessful. Overseas recruitment to be considered. Predicted	KSO1 KSO2 KSO3 KSO5

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Philip Kennedy	Patient Safety	15	6	June 2021: recruitment to substantive post underway following job evaluation. □ May 2021: Locum appointed and undergoing induction□ 23/04/21: □ EMT have agreed to support a Principal Pharmacist post, to work closely with Sleep and manage prescription related issues, including progressing the shared care agreements with CCG/ICS. A JD has been drafted and will be submitted for formal Grading before going to external advert. Chief Pharmacist has also been asked to source locum Pharmacist support in the interim.	KSO1 KSO2 KSO3

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Sarah Solanki	Patient Safety	12	6	**29-07-2021** - Agency consultant now bank. Other consultant needs to confirm PAs with clinical lead and confirm likely start date.□ □ 20-07-2021 - one doctor should be on fixed term contract by 26th July. Other consultant should be on-boarded by mid August - hopefully. Then can close risk once staff onboard.□ □ □ 30-06-2021 - one consultant interview today. Other fixed term contract - submitted ID paperwork/DBS today. Risk closed when contractual arrangements in place □ □ 04-06-2021 - HR processes still under way for both clinicians.□ □ 07-05-2021 - risk will not be closed until all contractual paperwork complete and contracts in place.□ □ 22-04-2021 - paper written for BM to outline current position. Score reduced to 12. Locum wants to join trust to cover fixed term. Bank consultant wants to become permanent for 5 PAs. Once contractual work secured and in place (likely August), this risk can be closed.□ 22-03-2021 - The on-call is now being outsourced to a company meaning the consultant who was	KSO1 KSO3 KSO5

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Mary Gwynn	Finance	12	6	**07/07/2021** - clinician led workshops have taken place. Clinical coder overview workshop booked. Procurement work has began. POAP to extend Monmouth support has been submitted and is awaiting EMT approval.□ □ 04/06/2021 - backlog reduced again following staff absence issues. Monmouth support increased. Clinician engagement T&F group created and engagement work has begun. Encoder in test.□ □ 07/05/2021 - encoder integration work complete and testing will begin this month. Monmouth support remains at reduced level and planning for support procurement underway.□ □ 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.□	KSO4

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Sarah Solanki	Information Management and Technology	15	4	**20-07-2021** - PACS BC discussed at EMT/HMT - supported. Awaiting Trust Board approval 5th August. Risk update paper submitted for F&P on the 20th July. □ □ 30-06-2021 - RIS timeline likely to slip a little. VNA - now have come up with an archive only solution which is the best least risk option for the consortium given the delete API issue cannot be sorted. PACS BC being finalized and need approval at august board. rationale/scope/general risks presented to diagnostic elective care board 30-06-21. Only queries around downtime - not possible to answer currently.□ □ □ 04-06-2021- RIS BC approved. Timelines aggressive for migration so could impact wider project. PACS BC - BAFO completed by 2 final vendors. Clinical consensus over preferred vendor has been reached and formal BC being written. Approval board within Trust has identified. VNA - no update. ongoing issues with delete API. Other trusts have started migration.□ □ 22-04-2021 - VNA work not complete. Less risk to QVH due to current level of available storage. PACS demos and site visits occurring last week and next week. Staff giving feedback on demos. one of the excluded PACS providers have raised	KSO1 KSO2 KSO3 KSO4

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Mr Paul Drake	Information Management and Technology	12	6	**7th July 2021**: complete review of risk and presentation to Q&GC (June) - all 'controls' updated to reflect current situation.□ May 2021: it is anticipated that risks related to scanning turnaround, eForm stability, and system speed will be reduced with the new scanning contract and evolve upgrade that are planned for this year. Access to documentation will be improved with increased eForm development, which will begin when the new EDM team is in place. EDM rollout has almost reached completion, with the inclusion of therapies. Risks related to upload errors and inappropriate retention of event packs remain, and we continue to work with clinical and admin teams to reduce this risk□ 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:□	KSO3 KSO4

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Claire Ziegler	Patient Safety	12	4	**16.07.2021**: International recruits all being supported in theatres completing their competencies. Higher than normal numbers of staff requiring support. Vacancy rate of 7.86 B5 WTE, 1 B6 WTE, 4 B2 WTE recruitment on going. Poor uptake on weekend bank shifts for trauma - staff note enhanced bank rate paid in surrounding trusts and preference to work outside of the trust. Unable to staff all theatres - reviewed on a daily basis. International recruits not in a position to take on additional shift. Reduction in availability of agency ODP's. Currently block booking X 3 for full time hours. One moving out of area and will not continue to work for the Trust. Unable to staff DTC1 for blocks first session - reviewed daily. Combining paed and adult trauma weekly due to lack of ODP. Recruitment on going. □ □ 28.06.2021: Overseas nurses X 2 have now joined. One has received her PIN, one awaiting. Currently working in Admissions due to 6 supernumerary already being supported in theatre. Aim to transfer to theatres within 4 weeks. Interview set for beginning of July for Recovery practitioners with 5 suitable applicants. Band 6 admissions advert had 2 applicants but will readvised for band 5 theatre practitioner. ODP apprenticeship process awaiting final support.□ 25.05.2021: International recruits X 6 now received their PIN's, completed their	KSO1 KSO2

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Sarah Solanki	Patient Safety	12	2	**20-07-2021** - ground work surveys begin over the next week for proposed MRI location. Engineering company visiting site 3 times. Report expected to take 25 days due to soil samples needing lab analysis. ITT draft submitted but project progress needs to wait until surveyor report back. 30-06-2021 - 5 expressions of interest. 15 year contract term agreed. equipment specifications completed. ITT document for framework almost completed. Ground survey needs to occur ASAP. Estates to ask for capital code from capital accounts team. Req to be raised for framework costs and survey ASAP. 16-06-2021 - MES project has started. Working with framework about formal contractual parts. Early contact has shown 3 expressions of interest so far. Estates need to hire surveyor to perform ground surveys/ power surveys etc for the proposed MRI location. 22-04-2021 - RSM has been working on the specifications with PM. Dental specs still need compiling. Estates team engaging with companies about completion of a QS report to establish if proposed site suitable for MRI modular build. Provisional plans completed show the unit would work in that location and deviation of link corridor would benefit those patients walking to eye dept. and hurricane café. Framework still not formally	KSO1 KSO2 KSO3

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
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	KSO2 KSO3 KSO5

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Jason Mcintyre	Finance	20	16	**July 2021**: Current financial regime has continued as block arrangements for H1 (Months 1-6) as yet guidance is awaited for H2 (months 7-12. Currently due to the increase in activity above activity thresholds the Trust is forecasting to achieve plan by Month 6. Further guidance is likely to show an increased need for efficiencies in H2.□ 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□	KSO4

Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
Dr Edward Pickles	Patient Safety	12	4	June 2021: SLA with Associate Director of Business Development. DoN and QVH Paediatric Lead reviewing 2015 standards with a view to updating or changing GAP analysis 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	

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/09/2021**		**Agenda reference:**	**139-21**	
Report title:	Quality & Safety Board Report				
Sponsor:	Nicky Reeves, Director of Nursing and Quality				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	Infection Prevention and Control Board Assurance Framework June 30th, 2021. V1.6				
Executive summary					
Purpose of report:	To provide information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Summary of key issues	The Board's attention should be drawn to the following key areas detailed in the reports: • Assurance regarding asymptomatic staff testing and review of covid vaccination data to identify non-compliant staff and take steps to address • QVH is seeing lower levels of compliance for MRSA screening of elective patients • Intention to re-open the newly refurbished relaxation area in the Surgeons' Mess in early August.				
Recommendation:	The Board is asked to **note** that the contents of the report which reflect the quality and safety of care provided by QVH during this time				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	KSO4: *Financial sustainability*	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	The Quality Report contributes directly to the delivery of KSO 1 and 2, elements of KSO 3 and 5 also impact on this.				
Corporate risk register:	CRR reviewed as part of the report compilation –and the workforce and RTT18 risk impact the most on quality, safety and patient experience.				
Regulation:	The Quality Report contributes and provides evidence of compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's Essential Standards of Quality and Safety.				
Legal:	As above The Quality and Safety Report uphold the principles and values of The NHS Constitution for England and the communities and people it serves – patients and public – and staff.				
Resources:	NA				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	23/08/21	Decision:	Noted	
Next steps:					

Executive Summary - Quality and Safety Report, September 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 staff are also utilising Lateral Flow testing for those who prefer this method. Departmental managers are aware of the requirement to ensure all staff in their teams are carrying out asymptomatic screening. The Covid Infection control BAF is included in appendix 1 for information - updates are highlighted in yellow to reflect changes in national guidance and QVH actions.
Medical Director	**Appointments** Ian Francis, Consultant Radiologist, has been appointed as Deputy Medical Director for Clinical Strategy & Cancer and has taken up his post from April 1. Sofia Ahmad, Consultant Orthodontist, has been appointed as Clinical Lead for Governance. She will be responsible for governance programs including audit, GIRFT projects, 7 day services and starts her role September 1. **Medical Appraisal** Revalidation recommendations are proceeding well with more appraisal group meetings planned to cope with the backlog due to postponement of revalidation and appraisals.

Report by Exception - Key Messages

Domain	Issue raised	Action taken
Responsive: Quality and Safety	Assurance regarding asymptomatic staff testing and risk assessment process for individuals essential for service delivery.	All heads of departments and matrons reminded regarding the importance of maintaining accurate records of asymptomatic staff testing either via LAMB (Optigene) or lateral Flow testing. QVH has a risk assessment process for staff deemed as “essential” to ensure they are able to safely work if they have been contacted via “track and trace”. Review of covid vaccination data commenced to identify non-compliant staff and take steps to address.

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	Q1 2020/21		Q2 2020/21			Q3 2020/21			Q4 2020/21			Q1 2021/22		12 month total/ rolling average
		Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-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	3	4	0	0	1	0	8
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%	81%	83%	90%	83%	99%	93%	99%	94%	95%	94%	95%	96%	86%	92%
MRSA screening - trauma	95%	94%	99%	98%	99%	100%	99%	95%	96%	94%	97%	96%	98%	97%	97%
Incidents															
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Serious Incidents	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Theatre metrics															
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	4	3	3	2	3	3	4	0	5	2	8	5	7	45
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	1	0	1
WHO quantitative compliance		98%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Non-clinical cancellations on the day		0	6	4	5	7	8	0	0	2	5	3	8	5	53
Needlestick injuries	0	0	0	3	0	0	3	4	3	3	2	1	3	2	24
Pressure ulcers (all grades)(Theatre metric)		1	0	0	0	0	0	0	0	1	0	0	0	1	2
Paediatric transfers out (<18 years)		0	2	0	0	0	1	1	0	1	0	0	1	0	4
Medication errors															
Total number of incidents involving drug / prescribing errors		5	1	7	16	7	6	6	9	10	3	9	8	10	92
No & Low harm incidents involving drug / prescribing errors		4	1	6	12	7	5	6	8	8	3	9	5	8	78
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	0.0	0.6	2.2	0.0	0.6	0.0	0.7	1.1	0.0	0.0	1.7	1.1	0.7
Pressure Ulcers Hospital acquired - category 2 or above		2	0	0	0	1	2	0	1	0	2	0	0	0	6
VTE initial assessment (Safety Thermometer)	95%	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	97%	96%	96%	99%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	95%	100%	100%	100%	100%	97%	97%	100%	100%	93%	100%	100%	93%	93%	98%
Patient Falls resulting in no or low harm (inpatients)		4	3	3	2	5	4	4	6	2	1	3	3	4	40
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	0	0	0	0	0	0	0	0	0	0	1	0	1
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

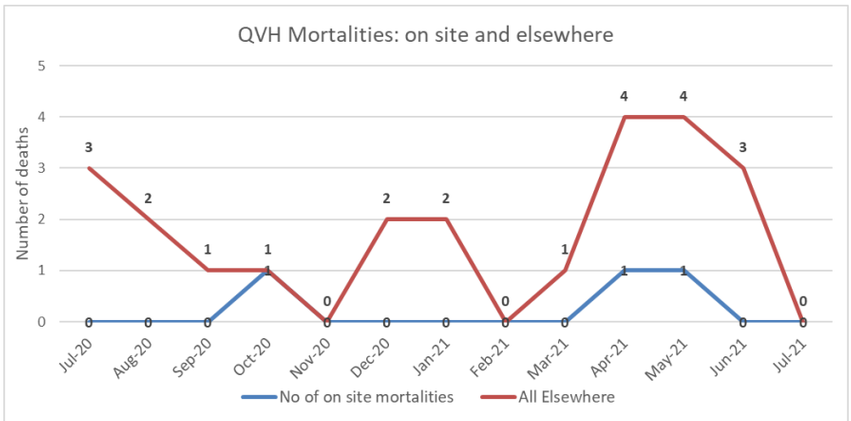
Safe - Performance Indicators

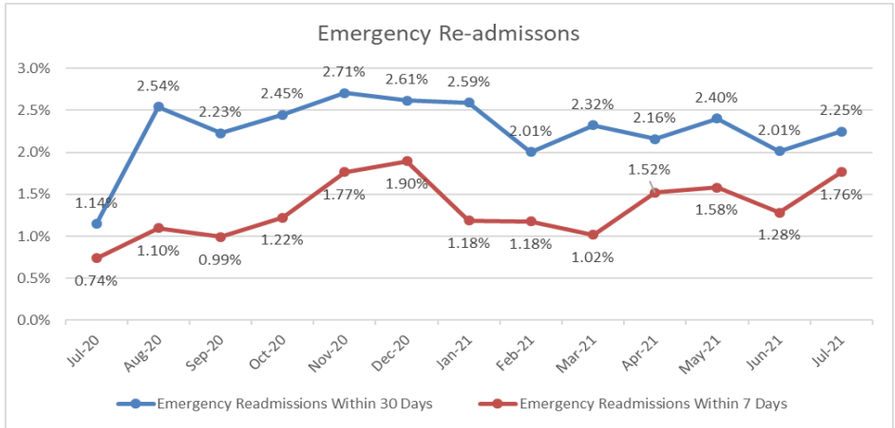
KPI	Latest month	Measure	Target	Variation	Assurance	Average
MRSA - Elective	Jul-21	86%	95%			95%
MRSA - Trauma	Jul-21	97%	95%			95%
Serious Incidents	Jul-21	0	0			0.2
Total no of incidencts involving drug/prescribing errors	Jul-21	8	0			11.2
Falls per 1000 bed days	Jul-21	4.4	0			3.2
Pressure ulcers per 1000 bed days	Jul-21	0	0			0.6
Complaints	Jul-21	1	0			4.7
Mortalities	Jul-21	0	0			1.4

Of concern, we are seeing lower levels of compliance for MRSA screening of elective patients. Positively we continue to see lower levels of drug/prescribing errors. The remaining metrics are not consistently achieving or falling short of our target, but is subject to random variation.

SPC limits calculated using data from September 2017 to date.

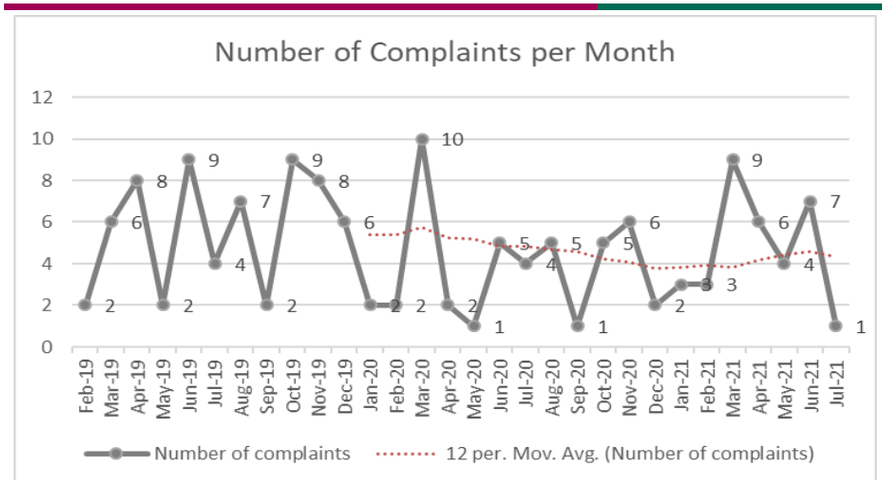
Effective - Performance Indicators

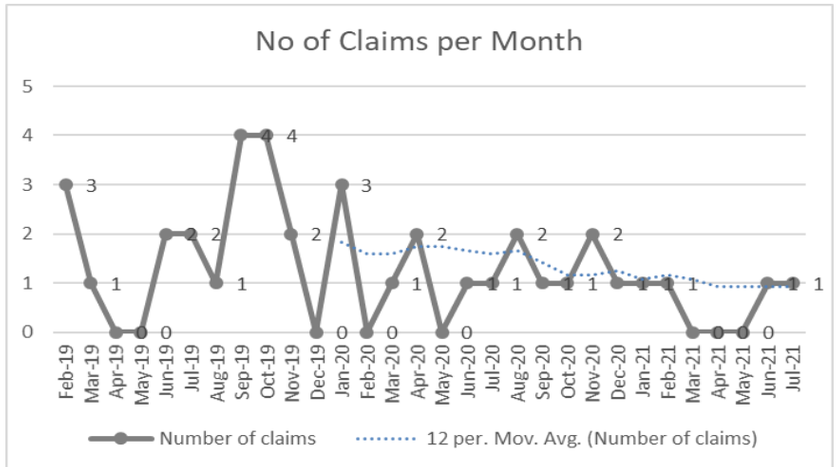




Mortalities Report			Q2 2020/21			Q3 2020/21			Q4 2020/21			Q1 2021/22			Q2 2021/22
			Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Mortalities within 30 days of an inpatient episode or outpatient procedure	Inpatient	No of on site mortalities	0	0	0	1	0	0	0	0	0	1	1	0	0
		No of mortalities elsewhere	2	2	1	1	0	1	1	0	0	1	3	3	0
	Outpatient		1	0	0	0	0	1	1	0	1	3	1	0	0
	All Elsewhere		3	2	1	1	0	2	2	0	1	4	4	3	0
Reviews		Completed Preliminary Reviews	3	2	1	2	0	2	0	0	0	1	1	0	0
		No of deaths subject to SJR	0	0	0	1	0	0	0	0	0	1	3	3	3
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
	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Number of complaints	4	5	1	5	6	2	3	3	9	6	4	7	1
Complaints per 1000 spells	0.27	0.35	0.06	0.28	0.33	0.12	0.20	0.20	0.50	0.31	0.21	0.34	0.05
Number of claims	1	2	1	1	2	1	1	1	0	0	0	1	1
Claims per 1000 spells	0.07	0.14	0.06	0.06	0.11	0.06	0.07	0.07	0.00	0.00	0.00	0.05	0.05
Number of cases referred to PHSO	0	0	0	0	3	0	0	0	0	0	1	0	0

Nursing Workforce - Performance Indicators, Safe staffing data

Peanut ward - In June there were 14 overnight cases on 11 occasions and there were 3 occasions when the ward was unable to accept an inpatient overnight. In July there were 3 patients overnight on three occasions. There were 12 occasions in July when the ward was not able to accept an inpatient, this was as a result of increased vacancies leading to an inability to cover with bank or agency.

June 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%

	Planned staff			Actual staff			Jun-21	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA		RN	NA	HCA	RN	NA	HCA
DAY	5509	218.5	2013	5440	218.5	1955	Total Hrs Planned and Actual	NIGHT 4370	149.5	1254	4324	149.5	1242
				98.7%	#####	97%	% Planned Hrs Met				98.9%	100.0%	99.1%
			7740			7613	Total Hrs Planned & Actual - Combined reg & support			5773			5716
						98.4%	% Planned Hrs Met - Combined reg & support						99.0%

July 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%

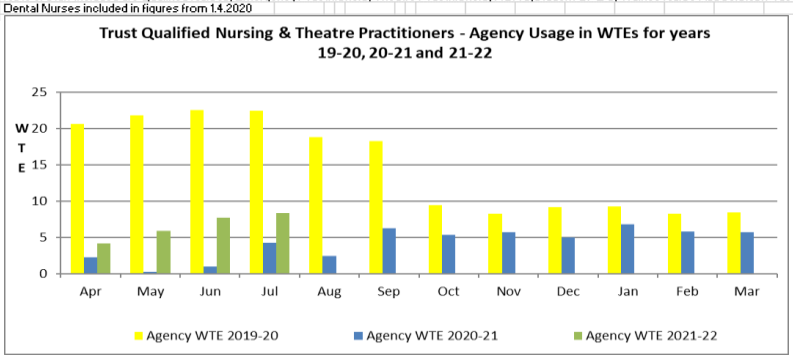
	Planned staff			Actual staff			Jul-21	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA		RN	NA	HCA	RN	NA	HCA
DAY	5704	195.5	2335	5670	195.5	2300	Total Hrs Planned and Actual	NIGHT 4186	218.5	1265	4129	218.5	1254
				99.4%	100.0%	99%	% Planned Hrs Met				98.6%	100.0%	99.1%
			8234			8165	Total Hrs Planned & Actual - Combined reg & support			5670			5601
						99.2%	% Planned Hrs Met - Combined reg & support						98.8%

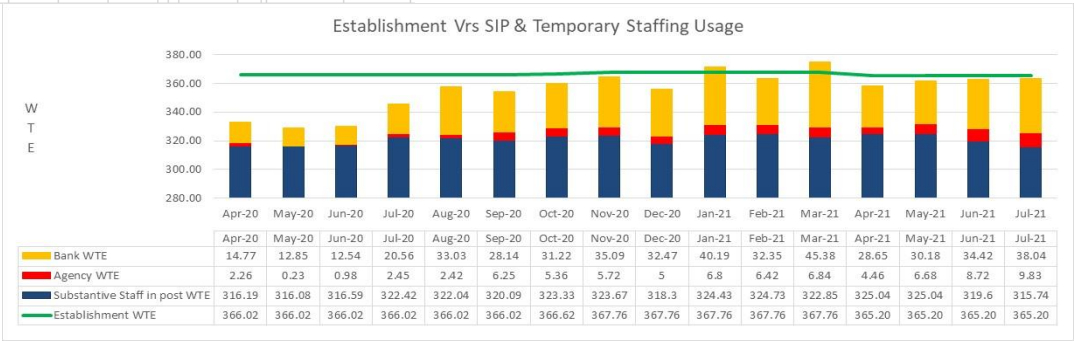
Nursing Workforce - Performance Indicators

ALL QUALIFIED & UQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020-21	Jul-20	####	####	Oct-20	####	####	Jan-21	Feb-21	Mar-21	Apr-21	####	Jun-21	Jul-21	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)		366.02	366.02	366.02	366.62	367.76	367.76	367.76	367.47	367.47	365.20	365.20	365.20	**365.20**	◄►
Staff In Post WTE		322.42	322.04	320.09	323.33	323.79	318.30	324.43	324.73	322.85	325.04	325.04	319.60	**315.74**	▼
Vacancies WTE		43.60	43.98	45.93	43.29	43.97	49.46	43.33	42.74	44.62	40.16	40.16	45.60	**49.46**	▲
Vacancies %	>18% 12%<>18% <12%	11.91%	12.02%	12.55%	11.81%	11.96%	13.45%	11.78%	11.63%	12.14%	11.00%	11.00%	12.49%	**13.54%**	▲
STARTERS WTE (Excluding rotational doctors)		0.61	2.00	2.00	3.63	3.00	0.00	11.56	1.00	1.00	6.15	2.00	3.43	**0.00**	▼
LEAVERS WTE (Excluding rotational doctors)		2.32	2.75	1.00	1.00	4.61	4.36	4.18	0.00	2.88	3.80	0.87	7.62	**3.21**	▼
Starters & Leavers balance		-1.71	-0.75	1.00	2.63	-1.61	-4.36	7.38	1.00	-1.88	2.35	1.13	-4.19	**-3.21**	
Agency WTE [Data from Healthrostered]		2.45	2.42	6.25	5.36	5.72	5.00	6.80	6.42	6.84	4.46	6.68	8.72	**9.83**	▲
Bank WTE [Data from Healthrostered]		20.56	33.03	28.14	31.22	35.09	32.47	40.19	32.35	45.38	28.65	30.18	34.42	**38.04**	▲
Trust rolling Annual Turnover %	>=12% 10%<>12% <10%	8.48%	8.23%	7.79%	7.44%	8.35%	9.21%	8.90%	8.93%	9.34%	9.33%	8.58%	10.91%	**11.36%**	▲
Monthly Turnover		0.77%	0.91%	0.33%	0.33%	1.51%	1.10%	1.14%	0.00%	0.95%	1.26%	0.29%	2.58%	**1.09%**	▼
Sickness Absence %	>=4% 4%<>3% <3%	3.30%	2.54%	2.94%	3.82%	3.87%	4.50%	4.48%	3.13%	3.30%	2.30%	3.70%	3.81%	*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





	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Bank WTE	14.77	12.85	12.54	20.56	33.03	28.14	31.22	35.09	32.47	40.19	32.35	45.38	28.65	30.18	34.42	38.04
Agency WTE	2.26	0.23	0.98	2.45	2.42	6.25	5.36	5.72	5	6.8	6.42	6.84	4.46	6.68	8.72	9.83
Substantive Staff in post WTE	316.19	316.08	316.59	322.42	322.04	320.09	323.33	323.67	318.3	324.43	324.73	322.85	325.04	325.04	319.6	315.74
Establishment WTE	366.02	366.02	366.02	366.02	366.02	366.02	366.62	367.76	367.76	367.76	367.76	367.76	365.20	365.20	365.20	365.20

Medical Workforce - Performance Indicators

Metrics	Quarter 2 2020/21		Quarter 3			Quarter 4			Quarter 1 2021/22			Quarter 2	12 month rolling
	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	
Medical Workforce													
Turnover rate in month, excluding trainees	3.28%	1.01%	1.06%	0.87%	1.08%	1.08%	0.00%	2.70%	30.18%	0.55%	1.33%	0%	16.44%
Turnover in month including trainees 9%	15.26%	4.07%	5.98%	0.55%	2.07%	0.69%	3.26%	6.77%	8.02%	0.35%	2.10%	0%	46.89%
Management cases monthly	0	0	0	0	1	0	0	0	0	0	1	0	2
Sickness rate monthly on total medical/dental headcount	0.55%	1.56%	2.42%	2.03%	1.71%	1.67%	1.24%	1.70%	1.21%	1.52%	1.52%	TBC	1.31%
Appraisal rate monthly (including deanery trainees)	74.51%	77.27%	75.25%	85.88%	76.14%	76.83%	78.05%	83.81%	62.00%	66.67%	67.46%	68.70%	N/A
Mandatory training monthly	86%	81%	80%	82%	85%	85%	82%	81%	83%	85%	84	82	N/A
Exception Reporting – Education and Training	0	1	0	1	0	0	0	1	0	2	1	1	7
Exception Reporting – Hours	0	4	0	1	0	2	3	1	2	2	1	5	21

Medical & Dental Staffing

The plans for August junior doctors' induction are in place, with over 20 new starters across all specialties. Timetables are also being drawn up for the September and October doctors' inductions.

The intention is to re-open the newly refurbished relaxation area in the Surgeons' Mess in early August.

Education	Face to face teaching is completely returning to the Trust, with QVH hosting a regional training day for core surgery in July, and joint full length teaching days restarting for OMFS and Orthodontics. A new HEE County Dean for Sussex is now in post; Fiona O'Sullivan has taken over from Chris Carey as the Trust's point of contact with HEE. The Director of Medical Education and Medical Education Manager have met with her to brief her on QVH so that she can be fully engaged with the trainees at the Trust. Plans are being developed to make full use of the additional funding received from HEE relating to PGME Training Recovery, with some clear guidelines on how the funding can be used. The HEE-funded Dental Skills Lab has hosted its first CPD day for dental staff and the aim is to start running regular sessions, as well as the dental foundation training which will start in September.

Appendix 1
Infection Prevention and Control board assurance framework June 30th, 2021. V1.6

Updates from V1.5 highlighted

1. **Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users**			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; • the documented risk assessment includes: ○ a review of the effectiveness of the ventilation in the area; ○ operational capacity; ○ prevalence of infection/variants of concern in the local area. • triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;	• Each area has been assessed to ascertain safe pathways for patients with clear green and amber routes identified. • Evidence of planning evident through 'Restoration and Recovery' meeting minutes with SOP's produced throughout pandemic for individual services, departments and specific re-starting of procedures. • Ventilation reviewed in key green areas with improvements made through the purchasing of air scrubbers	• Due to the age of the site and infrastructure most departments are without mechanical ventilation with only natural ventilation achieved through windows and doors being opened • There is no way to confirm patients are completing the required isolation period pre-admission and are therefore exposing the Trust to Covid-19 by not following infection control instructions	**July 2021 update** Air scrubbers installed within the CCU to improve ventilation and air flow and potentially increase capacity to facilitate 'amber' CCU level admissions All departments assess the patient flow to ensure green and amber patients follow different pathways. AGP's are performed in side rooms with guidance on fallow time given. Guidance given to reduce fallow time for green patients by utilising on site LAMP

• when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;
• there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative;
• that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance;
• resources are in place to enable compliance and monitoring of IPC practice including:
  ○ staff adherence to hand hygiene;
  ○ patients, visitors and staff are able to maintain 2 meter social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE;
	• All elective admissions are PCR screened pre-admission and isolated as per national guidance
	• High risk/vulnerable patients are isolated for an extended period of time pre-admission
	• Strict admission criteria's in place for green areas
	• All trauma patients are Sars Cov 2 tested on arrival with entry to departments dependent on the result
	• Clear guidance and SOP in place for isolation routes for high risk patients or those confirmed positive
	• Infection control advise on PPE/RPE requirements for all positive cases due to low numbers being admitted
	• All staff are instructed on correct application and removal of PPE with guidance published on what PPE should be worn in each area, FIT testing Trust database held to ensure staff are FIT tested
			(Optigene) Sars-Cov2 testing to ensure patients not Covid-19 positive at the time of procedure
			
			August 2021
			
			Sop produced to provide guidance for staff on whether they can break isolation following a notification to isolate due to contact with a Covid positive case. Strict guidance in place to ensure risk to staff and patients is minimised.

○ 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; • that the role of PPE guardians/safety champions to embed and encourage best practice has been considered; • that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace; • additional targeted testing of all NHS staff, if your location/site 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 is provided to all staff; • IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training; • all staff (clinical and non-clinical) are trained in:	• Regular communication sent to all staff and updated on visitor/patient forums to reinforce the need for social distancing and the continuing need to wear face coverings whilst within the Trust • Waiting areas continue with reduced numbers, staff and rest areas are socially distanced with staff reminded to stagger break times to facilitate this • 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		

○ putting on and removing PPE; ○ what PPE they should wear for each setting and context; • all staff (clinical and non-clinical) have access to the 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; • 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; • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens; • the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data	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 • 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		

submissions via the daily nosocomial sitrep; • the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board; • the 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.	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		
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 nursing/medical teams with appropriate training are assigned to 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	• 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		**July 2021 update** No changes made. Trust already compliant with the stipulated changes in the document evidence of this included in evidence section

cohort areas is carried out in line with PHE and other national guidance; • assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk; • cleaning and decontamination is carried out with neutral detergent followed by 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' is followed for all cleaning/disinfectant solutions/products as per national guidance; • a minimum of twice daily cleaning of: ○ areas that have higher environmental contamination rates as set out in the PHE and other national guidance; ○ 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails;	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 • 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		

○ electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards; ○ rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff; • reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing or repair equipment; • 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 and	clean process. • Reusable sterile equipment is decontaminated and sterilised by Steris • All re-usable patient equipment is cleaned between each patient use and then at regular intervals e.g. weekly/monthly depending on type of equipment and storage space in line with the guidance laid out in the National standards of cleanliness • Decontamination and Disinfection policy in place which details cleaning guidance. • All equipment requiring servicing or repair must have a decontamination form completed and attached to it before work undertaken • Cleaning of patient equipment is documented in ward based cleaning charts		

that actions in place to mitigate any identified risk; • cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment; • where possible ventilation is maximised by opening windows where possible to assist the dilution of air.			
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 for antimicrobial stewardship are maintained • mandatory reporting requirements is 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 • Antimicrobial pharmacist has left the Trust	**July 2021 update** Lack of onsite Microbiology present raised at quarterly pathology review meeting and SLA being reviewed Antimicrobial task and finish group established and meeting twice a month to look at non-compliance with antimicrobial prescribing and identify ways to improve

			Antibiotic prescribing still monitored by pharmacy staff with Infection control team conducting quarterly reviews
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: • national guidance on visiting patients in a care setting is implemented; • areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access; 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, written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	• 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 • Clear guidance available on Trust website for all patients and visitors on current Covid-19 guidance		July 2021 update Regular communication sent out to all staff reminding them of the need to social distance and continue wearing face coverings Infection control maintain an increased availability to provide assurance and guidance to staff on Covid requirements with the incident control centre which continues to be staffed 7 days a week Clear guidance given around when to isolate and to undertake PCR testing A risk averse approach to ill health in staff is maintained to minimise

• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)			the risk of spread of covid-19 within the trust Staff continue with, as a minimum weekly Optigene testing for clinical staff and every other week for non-clinical for prevalence. Lateral flow screening twice weekly is offered as an addition
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 is undertaken to enable early recognition of COVID-19 cases; • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non Covid-19 cases to minimise the risk of cross-infection as per national guidance; • staff are aware of agreed template for triage questions to ask;	• The Trust has been separated to create COVID-19 clear areas for all elective admissions who have undertaken the required isolation and screening. • There is separate area for trauma and elective patients who are non-symptomatic but have not under taken the isolation and screening • All patients are met at the front entrance where they are temperature checked and then directed to the appropriate area.		**July 2021 updates** No changes made, Trust compliant with previous and updated guidance

• triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible; • face coverings are used by all outpatients and visitors; • individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation; • clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with	• 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 • Patients deemed to be clinically vulnerable are put into increased isolation preadmission and treated through separate green areas within the Trust • Side rooms are prioritised for infection control requirements with immunocompromised patients being prioritised for isolation		

separate spaces, but there is potential to use screens, e.g. to protect reception staff. • isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, 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: • patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate	• All staff have received training to ensure they are working in a safe environment. • Communication to staff around social distancing, hand		**July 2021 update** No changes made

entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas; • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe; • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • a record of staff training is maintained; • adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk; • hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ○ hand hygiene facilities including instructional posters; ○ good respiratory hygiene measures; ○ staff maintaining physical and social distancing of 2 metres	washing, good respiratory etiquette has been reinforced • All staff are now screened for Covid-19 on a rolling basis. High risk areas are screened more regularly on a weekly basis. This is monitored on a departmental basis and overseen by a dedicated research team • All staff providing care have been trained on the use of PPE with physical demonstrations and posters produced to ensure they know which PPE to use when and how to put it on and take it off correctly. All staff are FIT tested before they can use an FFP3 mask • Re-use of PPE is in place following PHE guidance with clear instructions on decontamination of PPE. • Monthly hand hygiene and uniform audits are undertaken. • Staff are reminded of		

wherever possible in the workplace unless wearing PPE as part of direct care; ○ staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace; ○ frequent decontamination of equipment and environment in both clinical and non-clinical areas; ○ clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas. • staff regularly undertake hand hygiene and observe standard infection control precautions; • 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;	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- they or a family members displays any of them. –Staff screening is available. • IPC team keep numbers of staff trained , individual training is recorded by staff member • PPE has not needed to be reused at this time. CAS alert guidance would be followed if the situation were to change • The trust follows the national PPE guidance and has a QVH visual guide as well displayed in all clinical areas. Spot check are undertaken by IPC team • This monitoring		

• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas; • staff understand the requirements for uniform laundering where this is not provided for onsite; • 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 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	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		

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 isolated in appropriate facilities or designated areas where appropriate; • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance; • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	• If a patient is suspected of or confirmed to be COVID-19 positive then there is a designated area that they will be cared for, this has been set up with a clear entry and exit room, donning and doffing areas, shower facilities for staff, areas to care for the symptomatic well patient and the deteriorating patients. This area is distanced from other areas within the Trust to minimise the risk of spread. • Any patient with an infectious organism would be managed as per standard infection control precautions. • Departments relocated to different areas within the Trust in order to facilitate trauma patients being brought back to		**July 2021 update** No changes made

	site whist still being able to segregate green and amber patients • All areas assessed by the MDT including department leads, IPACT and estates		
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 and other 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;	• 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.		**July 2021 update** No changes made. All staff continue to be screened for prevalence through optigene screening weekly for clinical staff and every other week for non-clinical. If indicated screening is increased for staff in certain areas. This is supported with staff using twice a week lateral flow tests available through the national testing system.

• that all emergency patients are tested for COVID-19 on admission; • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise; • that 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 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 patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they 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.	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.		
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: • 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 and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current 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.		**July 2021 update** No changes made
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 are risk assessed by their department leads to identify safe		**July 2021 update** 6 further members of staff completed FIT

• 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 assessments 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 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; • 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; • members of staff who fail to be adequately fit tested a discussion	working practices on an individual basis following guidance from PHE • HR have developed and circulated extensive health and wellbeing information and tips. • We currently do not have reusable respirators within the Trust but all staff required to wear a disposable respirator are FIT tested to do so and a log maintained. • Any staff member who tests positive is given information about isolation and keeping well, they are able to contact the infection control team at any time for further advice or support. Support is offered via incident control room and line manager. Return to work advice follows national guidance and this is confirmed with IPC Team or EPRR lead if any queries re this		tester training to ensure all required staff have access to FIT test training

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 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 to adhere to national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas 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:	**02/09/2021**	**Agenda reference:**	**140-21a**		
Report title:	**Safeguarding Adults & Children's Annual Report 2020/21**				
Sponsor:	Nicky Reeves, Interim Director of Nursing				
Author:	Pauline Lambert, Safeguarding Adults Named Nurse and MCA lead Katy Fowler Named Nurse for Safeguarding Children and LAC.				
Appendices:					
Executive summary					
Purpose of report:	Each year a safeguarding report is produced to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.				
Summary of key issues	**Current challenges:** • Safeguarding team have remained on-site during the pandemic; activity has increased • Liberty Protection safeguards legislation to be implemented April 2022 • Developing Restrictive interventions Policy; staff training will be required to support it. **Current achievements:** • All members of the safeguarding team attended level 4 virtual training. • Raising the profile of safeguarding and MCA throughout the trust • Maintaining high levels of staff compliance with safeguarding training • Introduction of a new MCA, best interest and LPA form • Robust connections with West Sussex Safeguarding Adults Board and Safeguarding Children Partnership, and establishment of Child Safeguarding Liaison Group in W. Sussex. • Systematic review of safeguarding polices, protocols, standards & guidance. • National Child Protection Information Sharing system (CP-IS) used by MIU and Peanut • Strengthened Looked After Children (LAC) safeguarding systems across the trust. • Maintained outward facing presence with increased engagement • Safeguarding meetings have continued using online platforms. • Strengthening links with UHS Paediatricians. Including links with Brighton Medical School				
Recommendation:	The Board is asked to **receive** the Safeguarding Adults & Children's Annual Report 2020/21.				
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:	Applicable to KSO1,2, 4 and 5			
Corporate risk register:	No current open corporate risks.			
Regulation:	All Boards must publish an annual safeguarding report and demonstrate to regulators that appropriate safeguards are in place to protect vulnerable adults and all children.			
Legal:	All health care providers are required to meet safeguarding criteria for adults- Care Act 2014. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to safeguard and promote the welfare of children.			
Resources:	No new resources required			
Assurance route				
Previously considered by:	Quality and Governance Committee			
	Date:	26/07/21	Decision:	Noted
Next steps:				

Queen Victoria Hospital
NHS Foundation Trust
Holtye Road,
East Grinstead
RH19 3DZ

Safeguarding

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2020 to March 2021

DRAFT VERSION 2

Document Control: committees and groups who have approved this report
Executive sponsor: Nicky Reeves, Interim Director of Nursing

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

Date: April 2021

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DRAFT VERSION 2

Contents List

1.	Executive Summary
	Each year a Safeguarding Report is produced for QVH Board to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively. The report is reviewed and scrutinised by the Quality and Governance Committee before being shared with the Board for information. QVH safeguarding systems and arrangements continue to be improved and strengthened. Safeguarding support for staff is well established. Safeguarding Audits continue to provide assurance for the organisation and also identify any key development areas. **Current challenges are:** COVID has continued to be a challenge throughout 2020- 2021. The safeguarding team have remained on-site throughout this period to provide advice and support to staff; during this period safeguarding activity increased. This was partly due to ensuring that our most vulnerable patients were kept safe. Part of the role of the safeguarding team is to provide training; to enable us to continue safe delivery of safeguarding training programme and maintain consistently high levels of compliance, the safeguarding team, with the support from the learning and development team, have successfully delivered virtual training at levels 1-3. MCA Liberty Protection safeguards Restrictive interventions **Current achievements are:** All members of the safeguarding team have worked to maintain and develop their knowledge and experience in the role, attending level 4 virtual training, with the support of the trust. The safeguarding team strive to raise the profile of safeguarding and MCA throughout the trust and have recently had approved a safeguarding supervision policy to lay out with staff how support and supervision is delivered at QVH. Continuing engagement of staff and recognition of safeguarding responsibilities. Maintaining high levels of staff compliance with safeguarding training at all levels throughout the Covid pandemic, with delivery switched online. Staff have adapted well to this change; however, the safeguarding team look forward to getting back into the classroom soon as face-to-face sessions generate discussion resulting in enhanced learning. Datix reporting systems continues to enable the safeguarding team to monitor safeguarding decisions made and effectively enabling production of monthly board metrics.

	Mental Capacity Act (MCA) has been a trust priory for the last year. Much work has been completed in 2020/21, which has culminated in the introduction of a new MCA, best interest and LPA form, which was launched at a recent Joint Hospital Governance by Pauline Lambert and Mr Keith Altman. There is a workshop planned during 2021 to update consultants on MCA case law. Robust connections with West Sussex Safeguarding Adults Board and Safeguarding Children Partnership and the establishment of Child Safeguarding Liaison Group within West Sussex. Systematic review of relevant QVH safeguarding polices, protocols, standards and guidance. QNet intranet safeguarding and MCA pages are kept updated. National Child Protection Information Sharing system (CP-IS) being used by MIU and Paediatric Ward; this works well for identifying Looked After Children and those on a Child Protection Plan. Strengthened Looked After Children (LAC) safeguarding systems across the trust. QVH Named Nurse for safeguarding children and looked after children's attendance at the newly created LAC NHS professionals meeting. This encourages dissemination of good practice across the network of professionals working with this cohort of children and networking opportunities. QVH maintains an outward facing presence with increased engagement across both the safeguarding adult and children's agendas. During Covid, safeguarding meetings have continued using online platforms enabling us to be actively involved. Ongoing and strengthening links with UHS Paediatricians. Including incorporating links with Brighton Medical School to research the features of accidental and non-accidental injuries using the MDT database, next year.

2.	**Introduction**
2.1	Each year a Safeguarding Report is produced for QVH Board to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.
2.2	QVH is registered with the Care Quality Commission (CQC). To be registered, QVH must be assured that those who use the services are safeguarded and that staff are suitably skilled and supported to provide effective safeguarding as part of health care delivery. As a Foundation Trust, QVH is licensed via NHS Improvement, which is conditional upon registration with the CQC. In the last CQC inspection report (2019) the CQC report said: 'There were arrangements to keep service users safe from abuse which were in line with relevant legislation. The majority of staff had received training, were able to identify who might be at risk of potential harm and knew how to seek support or advice', 'Staff understood and complied with the relevant consent and decision-making requirements of legislation, including the Mental Capacity Act, 2005'.

	Mandatory training targets for 2020 were 90%. At QVH safeguarding Level 1, 2 and 3 uptake is achieving over 90%. WRAP/ Prevent Level 3 training is also above the target; currently at 91% uptake. QVH had a CCG Safeguarding Site visit in July 2019. Due to Covid there have been no site visits during 2020. QVH must demonstrate that there is safeguarding leadership and commitment at all levels of the organisation and that staff are fully engaged. To support local accountability and assurance structures QVH safeguarding leaders need to engage with West Sussex Safeguarding Children Partnership (WSSCP), West Sussex Safeguarding Adults Board (WSSAB) and relevant commissioners. QVH must ensure a culture exists where safeguarding is every bodies business and poor practice is identified and addressed. QVH must have in place effective safeguarding arrangements to safeguard children and adults who are at risk of abuse or neglect. These arrangements include: safe recruitment, effective training for staff, effective supervision arrangements, working in partnership with other agencies, identification of a Named Doctor and Named Nurse for safeguarding, plus a Named Nurse for adult safeguarding and Mental Capacity Act lead. The named professionals have a key role in promoting good professional practice within QVH, supporting local safeguarding systems and processes, providing advice and expertise, and ensuring safeguarding training is in place, is delivered and of a suitable quality. They are expected to work closely with QVH Director of Nursing, West Sussex Designated Professionals, WSSCP and WSSAB.
2.3	The effectiveness of safeguarding systems is assured and regulated by a number of mechanisms. They include: • Internal assurance processes and Board accountability • Partnership working with WSSCP and WSSAB • External regulation and inspection by Care Quality Commission (CQC) and NHS England. • Local safeguarding peer review and assurance processes • Effective contract monitoring
2.4	QVH Board members review monthly safeguarding metrics at the Quality and Governance Committee and receive an annual safeguarding report, which is provided so that the Board can be assured that the Trust is undertaking its safeguarding duties and responsibilities, as well as delivering its statutory safeguarding responsibilities safely and effectively.

	The Board should critically appraise the QVH safeguarding report by making sure patient safety, staff activity, governance arrangements and safeguarding data are transparent and clear so that they can confirm they are assured.

3.	**Legislative Frameworks and National Safeguarding Agenda.**
3.1	**Safeguarding Adults:** Safeguarding means *"protecting an adult's right to live in safety, free from abuse and neglect" (Care Act 2014).* To implement this Act a three-step test is applied to patient circumstances: does the patient have care and support needs, are they at risk of or experiencing abuse or neglect, and are they unable to protect themselves. The arena for safeguarding adults continues to evolve since the implementation of the Care Act (2014). However, the aims of safeguarding adults remain unchanged. Organisations such as QVH, must stop abuse or neglect wherever possible, prevent harm and reduce the risk of abuse or neglect to adults with care and support needs. They should safeguard adults in a way that supports them in making choices about how they want to live their lives and provide information in accessible ways to help adults understand how to stay safe and what to do to raise a concern. In order for staff at QVH to achieve these aims, it is necessary to ensure that all staff are clear about roles and responsibilities, create strong multi-agency partnerships and support the development of a positive learning environment. As an organisation, QVH adhere to the Sussex Safeguarding Adults policy & procedures as this provides an overarching framework to coordinate all activity undertaken where a concern relates to an adult experiencing or at risk of abuse or neglect. These procedures represent standards for best practice in Sussex and have been endorsed by Brighton & Hove, East Sussex and West Sussex Safeguarding Adults Boards. They are available online, with links to the website via the internal intranet (QNET). This document is reviewed and updated by the West Sussex Safeguarding Adults Board.
3.2	**Safeguarding Children:** *'The welfare of the child is paramount'* principle was enshrined in the Children Act 1989 and has driven the development of systems and arrangements used to safeguard and/or protect children since that time. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to ensure that services are designed to safeguard and promote the welfare of children. The Section 11 self-audit is required to be completed bi-annually and was completed in 2020. All actions were assessed as green, with evidence provided to support the assessment, with the exception of one amber section, which required the creation of a safeguarding supervision policy. This has been ratified and is now live within the expected timescales. National guidance also stipulates that each NHS trust must identify a lead nurse for Child Sexual Exploitation (CSE) and Looked After Children (LAC, sometimes referred to as 'children in care'). These responsibilities are part of the Safeguarding Children Named Nurse Job Description. The Local authority have requested that we make them aware of any children who are not in education or privately fostered to enable them to undertake their statutory duties; we have

	ensured that this is completed for all children throughout the geographical area that QVH cover. These are reported in the monthly metrics that go to the board for information.
3.3	**Mental Capacity Act (MCA) 2005 & Deprivation of Liberty Safeguards (DoLS):** The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) have placed an emphasis on ensuring that the rights of vulnerable people (aged 16 and over) to make decisions are protected. Decisions made on behalf of people who lack capacity to do so themselves should only be made using the MCA legal framework. Capacity is described as a person's ability to make a specific decision at a specific time, for example - for specific serious medical treatment or surgery. The DOLS were added into the MCA and is an additional Safeguard providing guidance on procedures that ensures care and treatment for those who lack capacity to consent to their accommodation is only delivered in their best interest and using the least restrictive options to ensure their safety. To be lawful, it needs to be authorized by the local authority, but in the hospital urgent self-authorization can be used when necessary. QVH staff are required to understand and comply with the requirements set out in the MCA 2005. The QVH Mental Capacity and Deprivation of Liberties Policy was reviewed and updated during 2021. A new QVH orange mental capacity assessment and best interest form has been introduced in the trust, based on a Department of health template we are currently testing out whether this works for medical colleagues. At year-end compliance rates for Mental Capacity Act training are currently at **92%** across the organisation. A departmental risk assessment for MCA is in place until a clear organisational overview of implementation in practice is embedded using Datix to capture the required data. Currently the organisation is aware of cases reported to the MCA lead, re-audit of MCA knowledge was completed. A patient file audit is being planned for 2021. Implementation of Liberty Protection Safeguards (LPS)legislation to replace Deprivation of Liberty Safeguards (DOLS) has been delayed until April 2022.QVH are represented at the Sussex LPS steering group by QVH named nurses. The new legislation will apply to patients who lack capacity from 16 years onwards. There is a departmental risk in place regarding LPS as legal implementation will be required once it starts.
3.4	**PREVENT** The United Kingdom's long-term strategy for countering international terrorism is called 'CONTEST'. Published in 2006 and reviewed in 2009, 2011, 2018, its aim is 'to reduce the risk to the UK and its interests overseas from terrorism, so that people can go about their daily lives freely and with confidence'. CONTEST comprises of four key elements: • Pursue: to stop terrorist attacks ~ detecting and disrupting threats of terrorism. It is targeted at those who have committed a crime or are planning to commit a crime.

	• Protect: to strengthen our protection against a terrorist attack ~ strengthening our infrastructure from an attack including buildings, public spaces and our borders. • Prepare: to mitigate the impact of a terrorist attack. Focuses on where an attack cannot be stopped and aims to reduce its impact by ensuring we can respond effectively. • Prevent: to stop people becoming terrorists or supporting terrorism. 'Prevent' is different from the other three in that it focuses on early intervention before any illegal activity takes place and hence operates in the non-criminal sphere. Involving a broad range of partners, it is about minimising the risk, at an early stage, of people adopting extremist views which support violence or terrorism. NHS providers are expected to contribute to the Prevent agenda. All clinical staff are expected to undertake Level 3 Prevent training which is currently at 91%. Prevent basic awareness training is provided to all QVH staff as part of safeguarding training sessions at levels 1 and 2 and is currently uptake is at 92%. The Named Nurses represent QVH at the newly formed Prevent Leads Meeting run by the Clinical Commissioning Group Designated Nurse for Safeguarding Adults. The meetings have included a presentation from the Department of Health and Social Care where attendees had the opportunity to input into changes to national training as well as emerging national priorities within Prevent.

4.0	**Sussex Clinical Commissioning Groups (CCGs) Safeguarding Standards**
	During 2016-2017 the CCGs used the *Safeguarding Vulnerable People in the Reformed NHS : Accountability and Assurance Framework* (March 2013, updated 2019) to produce a set of Sussex Safeguarding Standards to make explicit their expectations of NHS providers in relation to safeguarding. The CCGs across Sussex have in place quality and safety systems, and processes in order to enable continuous improvements and the 'safeguarding standards guidance' now forms part of these arrangements. The nine standards were developed to enable assurance to be provided to demonstrate patients of all ages are safeguarded effectively. The standards enable all parties to identify key benchmarks to ensure an effective, systematic, auditable approach to enable the safeguarding of all patients, whatever their age. The Sussex standards were reviewed and updated by the CCGs during 2019.These standards were shared with QVH Board at a safeguarding seminar during November 2019, this will be repeated in 2022. In the meantime, one to one discussions are undertaken with all new board members. The standards enable the safeguarding team at QVH, as well as commissioners to audit against benchmarks to ensure effective measures are in place. This section of the report is organised based on these standards. Additional standards for Looked After children (LAC) have been added which the safeguarding team reports on via the CCG exception reporting system.

4.1	**STANDARD 1: Strategic Leadership**

The Executive Board Lead for safeguarding vulnerable people, MCA & DOLS is the Director of Nursing who oversees compliance with safeguarding legislation and trust responsibilities. The purpose of this role is to monitor protection of people who use services at QVH and to ensure these are understood by staff and implemented throughout the organisation**.**

The QVH Safeguarding Strategy (2019 due for review and update 2022) supports a progressive response to the changing landscape framing the delivery of healthcare services at QVH. An action plan sits under this strategy and this can be reviewed in Appendix A.

QVH has robust safeguarding governance arrangements in place, which are led and supported by a team of specialist safeguarding clinicians. The QVH governance structure provides transparent lines of accountability, clear partnership connections with internal QVH meetings which are in place to support learning from practice and delivery of effective safeguarding.

In March 2020, due to the COVID-19 pandemic, the safeguarding steering group meetings were paused; these recommenced in September 2020. During this period staff were updated with safeguarding messages which were shared via regular trust COVID 19 updates and through Connect, QNET and the Safeguarding team.

The Safeguarding team currently links with the Designated nurses and the wider Sussex safeguarding network via regular meetings to ensure that QVH is kept updated on the fast-changing local safeguarding picture. During COVID 19 weekly safeguarding children and two weekly safeguarding adult virtual meetings were used to manage safeguarding pressures across the county. The safeguarding team disseminate relevant information to staff in a timely way. QNET safeguarding and MCA pages both have COVID 19 sections which staff can also access.

The QVH safeguarding team comprises of (see structure chart appendix B) :

- Nicky Reeves, Interim Director of Nursing and Quality, Executive Board Lead for Safeguarding
- Pauline Lambert, Named Nurse for Safeguarding Adults (covers: Adults, MCA & DoLS Lead and Prevent Lead)
- Katy Fowler, Named Nurse for safeguarding Children (covers: Children, Child Sexual Exploitation (CSE) lead and Looked After Children (LAC) lead and Prevent Lead)
- Ms Tania Cubison, Named Doctor Safeguarding.
- Debra Yeoh, Nurse Specialist Safeguarding Children.
- Hillary Durrant has provided additional adult safeguarding resource.

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

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

Across QVH there is a network of link champions for safeguarding from service areas. They attend a safeguarding steering group to discuss clinical issues, access information, review learning and to share practice improvement across the organisation. We are reconnecting with link champions now that the steering group has been recommenced.

The Joint Hospital Governance Group provides a far-reaching internal audience where safeguarding discussions can be undertaken, such as sharing learning from Safeguarding Reviews and Audit, and how improvements in practice might be applied in QVH. It is a useful conduit for learning from case examples and experiences. It was used to launch the new MCA paperwork and for presentation of a complex adult safeguarding case during 2020-21.

Driving improvement in all aspects of safeguarding practice is a continuous process and as such has to be reviewed, evaluated, developed and adapted over time. There is a safeguarding learning and development strategy for the organisation to steer and facilitate staff competency development in all aspects of safeguarding. Level 1 and 2 safeguarding training now incorporates both adult safeguarding, child safeguarding and MCA into a single session to allow staff to be updated on all safeguarding issues and reduce repetition.

Safeguarding training is currently delivered via MS Teams, due to the Covid pandemic. This has meant limited opportunity to gather evaluation formally; however, feedback from the online training sessions has been positive. We are setting up a formal process working with our colleagues in LDC.

We continue to offer level 3 Adult and Child Safeguarding sessions separately for consultants and those members of staff who require this additional level of training. These sessions are undertaken twice yearly. Staff also have the opportunity to access other level 3 training off site, as part of their personal development, including those run by the local safeguarding Boards, external conferences and workshops. During 2020-21 the CCG offered funded training through an external training provider.

The delivery of effective safeguarding is dependent on multiagency working. We are actively involved in West Sussex board and partnership work streams and groups. The responsibility to attend meetings have been shared between the Named Nurses and Director of Nursing.

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

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

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

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

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

Safeguarding supervision is offered to all QVH staff as required on a case-by-case basis, supported by QVH safeguarding supervision policy. The safeguarding team also offer bespoke training sessions for teams or individuals via discussions in team meetings. The purpose of these activities is to strengthen communication, networking and dissemination of safeguarding information and practice across the organisation. For example, a safeguarding alert was raised regarding a patient consent process. This was discussed at the plastics governance and learning shared.

Safeguarding supervision is provided to the Safeguarding team on a regular basis by the Sussex Designated Nurses team for Safeguarding Children and Adult Safeguarding Named Nurses. During the Covid period QVH has been designated as 'a clean hospital' meaning we have not been expected to care for COVID patients on site. Therefore, to reduce movement across the QVH site safeguarding supervision was provided via telephone to prevent additional traffic coming onsite and minimise infection risk.

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

Staff are provided with support to manage any concerns they raise.

Human Rights: Protecting the vulnerable and those at risk, is a key component of our trust objectives. Focussing on quality and patient experience we work alongside partner agencies to promote the safety, health and well-being of people who use our services.

QVH has effective systems in place to highlight and respond to shortfalls in capacity which have an impact on the ability to meet safeguarding responsibilities. These are highlighted to the board through the internal DATIX reporting system, and regularly discussed at the strategic safeguarding group meetings and reviewed by the Safeguarding Named Nurses.

There is currently no safeguarding corporate risks.

There are three safeguarding departmental risks:

- Not able to demonstrate full compliance with implementation of the MCA, currently data captured on the Datix system covers cases brought to the attention of the safeguarding team (risk rating 9 - LOW) Nursing and Quality department. MCA quality priority was in place this year, details are outlined later within this report.

	• MIU risk (Risk rating 6- LOW) relating to access to previous information held in the trust about patients re-attending. Staff in MIU do not access the full records of patients when they attend, this poses a risk in terms of safeguarding. Work is underway to mitigate the risks including health records now amalgamating individuals MIU records from January 2021. The trust has approved the implementation of EMIS an integrated community facing system where primary care information is available for MIU staff to access, this should include social information shared with the GP. • The introduction of Liberty Protection Safeguards (LPS) to replace DOLs during 2022. Corporate risk (Risk rating 9): legislation due to be implemented in 2022. Records will be subject to legal scrutiny for this aspect of care delivery. QVH safeguarding team are involved in the Sussex-wide LPS steering group. QVH has a 3-year rolling safeguarding audit programme in place, which includes information on the audit methodology being used, involvement of managers and staff and how the findings from audit will be disseminated. QVH Safeguarding Audit programme was delayed due to COVID-19, however the safeguarding team are working hard to catch up with the rolling programme. An overview of the rolling audit programme can be found in Appendix C.
4.2	**STANDARD 2: Lead effectively to reduce the potential of abuse**
	QVH has policies, processes and procedures in place to enable staff to manage and when required to report any concerns they have for patients or members of the public attending QVH sites. If their concerns are not heard there are escalation processes which can be used. Training and procedures help to highlight how people's diversity, beliefs and values may influence the identification, prevention and response to safeguarding concerns. The QVH safeguarding 'documents and information overview' is provided for the organisation in APPENDIX D to demonstrate interaction between a range of policies and procedures when safeguarding is might be under consideration. QVH has a clear, accessible and well-publicised complaints procedure. This includes information about how to complain to external bodies such as regulators and service commissioners, as well as relevant advocacy and advisory services. Information regarding Gillick competence, mental capacity and Lasting Powers of Attorneys (LPAs) is cross-referenced with other policies (such as consent) and safeguarding procedures. The Datix data collection system captures safeguarding (adults, children and MCA) practice and learning across the organisation. Safeguarding Datix reports are shared across the organisation to aid case discussion and to share learning via the Steering group. QVH place great importance on ensuring patients have an excellent experience. The trust continues to develop ways to engage and listen to patients, collecting views, comments and ideas from them, their families and carers which then inform future plans to further improve patient experience. Board committees review results from Family and Friends Tests (currently suspended nationally due to COVID-19) and the NHS Annual Staff Survey. QVH safeguarding team review and update information produced for patients and their families. Including:

	• QVH safeguarding children and young people leaflet for families. • Information leaflet regarding attendance at the trust with dog bite injuries for all patients. • Next of Kin: understanding decision making authorities • Mental Capacity Act Guide for patients and their families • Young People in Work experience from Health and Safety Executive. This can be provided for those YP who are injured at work • Deprivation of Liberty Safeguards and you. • Parental Responsibility • Children missing in education The Safeguarding Team are producing additional leaflets to support patients; once approved they are made available on our website, such as 'MCA for 16 and 17 year olds; a parents guide' and 'MCA for 16 and 17 year olds: a young persons guide'. QVH posters and leaflets encouraging patients to talk to staff, clinical managers, PALs and the safeguarding team if they have any concerns about a patient are available across the hospital site. Safeguarding and MCA Team posters have been distributed across all patient-facing departments to ensure staff have rapid access to contact details. We have continued to work to make sure all clinical areas have Domestic Abuse support contact posters on display. During 2020 the CCG launched ICON throughout Sussex, this programme addresses infant crying. Its aim is to prevent abusive head trauma and is evidence based. Although QVH does not have a maternity unit, we have supported the key messages of ICON by having posters available in key areas within the trust for parents to see, we also include this in training. During 2019-20 Max-fax adult safeguarding and Safeguarding referrals audits were undertaken as part of a rolling programme of safeguarding team audits. These audits are useful to inform development of practice, policy and training. The Max-Fax team have produced two audit papers and submitted them for publication following on from the safeguarding children and adult safeguarding audits they undertook. This is to provide opportunity for shared learning and peer scrutiny with a wider audience. Due to the Covid pandemic all training, levels 1, 2 and 3, were provided virtually via MS Teams to minimise the risk of infection transmission. The safeguarding team have worked hard to change delivery of the training to ensure that compliance has remained high throughout the pandemic. As a result of new systems, formal evaluations were not obtained from staff undertaking safeguarding training. The safeguarding team are working with the learning and development team to discuss how safeguarding training will be delivered in 2021 forwards. There has also been agreement on how to obtain ongoing evaluations this coming year.
4.3	**STANDARD 3: Responding effectively to allegations of abuse**
	QVH have arrangements in place to ensure that patients are safeguarded by responding appropriately to any allegation of abuse or neglect. <u>Safeguarding Adults Activity</u> The Safeguarding Named Nurse receives notification of any safeguarding concerns relating to adults via email or the DATIX reporting system. Each concern raised is reviewed and investigated. Process issues and learning from each event is now shared using monthly and quarterly safeguarding Datix Reports.

This approach provides oversight of all safeguarding adult referrals made to social care services across the region.

The table in Appendix E provides details of the monthly safeguarding adult activity reported on DATIX for the past year.

Safeguarding Children Activity

The Children's Safeguarding Team receive reports of any safeguarding children concerns, which occur within QVH via email and through DATIX. These are followed up by the Children's Safeguarding Team; providing support for staff managing these situations as well as a means to review case management, following up outcomes with statutory partners and to enable learning to be shared.

The QVH Electronic Document Management system (Evolve) is currently being used within the trust. There is a safeguarding section available for all patients, which can be used to file safeguarding information to make sure it is available for staff seeing the patient. There is an access audit system in place so that all access is monitored.

The safeguarding team have been working closely with the Evolve team during this year. Some safeguarding information had been scanned to the wrong section and therefore not easily seen. Evolve team have been working to address this problem. Safeguarding team involvement is captured in children's paper record and for adults is added to EVOLVE safeguarding section.

The safeguarding children named nurse worked with the paediatric matron to redesign the children's trauma proforma and produced a separate safeguarding section that can be filed in the right place on EVOLVE.

The safeguarding section in QVH Electronic Discharge Summary was to be audited this year but this has been delayed because of the pandemic. The purpose of this section is to enable handover of care to GP and other community health services.

The National Child Protection Information systems (CP-IS) is used by Minor Injuries Unit and Peanut Ward to check whether children or young people have a child protection plan or are looked after by a local authority. This national database provides the means for robust communication regarding vulnerable children across and between NHS and local authority systems nationwide, although there are limits to the system.

When Looked After Children (LAC) attend the hospital for treatment, staff check who can provide consent, contact details for their Social Worker and which Looked After Children nursing team to liaise with. QVH safeguarding training includes LAC and is backed up by QVH prompt cards. These cards also provide guidance on managing information regarding privately fostered children as well as for those in the care of a local authority. The QVH safeguarding team have taken advice from the LAC Designated Nurse system regarding special guardianship orders and record keeping requirements.

All QVH safeguarding concerns are captured on the DATIX system for recording purposes only. Enabling monthly Board metric reports to be provided to the Director of Nursing and Clinical Governance group. See Appendix B for overview of paediatric safeguarding activity during the past year

Allegations Against Staff

	The Director/Deputy Director of Human Resources would be involved in the management of the Trust response to any allegations against trust staff. *'Allegations against staff'* procedures are followed. During the last year, there have been no concerns, which required investigation relating to staff. We did have one inquiry from the police but no further action was necessary. We do not currently have any National *Allegations against staff* data with which to compare against other trusts.
4.4	**Standard 4: Safeguarding practice and procedures**
	The Safeguarding Team develop a wide range of documents for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. For a list of what is in place for QVH please refer to Appendix B. Documents are placed on the Website or QNET intranet. Patient leaflets are made available in clinical areas. All documents are systematically reviewed and updated in collaboration with relevant services and governance groups. Information is monitored and reviewed regularly and updated on the QNET, including information on who to contact for advice and support. QVH prompt cards have been updated in 2020 and are available on the Intranet for staff. The safeguarding team are keen to develop these in an App form for staff, this has yet to be progressed. We also promoted the use of the national safeguarding guide App at governance events and during training. This provides useful safeguarding information in an easy to access form. <u>Prevent:</u> The delivery of the '*Prevent*' agenda in the trust, is led by the Safeguarding Named Nurses who are both 'Prevent Leads' for the trust. Level 3 PREVENT training is now delivered via a National eLearning package. Staff refresh reminders are incorporated into Level 1, level 2 and level 3 face to face training events (Currently via MS teams). The PREVENT approach is explained in the QVH Safeguarding Policy. The Prevent delivery plan which is a tool kit for the Prevent leads is available via the QNET. Level 3 Prevent training compliance data increased to 92% across QVH; a figure of 85% compliance is required nationally. The safeguarding team provide refresh update training with staff as part of safeguarding training sessions. QVH report Prevent data to NHS England quarterly, no Prevent referrals were made during 2020-21. <u>Safeguarding referral:</u> Many safeguarding referral forms are now provided on line by local authorities, staff are supported to complete these when help is requested. <u>Restrictive interventions:</u> When a patient is identified as needing any form of control, restraint or therapeutic holding staff need to follow hospital policy. In the last year existing policy has been reviewed but not yet launched. This is a complex aspect of practice and it is important to get the right advice and guidance in place.

The children's restrictive interventions and therapeutic holding policy is ready to launch. But we are still working on the adult version of the policy which provided a number of dilemmas to be resolved. Advice has been taken from the designated Team on how best to approach the problems being faced by staff. It comes down to interpretation of MCA or Mental Health legislation.

MCA:

All QVH staff are required to understand their legal responsibilities under the Mental Capacity Act including undertaking mental capacity assessment, best interest decision making processes and when to complete a deprivation of liberties safeguard process. MCA data is captured on the Datix system. Monthly reports are shared to aid case discussions and to share learning.

The data captured includes cases brought to the attention of the MCA lead. The MCA lead has worked with Clinical Directors within QVH to agree the new orange MCA consent form. This has now gone live across the trust; feedback has been constructive.

MCA was a trust priority in 2020 which has raised the profile in the Trust. This resulted in the safeguarding team receiving more inquiries in relation to MCA. Further training for Consultant staff has been set up to occur in this coming year.

The implementation of Liberty Protection Safeguards to replace DOLS legislation has been delayed until 2022.

Domestic violence and abuse (DVA)

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

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

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

It has been recognised both nationally and locally that the incidence of Domestic Abuse cases increased during the COVID pandemic. The safeguarding team have been raising awareness with regard to DVA using training and QNET. The team had also placed posters in clinical areas across the trust. There is a 24-hour helpline available for members of the public run by Refuge; links are on the QNET.

Safeguarding Audit

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

Reports and action plans are reviewed and monitored either in the QVH strategic safeguarding group or on of the QVH safeguarding steering groups.

Child Sexual Exploitation and Criminal Exploitation.

Recognition of Child Sexual Exploitation (CSE) or child sexual abuse requires careful assessment and consideration when concerns arise. The Safeguarding Children Named Nurse is the CSE lead for QVH and supports staff to access specialist support if required. An Understanding Exploitation Event was postponed due to the Covid pandemic, we are waiting for new dates.

QVH has accessed two virtual level 3 training sessions, funded by the CCG, on gangs and youth violence. These sessions were facilitated by an external trainer and were well evaluated by staff who dialled into the session.

In the last year, there have been a few cases where concerns were raised in relation to possible exploitation of children. In cases such as these staff have referred into the local MASH team and, where appropriate, ensured police were made aware.

Looked After Children.

Looked after children (LAC) or Children in Care are a group of children and young people who are cared for by the local authority. There can be consent implications for these children and clinicians need to understand what voluntary or court agreement is in place for each child.

The Safeguarding Children Named Nurse is the LAC lead for QVH and supports staff to understand court orders and how to make contact with a child's social worker or NHS LAC team from the area in which they live. In 2020 a Named and Designated Professionals Strategic Group for Looked After Children was set up across Sussex, QVH Named Nurse for Safeguarding Children attends this group.

If QVH when staff are made aware of private fostering arrangements for children less than 16 years of age they notify social care services for routine follow up. Raising awareness of staff responsibilities in these situations is included in safeguarding training sessions.

Modern Slavery

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

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

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

The Trust's recruitment and selection procedures include appropriate pre-employment screening of all staff to determine right to work in the UK, and all salaries are above the National Living

	Wage. All employment agencies that are engaged also meet these standards as a minimum entitlement. The Trust supply chain entails the purchasing of goods and services that support the operation of our core business of healthcare. Consumables purchased include medical supplies and equipment, office supplies, marketing materials, ICT equipment and estate and facilities services such as cleaning, waste management, office fixtures and fittings, security services and uniforms. Operating with integrity governs our approach and therefore our aspiration to be recognised by our stakeholders as an organisation which is a responsible corporate citizen in all our relationships. The NHS Standard Terms and Conditions 2018 are referenced on all Trust purchase orders which include clauses around anti-slavery and human trafficking. The Trust also, where possible, will use the NHS Standard Terms and Conditions 2018 for its contracts or use NHS Framework Terms and Conditions. The Trust is committed to better understanding its supply chains and collaborating with stakeholders to improve transparency of its arrangements to ensure adequate safeguards in place to prevent incidents of slavery or human trafficking. In the event of a patient possibly experiencing slavery or human trafficking staff need to carefully assess the situation using translation services and seeing the patient alone. Data relating to these aspects of safeguarding are collected by the safeguarding team. This type of situation is often raised by the Trauma team when they have non-English speaking patients who attend with work related injuries. <u>Working with QVH communications team:</u> The safeguarding team have close links with the communications team at QVH where there are strict guidelines for dissemination of information internally for all staff across the organisation, including updates and reviews. During the COVID pandemic the weekly newsletter was used to keep staff up to date with safeguarding requirements and developments.
4.5	**STANDARD 5: Staff competence**
	QVH Staff have access to a comprehensive Safeguarding training programme across levels 1, 2 and 3 internally. Levels 1 and 2 are a combined session including all aspects of safeguarding, MCA, Prevent, CSE, LAC, FGM and DVA. Level 3 sessions are provided on site twice a year for Safeguarding Children & LAC, as well as Adult safeguarding & MCA and Prevent. In addition to this, external training and conferences are also offered as options for staff requiring level 3 development to enhance knowledge and competencies where required. A portfolio of eLearning opportunities are made available via ESR. Staff and teams can also request bespoke training when the need is identified. **Safeguarding Learning and development Strategy.** QVH Safeguarding learning and development strategy was reviewed and updated in 2019. This document is aligned with the core skills framework document and with national guidance from the NHS England regarding roles and competences for health care staff – from 4 intercollegiate

documents (Prevent, LAC, Adults and Children). It makes transparent QVH expectations for staff including the Board with regard to safeguarding training and development.

Safeguarding Training:

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

Session	**Participants**	**At end of year training uptake is currently:**
Safeguarding **Level 1** (covers children and adults) (includes: Prevent, DVA, LAC, CSE)	Non-clinical staff Required every three years	94%
Safeguarding **Level 2** (covers children and adults) (includes: Prevent, DVA, LAC, CSE)	Clinical Staff (includes level 1 competencies) Required every three years	96%
Safeguarding Children **Level 3** (includes: Prevent, DVA, LAC and CSE)	For specified clinical staff (includes Level 1 and level 2 competencies) Required every three years Consultants attend QVH in-house training session, or undertake specified eLearning, or passport existing training evidence from another NHS trust	91%
Adult Safeguarding and MCA **Level 3** (includes: Prevent and DVA)	For specified clinical staff (includes Level 1 and level2 competencies) Required every three years Consultants attend QVH in-house training session, or undertake specified eLearning, or passport existing training evidence from another NHS trust	94%
DVA DASH Workshops Level 3 Once every three years	For specified clinical staff	100%
Safeguarding Children and LAC **Level 4**	Safeguarding Named Nurse as part of personal development Safeguarding Children Named Doctor as part of personal development	100%
Adult Safeguarding and MCA **Level 4**	Safeguarding Named Nurse as part of personal development	100%

Safeguarding **Induction**	Trainee Doctors Passport existing safeguarding training over or update to Level 2 (children and adults) whilst at QVH	100%
WRAP	All clinical staffx1	92%

Specialist Support
Sussex Designated professionals who are employed by Clinical Commissioning Groups provide clinical supervision and support for specialist safeguarding staff within QVH.

In 2020, QVH completed the bi-annual safeguarding children's self-assessment audit. This provides assurance both to the trust and externally that QVH meet the expected standards for safeguarding children. All actions were rated as green with the exception of an amber rating for the provision of a safeguarding supervision. In response, QVH now has a safeguarding supervision policy setting out provision of specialist safeguarding supervision, advice and support to QVH staff.

Adults Safeguarding self-assessment audit will be undertaken in 2021.

QVH have utilised the expertise of the designated nurses in delivering level 3 training around Looked After Children.

All staff job descriptions include a safeguarding section which identifies responsibilities for safeguarding and these are reviewed through an annual appraisal and personal development planning process.

4.6 STANDARD 6: Safer recruitment

QVH work to ensure that those working or who are in contact with children, young people and adults are safely recruited and Human Resource processes take account of the need to safeguard and promote the welfare of all. Making sure that QVH do everything we can to prevent appointing people who pose a risk to vulnerable people is an essential part of safeguarding practice and QVH recruit staff and volunteers following safer recruitment procedures.

All staff at the Trust are employed in accordance with the NHS Employers safe recruitment pre-employment check standards.

As part of their induction, new employees, including volunteers are expected to undertake mandatory training in safeguarding at either level 1 or 2 or be able to provide evidence that this has been completed at another trust within the last 3 years.

In March 2019 the Trust approved a new 'Disclosure and Barring Service (DBS) Checks Policy' which confirmed the process for Disclosure and Barring Service (DBS) checks for applicants and employees within the Trust and the responsibilities of Recruiting Managers, the Recruitment and Workforce Services teams to ensure that suitable DBS checks are completed as required. This

	includes a new provision for undertaking 3-yearly periodic checks for current staff within the high risk areas of Paediatrics and Critical Care. During this last year HR provided a DBS report to the strategic safeguarding group. No issues of concern were identified.
4.7	**STANDARD 7: Learning from incidents**
	Statutory Safeguarding Reviews: <u>Safeguarding Adult Reviews (SAR)</u> Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. QVH were not directly involved in any SAR during 2020-21. Learning from SARS outside of QVH is shared at safeguarding groups if relevant for care delivery. <u>Child Safeguarding Practice Reviews.</u> When a child dies or is seriously harmed, including death by suspected suicide, and abuse or neglect is known or suspected to be a factor in the death, West Sussex safeguarding Children Partnership (WSSCP) is required to conduct a Serious Case Review into the involvement of organisations and professionals in the lives of the child and the family. The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and, as a consequence, improve multi-agency working to better safeguard and promote the welfare of children. QVH were not directly involved in any Child Safeguarding Practice Reviews during 2020-21. However, in 2020 QVH did complete a rapid review for a child requested by another safeguarding children partnership. The purpose of a rapid review is to gather the facts about a case, to discuss if any immediate action is required and to share any learning appropriately. Although the review met threshold for a safeguarding practice review the learning was aligned with similar cases and shared. <u>Child Death Reviews.</u> The WSSCB is also required to conduct a review of every child death to identify whether there are any lessons to be learned to prevent child deaths in the future. QVH has contributed to one child death review this year. A young person committed suicide a few weeks after being treated at QVH. He had mental health issues which were unknown to us but his injury when seen at QVH did not identify him for referral to other services. <u>Other types of reviews.</u> The WSSCP carry out a range of learning activities in order to understand how to improve safeguarding. This includes reviews into individual cases and reviews of practice across areas of safeguarding. QVH has not contributed to other case reviews during the year.

	QVH Staff have access to specialist advice and support through the named nurse, specialist nurses and link staff. Where appropriate, staff and staff groups are provided with debriefing/supervision sessions by the Named Nurse and/or other senior staff at QVH. Bespoke safeguarding and MCA training sessions are all offered to teams and services.
4.8	**STANDARD 8: Commissioning**
	Contract Monitoring -Sussex Clinical Commissioning Groups (CCG's) Safeguarding Standards CCG's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective safeguarding arrangements in place. A self-assessment tool is completed bi-annually for adult safeguarding and also a section 11 self-assessment audit for safeguarding children. These contribute to providing evidence of assurance in conjunction with assurance site visits and submission of quarterly exception reports. The section 11 safeguarding children self-assessment audit submitted to WSSCB during 2020 provided assurance to WSSCP scrutiny panel that QVH has a good understanding of statutory requirements and is working in a positive way to ensure standards are met. The panel noted that there was no further action required other than that identified by QVH. This was the requirement for a safeguarding supervision policy, which is now in place. A self-assessment tool was completed in 2019 for adult safeguarding. The action plan is reviewed and updated 6 monthly. An updated Safeguarding Supervision policy has been developed. Prompt Cards have been reviewed and updated and a business case to develop and App is being followed up. CCG exception reports are provided by QVH Safeguarding Team in April, July, October and January of each year. No issues of concern were raised during the last year. **External regulation and inspection by CQC and NHSE** QVH CQC re-inspection during February 2019 overall the Trust sustained 'good' rating and also an 'outstanding' for care. There was no concerns raised regarding safeguarding. The CQC reported: 'Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. They were knowledgeable about the issues and priorities for the quality and sustainability of the service, understood the challenges and how to address them. All staff we met spoke positively about the leadership, both at local and executive level. They described leaders as being visible and approachable and supporting them to deliver the best possible patient experience.' Any safeguarding issues or concerns are captured and reported to the Board alongside the Board's monthly safeguarding metrics. • No specific paediatric safeguarding concerns were raised for QVH during the last year. • 2 adult safeguarding alerts were raised regarding QVH patient care during 2020-21. Details are captured on Datix and reported in the monthly Board metrics.
4.9	**STANDARD 9: Safeguarding data requested by Department of Health**
	Female Genital Mutilation (FGM)

	Understanding of FGM and mandatory reporting duty is incorporated into QVH mandatory safeguarding training for staff. DH/NHS approved and recommended FGM e-Learning packages are also available to staff to enhance their knowledge and understanding of this subject and required practice. FGM guidance and information, with particular regard to risk assessment, mandatory reporting and recording, can be accessed by staff via the Trust QNET Safeguarding page. At QVH no FGM risk assessments were undertaken on any patients during the last year. <u>Prevent Returns</u> QVH submit quarterly reports to Regional Coordinator at NHS England with prevent information which reflects the number of prevent referrals and details of staff compliance with training. This information is also copied to the CCG for assurance. At QVH no PREVENT referrals were made during the last year.

5.0	**Activity analysis/ achievement**
5.1	Health care at QVH is patient centred and QVH works closely with partners to manage achievement of effective safeguarding for all vulnerable patients whether they are children, young people, adults or other family members. National metrics are reported on a quarterly basis to CQC and DH including: FGM assessments and PREVENT referrals. QVH continuously strive to develop staff knowledge, competence and to support its staff to achieve the best outcomes for patients at risk of harm. Level 3 adult safeguarding and Safeguarding children training sessions are part of their consultant mandatory training days and have reached over 90% uptake. QVH promotes a culture where staff are encouraged to raise concerns and to whistle blow without fear, this is evidenced in the staff survey. QVH also promotes feedback from patients and encourages them to raise concerns about anything they see and are worried about. There are close working links with the Patient Experience Manager and the Director of Nursing. There have been 7 safeguarding plaudits this year.
5.2	Training for staff is reviewed annually and updated in line with legislative requirements. Training data uptake continues to improve each year and is above 90% required by the Board. Paediatric safeguarding systems in QVH have been well established for many years. They continue to be strengthened. There is a transparent overview of what is in place and of safeguarding children activity occurring in the organisation. The embedding of Adult Safeguarding has continued through 2020-2021.. Feedback from staff has been positive. Succession planning is underway for Autumn 2021.

	QVH have a Safeguarding Named Doctor who is a member of QVH staff one of the Burns Consultants and Deputy medical Director Ms Tania Cubison. Safeguarding governance arrangements are well embedded.
5.3	QVH has a range of internal assurance processes in place. An overview of adult safeguarding and safeguarding children, and MCA activities in QVH are in place using the Datix systems for reporting purposes. QVH staff training programmes for adult and child safeguarding have been reviewed and continue to be updated and clinically focused. During COVID, the safeguarding team have been unable to collect evaluations from delegates but have already taken steps to address this. QVH has an overview of all relevant safeguarding information and documents, which are systematically developed, reviewed and/or updated. There were no corporate Safeguarding risks and three safeguarding departmental risk assessments in place. These were discussed at strategic safeguarding group quarterly, monitored monthly and details reviewed at least every 6 months by the Safeguarding Named Nurses.
5.4	QVH has local external regulation undertaken by the CCGs, WSSCP and WSSAB. NHS England ensures QVH are registered with the CQC. A Care Quality Commission (CQC) inspection occurred during February 2019. The report was published on 23rd may 2019 and is on the CQC website.
5.5	Local safeguarding peer review and assurance processes are in place. The Named Nurses for Safeguarding were well supported by the Director of Nursing, Deputy Director of Nursing, Heads of Nursing and the Sussex Designated Professionals. QVH staff are guided and supported by a team of specialist safeguarding clinicians. This team are supported by Peanut Paediatric ward staff, Minor injuries Unit Staff, Site Practitioners and Heads of Nursing. Consultants now receive level 3 training for all aspects of safeguarding and MCA
5.6	Partnership working with WSSCP and WSSAB is in place.
5.7	Effective contract monitoring is undertaken through audits and regular exception reporting to WSSCP, WSSAB, CCGs and the CQC.

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

	• Undertaking key areas of safeguarding work/projects • Sharing safeguarding information In the coming year we will also start working with council of Governors. Learning Disabilities Strategy will be discussed and developed. A LD peer review is due to be undertaken it has been delayed because of COVID pandemic.

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

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

	• Learning Disability agenda is now covered in the Strategic safeguarding group reporting on the aspect of practice needs to be covered as a separate report.

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

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

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

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

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APPENDIX A
TITLE: Safeguarding Strategic Group Action Plan

2020-21 work plan for group based on Safeguarding Strategy Objectives, which contribute to achieving key strategic objectives of the trust:
Outstanding patient care

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

Strategic Objective	QVH initial assessment	Rating (RAG)	Action Required	Timescale	Implement-ation Lead	Progress/ comments
1. To provide senior and Board leadership	QVH require: • Lead Board Director • Nominated Non-Executive Board Director • Safeguarding Adults and Children Named Nurses • Safeguarding Named Doctor • MCA & DOLs lead • Prevent lead • Child Sexual Exploitation Lead	Green	Review allocated specialist resources in coming year	Ongoing	Director of Nursing & Quality	Safeguarding Named Nurses & MCA Lead in post Departmental risks in place KPIs to Board Annual Report to Board
2. Senior leadership responsibility and lines of accountability for safeguarding arrangements are clearly outlined to employees and members of QVH, as well as to external partners.	QVH require: • Safeguarding Accountability and communication document on Website • Safeguarding Strategy on website • Safeguarding QNET page • Safeguarding Policy, standards, protocols, guidance • Information for staff	Green	Sustain systems Annual review and update training program Use Evolve/EDM	Ongoing	Director of Nursing a & Quality with Named professionals	Website safeguarding statement updated 2021 QNET update ongoing Quality assurance processes in place Policy review and updates ongoing.

	• Information for patients • Safeguarding training strategy and program in place • safeguarding activity data via Datix system. • Patient information via Evolve, paper record, EDN		safeguarding section as new system rolled out. Use Datix to capture data			Training uptake data and evaluations scrutinized monthly Datix - used to capture safeguarding and MCA data. Development of new leaflets for patients and their family
3. QVH contribute to the work of West Sussex LSCP and SAB and their strategic Business Plans and priorities, and provide support to ensure that the Boards meet their statutory responsibilities.	QVH require; • Regular representation at WSSCP • Regular representation at WSSAB • Completion of Section 11 self-audit • Bi-monthly reports to LSCP and SAB • Quarterly reports to CCGs • Quarterly reports to NHS England – *prevent* coordinator	Amber	Overlap between reporting requirements – manage and sustain effectively Regular representation at WSSCP and WSSAB Regular updates from NHSE		Director of Nursing & Quality with Named professionals	Safeguarding Children Section 11 self-assessment completed 2020. Director of nursing attending WSSCP: QVH has had difficulties with attendance at Partnership Board meetings. This has been escalated through the designated professionals and the Partnership. Adult Safeguarding Named Nurse attending WSSAB WSSAB self-audit undertaken 2019- due 2021, to follow up with designated nurse as no request for information has been made.

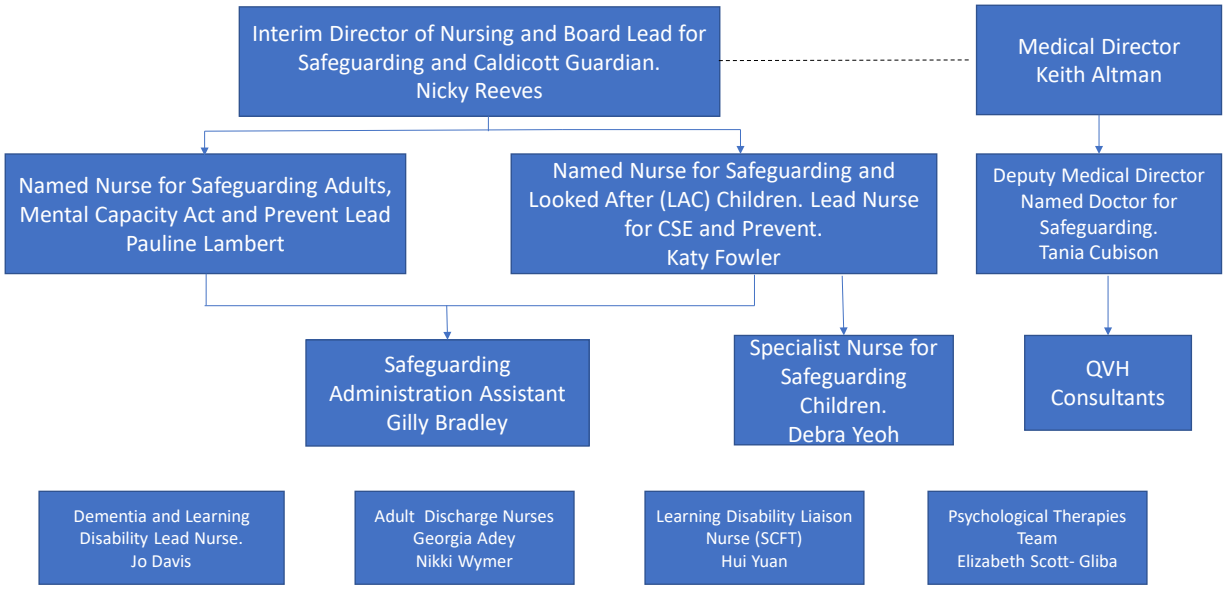
4. QVH support their safeguarding leads to contribute to and influence the work of the LSCP and SAB subgroups and other national and local safeguarding implementation networks.	QVH require; • Named professionals involvement in specific subgroups • Supervision from designated professionals for named professionals • Attendance at West Sussex networks • Attendance at Regional Networks	Green	Input into NHS professionals groups		Director of Nursing a & Quality with Named professionals	Supervision in place Attendance at Regional and national conferences

DELIVERING THE STRATEGY

Ensure all aspects of safeguarding work and practice are considered and incorporated into all QVH services.
Service developments take account of the need to safeguard all patients and are informed by service users and quality impact assessments.
Processes in place to disseminate, monitor and evaluate outcomes of all case review recommendations and actions.
Ensure there are effective arrangements in place to share information when required.
Safeguarding training and systems compliance will be monitored by safeguarding leads.
QVH will demonstrate it is meeting its statutory requirements via annual reporting and an audit programme.

APPENDIX B

QVH safeguarding team structure chart.



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APPENDIX C SAFEGUARDING AUDIT PROGRAMME 2020-2021, 3 year cycle

QVH rolling safeguarding audit programme

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

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

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

2020 topic/s	**Progress**	**Next steps**
NICE CG89 when to suspect child maltreatment audit	Underway survey monkey	Completed
NICE DVA (PH50 and QS116)	Underway survey monkey	Completed
Referrals audit Adult children	Due September 2020	Completed December 2020

LAC (CIC) ready for records audit	Identify children on DATIX recording system – this is being done	Designated professionals have not progressed this audit

2021 topics		
Survey monkey topics		
Restrictive interventions awareness to inform training	Prepare September 2020	Delayed until policy is finalised- Liz Blackburn (HoN) leading.
LAC awareness	Prepare November 2020	
MCA audit	February 2021	Report pending
NICE CG89 when to suspect child maltreatment audit NICE DVA (PH50 and QS116)	Repeat March 2021	Repeat delayed due to Covid.
West Sussex Safeguarding Children Partnership multi-agency exploitation audit.	Summer 2021	QVH has submitted audit tool.
File audits		
Evolve and records safeguarding sections audit Children Adults	Prepare December 2020	Delayed
Referrals audit Adult children	Due December 2021	
LAC (CIC) records audit: Liaison with SW and LAC Nurse Valid consent in place Missed appointments correct action taken	March 2021	
Child not brought to appointment audit	July 2021	Underway

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

QVH SAFEGUARDING DOCUMENTS AND INFORMATION 2021

1.	Item	Date	Location	Next Review
1.1	QVH assurance statement	2019	Website	2021
1.2	QVH safeguarding strategy	2019	Website	2021
1.3	QVH Website and QNET	ongoing	Intranet	Ongoing review and update as required by QVH safeguarding leads
1.4	Sussex Child Protection and Safeguarding Procedures	Updated on line	Link via QNET	Ongoing review and update as required by WSSCB
1.5	Sussex adult safeguarding procedures	Updated on line	Link via QNET	Ongoing review and update as required by WSSCB
1.6	QVH safeguarding annual report	2019-20		April 2021
1.7	QVH and BSUH Paediatric SLA			Copy with Deputy Director of Nursing
1.8	QVH Safeguarding Strategic Group terms of reference	April 2021		Due April 2023
1.9	QVH Safeguarding Steering Group terms of reference	October 2018		Due October 2020- Steering group restarted January 2021 (due to covid)
1.10	QVH safeguarding prompt cards for staff	June 2020		Review 2023 or sooner if required. Create App
1.11	QVH NMC examples of revalidation forms- completion for safeguarding practice	2016		Available for staff on request
1.12	QVH Safeguarding Learning and Development strategy	2018	QNET	Due for review 2021
1.13	QVH safeguarding risk assessments	ongoing	Overseen by strategic safeguarding Group	Dashboard updated quarterly
1.14	CCG exception reports- ASG	Ongoing	Overseen by strategic safeguarding Group	Jan, Apr, Jul, Oct
1.15	CCG exception reports- SGC	Ongoing	Overseen by strategic	Jan, Apr, Jul, Oct

			safeguarding Group	
1.16	National Prevent reports	Ongoing	Overseen by strategic safeguarding Group	Jan, Apr, Jul, Oct
1.17	Combined safeguarding policy	2019	QNET	Review 2022
1.18	QVH *Prevent* Delivery Plan	2019	Q-Net	Due 2021
1.19	QVH Mental Capacity Act and DOLS Policy & Procedures	2021	Q-Net	Review 2022, LPS replacing DoLs in 2022
	PROTOCOLS and GUIDANCE			
1.	Safeguarding Record keeping	2020	QNET	Review 2023
2.	Safeguarding Datix guidance	2020	QNET	Review 2023
3.	ASG form guidance	2020	QNET	Review 2023
4.	Child protection Referral form guidance	2020	QNET	Review 2023
5.	Making safeguarding team aware of safeguarding concerns	2020	QNET	Review 2023
6.	Reporting dog bite injuries	2020	QNET	Review 2023
7.	Children not brought to appointments	2020	QNET	Review 2023
8.	MIU transfer of care			MIU responsibility to review.
10.	QVH Guidance on management of risks posed by sex offenders/sex related crime /potentially dangerous offense whilst at QVH site	2019	QNET	Approved by Strategic safeguarding group
11.	QVH Abduction or suspected Abduction of an Infant/Child Policy	2020	QNET	Review 2023
12.	Burns MDT risk assessment process	2020	QNET	Review 2023
13.	Circulation of missing alerts	2020	QNET	Review 2023
14.	Safeguarding PAS patient alert	2020	QNET	Review 2023
15.	Adult fire safety checklist			Discuss with burns matron
16.	QVH DVA procedures for patients	2020	QNET	Review 2023
17.	Modern Slavery Protocol	2020	QNET	Review 2023
18.	Safeguarding supervision policy	March 2021	QNET	Review 2024

Queen Victoria Hospital
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APPENDIX E

QVH Metrics for The Board – Safeguarding, MCA & Prevent (March 2021)

Item	Feb 2020	March 2020	APR 2020	MAY 2020	June 2020	July 2020	August 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
Adult SG Activity	8	7	5	12	3	9	11	10	4	7	14	9	9	13
Paediatric safeguarding activity	28	19	26	22	26	25	40	32	19	34	30	21	17	36
Allegations against staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support for staff possible DVA	0	1	1	0	1	0	0	0	0	0	0	0	0	0
DVA cases			Start collecting data	4	0	0	3	3	0	1	2	2	1	4
Modern slavery/exploitation cases			Start collecting data	0	0	0	2	0	0	1	1	0	1	1
DASH Risk assessments	0	0	0	0	0	0	1	0	0	0	0	0	0	0
MARAC referrals	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FGM Risk Assessments undertaken	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Children SCR	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Safeguarding Adult Reviews	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Prevent Referrals	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Damage grade 3/4	0	0	0	0	0	1	0	0	0	0	0	1	1	0

*MCA assessments *See notes*	5	4	2	2	5	5	9	7	10	7	13	3	6	16
MCA BI decisions	3	4	1	2	4	4	4	3	4	6	7	3	2	11
MCA DOLS	0	1	0	0	0	0	1	0	0	0	1	0	0	0
IMCA	0	0	0	0	0	1	1	2	2	1	1	0	1	2
Adult SG Training level 1	93	94	94	94	94	94	95	94	94	94	95	95	94	94
Adult SG Training and MCA Level 2 *Permanent Staff*	91	92	93	94	94	93	95	94	94	94	95	95	96	96
Adult SG L3	92	93	93	93	94	92	93	92	92	91	92	90	94	94
WRAP Training L3 Prevent ELearning option added April 2018	88	89	89	90	91	91	91	89	90	90	91	92	93	92
Paediatric SG and LAC L1	95	97	95	95	95	95	95	94	94	94	95	94	94	94
Paediatric SG and LAC L2	95	95	94	94	95	95	95	93	94	94	95	95	96	96
Paediatric SG and LAC L3	92	97	95	95	95	93	93	85	87	85	87	88	90	91

TRAINING Data:

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

Adults Safeguarding Commentary:

- 13 Adult safeguarding case details taken from DATIX ,
- Mar 2021 4 cases referred to local authority.
- 1 Modern Slavery cases referred to police
- 4 Adult DVA cases reported to police
- 0 reported to Police - Adult dog bite cases
- 0 grade 3 pressure ulcer acquired prior to admission to QVH.
- Police requested copies of records for DVA injuries 2

Paediatric Safeguarding Commentary:

- 36 Paediatric safeguarding case details taken from Datix
- March 2021: 1 case referred to social care by QVH,
- 14 Cases referred/known to social care prior to transfer to QVH.
- 7 Dog bite cases referred to police,
- 1 Home schooled children.
- 4 Looked After Children identified.

1 Rapid Review being undertaken by Surrey Safeguarding Children's Partnership.

MCA data taken from DATIX

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

- 16 MC assessments undertaken
  11 BI decisions
- 1 LPA signed consent form
- 2 IMCA
- 0 DOLS
- 2 patient able to consent

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

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Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/09/2021**		**Agenda reference:**	**140-21b**	
Report title:	**Infection Prevention & Control Annual Report 2020/2021**				
Sponsor:	Nicky Reeves, Director of Nursing				
Author:	Sarah Prevett, Infection Control Lead Nurse				
Appendices:					
Executive summary					
Purpose of report:	To provide assurance that there is a systematic leadership in place in the organisation for the effective management of infection prevention and control for patients, staff and visitors.				
Summary of key issues	The Board's attention should be drawn to the following key areas of infection prevention and control management detailed in the report: The Trust has continued to achieve low rates of reportable infections. There has been greater challenges around achieving these targets with cases of reportable infections rising in hospitals and the community due to health restrictions which are a direct result of the ongoing pandemic. These challenges have impacted on the Trust with an increased period of C.diff noted and treated as an outbreak. Assurance process has been maintained through a robust audit programme, however some audits have had to be delayed due to increased pressure on the infection control teams' time, and those that have been delayed will be prioritised for the next financial year. This has been a challenging year due to the Covid-19 pandemic that has impacted on service delivery since January 2020. This has required a strong approach to manage safe pathways for staff and patients to minimise the risk of Covid transmission. Infection control have been closely involved in all				
Recommendation:	The Board is asked to note the increased robustness and rigour of infection prevention and control across the Trust, and the developments/ work streams within 2021/22 which will further increase the safety and effectiveness of patient care.				
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:	Infection Prevention & Control contributes directly to the delivery of KSO 1 and KSO 2				
Corporate risk register:	Infection, Prevention and Control contributes to compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's Essential Standards of Quality and Safety.				
Regulation:					
Legal:					
Resources:	This annual report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	26/07/21	Decision:	Noted	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

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Infection Prevention and Control

Queen Victoria Hospital NHS Foundation Trust Service Annual Report

Report covering the period from
April 2020 to March 2021

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

Authors: Lead Infection Control Nurse

Date:

Type: Annual Report
Version: 3
Pages:
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1.	Executive Summary
	The purpose of this report is to inform and provide assurance to the trust Board, patients, public and staff of the processes in place at The Queen Victoria NHS Foundation Trust (QVH) to prevent and control healthcare associated infections (HCAI). The trust has a statutory responsibility to comply with the Health and Social Care Act: Code of Practice for the prevention and control of Healthcare-Associated Infection 2008 (DH 2015). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. This report provides an overview of infection prevention and control activity at QVH for the reporting period from 1st April 2020 to 31st March 2021 and demonstrates compliance with the Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare related guidance. The key findings of the report are: • The Trust has maintained compliance with Care Quality Commission regulations relating to Infection Prevention and Control despite resources being stretched to the additional pressures put on the team from the Covid-19 pandemic • Overall incidence of Healthcare Associated Infection remains low with zero cases of methicillin Sensitive Staphylococcus (MSSA) bacteraemia, zero cases of Escherichia coli (E.coli) bacteraemia and seven Clostridium Difficile (CDI) infections. With each of the positive results for CDI a Root cause analysis was undertaken (RCA) with actions implemented at the time, this process showed three of the cases were likely to have been acquired in the referring Trusts, two cases were likely antibiotic related and two cases were probable hospital acquired • Achieved an increase in uptake and exceeded previous year's targets for seasonal flu vaccinations in staff groups. • Actions taken by the Infection Prevention and Control team (IPACT) in response to the Global Pandemic of Covid-19 to minimise the risk to staff and patient safety.

2.	Introduction
	The Trust recognises that the effective prevention and control of HCAIs is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained. This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. The purpose of this report is to provide the Board with information on trust performance and provide assurance that suitable processes are being employed to prevent and control infections. This paper provides the board with an overview of work completed during the previous year and goals for the continuing programme of infection prevention and control for the upcoming financial year. The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008, at the heart of this law there are two principles: • to deliver continuous improvements of care • it meets the need of the patient

With this in mind, patient safety remains the number one priority for the Trust. Infection prevention strategy and a consistent approach are key elements to ensuring the QVH has a safe environment and practices. Infection prevention and control is the responsibility of everyone in the healthcare and is only truly successful when everyone works together.

2.1 The Infection Prevention and Control Team (Appendix A)

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

- Director of Infection Prevention and Control
- Infection Lead Nurse and Decontamination Lead. (full time, 37.5 hours/week)
- Infection Control Nurse. (part time 22 hours/week)
- Administration assistant.
- Antimicrobial pharmacist.
- The microbiology and virology laboratory services are provided by University Hospitals Sussex (UHS). As part of this service UHS provide QVH with a Consultant Microbiologist, due to the restrictions and precautions in place due to the Covid-19 pandemic the Trust has had no onsite presence from the Consultant Microbiologist since February 2020 they have however continued to support remotely running 24 hour advice via telephone or email to support safe provision of infection control services.

2.2 The Director of Infection Prevention and Control (DIPC)

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

3. Service aim, objectives and expected outcomes

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

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

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

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

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

Internal assurance processes and board accountability.

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

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

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

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

Members of the IPACT share infection control information and learning with a number of groups and committees which include:

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

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

Infection Prevention and Control microbiology activity

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

Infection prevention & control link persons (ICLP)

Infection prevention and control remains central to the maintenance and promotion of high standards throughout QVH. The ICLP Group aims to meet every quarter. Its purpose is to provide a link between the IPACT and ward/departmental staff in all clinical and non-clinical areas in order to facilitate the dissemination of information and to promote compliance with infection control policies and the Health & Social Care Act (2015). Every meeting includes an educational element. The ICLP members are reviewed on an annual basis. Or more frequently if there has been staff changes. The link staff conduct monthly infection control audits and champion good infection control practices within their teams/departments. Due to restrictions in place, changes in the way meetings are conducted and increased pressures on the infection control team due to the Covid-19 pandemic for this year the link group has not been held quarterly. Information has been disseminated through alternative methods including regular all site updates, emails, weekly meetings for department leads and increased ICN presence on the wards and attendance at ward meetings/daily huddles.

External Meetings

Infection control remains high on the national agenda although the focus for the year 2020-2021 has been on how to safely manage the risks and precautions required due to the Covid-19 pandemic all aspects of infection prevention and control has remained a priority. The ICN participates in local and national webinairs and virtual meetings to ensure robust links with other

infection control teams, utilising the opportunity to share learning and resources and ensure all practices in the Trust are in line with current national guidance and best practice.

Mandatory Surveillance

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

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

Carbapenemase-producing enterobacteriaceae (CPE), Glycopeptide Resistant *Enterococci* bacteraemia (GRE) and Vancomycin Resistant *Enterococcus* bacteraemia (VRE) are reported to the Commissioners as required and to Public Health England (PHE) on a quarterly basis.

IPACT also monitor Urinary Tract Infection (UTI), *Acinetobacter, Pseudomonas, Klebsiella spp* and any other Multi Drug Resistant (MDR) organisms.

Root Cause Analysis (RCA)

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

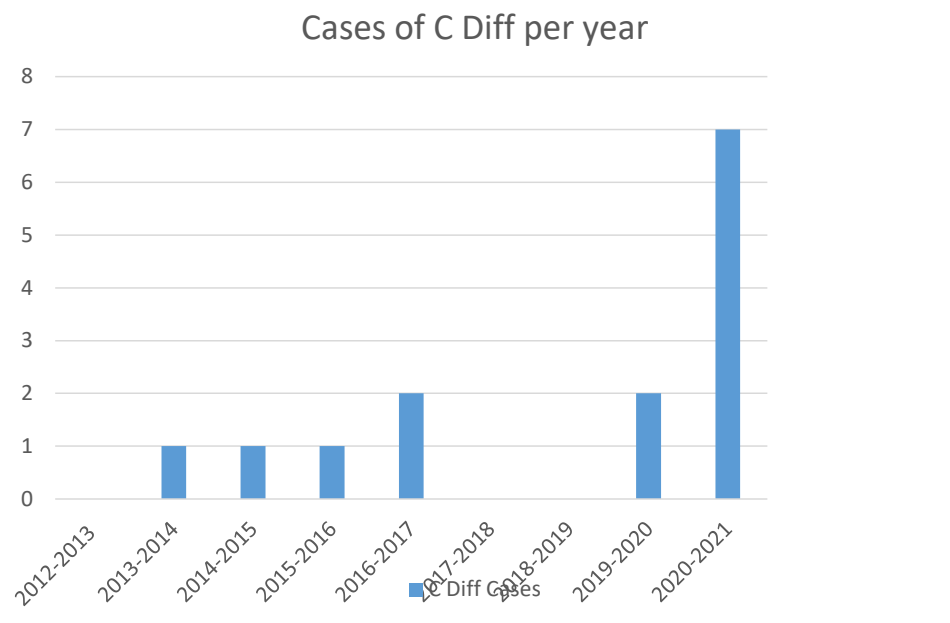
MRSA Bacteraemia

QVH have a target of zero cases of avoidable MRSA bacteraemia every year – the trust achieved this during the 2020/2021. There has not been a revision of this target for 2021/22.

***Clostridium difficile* infection (CDI)**

The CDI lapse in care objective target for QVH for 2020/2021 was set at zero. The Trust had seven cases of CDI across two departments in 2020/2021. An outbreak was declared at the time with robust control measures being implemented. All cases were investigated using the Root Cause Analysis framework to look at triggering factors and identify learning needs to prevent further cases. The results of these showed 3 of the patients likely contracted CDI in the referring hospitals, 2 cases were likely to be caused by inappropriate antibiotic prescribing and 2 cases were likely to have been hospital acquired. Learning needs including ensuring timeliness of sending samples and prescribing antibiotics in line with Trust and national guidance. PHE, CCG and CQC were fully involved in the outbreak process and satisfied with all actions taken. No sanctions were implemented by the commissioners following review of the cases.
Figure 1 shows previous performance.

Figure 1



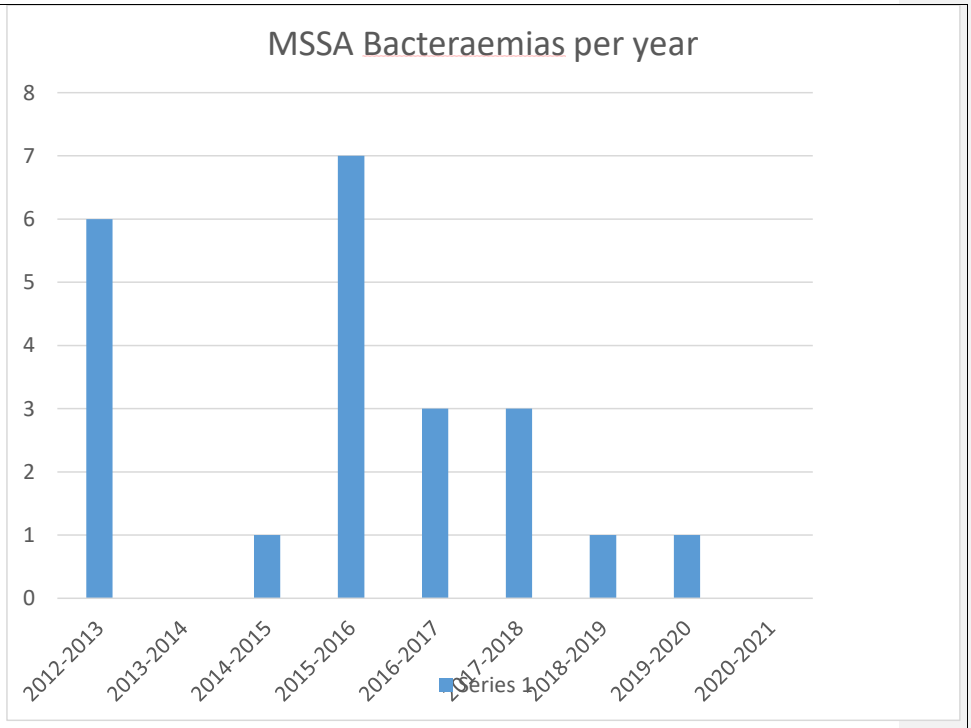
The CDI lapse in care objective target for the Trust remains at zero for 2021/2022.

MSSA bacteraemia

No target has been set for MSSA bacteraemia to date although every effort should be taken to prevent all healthcare associated infections. QVH had zero MSSA bacteraemia cases in 2020/21.

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

Figure 2

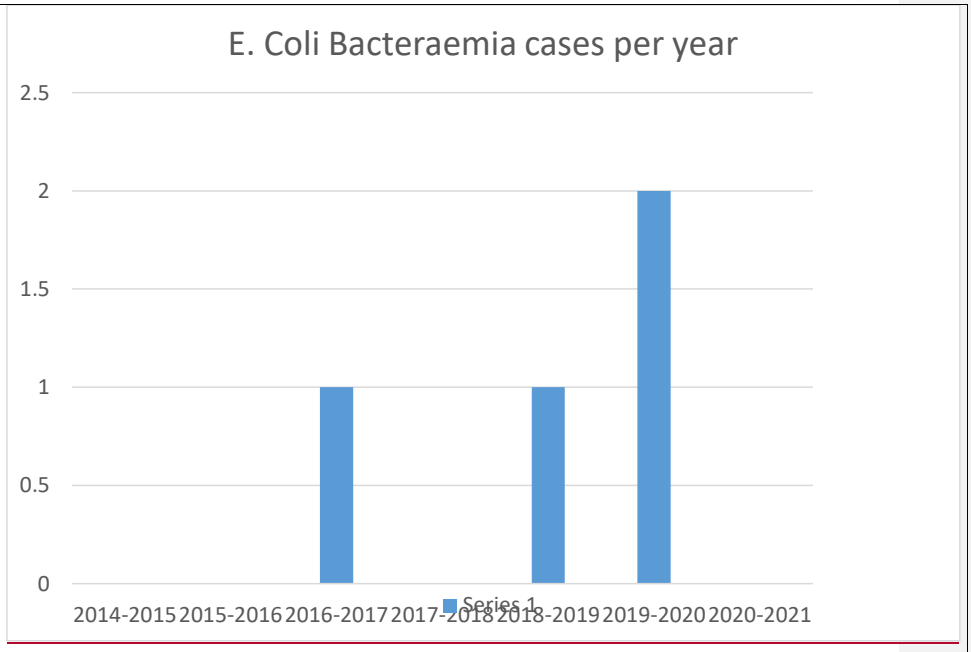


E. Coli bacteraemia

QVH had zero reportable *E.coli* bacteraemia in 2020/21,

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

Figure 3

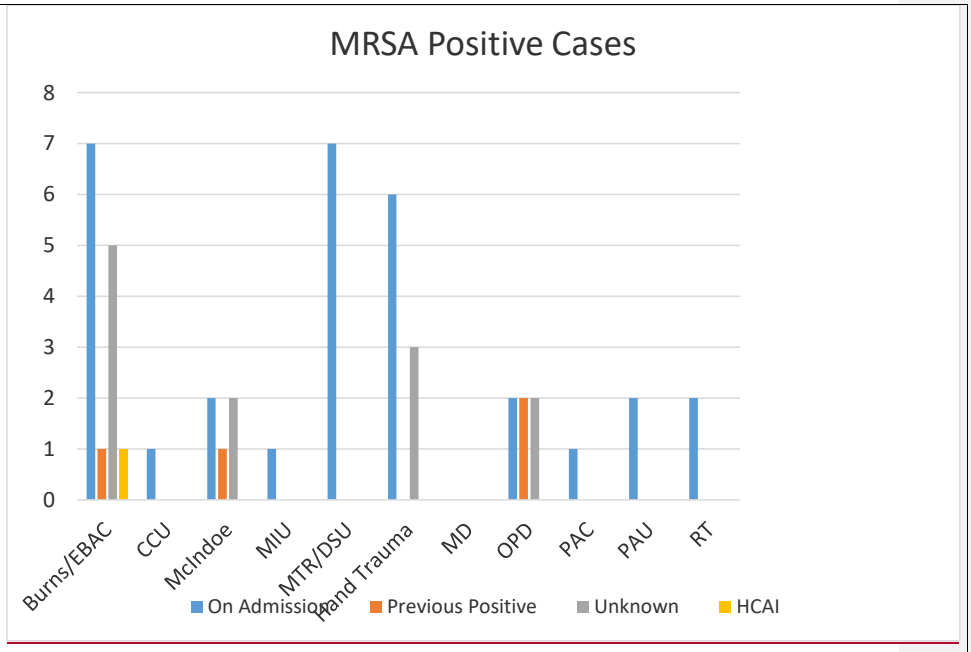


Glycopeptide resistant enterococci bacteraemia (GRE)

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

MRSA positive patients April 2020 to March 2021 (Infected and colonised)

During the period of 2020/2021 there were 48 patients who were confirmed MRSA positive either colonised or infected. None of the positive results were acquired from blood cultures (bacteraemia) but from either surface swabs (such as nose and groin) or from wound swabs. Of these 1 was classed as healthcare associated or hospital acquired (HCAI), 31 were identified from admission or pre-admission swabs (O/A), 4 were from patients known to be previously positive (PP) and 12 patients it was difficult to determine the source of acquisition. In July 2020, the Trust's MRSA policy changed to focus on screening only high risk patients, therefore, we may not always have a baseline admission swab for MRSA if patient was deemed to be low risk on admission. Without an admission swab to provide this baseline data, we are unable to ascertain if the MRSA was acquired in the hospital setting or in the community before admission. It should be noted that any positive results received from paediatric patients (this group of patients are not routinely screened on admission) will also be difficult to pinpoint cause of MRSA acquisition. RCA's are completed for all HCAI cases to look at any lapses in care or areas of improvement.



4.	Activity analysis/ achievement

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

The CQC did not conduct any inspections in between April 2020 to March 2021. The Trust continues to monitor the standards set out in the Health & Social Care Act (2010) via an annual programme of PLACE compliance inspections. Findings are reported to Quality and Governance Committee, Clinical Governance Group and other quality groups.

The Trust Board

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

Key Performance Indicators (KPIs)

KPI's set for the IPACT include monitoring hand hygiene compliance, monitoring MRSA screening compliance and monitoring trust acquired reportable infections. Results for these are all included within the document. Ensuring policies are in line with national guidance and within date, a list of all updated policies is included in this document, and that regular audits are completed to monitor compliance against the policies. Completed audits are included in this report in the audit section of this report.

The remaining KPI's are ensuring all members of the IPACT are attending mandatory training and are undertaking an annual appraisal. All members of the IPACT achieved this during the year April 2020 to March 2021

Complaints

If necessary the IPACT will liaise with the Patient Experience Manager to assist with the investigation of complaints associated with infection prevention and control. The outcomes of these are fed back at the monthly IPACT and quarterly committee meetings. During this year due to heightened anxieties from patients and visitors in relation to the Covid-19 pandemic more concerns that involve infection control practices have been raised with the patient experience manager than we have seen in previous years. There were 8 separate concerns raised that required input from the infection control team, 1 relating to a patient who felt uncomfortable being asked to wear a face covering when attending an outpatients appointment, 2 related to patients/visitors who were concerned about the safety measures, including temperature checking and mask wearing, on arrival at the hospital, 4 related to patients who felt that it was too difficult and/or unnecessary to attend the Trust three days before admission to have a Covid screen and then be expected to isolate, the final case related to a patient who claimed to have developed a surgical site infection following surgery in December 2020 which was conducted at the McIndoe surgical centre, this was passed to their infection control team to investigate. The patient also claimed to have attained a SSI at a previous appointment in 2017, there was no evidence or documentation to support this. In each case the ICNs worked with the patient experience manager to answer the patients concerns or questions citing Trust and national guidance.

Infection Prevention and Control Learning and Development

Infection Prevention and Control is part of the Trust's mandatory training programme. Due to current social distancing measure and the threat of Covid-19 face to face training sessions for the year 2020-2021 were only held for induction training. All clinical and non-clinical mandatory training sessions have been done using E-learning. The infection control team have to continue to offer small departmental training where it is not possible for teams to use the E-learning process. Induction training days have been held monthly for all categories of staff, with separate sessions for new Doctors' Induction. Training is carried out by the ICN's.

	Required	Achieved	Compliance %
Quarter 1	1245	1112	89.25%
Quarter 2	1232	1078	87.43%
Quarter 3	1196	1061	88.71%
Quarter 4	1235	1128	91.34%

The theme for 2020-2021 remained as 'Infection Prevention and Control, At the heart of everything we do'. Having to conduct training in a different method altered the way the message was delivered, however the IPACT ensured the training method covered the following key subjects:

- How does infection spread?
- How staff can help prevent the spread of infection
- Hand hygiene and bare below the elbows
- Correct wearing of PPE
- Dress code
- Spillage management

- Sharp safety
- Safe disposal of waste
- Compliance with DH *Pseudomonas* guidance
- Deep cleaning
- What is an HCAI
- CPE
- The rise of anti-microbial resistance
- The Health and Social Care Act (2015)
- Food hygiene
- Flu preparations including FIT testing

Additional training has been delivered to all clinical staff on Covid precautions, this has included swabbing training, FIT testing, Donning and Doffing training to ensure the correct application and removal of the required personal protective equipment that is required as part of the national Covid precautions.
Regular departmental training and updates have been held including drop in sessions, attendance in clinical and non-clinical departments to increase the ways information has been disseminated to all staff around the precautions and changes that have been made in the Trust as part of the pandemic management.

Infection Prevention and Control audit

Clinical audit is a fundamental component of clinical governance and underpins the assurance process for a high-quality service (CQC, 2010). The IPACT maintained an audit timetable that is monitored to ensure compliance with national recommendations for assurance. The following audits have been undertaken in the period April 2020 to March 2021. All Ward/Department Matrons are informed of audit results pertinent to their area as they are completed. They are asked to complete any recommendations made within the audit reports. The audit timetable was risk assessed and some audits have had to be delayed due to the need to minimise non-essential staff being on site and in the clinical departments and due to the increase pressures on the infection control team. Regular walkabouts of the Trust have been completed and key audits have all been maintained to ensure compliance with all aspects of national infection control guidance not just Covid precautions. The audits that have been postponed are:

- Surgical Site Infection (SSI) Audit
- Environmental audits of clinical and non-clinical areas
- Bedside Equipment Audit
- MRSA decontamination Audit
- Sharps box Audit

Saving Lives – Department of Health High Impact Intervention (HII) Audits

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

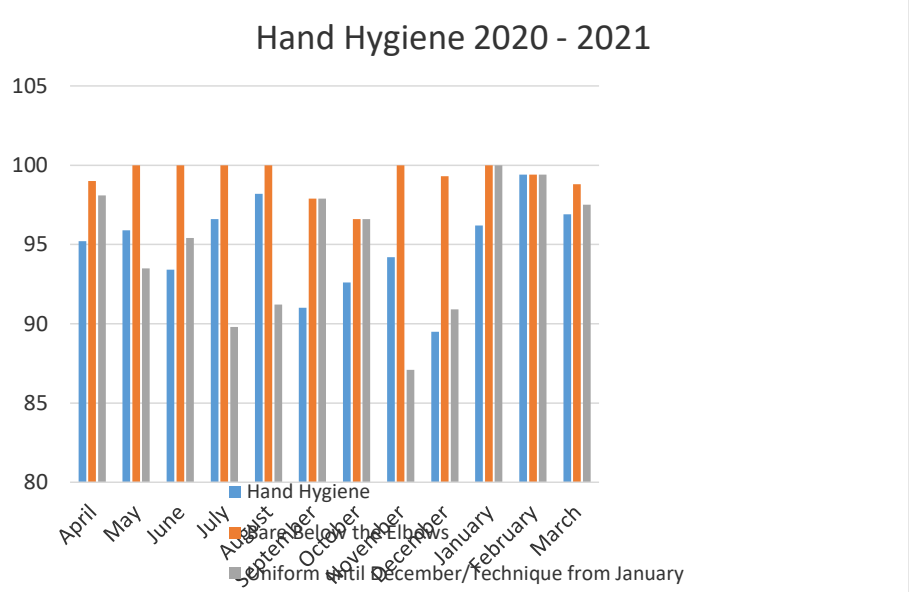
- Prevention of ventilator associated pneumonia
- Prevention of infections associated with peripheral vascular access devices
- Prevention of infections associated with central venous access devices
- Prevention of surgical site infection
- Prevention of infections in chronic wounds
- Prevention of urinary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

The data that has been collected has highlighted some areas that require improvement. The infection control team have been working with the ward matrons to identify issues and drive the improvement required. The area's completion and submission of the audits are generally much better however, there are low numbers of patients audited for some HII's which can distort the audit percentages. Going forward, infection control will continue to work with matrons, practice educators and Heads of Nursing to improve compliance with the HII guidance.

Isolation Room Audit

The annual spot check audit was carried out to ascertain the Trust's level of compliance against the Isolation policy in relation to appropriate allocation of isolation facilities. During the recent global pandemic, the Trust has been required to make many changes to how we function and as such the patient flow and some clinical areas have been adapted. Typically, there has been changes as to how isolation and side rooms have been used within the Trust to best cope with the evolving situation
The audit demonstrates that the Trust is allocating its isolation rooms appropriately as all patients deemed to be an infection risk have been nursed in isolation.
The trauma sheets for that day were reviewed and all patients that were being nursed in the bays were low risk and therefore nursed appropriately.
For those in isolation who were not an infection control risk it was also an appropriate allocation of facilities as it related to a privacy and dignity issue.
At all times the IPACT are monitoring and ensuring, with the co-operation of the ward staff, that all patients deemed to be high risk are isolated as per Trust policy and where this is not possible risk assessments are completed with the advice of the consultant microbiologist to minimise any risk to both the patients and staff.

Hand Hygiene Audits



Monthly hand hygiene and bare below the elbows compliance audits have continued. This audit is conducted by the Infection Control Link staff in their own areas. The audit tool is modelled on the NPSA 5 moments of hand hygiene. Overall compliance in all areas has fluctuated throughout the year. All staff are reminded at mandatory training sessions of the hand hygiene, bare bellows and uniform policy and any staff seen not complying is spoken with by the department lead. Audit results show that the staff group who achieve the lowest compliance each month is the Medical staff. The audit toll was modified to bring the focus of the audit to the key requirements: hand hygiene at the point of care, ensuring staff are bare below the elbows and making the audit personal. This has been done as we felt the audit contained too many questions/points that overwhelmed the auditor and lost the focus of the audit, we also wanted to make it an integral part of the audit to name each individual who was being audited so that areas of non-compliance could be addressed with person directly rather than completing departmental action plans.

Aseptic Technique

The purpose of the annual audit was to ascertain the level of compliance to the Trusts Aseptic Technique policy. An aseptic technique ensures that only uncontaminated equipment and fluids come into contact with susceptible body sites. It should be used during any clinical procedure that bypasses the body's natural defences. 73% of the audits were compliant having all ‘yes’ or ‘N/A’ answers which is a further decrease on the previous audit which was 83% in 2019. One factor that needs to be taken into account is that many of these no responses were found of the audit forms returned from the Paediatric areas whereby a slightly different approach is taken in order to safeguard the children. This was namely noted in not putting the equipment on the

bottom shelf of the trolley or loosening the dressing ahead of time. Going forwards, more time may need to be given to tailor an audit form specifically for the paediatric area and examination of how other paediatric areas perform aseptic techniques. On a positive note, many more audit forms were returned this year meaning that the conclusions drawn from the audit can be of more relevance.
Three no answers were given related to staff decontaminating their hands which is concerning. The infection control team will continue to focus on the importance of basic hand hygiene in all roles and areas particularly in our burns unit and burns assessment unit where these three lapses in hand hygiene were seen. it is worth noting that all three lapses were for the mid procedure hand cleansing that was missed and therefore it would appear that the individuals could do with some refresher training with regards to the Aseptic Technique process. Sadly, there was nothing written on two of the audit forms to state whether the auditor challenged these lapses at the time or post procedure with the individual involved. As a Trust, we are focussing on driving improvements across the board in hand hygiene with all staff groups.

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

- Due to Covid-19 pandemic precautions this visit was not conducted on order to limit movement of staff between different areas/sites and minimise the risk of spread of infection.

Duty of Care visit to Steris the sterile service provider

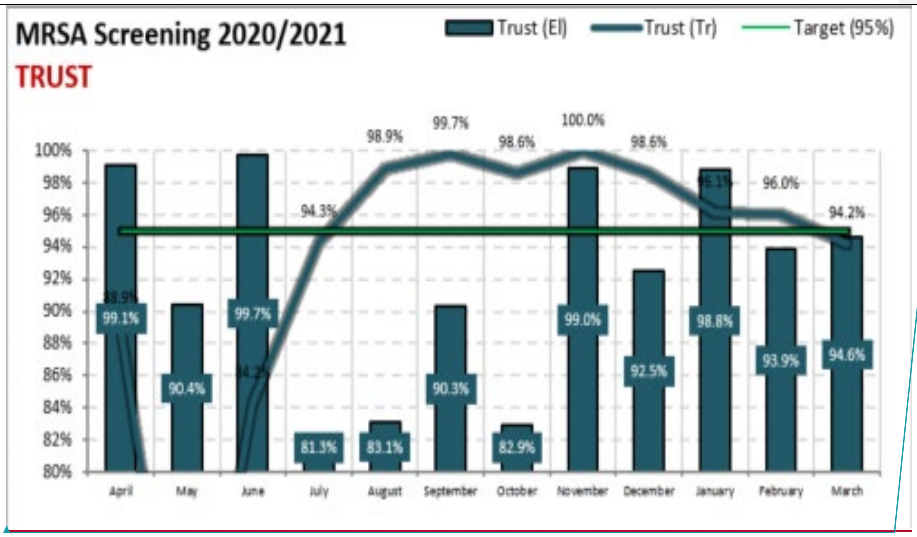
- Due to Covid-19 pandemic precautions this visit was not conducted on order to limit movement of staff between different areas/sites and minimise the risk of spread of infection

Duty of Care visit to Eastbourne Laundry

- Due to Covid-19 pandemic precautions this visit was not conducted on order to limit movement of staff between different areas/sites and minimise the risk of spread of infection

MRSA screening

Monthly audits are undertaken to ascertain the level of compliance with Trust policy for the mandatory screening of all elective and trauma in-patients. The Trust policy for MRSA screening was changed in July 2020 to bring it in line with national recommendations for screening patients for MRSA. The previous policy was to screen all patients for MRSA either pre-admission or within 48 hours. National recommendations are that all patients are now risk assessed as to whether they are high risk. High risk is defined as: previous MRSA positive, current MRSA positive diagnosis, transfer from another healthcare provider, patients who are resident of a communal living facility e.g. prison or nursing home, and healthcare workers. The Trust has included all admissions to the Burns unit and CCU as being high risk. All patients identified as being high risk must be screened for MRSA either in the 7 days before admission or within 48 hours of admission day. This is to include all patients including in-patients, day cases and paediatric admissions.



MRSA Screening Audit of High Risk Patients

This audit was previously conducted as a one day snapshot audit to assess compliance with screening of high risk patients, however since the Trust policy was changed to state only high risk patients require screening this is now audited monthly as above.

Environmental Audits

Due to restrictions being in place to reduce the amount of non-essential staff in patient areas to minimise the chances of spread Covid-19 the environmental audits were not undertaken during this year.
Assurance was still maintained by regular department inspections by the infection control and estates team to assess compliance with Covid restrictions including social distancing, ventilation, clear pathways, separation of 'red', 'green' and 'amber' pathways.

Maintenance and refurbishments continued in areas of concern and in multiple departments due to patient areas being changed to facilitate safe pathways for Covid-19. Where work has been undertaken infection control has had oversight to ensure compliance with national infection control guidance. Any concerns noted were escalated through the site transformation team and estates and facilities.

Formal environmental audits are to be rescheduled when national restrictions are lessened in 2021/2022.

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

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

Field Code Changed

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

The Trust website has been updated regularly through the year with the changing Covid-19 guidance and requirements. All communications relating to infection control are sent through the Corporate communication team before publication for the visitors and patients.

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

Local peer review and assurance processes

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

The purpose of these groups is to strengthen communication and dissemination of infection prevention and control information and practice across the organisation. The meeting has been attended remotely by the Consultant Microbiologist as they have not been attending site since February 2020.

Influenza arrangements

During 2020/21 support has again been given to the management of influenza (flu), with the ICN's encouraging vaccination of staff within the annual flu vaccination programme. Flu vaccination update is reported through the emergency planning reporting system.

A vaccination programme for Covid-19 was initiated in January 2021. Infection control assisted in the setting up of this programme which was run following national guidance for a 2 dose vaccination programme being offered to all healthcare workers, the first dose administered in January and the second in March.

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

Untoward Incidents including Outbreaks

This is a summary of events with further details having been included in the Infection Control quarterly reports.
There has been an ongoing global pandemic of Coronavirus (Covid-19) This has had a significant impact on the working of the hospital and patient/visitor flow. An infection control board assurance framework has been maintained and submitted to board as an assurance process.

- The Infection Control team has continue to prioritise the following actions due to Pandemic
    1. Coronavirus Screening overseen to screen all elective admission patients 72 hours pre-admission. Some of these through the drive through swabbing centre on site, some by a Trust team working in the community and some by engaging with primary care teams across the country due to the areas patients

are being referred from. We have engaged with the National Home testing system to facilitate testing of patients who cannot attend a drive through centre by utilising a postal screening system. As one of the first Trust to trial this there has been multiple issues during the initial set up which has required alternative screening methods. All of these have presented logistical challenges This service has been expanded to include all paediatric admissions

2. Being involved in the ongoing staff screening programme using an Optigene testing method. And then advising on actions for any positive results
3. Overseeing actions during a small outbreak of Covid 19 within a staff area. No patients were involved and spread limited to one department
4. PPE training, including donning, doffing and disposal of PPE this has been modified on multiple occasions to ensure we are following best practice as advised by Public Health England.
5. Reviewing and trialling alternative FFP3 masks due to sudden unavailability of certain makes and models
6. regular site walkabouts to ensure staff feel supported and have access to infection control for concerns and queries
7. Attendance at theatre and departmental huddles when requested to inform staff of the current situation
8. Fit testing staff members of staff to ensure FFP3 masks are fitted and worn correctly to ensure adequate protection,
9. Completing SOP's and procedures in line with evolving national guidance provided by PHE.
10. Communicating with Infection Control Lead for the McIndoe Centre to ensure cohesive and safe pathway for all NHS patients attending and for QVH staff assisting in this area.
11. Attendance at ward meetings
12. Reviewing and implementing PHE guidance around PPE and Infection Control
13. Working with teams to move patients around the hospital
14. Continue training on the use of the air powered hoods which are a replacement for staff who are unable to be FIT tested
15. Working closely with Supplies to source appropriate PPE in required quantities within the Trust
16. Ensuring PPE required in each department available and staff educated on how to use it to protect themselves and patients
17. Advising on admission pathways for patients to ensure there is minimal risk to staff and patients
18. Working with staff to answer queries as they arise
19. Working with estates to review ventilation systems
20. Collaboration with other Infection Control colleagues locally
21. Supported staff to undertake Coronavirus swabbing
22. Continuing a screening programme for staff members or their immediate families who cannot access the national testing service in order to ensure they receive a PCR swab in a timely fashion and reduce time away from work
23. Working with business unit managers and department leads to produce SOP's and guidance on restarting services within the Trust to ensure they are done safely with the right level of PPE
24. Assisting with the management of positive cases both in patients and staff, participating in contact tracing, testing of symptomatic staff and managing growing anxiety levels
25. Co-ordinating actions for localised outbreaks of Covid-19
26. Expanding the screening programme through the drive through Covid screening POD to include all trauma admissions for optigene screening
27. Guidance relating to visitors reviewed and strengthened

28. Policies and SOP's reviewed and amended as guidance changes specifically in relation to pre-operative isolation and then re-admission following a Covid positive result.
29. Daily checks of BSUH Covid-19 reporting spreadsheet and actions taken as required.
30. Infection control continue to provide out of hours and weekend support and advice for staff

April 2020 to June 2021

- No significant events.

July 2020 to September 2021

- Patient admitted to the head and neck unit with CPE. Patient identified as high risk on admission as had been previously positive of CPE. Screening sent as per policy and patient isolated with full infection control precautions. Infection control team worked with the department to ensure isolation was maintained but also to identify ways patient could safely have rehabilitation. No further cases.

October 2020 to December 2021

- Patient admitted to Ross Tilley on the 26th December for wound infection following hand surgery in the McIndoe on the 16th December. Patient attended MIU and then transferred to Ross Tilley for IV antibiotics and monitoring. Patient well on admission and swab sent for Sars Cov-2 PCR and Lateral flow – lateral flow showed negative on admission. On 29th December patient reported feeling unwell and when staff checked the microbiology the PCR swab was Covid positive. Patient transferred into a side room and full deep cleaning of bay undertaken. IPACT reviewed PPE compliance in the ward setting. No track and trace required and no secondary cases identified. Patient kept isolated for a further 24 hours and then discharged home when surgically fit.
- Patient admitted to Margaret Duncombe on the 29th December for an excision of lesion. Patient had a Sars Cov-2 PCR swab sent pre-admission on the 24th December and was then instructed to strictly isolate until date of admission. On admission patient was asymptomatic of Covid and surgery performed. Routine Sars Cov-2 PCR swab sent on day 3 of admission as per policy which returned Covid positive. Patient informed of result as she had been discharged before result known and she confirmed she was well in herself, instructed to strictly isolate for a minimum of 10 days from date of swab. All relevant staff informed and PPE states confirmed. No requirement for any further isolation of staff as all confirmed IPAC guidance had been followed. No secondary cases identified
- MRSA acquisition in Burns. Patient had a positive MRSA swabs result from his wounds on the 19/11/20. Patient had been admitted on the 15/10/20 for debridement and grafting with all admission swabs negative to MRSA. Repeat swabbing in EBAC also showed negative until the 15/11/20 when swabs sent from donor site and back returned positive. MRSA resistant pattern reviewed with no other cases with the same pattern being identified in any current patients. RCA completed to see if cause can be identified. Some concerns noted as they unit had recently moved to a new area due to Covid restrictions resulting in some changes in practice due to layout. No obvious issues or causes noted and no further cases identified.

- Outbreak of Covid-19 in a staff only area within the Trust. Four members of staff (approximately 25% of the team) were confirmed Covid positive between the 17/12/20 and 20/12/20. Strict infection control measures implemented, with all affected staff put into strict isolation for a minimum of 10 days, any staff who display any symptoms to have a PCR test, leave site and isolate immediately. Non-infected staff to remain in their department only with no patient or staff contact, strict adherence to social distancing, hand hygiene and mask wearing. Department including work areas, toilets, staff rooms and kitchens deep cleaned. CCG informed and situation monitored, outbreak stood down on 15/1/21. No other departments or patients affected.

January 2021 to March 2021

- Outbreak of Covid-19 in a staff only area within the Trust. Five members of staff (100% of the team) were confirmed Covid positive between the 05/01/21 and 15/01/21. Strict infection control measures implemented, with all affected staff put into strict isolation for a minimum of 10 days, any staff who display any symptoms to have a PCR test, leave site and isolate immediately. Non-infected staff to remain in their department only with no patient or staff contact, strict adherence to social distancing, hand hygiene and mask wearing. Department including work areas, toilets, staff rooms and kitchens deep cleaned. CCG informed and situation monitored, outbreak stood down on 15/2/21. No other departments or patients affected.
- Three patients identified as being C.diff positive all within the Burns unit in February. Outbreak declared as all cases reported as hospital acquired. RCA's completed for each patient which highlighted that stool samples are were not being sent in line with local policy. All samples sent for typing which showed all three were different strains of C.diff indicating that these were likely to have been acquired pre-admission. Burns unit closed for all new admissions during this time. Department deep cleaned twice including all clinical rooms, non-clinical rooms and staff areas. CCG aware and consulted on actions including conducting a walk around of the department with the infection control lead nurse. They were satisfied with all actions taken. All C.diff positive patients discharged with three remaining long stay patients in the unit on re-opening.
- Two further patients within the Burns unit and 2 patients in CCU identified as C.diff positive following the re-opening of Burns in March. RCA's completed for all four patients and stool samples sent for typing. Burns closed to all new admissions and CCU put on restricted admissions. Typing results received which showed likely cross contamination in Burns but alternative source in CCU. RCA process showed inappropriate antibiotic prescribing as likely cause of CCU C.diff acquisition. Both wards deep cleaned and strict infection control precautions implemented in line with outbreak policy. CCG aware of the situation and following actions being undertaken. Advice sought from the Consultant Microbiologist. Burns remains closed throughout March. CCU re-opened with patients affected managed in side rooms. Learning to be shared when outbreak closed and RCA's completed. All cases reported on the HCAI database to PHE and CQC aware.

5. Involvement and Engagement

Antimicrobial report

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

Decontamination and disinfection report

Routine decontamination of nasendoscopes and specific theatre equipment continues through the Wassenburg (endoscope washer disinfector). Routine water testing and servicing of the Wassenburg has been performed minor fluctuations in the levels within the water were rectified using approved processes such as thermal cleans and disinfections. Repeat samples following positive results have all returned negative and no positive cases required the closure of the decontamination service. The Trust continues to have an external Authorised Engineer who conducts the annual audit and ensures compliance with national guidance.

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

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

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

Facilities report

Cleaning audits are undertaken by the Domestic Supervisors weekly, each clinical area is audited every week and non-clinical areas 3 monthly. Where issues or concerns related to cleaning are noted these addressed and resolved within 48 hours with a repeated audit conducted within 7 days.
Deep cleaning programme has continued with all areas deep cleaned in line with the National Standards of Cleanliness with clinical areas done every 6 months and non-clinical areas annually.
The annual Trust PLACE inspection was cancelled by health watch this year due to Covid restrictions.

Estates report – Associate Director of Estates

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

Water Safety

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

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

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

There are no Infection Control Risks on the corporate risk register. This is discussed at the quarterly infection prevention and control group each quarter to provide assurance there are no areas that require a risk entry.

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

6.	Learning from Experience
	2020/2021 was an incredibly challenging year for the Trust as a whole and the Infection Prevention and Control team specifically with the global pandemic of Covid-19. The Infection Control team has risen to the challenges to keep the risk of Covid-19 cases to a minimum within the Trust. We have achieved this by forming close working relationships with the estates team, facilities team, clinical leads, emergency plan lead and Covid-19 groups set up to review national guidance, PPE requirements, patient pathways and flow through the Trust, estates and infrastructure, ventilation requirement, screening requirements for both patients and staff. The infection control team has adjusted the way they work to be more accessible for all staff throughout the last year by increasing their presence in the wards, at departmental meetings, providing an out of hour on-call service and maintaining close links with the Microbiology service at UHS to ensure timeliness of results being reported. Much of the infection control team's time and resources has been spent managing the Covid-19 outbreak, actions for this include mass FIT testing staff, working with procurement to ensure adequate supplies and much more as detailed in the sections above. As a result of the additional pressures on the infection control team, the movement of clinical services and the limitations put in place around visiting other sites some of the audits have not been conducted therefore these audits will prioritised for the coming audit period. Despite the pressure on the infection control team caused by the Covid-19 pandemic we have continued to ensure general standards of infection control have been maintained for all patients to prevent a rise in health care associated infections. Patients and staff can be put at risk by failure to adhere to good infection control practice. The Trust continues to strive to improve compliance with all aspects of Infection Control in order to safeguard the patients, service users and staff through a robust programme of education, audit and reporting. The rates of both reportable and non-reportable infections remained low however there is still improvement to be made. The areas that have been shown through the auditing process for this year as requiring improvement are: compliance with MRSA screening, compliance with hand hygiene and bare below the elbows and compliance with antibiotic prescribing. The infection control team will continue to champion and promote the implementation of infection control to all staff in all departments with the emphasis on 2021/2022 programme being reinforcing compliance with infection control. The infection control team aims to increase departmental based inspections, offer a variety of events for staff to learn more about infection control and ensure that the infection prevention and control team is a visible and constant presence within the Trust.

7.	Recommendations
	This report has evidenced the challenges faced for the trust's Infection Control team through the use of audit, training and engagement with key service providers across the Trust. The results of these have shown that overall, compliance with National guidance, Trust policy and National targets is good although there is still some improvement required. There will be ongoing challenges to be faced from the continued global pandemic of Covid-19 with guidance still being updated and modified in response to the changing national and global situation, the infection control team will strive to maintain a Covid 'green' site and minimise the risk to all patients, staff and visitors. Looking forward, using the experiences and knowledge gained throughout the last financial year, further targeted work could be undertaken to improve the internal structure of key clinical areas. Priorities for this year have

	been identified as increased focus to increase compliance with antibiotic prescribing and further targeted auditing for surgical site infection.

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

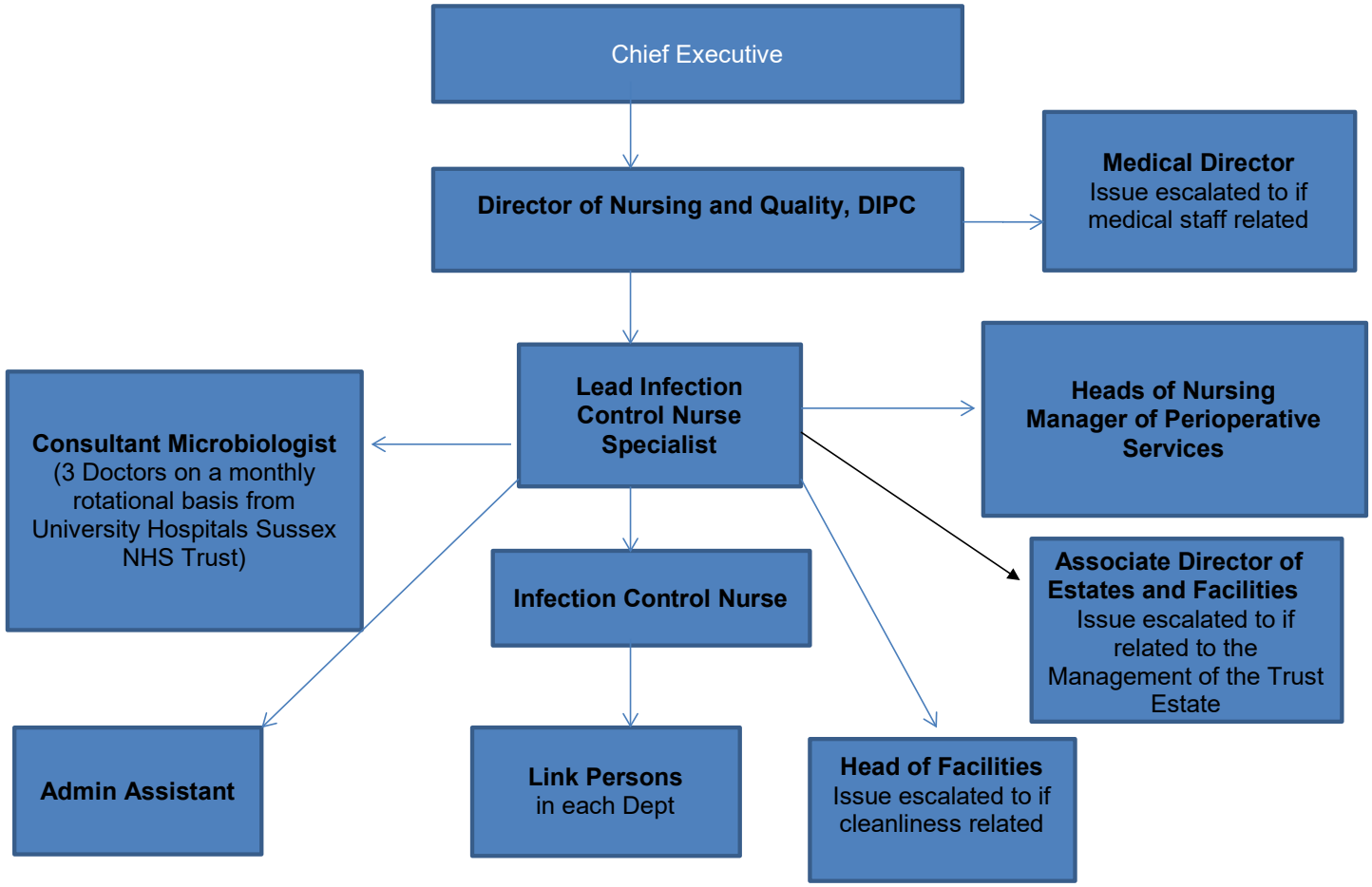
9.	Conclusions and assurance
	This report demonstrates the systems and processes in place to ensure that the trust meets the requirements of the Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare related guidance. The completion of the infection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

	To conclude, the Infection Control Team believes this annual report accurately reflects the commitment and achievements of the infection prevention and control service in the trust.

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

11. Appendices

APPENDIX A **Infection Prevention and Control Structure Chart 2020/2021**



Appendix B
Infection Control Annual Programme Objectives for 2021/22

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

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

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

IC	Education	Updates for Clinical Practice Educators / Department Managers / departments	As required
IC	Education	Mandatory training: Clinical Non-clinical Induction Junior doctors Consultants	X2 month X1 month X1 month X6 year X2 year
IC	Education	Link person training	quarterly
IC	Education	Infection control awareness week	Annual
IC	Education	Deliver training to staff on current issues and attend department meetings on request	As required
Estates	Management	Involvement in the Capital Programme	As required
Estates	Management	Review of estates policy and new guidance	As required
Estates	Management	Involvement in reviewing water sampling and ventilation results	As required
Estates	Management	Involvement in the prioritising of general refurbishment works within the Trust	As required
Estates	Audit	Waste facility	Annual
Decontamination	Management	Review of decontamination and disinfection policy	As required
Decontamination	Management	Update for ICC	Quarterly

Appendix C

IC Policies Ratified April 2020 – March 2021

IC.7028.3	Infection Control	Protocol for Animals in Hospital	Director of Nursing and Quality	Lead Infection Control Nurse	Infection Prevention & Control Group
IC.7008.9	Infection Control	Policy for the Screening of Patients for Meticillin Resistant Staphylococcus Aureus (MRSA) and Treatment and Management of MRSA Positive Patients	Director of Nursing and Quality	Lead Infection Control Nurse	Clinical Governance Group
IC.7029.3	Infection Control	Carbapenemase-producing Enterobacteriaceae (CPE) Policy	Director of Nursing and Quality	Lead Infection Control Nurse	Clinical Governance Group
IC.7025.5	Infection Control	Policy for the Prevention of Healthcare Associated Infections (HAI) in Short and Long Term Urinary Catheterisation in Acute Care	Director of Nursing and Quality	Lead Infection Control Nurse	Clinical Governance Group

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Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/09/2021**		**Agenda reference:**	**140-21c**	
Report title:	**Patient Experience Annual Report 2020-2021**				
Sponsor:	Nicky Reeves, Director of Nursing and Quality				
Author:	Nicolle Ferguson, Patient Experience Manager				
Appendices:	None				
Executive summary					
Purpose of report:	The Patient Experience Annual Report 2020/21 aims to present a rounded picture of patient experience and, as such, provides information on all aspects of experience, good and less positive.				
Summary of key issues	This report covers the period of April 2020-March 2021. We received 47 complaints during this time. This is 22 less than the same period last year. There is a full analysis of the complaints along with outcomes and actions taken within this report. During the COVID-19 pandemic, NHS England and NHS Improvement supported a system wide "pause" of the NHS complaints process. However the Trust was able to continue to respond to complaints and did not impose the pause as suggested at a national level. Including within the report are details of the annual Friends and Family Test scores, which compare extremely positively when compared with other trusts.				
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):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	Links to KSO1, KSO2, KSO3, KSO4, KSO5				
Corporate risk register:	Links to workforce and access and performance risks on CRR				
Regulation:	Reputational implications of delivering sub-standard safety and care				
Legal:	The trust adheres to Regulation 18 of the The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, which requires NHS bodies to provide an annual report on complaint handling and consideration, a copy of which must be available to the public.				
Resources:	No new resource requirements identified				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	26/07/21	Decision:	Noted	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Patient Experience Annual Report

Queen Victoria Hospital NHS Foundation Trust

Report covering the period from
April 2020 to March 2021

Document Control: Quality and Governance Committee

Executive sponsor: Nicky Reeves, Director of Nursing and Quality

Author: Nicolle Ferguson, Patient Experience Manager

Date: June 2021

Type: Annual Report
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Circulation: QVH Trust Board

Contents List

1. Executive Summary

We are pleased to publish the combined patient experience complaints and Patient Advice and Liaison Service (PALS) annual report for Queen Victoria Hospital NHS Foundation Trust during 2020/21

With much of the NHS treating patients with COVID-19, Queen Victoria Hospital (QVH) was asked to take on a special role, becoming a surgical cancer centre, providing appropriate and timely treatment for patients with high-risk cancers (breast, head and neck, and skin). Working with hospitals from across Sussex, Surrey and Kent, our staff were able to build on our regionally and nationally recognised expertise, and agree the best approach for each patient to provide them with the timely treatment they needed.

Therefore due to the ongoing COVID-19 pandemic NHS England and NHS Improvement are supporting a system wide "pause" of the NHS complaints process which would allow all health care providers in all sectors to concentrate their efforts on the front-line duties and responsiveness to COVID-19 this means that:

- All providers should ensure that patients and the public are still able to raise concerns or make a complaint, but that the expectation of an investigation and response in the near future is managed.
- All providers would continue to acknowledge complaints, log them on their respective systems, triage them for any immediate issues of patient safety, practitioner performance or safeguarding and take immediate action where necessary. All complaints would then remain open until further notice, unless an informal resolution could be achieved, or the complainant chooses to withdraw their complaint.
- In secondary care where PALS offices still operate, they could still provide support by email and telephone and this should be encouraged for patients and the public to engage with the organisation.
- We would advise the system that consideration should be given to complainants who, at the time of the "pause", have already waited excessively long for their response (specifically those who have waited six months or more) these should be reviewed to ascertain if and how these can be resolved to the complainant's satisfaction.

The initial "pause" period was recommended to be for three months with immediate effect.

However the Trust was able to continue to respond to complaints and did not impose the pause as suggestef at a national level. During the second wave there was no national pause on complaints. National guidance was issued advising that trusts could extend response times in negotiation with the complainants. However, the Trust did need to implement the extended period in the second. Our dedicted Patient Expereince Manager who is a lone worker has been on-site and continued to promote patient expereince and provide assistance and help to patients/carers and service users.

We are committed to delivering safe, effective and person centred care. The use of feedback is central to ensuring delivery of these aims and we offer a variety of appraoches which allow people to choose a feeback mechanism that best suits their needs. These include:

- in writing via letters, surveys, conuslations and Friends and Famly Test feedback forms.
- by e-mail via our Informaion and PALS e-mail adresses
- by telephone direct to our Patient Experience Manager
- via the NHS website and Care Opinion which are sites where patients can share their experience of health or care services, and help make them better for everyone.
- on social medica via posts, links and direct messages
- face to face and daily contact with the public

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

2. Introduction

This annual report demonstrates how the Trust measures progress towards the ambitions set out in the Trust Key Strategic Objectives (KSO), focusing on KSO1 Outstanding Patient Experience. The report includes a summary of patient and carer feedback and actions and initiatives to improve patient experience during 2020-21.

The Trust's Patient Experience Group (PEG), a sub-group of the Quality and Governance Committee, provides the direction to deliver the strategy. PEG analysis and triangulates the intelligence gathered from patients/relatives/carers to identify themes, patterns, trends and issues in the data that may require further investigation.

Complaints received provide much learning for the Trust on where and how we need to improve. The themes and trends identified from complaints in 2020-21, and previously in 2019/20, highlight the need to improve communication and information provided to patients, carers and families, improve communication on clinical treatment, improving waiting times and improving the care provided.

A key objective of the Trust, and one we need to do better at, is to learn, change, improve and evolve in response to complaints. The lessons learned and trends identified through monitoring data collected through complaints plays a key role in improving the quality of care received by patients and their experience and is a priority for the Trust reaching its vision of outstanding care every time. The efficient and effective handling of complaints by the Trust matters to the people who have taken the time to raise their concerns with us. They deserve an appropriate apology for their experience alongside a recognition where substandard and inadequate care was provided and assurance that we will put actions in place to ensure other patients are not affected by a reoccurrence of the same concerns.

This assurance comes through robust investigation with meaningful actions put in place. Posters and leaflets are displayed around the Trust and there is information on the Trust website to ensure that patients are made more aware about their options and the process for raising a complaint.

We view all types of patient feedback as positive and we are constantly looking at ways in which we encourage patients, carers and families to give their views. Throughout 2020-21 the Trust continued to proactively manage complaints, improving the process and quality of the responses, and embedding the learning from complaints in to services and practice.

The purpose of this report is to provide a review of the Patient Experience data collected

through the Friends and Family Test (FFT), the real time survey system, national surveys as well as themes from PALS enquiries and formal complaints received within Queen Victoria Hospital NHS Foundation Trust during 2020-21.

At Board level, the Trust's director of nursing has responsibility for patient experience which includes:

- delivery of or patient experience strategy
- compliance with the mandatory national FFT.
- reporting and demonstrating that we have used patent experience feedback to import the experience of care.

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

The Trust Board has oversight of patient experience through bi-monthly reports at public Trust Board meetings. The Director of Nursing and Quality is the Executive Lead for patient experience, who chairs the Patient Experience Group (PEG) within the Trust. Their role is to be assured that action on improving and responding to patient experience concerns are addressed. Membership of PEG includes representation from; Trust staff, Trust Governors, and Healthwatch. This group routinely reviews patient experience actions and progress, to ensure areas of poor patient experience are addressed. We know from existing feedback there are many examples of excellent care and experience being delivered by our staff and the overwhelming majority of patient's comments are very positive. Staff are frequently described of as being kind not only towards patients but also towards each other and go beyond the expected level of care.

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

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

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

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

3. Friends and Family Test - Capturing patient experience

The Friends and Family Test (FFT) gives patients who have received care throughout the Trust the opportunity to provide immediate feedback about their experience.

In September 2019, NHS England and NHS Improvement published revised Friends and Family Test (FFT) guidance for implementation with effect from 1 April 2020. Principal among the revisions was the changing of the FFT question from: 'How likely are you to recommend our ward / hospital / department / service to friends and family if they needed similar care or treatment?' (Response options: Extremely likely, Likely, Neither likely nor unlikely, Unlikely, Extremely unlikely, Don't know) to: 'Overall, how was your experience of our service?' (Response options: Very good, Good, Neither good nor poor, Poor, Very poor, Don't know)

During 2019, preparations were made to ensure a seamless transition to the new requirements and revised data collection materials were in place with all teams Trust-wide ready for the 1 April 2020 launch. In line with national guidance issued shortly before the launch, the FFT was paused due to the Covid-19 pandemic.

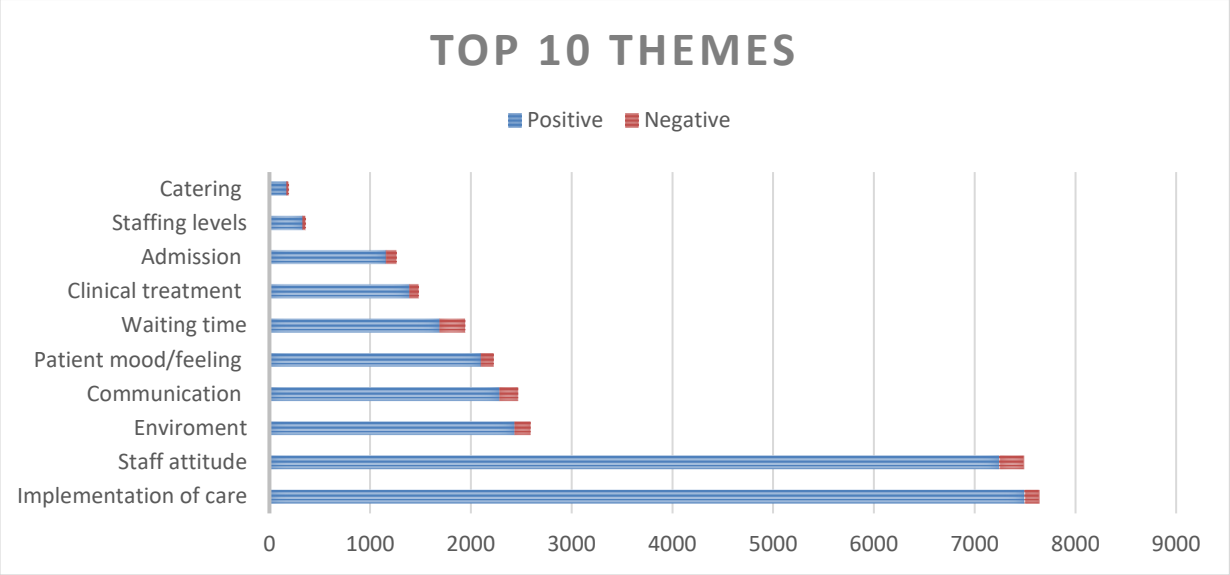
It was announced by NHS Improvement in August 2020 that all acute and community providers were to resume collecting and submitting monthly Friends and Family Test data from 1 December 2020. The first data to submit would be December's data, submitted in early January. The data will then be published in February 2021. However here at QVH we had already started collecting FFT from our patients in July 2020.

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

Positive and neutral feedback provides a further prospect of quality improvement. Our software's thematic analysis tool provides a rich source of the most commonly raised themes brought up by patients. The table below separate the positive and negative themes for the year, allowing a clear analysis of areas to celebrate and those that require further exploration.

Between April 2020 and March 2021, we received 16,852 responses to the FFT, with over 13,614 comments given. The overall percentage of inpatients recommending (Extremely likely or likely) was 99%.

The table below separate the positive and negative themes for the year. The figure denotes the amount of times that a particular theme was referred to by patients.



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

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

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

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

FRIENDS & FAMILY TEST DATA BREAKDOWN 2020/21		Target	April	May	June	July	Aug	Sept	Oct	November	December	January	February	March
Inpatients	% patients who would recommend us	90 %				98 %	97 %	100 %	99%	99%	100 %	100 %	100 %	99 %
	% patients who would not recommend us	0%				2%	2%	0%	0%	0%	0%	0%	0%	0%
	No. of responses	–				49	113	467	554	509	464	353	391	493
	No. of patients eligible	–				325	546	172	135	154	142	117	152	157

3.2 How do we report it?

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

3.3 Specialist cancer surgical hub

Queen Victoria Hospital was designated cancer surgical hub as part of the Sussex response to Covid in April 2020. With regionally and nationally recognised expertise in treating patients with high-risk cancers (head and neck, skin and breast) it was chosen as a hub to receive referrals from hospitals across Kent, Surrey and Sussex.

The usual focus of breast surgery at QVH is post cancer reconstruction but surgeons have carried out over 400 breast oncology surgeries (excisions and mastectomies) for women referred from other Kent and Sussex trusts.

It was felt that as the patients attended had never been to our hospital, therefore it was felt that this would be a good a opportunity to obtain feedback from this cohort of patient. We have sent out **313** questionnaires and received **143** replies, which is considered a very good response rate.

The patients who responded, found their experience either very good or good. The only negative issues were the distance the patients had to travel and the lack of communication about the amount of time that they had to wait in theatres to have the surgery. These particular comments were immediately shared with theatre teams and actions put in place where letters were updated and the patients were assigned their own named nurse who would regularly check up on the patient and keep them fully informed during their stay with us.

4. National Inpatient Survey 2020

This survey is currently underway with initial results tables due with the Trust by June 2021 (at the time of writing the report these were embargoed). The results are not due to be published nationally until October/November 2021.

5. Analysing the patient experience feedback

The systemic analysis and triangulation of all forms of patient experience feedback, including complaints, compliments, PALS, FFT and surveys, results in the production do detailed patient experience reports on a monthly basis.

Developing an understanding of the patient experience by identifying the touchpoints of a service and gaining knowledge of what people feel when experiencing the Trust's services and when they feel it is crucial to the process of enabling the Trust to improve the experience of patients in its care.

The effective analysis, accessibility and use of the large volume of data collected is facilitated by the use of our FFT database. This enables searching by keywords to analyse themes, collating date to generate comment reports for teams and the collating of the monthly FFT data for submission to NHS England, to be carried out more efficiently.

Key metrics are included in the Quality Scorecard provided to the Trust Board. Each ward displays the FFT score for that ward for patients and staff to see.

6. Patient Story at Board

Stories can help build a picture of what it is like to be in receipt of our services and how care can be improved or best practice shared. Every bi-monthly a patient, service user or carer attends a Trust Board supported by the Patient Experience Manager to share their story. By listening to lived experiences of those in receipt of our services or caring for a loved one in receipt of our services provides a valuable contribution to our Board meeting.

Patient stories are obtained either through the complaint process, letters to the chief executive, from patients who have approached the Trust, or from staff wo feel that one of their patients has had an experience which we can learn from

From April 2020 and March 2021, three stories were presented to the Board by the patients themselves but rather than in person these were presented via MS Teams or pre-recorded video. They included:

- Positive and very personal experience of attending during the pandemic for breast surgery (November 2020).
- Recording of an interview with a burns patient (January 2021)
- Positive patient experience of the treatment that a patient received from a patient who was one of the first patients an appointment via the video consultation and how the system could be improved (March 2021).

7. Patient Experience Group (PEG)

The group meet on a quarterly basis, chaired by the Director of Nursing and Quality, are the key vehicle for patient representation / participation, and the group is a formal, business/assurance group comprised mainly of Trust staff, patient representatives, dementia and learning disabilities leads and Healthwatch representatives. PEG is a sub-Committee of the Board's Quality & Governance Committee. The group is a taskforce that collaboratively work together to deliver on key patient centred based on the Trust Key Strategic Objectives (KSO), focusing on KSO1 Outstanding Patient Experience and Patient Environment and Action Team (PLACE) inspection. The group supports decision making and co-ordinates organisational change relating to patient experience and audit inspections results to support improving the delivery of patient centred care within an appropriate caring environment.

The group also work collaboratively with Hotel Services to review service criteria in light of latest cleaning standards and any audits which require action that impacts upon the level of current service ad to escalate as appropriate and share best practice across the organisation.

The role of PEG is to:

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

PEG has continued to receive and comment on reports including complaints, feedback, patient experience reports and national surveys. The committee has received updates on key projects, which impact on patient experience, including the outpatient improvement programme.

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

8. Complaints

This section provides a summary of formal complaints received in 2020-21 in accordance with the NHS Complaints Regulations (2009).

This includes:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

The Trust is committed to welcoming all forms of feedback, including complaint and using them to improve services. The Trust strives to provide the best care and service. However when we do not get this right, complaints from our patients, carers and relatives are a vital source of feedback and we use themes to establish learning and identify quality improvement opportunities.

The manner in which a NHS Trust investigates and learns from complaints is an important part of compassionate care. The Trust takes investigation, learning, timeliness and communication surrounding complaints very seriously.

The Trust uses the following definitions:

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

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

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

- Compliments are expressions of thanks and praise.

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

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

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

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

8.1 Standards for Complaints management and escalation

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

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

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

- When a complainant requests a review by the PHSO, all enquiries received from the Ombudsman's office are responded to promptly.

8.2 Complaints received

From April 2020 and possibly as a result of the COVID 19 pandemic, the number of new complaints started to drop. In the financial year 2020-21 we received 47 formal complaints, which is a decrease of 22 from the previous year (69 complaints).

The Trust has seen a reduction in the number of new formal complaints received since 2018/19. It should be noted that in quarters one and two of 2020/21, the Trust was focused on the response to the COVID Pandemic, and activity within the Trust was reduced. It is likely that this reduction in activity led to fewer complaints being received during these quarters.

The main themes of the complaints are related to clinical treatment, appointments, communications, and in relation to the Trust's values and behaviours amongst staff.

All complaints are managed individually with the complainant and in a manner best suited to resolve the particular concern raised. Methods of response can include a written response from the Chief Executive, a face to face resolution meeting with relevant staff (however during the pandemic face to face meetings were not being offered), and later, potentially if unresolved, an independent review of the care provided.

The Trust is committed to improving the experience of our patients from their first contact with the Trust. Complaints and concerns provide valuable information to monitor the experience of patients, carers and relatives. Users of the service are encouraged to discuss their concerns with staff at the time the problem arises. However, it may be the case that patients feel unable to do this, or perhaps staff have tried to resolve the issue but have not achieved this. The Patient Advice and Liaison Service (PALS) provide 'on the spot advice and support' with the aim of timely resolution. In the event that this has not been achieved, PALS will give advice on the formal complaints process. The Trust recognises the value that learning from complaints and concerns brings. It is vital to make the process simple and easily accessible and leaflets and posters are displayed throughout the hospital to help facilitate feedback. The following pages provide an indication of the Trust's position for complaints and concerns.

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

All complaints are acknowledged within 3 working days. In this period 97% of complaints were acknowledged within 3 working days. The Trust endeavours to respond to all complaints within 30 working days in an honest, open and timely manner. If it is clear on receipt of the complaint or at any point during the investigation that the investigation cannot be completed on time, for example when a complaint is more complex or requires a joint response from services/organisations a new timeframe will be agreed with the complainant.

During 2020/2021 the Trust managed 67% of complaints within timescales (30 working Days); an improvement on performance in 2019/2020 when only 46% of complaints were managed within timescale. However, the figure remains far below the target of 95% that the Trust strives to achieve.

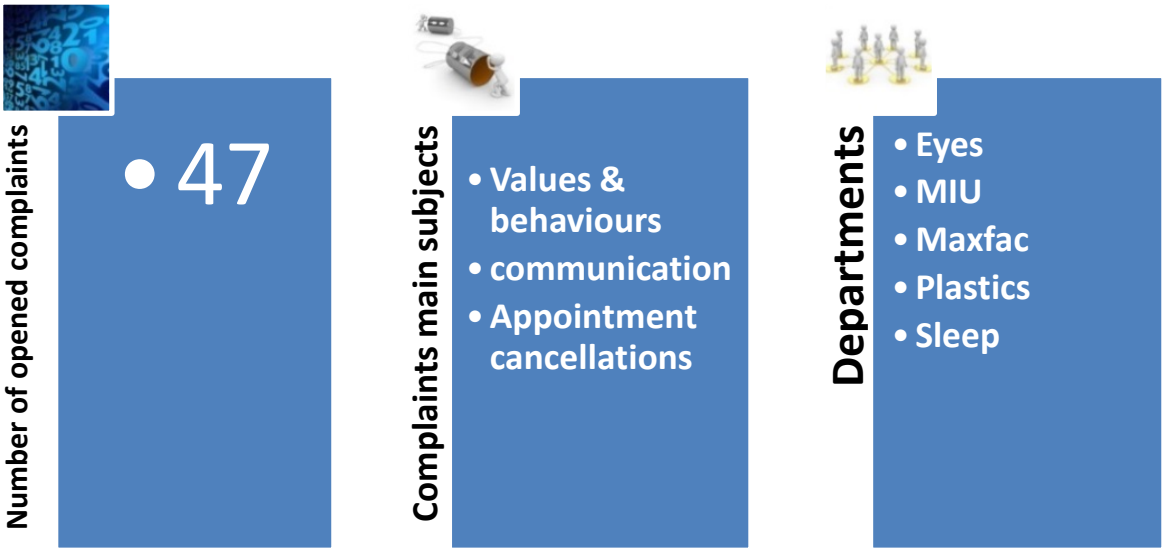
The two main reasons for a late response are divisional delay with the investigation, further details being requested following review and third party involvement. This may have been affected by the COVID-19 response and will be monitored by the Patient Experience Manager.

The Trust is committed to learning from any complaint received and considerable focus is placed on this aspect of the complaints process. We try to ensure that all complaints are robustly investigated and that, where action is needed to improve the care or service a patient receives, this is reflected in the complaint response.

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

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

Throughout 2020/21, face to face training sessions for staff on both handling complaints and concerns on the frontline was put on hold. All new staff have received a condensed session about customer care and handling concerns at the Trust induction programme and a training leaflet was developed to accompany this training.



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

The following is a cumulative chart showing the number of complaints received since 2015/16 to present.

QVH Patient Complaints	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total

2015/16	4	5	2	7	1	3	4	5	8	6	3	5	53
	4	**9**	**11**	**18**	**19**	**22**	**26**	**31**	**39**	**45**	**48**	**53**	
2016/17	3	7	6	0	7	5	5	3	2	7	4	4	53
	3	**10**	**16**	**16**	**23**	**28**	**33**	**36**	**38**	**45**	**49**	**53**	
2017/18	3	4	4	7	3	7	1	5	3	7	5	3	52
	3	**7**	**11**	**18**	**21**	**28**	**29**	**34**	**37**	**44**	**49**	**52**	
2018/19	1	6	8	8	3	4	5	5	3	3	2	6	54
	1	**7**	**15**	**23**	**26**	**30**	**35**	**40**	**43**	**46**	**48**	**54**	
2019/20	8	2	9	4	7	2	9	8	6	2	2	10	69
	8	**10**	**19**	**23**	**30**	**32**	**41**	**49**	**55**	**57**	**59**	**69**	
2020/21	3	1	5	4	5	1	5	6	2	3	3	9	47
	3	**4**	**9**	**13**	**18**	**19**	**24**	**30**	**32**	**35**	**38**	**47**	

8.3 Investigation outcomes

Complaints received by subject of complaint 2019/20	Total number of complaints received	Complaints upheld	Complaints upheld in part	Complaints unsupported
Appointments/admission delay/cancellation	5	3	1	1
Treatment (nursing)	2	1	1	0
Communication/information to patients (written & oral)	7	4	3	0
Treatment (medical)	9	2	3	4
Confidentiality	1	0	1	0
Surgery treatment/procedure	5	3	1	1
Values & behaviour	16	2	8	6
Health records	2	0	1	1
TOTAL:	**47**	**15**	**19**	**13**

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

Complaints received during 2020/21 included the following themes and whether the complaints was upheld, upheld in part or unsupported:

- The fifteen complaints that were graded to be upheld included concerns relating to service failure. This is categorised for example as appointment cancellations and communication.
- The nineteen complaints upheld in part were categorised as such due to clear concerns about a patient's experience being poor. This included poor communication, certain aspects where care could be improved and expectations not being met.
- The thirteen complaints that were unsupported, as the investigation concluded that the staffs values and behaviour were acceptable.

8.4 Learning from complaints, concerns or feedback

There is an organisational emphasis on both quality and timeliness of complaint handling which is re-enforced by the Board.

All complaints, together with their respective responses, are quality/accuracy checked and challenge by the Chief Executive and Director of Nursing. This includes recommendations for incident reporting or other independent clinical review where appropriate.

Because complaints reflect a personal experience, it is difficult to be precise about any common themes but most complaints are communication issues and the negative impact this has had. Poor attitude and behaviour is a trigger for a complaint when staff do not display empathy and compassion or are brusque and do not appear to be willing to give the patient the voice to speak. Complaints of this type are more apparent in the outpatient setting. Cancelled elective admissions and the rescheduling of outpatient appointments escalate to a formal complaint when patients cannot be given an early resolution or have ha had multiple poor experiences.

There were sixteen complaints received where attitude was recorded as the primary subject of concern. In relation to staff attitude, staff are encouraged to read the complaint letter and are supported by their line manager to reflect by providing a reflective statement on how they could have responded differently. The reflection is further reviewed with the staff member to ensure learning has taken place. Where indicated, training on values based leadership and effective people management is provided. Customer service training is also provided by Patient Experience Manager for staff teams. For medical staff, staff are required to discuss the complaint with their medical supervisor and agree a corresponding development plan.

Below are examples of actions and learning identified from complaints:

- The learning disability training now includes a section on autism. This training will ensure staff receive learning disability and autism training, at the right level for their role. They will have a better understanding of people's needs, resulting in better services and improved health and wellbeing outcomes.

- The Sleep centre have implemented a consent form, which will completed by a patient prior to a CPAP appointment being set up.

- Full review and changes made to pathway for immediate breast reconstructions patients. This will ensure that all tests and pre-assessment are undertaken on same day as the consultation.

8.5 Further analysis of formal complaints

- None of the 47 patients who had raised a formal complaint, approached advocacy services to support them through the complaints process.

- The Trust received no requests for a complaint response in large print or brail.

- As in previous years, all formal complaints were received in the English language with no requests made by a complainant (or enquirer) for the assistance of the Trust's Interpreting Service.

- The Trust received two formal complaints where people stated that they had a learning disability.

- One external review of care was commissioned as part of the Trust investigation during 2020/2021.

- In line with the Duty of Candour (November 2014) the trust investigation responses have been scrutinised to ensure they are open and transparent. Where it has been established that errors occurred, this was shared with the complainants and an apology given and lessons identified to enhance learning for the Trust.

8.6 Communicating the actions we have taken

When feedback results in an action being taken, it is vital that we communicate what we have done. Actions taken as a result of the patient experience feedback are communicated through various channels, as follows:

- Direct feedback to the patient e.g. via meetings, complain letters
- 'You said – we did' noticeboards at ward/department level
- Monthly integrate performance reports and the
- Trust annual report
- Quality Account
- Trust intranet
- NHS/Care Opinion

8.7 Parliamentary and Health Service Ombudsman (PHSO)

To help the NHS focus resource on tackling the coronavirus pandemic, the PHSO paused their work on existing NHS complaints and acceptance of new health complaints on 26 March 2020. After careful consideration, they decided to restart this work on 1 July 2020.

A complainant may refer their complaint to the PHSO if they do not feel that the Trust has responded to all of their concerns or they are unhappy with the way in which we have dealt with their complaint. The PHSO gives the Trust the opportunity to ensure that all local resolution has taken place to try and resolve the issues and will give an independent view on the complaint.

The outcome/final decision of a PHSO investigation can be to fully uphold, partly uphold or not uphold the complaint. If the complaint is fully upheld this could mean that they found that:

- the Trust made mistakes or provided a poor service that amounted to maladministration or service failure and

- this has had a negative impact on an individual which has not yet been put right.

They might partly uphold a complaint if:

- they found that the Trust got some things wrong, but not all the issues that were complained about or

- the mistakes made did not have a negative effect on anyone.

If not upheld this could meant that they found:

- the Trust acted correctly in the first place or

- the Trust made mistakes but we have already done what PHSO would expect to put things right for the person or people affected.

There was one case referred to the PHSO in 2020/2021. At the time of writing this report the Trust were still awaiting the PHSO to advise on the outcome of the investigation.

9. Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service provides confidential advice and support, helping prior to sort out concerns they have about their care, and guiding them through the different services available from the NHS.

The PALS lead works closely with the service leads to resolve problems and concerns quickly and effectively. If it becomes clear that the patient wishes to raise the issue as a complaint, we will ensure that the concern is addressed through the complaints process. It is made clear that concerns received from, or on behalf of patients in no way affects how they are treated, and are seen as valuable information to help improve services for all patients and carers.

During the period of 1 April 2020 to 31 March 2021, there were 51 PALS enquiries which is a decrease of 30% from 2019/2020:

- 34 of these were dealt with as initial complaints (none of these were referred as a formal complaint).
- 13 of these were for advice and information

The majority of these enquiries were related to appointment cancellations and operations being deferred to COVID-19. All of these enquiries were dealt with satisfactorily and none became formal complaints.

Although at the start of the pandemic there was full understanding of the change to our service however as time progressed patients understanding made enquiries as to when normal service would reside. Cancellation of appointments is the most common reason for seeking assistance form PALS in relation to the appointment process. With government changes being made on a daily basis patients were being advised that we are offering online or telephone outpatient consultations as an alternative to coming to our hospital in person.

We continue to build relationships with external partners and other NHS Trusts. PALS has also continues to ensure that learning is passed on to members of staff and general managers.

The PALS telephone contact line is operated during working hours Monday to Friday. A voice mail service is available during ‘out of hours’ and calls are returned on the next working day. During out of hours the Site Practitioner is the contact for patients/relatives who have urgent issues that require action.

10. Website feedback

The Patient Experience Manager responds to patients leaving feedback on online forums such as Care Opinion and the NHS website. Over the course of the financial year, 13 comments have been posted.

11. Summary

2020/21 has been a very different year for the NHS due to the impact of COVID. The Trust has had to work flexibly to respond to the pandemic and this has affected both our clinical services and our corporate teams. As can be seen in this Annual Report, we have been able to provide an on-site Patient Experience and PALS service, and this has enabled us to be very flexible to meet the needs of our patients and carers, whilst maintaining support to staff.

The Trust will continue to focus on further improving our complaint handling process and implementing new initiatives to ensure we are proactively listening and acting on feedback provided in a timely and high quality manner. Overall, the year has been a challenging one. However, the quality of the complaints response has been sustained and the very small number of complaints accepted for investigation by the Ombudsman evidences this.

Further work is required to ensure that the learning from complaints is effectively disseminated, shared, embedded into practice and the impact assessed, to offer the required assurance that improvement has been achieved because of complaints. This continues to pose the greatest present challenge to the Trust in terms of complaints management.

In order to improve the services provided to patients further, additional developments will be implemented.

12. Future developments 2020/21

- Continue to improve quality of final responses;
- Consistently achieve 75% of complaints managed within agreed timescales;

We will do this by:

- Continue to refine the patient experience reporting
- Improve the monitoring of complaint action plans post-investigation
- Improve the response timescales by aiming for 30 working day turnaround
- Continuing to be open and transparent in complaint responses
- Develop ownership with managerial and clinical leads that lessons learned from complaints are embedded into service delivery
- advise and support staff with tools and techniques with which to capture feedback, involve patients and carers and act on what they learn
- Continue to explore and refine our approach to gathering data on themes

NHS
Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/09/2021**		**Agenda reference:**	**140-21d**	
Report title:	**Emergency Preparedness Resilience and Response and Business Continuity Annual Report 2020/2021**				
Sponsor:	Nicky Reeves, Interim Director of Nursing				
Author:	Nicky Reeves, Interim Director of Nursing				
Appendices:	1				
Executive summary					
Purpose of report:	Annual report with 2020/21 "light touch" assurance document to provide assurance to the Board for sign off.				
Summary of key issues	The 2020/21 NHS England annual assurance review "light touch" process was undertaken in conjunction with our Clinical Commissioning Group Progress with the standards rated as "partially compliant" in 2019 Identification of administration support for the EPRR function All sections of the Emergency plan are in date Seasonal flu campaign with increased uptake Covid vaccine roll out Identification of non covid related business continuity incidents during the year				
Recommendation:	The Board is requested to **note** the Emergency Preparedness Resilience and Response and Business Continuity Annual Report 2020/21				
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:	BAF reviewed when compiling this report				
Corporate risk register:	CRR reviewed when compiling this report				
Regulation:	National requirement working with NHSE and local CCG				
Legal:	The Civil Contingencies Act 2004 places a number of duties on responding agencies in the event of a Major Incident				
Resources:	Additional administration resources have been allocated to support the Trusts EPRR function				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	26/07/21	Date:	Noted	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Emergency Preparedness Resilience and Response and Business Continuity Annual Report

Queen Victoria Hospital NHS Foundation Trust

Report covering the period from
April 2020 to March 2021

Document Control: Quality and Governance Committee
Executive sponsor: Nicky Reeves

Author: Nicky Reeves

Date: June 2021

Type: Annual Report
Version:
Pages:
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

1.	Executive Summary
	The emergency preparedness resilience and response (EPRR) annual report highlights the significant EPRR events and activities during 2020/21. It also identifies the background to the duties placed on the trust regarding emergency planning. The 2020 NHS England annual assurance review process was "light touch" due to the ongoing challenges with the Covid 19 pandemic. The review was undertaken in conjunction with our Clinical Commissioning Group (CCG) (appendix 1).

2.	Introduction
	The Civil Contingencies Act 2004 places a number of duties on responding agencies in the event of a Major Incident. QVH is defined as a Category One responder which include the following responsibilities: • To carry out a risk assessment of our operational areas • To make emergency plans • To make business continuity plans • To warn and inform the public • To cooperate with other responders through a Local Resilience Forum • To share information with other responders During 2020/21, EPRR and Business Continuity executive leadership within QVH was held by the Deputy Director of Nursing and Quality (DDNQ) who represented the organisation at the Local Health Resilience Partnership Executive Group (LHRP) which were held virtually due to the pandemic. This report provides a summary of the work undertaken in relation to Emergency Planning and Business Continuity within QVH in 2020/21.

3.	Service aim, objectives and expected outcomes
	QVH is expected to deliver the requirements of a category one responder for the purposes of EPRR. The EPRR lead has co-ordinated activities which demonstrate the trust has met its responsibilities as a category one responder the key outcomes being: • Updated EPRR policy • Refreshed and tested plans related to emergency plans • Collaborative working with LHRF • Establishing QVH in the wider EPRR health economy and utilising expertise within this network • Resilience test of business continuity. Maintaining effective continuity of our business is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management (BCM).

4.	Activity analysis/ achievement
	Policy Emergency Preparedness policies are held centrally on the Trust intranet pages accessed via a "tile" within the Policies section; for ease they are divided into sections to reflect specific guidance. Policy review is ongoing; seasonal policies (Cold Weather and Heatwave) have been changed in line with national guidance. All EPRR sections are currently in date.

Winter Planning

No adverse weather impact during winter of 2020/21

Seasonal Flu

The 2019/20 flu vaccination programme concluded in March 2021 with all data submissions to IMMFORM uploaded successfully.

QVH focussed on increasing the frontline uptake of vaccine and utilised a range of incentives to encourage staff to be vaccinated, In addition, reasons for refusal and opt out were reviewed and updates were taken to the Trust Board.

Final uptake for staff receiving the vaccination was 75.7%, a significant improvement on 63.9% for the previous year.

ImmForm Data Submission - Count of Current Vaccinated Staff		% of staff group headcount
All Doctors	**137**	**74.1%** *185*
Qualified nurses	**193**	**80.4%** *240*
All other professional qualified	**103**	**71.5%** *144*
Support to clinical staff	**189**	**74.7%** *253*
ImmForm Total Current Headcount	**622**	**75.7%**

Training

Training continues to be delivered at trust induction face to face. During the pandemic the clinical and non-clinical mandatory update has been via a leaflet as face to face learning has been restricted. Mandatory training for Non-clinical staff is delivered every 3 years. There has been no significant change in compliance in both clinical and non clinical staff groups.

Emergency planning non clinical as at 31 March 2021

Staff group	Assignment Count	Required	Achieved	Compliance %
Perm staff	404	404	389	96.29%

Emergency planning clinical as at 31 March 2021

Staff group	Assignment Count	Required	Achieved	Compliance %
Perm staff	650	650	570	87.69%

Business Continuity

Maintaining the effective continuity of our business operations is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management capability in line with BS 25999 Business Continuity Management. This includes the development of business continuity plans for core business activity.

	All business continuity plans can be accessed by the on call managers and site practitioner team via folders on the "N" drive and hard copies of the emergency plan area available in the incident control room in the event of a power or IT failure and all departmental leads have a copy of their individual plans. **Other activity undertaken over the year:** • Training sessions on Emergency Planning Preparedness were delivered for all new employees on induction and current employees at mandatory training as an ongoing rolling programme. • Bi monthly meeting for on-call managers, control personnel and bleep holders. • The Trust maintained its membership with the Sussex Resilience forum • Attendance at the LHRP executive Group • Additional administration support with EPRR function

5.	**Involvement & Engagement**
	Assurance process *Internally:* Bi-monthly on-call manager meetings continue with all managers and directors who undertake on call duties being invited to the meeting. At these meetings the on-call logs and incidents are reviewed and learning is shared and actioned. As previously, new managers receive an induction session from the EPRR lead and to facilitate the transition into the element of their role. A buddy system for new on-call managers to 'test' decisions is offered for the first couple of on-call periods. There is also a system in place for non-clinical on-call managers without an operational remit to have the contact details of a manager with a clinical background to call for advice as required. EPRR updates have been discussed at Quality and Governance Committee and the annual report is presented for information at Board. *Externally:* All NHS Trusts who are category 1 and 2 responders (Civil Contingencies Act 2004) are required to complete a self-assessment and submit a statement of readiness to NHS England stating compliance against the national requirements of EPRR. As stated above, the 2020 review was "light touch" and focussed on the non-compliant and partially compliant standards and progress made to address. The submission is contained in (Appendix 1) The 2019 non-compliant standard - IG Toolkit – has now been addressed and is compliant Of the ten standards rated as partial compliance in the 2019 report, eight have been addressed. The following two standards remain as partially complaint at the end of March 2021 with plans to address in Q2 and 3 of 2021/22. BCMS – ongoing need to review. This has not progressed as rapidly as QVH would have wanted but the new administrative support role will be overseeing the review of the document. QVH consider this to remain an partially compliant standard BIA - ongoing need to review. This has not progressed as rapidly as QVH would have wanted but the new administrative support role will be overseeing the review of the document. QVH consider this to remain an partially compliant standard.

6.	Learning from Experience

Practice Exercises and Live Events

During 2019/20 QVH has tested its emergency planning resilience during a number of "live" incidents as identified below.

The learning from these incidents is utilised to ensure the emergency plan remains up to date and is reviewed in the light of any recommendations as a result of these scenarios.

Any changes to the emergency plans are approved via the Quality and Governance Committee. Other than general review of the plans, no significant changes have been made following incidents.

The Trust has provided Covid 19 "lessons learned" to the CCG twice during the year.

Incidents

QVH has had a particularly challenging year with regards to managing incidents with a number of business continuity and emergency planning issues including:

- Core Switch Failure in May 2020, which led to a cross trust IT outage for approximately 8 hours.
- A planned IT outage which resulted in unplanned disruption in October 2020
- A power failure which resulted in switchboard failing for a short period of time in January 2021.
- A cybersecurity incident in March 2021
- Loss of internet connection March 2021

In all cases, datixes have been completed, learning points identified and any actions are monitored via the local governance groups for example, Estates and Facilities or IM&T Working Group

Covid 19 Pandemic

During 2020/21 QVH has been fully involved and engaged in the national response to COVID 19. Throughout the period and still, the incident room is open as mandated seven days per week. QVH complies with all requests for situation reports (Sitreps) and has robustly managed numerous competing demands during this time. Gold command for this incident has been held by DDN full time, ensuring the provision of consistent senior clinical and managerial decision making. An extensive integrated governance system has been embedded to take forward actions and decisions required from the external incident control as well as the internal ones and monitor progress and outcomes.

Covid 19 Vaccination Programme

During Q4 of 2020/21 QVH ran a successful Covid vaccination programme. 84% of the workforce were vaccinated. In addition, we offered vaccination slots to colleagues across health and social care from other providers to ensure effective use of the vaccine allocated.

7.	Future plans and targets
	The EPRR lead has reviewed the actions highlighted in the 2020 EPRR assurance document to ensure the organisation has satisfactory arrangements in place to meet the requirements of the EPRR function. The assurance process for 2021/22 has not yet been agreed but QVH will endeavour to achieve improved compliance with the standards.

8.	Conclusions and assurance
	The Trust currently has effective policy and systems in place for the effective management of expected and unexpected EPRR and business continuity incidents. It meets the requirements of the category one responder as evidenced in appendix 1. Due to the specialist and particular nature of the Trust, full compliance with national EPRR standards may always be a challenge.

Appendices

Appendix 1

EPRR Assurance Statement 2020		
Organisation:	**Queen Victoria Hospital**	
2019 Level of Compliance	**Partial**	
2019 Core Standards Non - Compliant	• 50 – IG Toolkit – 99/100 compliance. Training was under 95%	•
2019 Core Standards Partially Compliant	• 5 – EPRR Resource • 21 – Lockdown • 25 – Trained on call managers • 33 – Loggist availability • 41 – LRF attendance • 48 – Business Continuity scope • 49 – Business Impact Assessments • 56 - Telephone advice for CBRN • 66 – CBRN training • 67 – Decon training	•
Date of Assurance Meeting	**5th October 2020**	

1. Progress of partially or non-compliant organisation

QVH has been focusing on moving towards Substantial assurance during the course of this year.

Of note, throughout the COVID pandemic, QVH has been represented at every silver SRO call, has submitted SITREPS as required across a range of requests, has shared and managed PPE, has run internal incident escalation meetings within the existing resources. In addition, QVH suffered a significant IT failure and was able to respond appropriately and manage alongside the COVID response.

Below is a high level overview of the areas identified in the 2019 review with updates as appropriate

50. – IG training is now at above 95% therefore making QVH fully compliant with this core standard.

5. – EPRR resource. There is now administrative support for EPRR function, in addition, there is general manager support to ensure QVH is able to cover the external meetings required. Longer term, QVH intends to develop a “formal” partnership arrangement with another organisation and this will provide an additional level of support to the EPRR

function. The ambition is to achieve this by the end of September 2021. For QVH with less than 55 beds, no A&E or maternity and a “Covid “ secure patient workload, the above resource is sufficient to deliver the EPRR functionality required. There is now an individual seconded to the incident room to offer a consistent approach and this will be reviewed in December. QVH consider this to be a compliant standard

21. – Lockdown – Throughout COVID, the site has been “locked down” to support the designation of QVH being a secure site. The Policy is being amended and reviewed by our newly appointed Security Management Advisor. QVH consider this to still be partial compliance at time of reporting

25. – Trained On call Managers – QVH has developed the on call managers over the last year with a number of them attending the Strategic Leadership in a Crisis training. In addition, they have all been allocated to the incident room during COVID to ensure they have an awareness of the requirement and have participated in weekend escalation calls and SITREPS as required. QVH consider this to be a compliant standard

33. – Loggists – QVH has a pool of executive assistants who are available for loggist support and who are trained in minuting and note taking. They provide support for the internal incident calls and any addition requirement. If Sussex wide training was available we would put people forward however for QVH, this pragmatic solution is offering the level of support required at this time. QVH consider this to be a compliant standard as it meets the needs of the organisation.

41. - LRF attendance – There is general manager support to attend this. QVH consider this to be a compliant standard

48. - BCMS – ongoing need to review. This has not progressed as rapidly as QVH would have wanted but the new administrative support role will be overseeing the review of the document. QVH consider this to remain an partially compliant standard

49. – BIA - ongoing need to review. This has not progressed as rapidly as QVH would have wanted but the new administrative support role will be overseeing the review of the document. QVH consider this to remain an partially compliant standard

56. - Telephone advice for CBRN – The new MIU Clinical Services Manager is undertaking a review of the CBRN policy as a whole. QVH consider this to remain an partially compliant standard

66. – CBRN training - The new MIU Clinical Services Manager is undertaking a review of the CBRN policy as a whole. QVH consider this to remain an partially compliant standard

67. – Decon training - The new MIU Clinical Services Manager is undertaking a review of the CBRN policy as a whole. QVH consider this to remain an partially compliant standard

Of note relating to 56,66 and 67 – when benchmarked against two other MIU departments in the patch, neither had a CBRN policy specifically aimed at MIU – their default position was to call 999 for support. We are also engaging with the Burns unit to identify any chemical burn information.

2. The identification and application of learning from the first wave of the COVID-19 pandemic

QVH has reviewed their response to the first wave of COVID. There have been several learning points which have been fed back in to the system via the structured learning events. We also held an internal "debriefing" exercise

On the whole, QVH handled their response positively, the designation of the Trust as a "green" covid secure site has supported this but we have continued to run the incident room as required of other organisations.

Some of the learning points have focused on resourcing of the incident room. The on call managers now take turns and we have also seconded an individual to the room for the next 3 months. The requirement to complete numerous sitreps in the early days was a challenge as we have a limited BI team however, through collaboration this has been managed well.

Throughout COVID, as identified above, QVH has participated in the system response, supported others with PPE and mutual aid, has participated in calls and sitreps throughout and has been available to the system as a whole.

There are times when the focus tends to be on our surrounding acutes which has led to our contribution being overlooked even though we are present on calls and discussions.

Our internal IMT call has been well attended throughout, chaired by the AEO there have always been representatives from clinical and managerial leadership roles which has been positive. This group have driven the response throughout COVID and is the main communication forum for the cascade of information.

3. Incorporating progress and learning into winter planning arrangements

QVH has a robust winter plan, again due to the specialist nature of the organisation, this plan focuses primarily of delivery of the green pathway patients and our "business as usual" work.

Learning from the COVID response has been incorporated in to our winter plan. Particularly around ensuring there are no "single points of failure".

Our MIU continues to be a resource which could offer additional support to the system at times of increased pressure.

QVH is driving the winter flu vaccination programme internally and ensuring that the high risk workforce are prioritised with incentives and utilisation of peer vaccinators.

2020 EPRR Assurance Statement submitted by:	 **Nicola Reeves** **Accountable Emergency Officer - Queen Victoria Hospital**

Report cover-page					
References					
Meeting title:	**Business meeting of the Board of Directors**				
Meeting date:	**02 September 2021**		**Agenda reference:**	**140-21e**	
Report title:	A Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Board Report 2020/21 and Annual Statement of Compliance				
Sponsor:	Mr Keith Altman, Medical Director				
Author:	Katie Ally, Medical Appraisal & Revalidation Administrator				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance to the Trust Board that the statutory functions of the Responsible Officer were appropriately fulfilled. To report on performance in relation to those functions; to update the Committee on the progress since 2019/2020 annual report; to highlight current and future issues and to present action plans to mitigate potential risks. This report forms part of the Medical Director's duties as Responsible Officer (RO).				
Summary of key issues	• NHSE's national annual organisation audit (AOA) exercise was stood down and we were no longer required to submit Quarterly Reports. • From 1 April 2020 to 30 September 2020, all medical appraisals were suspended and recorded as missed approved. Revalidation recommendations deferred until 16 March 2021 • Appraisal process restarted on 1 December 2020 • 2020 medical appraisal template was adopted: this explored wellbeing, challenges, achievements and aspirations alongside the existing Medial Appraisal Form (MAG) • As at 31 March 2021, QVH was the designated body for 109 GMC registered doctors. The number of medical appraisals conducted during the year was: Completed appraisals = 22, Missed approved due to Covid 19 = 79, Missed unapproved = 8. • 7 revalidation recommendations were made • High volume of workload is expected in the upcoming year. The appointment of new Medical Workforce Manager will provide additional support and guidance.				
Recommendation:	To receive this report, noting that it will be shared with the South East Higher Level RO. To note the Statement of Compliance– Section 11 of this report confirms the Trust, as a Designated Body, is in compliance with the regulations. The Chief Executive is requested to sign this on behalf of the Trust.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO: *Outstanding patient experience*	KSO2: ***World-class clinical services***	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	KSO2				
Corporate risk register:					
Regulation:	The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'				
Legal:	As above				
Resources:	This annual report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality & Governance Committee				
	Date:	26/07/21	Action:	Noted	
Next steps:					

A Framework of Quality Assurance for Responsible Officers and Revalidation – Queen Victoria Hospital NHS Foundation Trust Annual Board Report 2020/21 and Annual Statement of Compliance

Covering reporting period
1st April 2020 to 31st March 2021

Document Control: Quality and Governance Committee

Executive Sponsor: Mr Keith Altman, Medical Director

Author: Keith Altman, Medical Director
Katie Ally, Appraisal & Revalidation Administrator

Date: July 2021

Type: Annual Report Medical Appraisal and Revalidation

Version: V4

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Status: Public. Written and prepared for the Trust Board

Circulation: QVH Trust Board

Contents List

A Framework of Quality Assurance for Responsible Officers and Revalidation – Queen Victoria Hospital NHS Foundation Trust Annual Board Report 2020/21 and Annual Statement of Compliance

1 Executive Summary

This report is presented to the Quality and Governance Committee for assurance that the statutory functions of the Responsible Officer are being appropriately and adequately discharged.

The prescribed format of this report retained for continuity and should be noted that the information is presented against the backdrop of the Covid 19 pandemic, which markedly affected the ability to deliver appraisals and revalidation during this appraisal year. NHSE's national annual organisation audit (AOA) exercise was stood down and we are no longer required to submit Quarterly Reports. Instead, continue to report on appraisal and revalidation data, using the NHSE published template board report. This includes qualitative questions previously contained in the AOA and are now presented to support reviewing progress in these areas over time plus incorporate the annual statement of compliance.

2 Recommendation

The Committee is asked to receive this report on behalf of the Trust Board, noting that it will be shared with the South East Higher Level RO.

The Committee is asked on behalf of the Trust Board to note the Statement of Compliance– Section 11 of this report confirms the Trust, as a Designated Body, is compliant with the regulations. The Chief Executive is requested to sign this on behalf of the Trust.

3. Purpose of the Paper

This report is to provide assurance to the Quality and Governance Committee on behalf of the Trust's Board that the statutory functions of the Responsible Officer are appropriately fulfilled. To report on performance in relation to those functions; to update the Committee on the progress since 2019/2020 annual report; to highlight current and future issues and to present action plans to mitigate potential risks. This report forms part of the Medical Director's duties as Responsible Officer (RO).

4. Background

Medical Revalidation launched in 2012 to strengthen the way doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Trusts have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that Trusts will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- Confirming that feedback is sought from patients periodically, so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring appropriate pre-employment checks (including pre-engagement of locums) are carried out confirming medical practitioners have qualifications and

experience appropriate for the work performed.

Due to the pandemic, the NHSE's national annual organisational audit (AOA) exercise and quarterly returns were stood down. This report however maintains the format and includes the qualitative questions previously contained in the AOA detailed in Section 5, 1-General though to Section 11, 7 – Statement of Compliance. Setting out the key requirements for compliance with regulations and key national guidance. Thus providing support to QVH in its pursuit of quality improvement, assurances to Mr Vaughan Lewis, Higher Level Responsible Officer and acts as evidence for CQC inspections.

The Statement of Compliance is combined for efficiency and simplicity and is offered to support QVH in reviewing its progress in the following key areas over time;

- Audit of Appraisals 2020-2021
- Effective Appraisal
- Recommendations to the GMC
- Medical Governance
- Employment Checks
- Summary and overall conclusion
- Statement of Compliance

All doctors are required to have a prescribed connection to a Designated Body. Designated Bodies include NHS Trusts, Local Education and Training Boards, (LETB), Locum Agencies and other organisations. Each Designated Body has a Responsible Officer (RO), usually the Medical Director who is responsible for the appraisal and revalidation process.

Doctors on training rotations are connected to the Local Education and Training Board (LETB) with the relevant Dean as their Responsible Officer. All other doctors who perform the majority of their practice at Queen Victoria Hospital (QVH) are connected directly to the Trust. Doctors connected to Queen Victoria Hospital fall under the responsibility of Mr Keith Altman, Medical Director, as the Trust's Responsible Officer (RO) appointed on 1 October 2019.

This report is based on 109 doctors whose prescribed connection is with the Trust as at 31 March 2021.

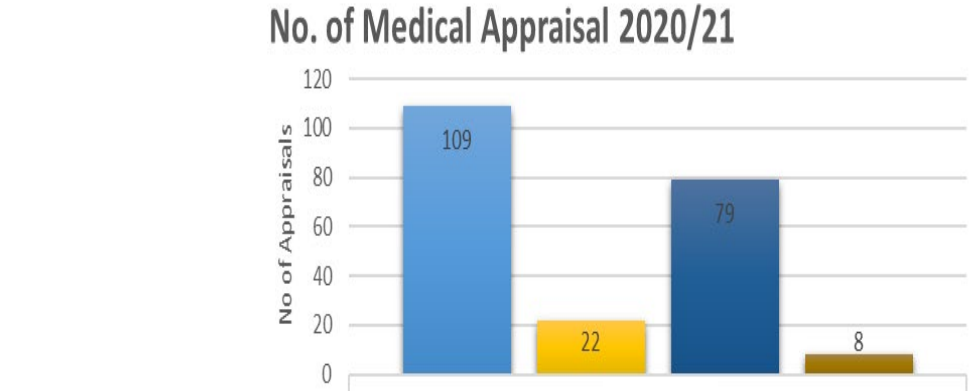
The last report submitted to the Committee was in July 2020 for the year 2019/2020. This report covers the appraisal year 1 April 2020 to 31 March 2021.

5. Section 1 - General

The Quality & Governance Committee of Queen Victoria Hospital can confirm that:

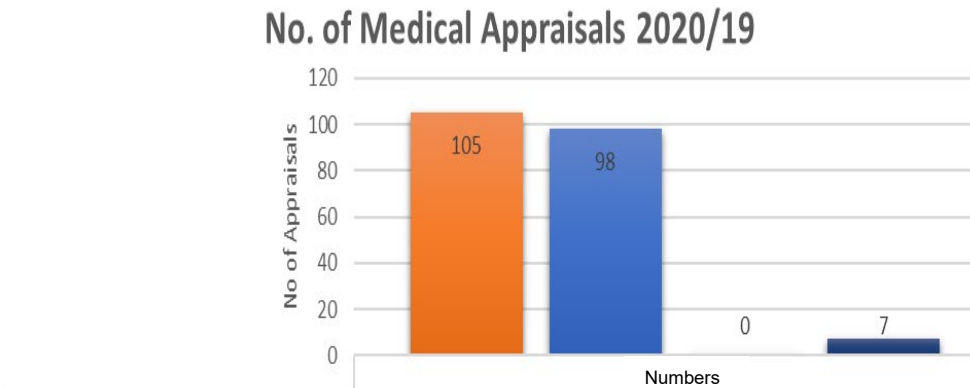
1. The Annual Organisational Audit (AOA) for this year was

Figure No 1. Total number of appraisals for 2020/2021



Number of Prescribed Connections 20/21	109
Completed Appraisals 20/21	22
Approved Incomplete or Missed 20/21	79
Unapproved Incomplete or Missed 20/21	8

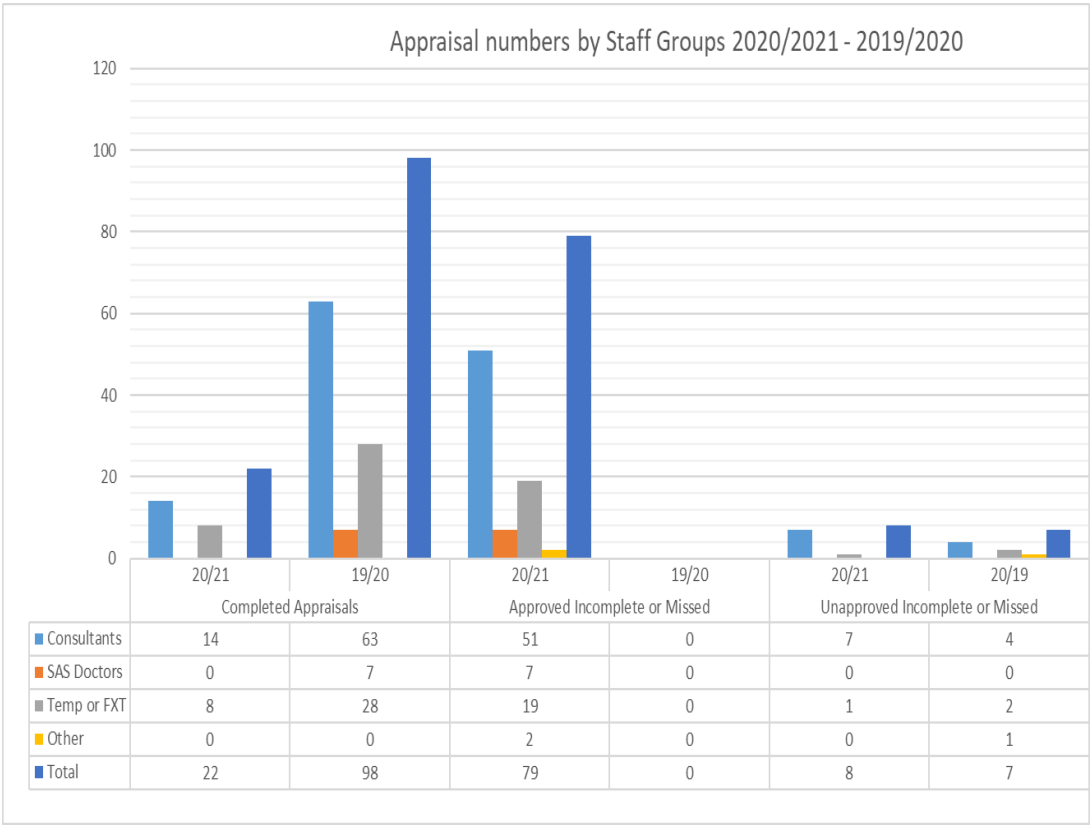
Figure No 2. Total number of appraisals for 2020/2019



Number of Prescribed Connections 19/20	105
Completed Appraisals 19/20	98
Approved Incomplete or Missed 19/20	0
Unapproved Incomplete or Missed 20/19	7

Approved Incomplete or Missed includes apraisals includes acceptable reasons e.g. due to Covid 19, maternity leave or long term sick leave. Unapproved incomplete relates to doctors whose appraial has been missed without an acceptable reason being provided.

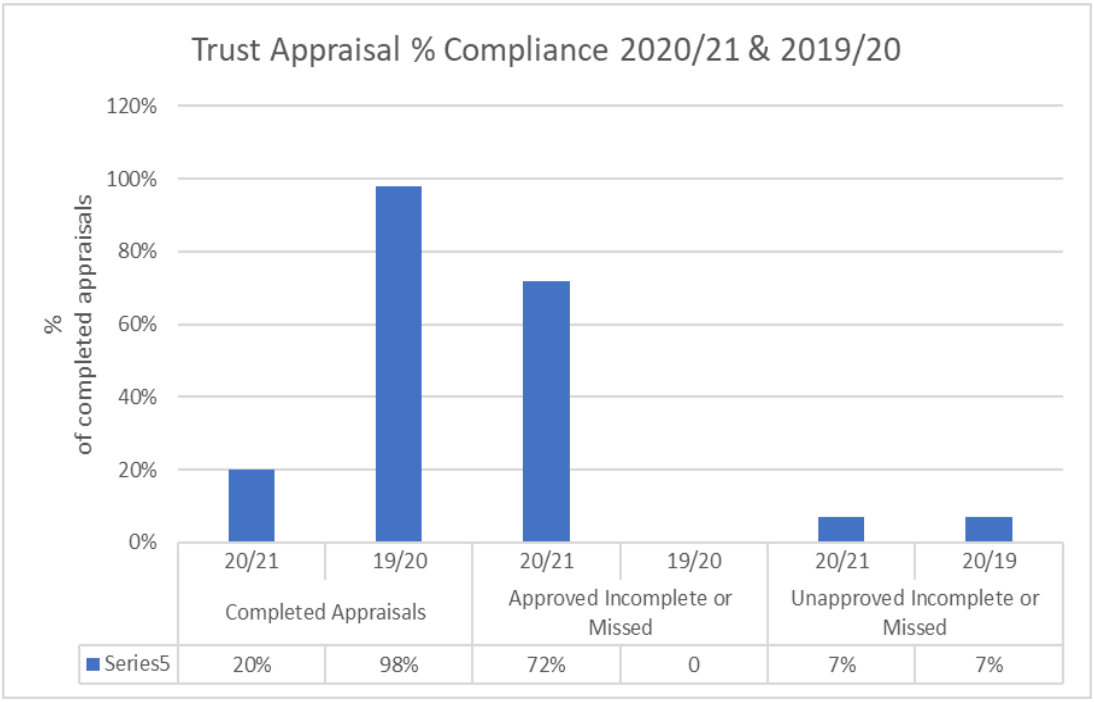
Figure 3. Appraisal numbers by Staff Groups for 2020/2021 and 2020/2019



	Completed Appraisals		Approved Incomplete or Missed		Unapproved Incomplete or Missed	
	20/21	19/20	20/21	19/20	20/21	20/19
Consultants	14	63	51	0	7	4
SAS Doctors	0	7	7	0	0	0
Temp or FXT	8	28	19	0	1	2
Other	0	0	2	0	0	1
Total	22	98	79	0	8	7

'Temp or FXT' includes Trust grade junior doctors. 'Other' comprises of doctors who hold bank contracts and do not hold substantive contracts of employment with QVH.

Figure 4. Appraisal Compliance % years for 2020/2021 and 2019/2020



	Completed Appraisals		Approved Incomplete or Missed		Unapproved Incomplete or Missed	
	20/21	19/20	20/21	19/20	20/21	20/19
Series5	20%	98%	72%	0	7%	7%

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer (RO).

Action from last year: None Comments: Mr Keith Altman appointed Medical Director and RO on 1 October 2019. Attended 3 RO regional update sessions during the year for the purposes of development and training. Action for next year: No changes anticipated.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes. Action from last year: Mr Keith Altman acknowledged sufficient funds, capacity and resources were available to carry out the responsibilities of this role. Supported by Lt Col Tania Cubison, Deputy Medical Director and Appraisal Lead. In addition, administrative support from the Medical Workforce Manager and appraisal & revalidation administrator. Comments: The Medical Workforce Manager retired in August 2020, and in the interim support was provided by the Medical Appraisal & Revalidation Administrator. Action for next year: Recruit and appoint Medical Workforce Manager to support RO alongside the administrator.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: continue with existing good practice. Comments: The GMC Connect portal is utilised to ensure an accurate record of all doctors with prescribed connection, is maintained and regularly monitored by the RO and the administrator. Action for next year: Continue using GMC portal.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year; policy monitored in line with schedule. Comments: Policy renewal due September 2022. Appraisal Lead and Administrator revised the standard operating procedure for appraisal delivery and escalation in April 2020. Action for next year; review Terms of Reference for Appraisal & Revalidation Recommendation Panel in June 2021.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: None Comments: An interim meeting with the HLRO was due to take place during 2020. This was pushed back due to the pandemic. Actions for next year; any actions will be identified post-meeting with HLRO.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: continue with personalised notifications, revalidation readiness reports and annual appraisal data packs.

Comments: During the suspension of revalidation and appraisals, all non-training grade Trust doctors continued to receive personal notifications. Internal processes were improved whereby doctors were sign posted to PALS and Risk team to obtain supporting information for the purposes of appraisal and revalidation. New doctors received guidance on the process and made aware of the expectation to undertake an annual appraisal once the suspension ended. Evidence of Colleague and Patient feedback continued to be conducted required for revalidation.

For locum agency doctors connected to their Agency RO – only agencies where we have assurance of appraisal and revalidation are used to source agency locum doctors.

Action for next year; Clinical Lead and General Managers are fully aware and support doctors in local processes to continue professional development, appraisal, and revalidation.

6. Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action for next year; improve appraisal guidance including the requirement for joint appraisal under Follett Principles for doctors with additional academic roles.

Comments: From 1 April 2020 to 30 September 2020, in line with Professor Stephen Powis' letter of 19 March 2020, all medical appraisals were suspended and approved missed. Any doctors whose appraisal was already overdue were not recorded as missed approved, as the delay was not deemed Covid 19 related. Appraisals restarted on 1 October 2020. Seven doctors were targeted and received personal notifications from the Appraisal Lead instructing them to complete appraisals within 3 months.

The appraisal process fully restarted on 1 December 2020, its focus being supportive and developmental as possible, and encouraging doctors to take a thorough and professional approach to the opportunities offered by a supportive but challenging dialogue at appraisal. For some, this may have been the only time someone sat down and focused on their individual needs, anxieties, hopes and plans. The new 2020 medical appraisal template was adopted encouraging dialogue exploring wellbeing, challenges achievements and aspirations alongside the existing Medial Appraisal Form (MAG).

A document entitled *An Medical Appraisal & Revalidation – What to do* was introduced, which included additional guidance on; Follett Principles, full scope of practice, necessary supporting information, contact details for the Pals and Risk Team enabling doctors to obtain information relating to complaints, compliments and significant events.

Action for next year: Utilise Qnet to provide all relevant documentation, guidance and signposting doctors to all relevant information relating to the doctor's fitness to practice, including information about complaints, significant events and outlying clinical outcomes.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action for next year; early escalation to Appraisal Lead identifying barriers and necessary improvements for late or missed appraisals.

Comments: During the year, there were 8 recorded unapproved incomplete or missed appraisals. Reasons given for delays recorded and escalated to Medical Appraisal and Revalidation Panel at quarterly meetings. Intervention/action plans agreed with RO or Appraisal Lead.

Action for next year: continue with existing process.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action for next year; monitor policy in line with policy's annual monitoring schedule.

Comments; We have a revalidation policy which incorporates the medical appraisal national policy and guidelines, ratified by the Finance & Performance Committee on 23 September 2019 and due to be reviewed in September 2022.

The small number of appraisals conducted during the year did not provide sufficient data to enable monitoring as per policy schedule.

Action for next year; monitor policy in line with annual monitoring schedule.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action for next year; recruit a further 1 appraiser from Oral & Maxillofacial Surgery.

Comments: Recruited 1 OMFS appraiser; we currently have 20 appraisers who conduct between 4-7 appraisals each year. A number of appraisals were conducted using virtual technology to comply with social distancing restrictions. However, diverse and significant other pressures on time, both clinical and non-clinical continued to be cited as a reason for declining an invitation to appraise a doctor. Other issues include insufficient notice provided to the appraiser by the doctor and/or Medical Workforce.

Action for next year: Develop standard operating process for the allocation of appraisers so workload is fairly and evenly distributed throughout the calendar year and across the Trust. Reduce timescale allocating/communicating appraiser details to new doctors.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action for year; to increase attendance rate to 90%+

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: Each appraiser is required to attend the Trust's appraiser training which covers annual updates and participation in peer network sessions. These sessions are included in the Consultants' Statutory and Mandatory update program and take place in February and September. The Appraisal Lead conducted training in September 2020 virtually. At these sessions, training needs are discussed and addressed, any actions plans are formulated and agreed by Appraisal & Revalidation Panel.

During this reporting period 85% of appraisers attended a training session.

Action for next year: Proposal to record future training sessions to allow those unable to participate on the day to do so at another time by accessing the recording.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: the appraisal outputs of 2 appraisers will be audited each month by the Appraisal Lead using ASPAT generic tool together with appraisal feedback questionnaires provided by doctors. The results shared with appraisers for purposes of continued personal development.

Comments: no audits conducted during the period due to the suspension of appraisals.

Action for next year: action to be carried forward to 2021/2022 action plan.

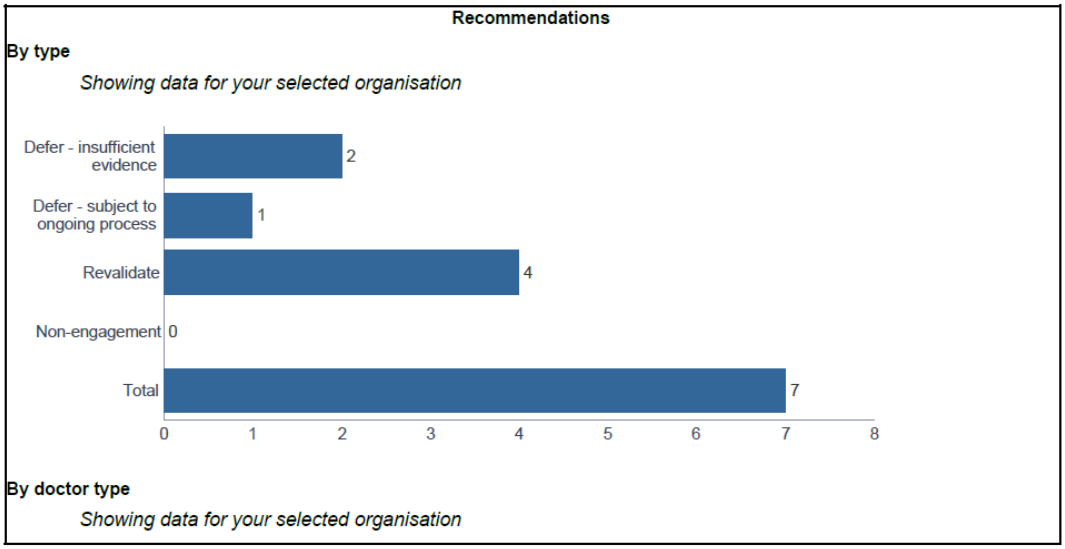
7. Section 3 - Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practice of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action for next year: in the following year, 50 recommendations will become due and an appropriate plan to manage this increased number required.

Comments: On 17 March 2020, the GMC suspended the revalidation process for the period 17 March to 30 September 2020. All doctors with a recommendation due in this period had 12 months added to their due date. The suspension was extended further in early June to cover the period up to 16 March 2021.

Number of recommendation 1 April 2020 to 31 March 2021



Action for next year: Due to the large number of recommendations due in year 2021/2022, additional Medical Appraisal & Revalidation panel meetings have been scheduled.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None.

Comments: Revalidation panel agree all recommendations prior to revalidation date. Doctors advised if the outcome is recommendation or deferral. For all deferrals, doctors advised what is missing from their portfolios and the missing information monitored until all the missing information received. Further recommendations then requested from the RO.

Action for next year; to maintain current practices.

8. Section 4 - Medical governance

1. This organisation creates an environment, which delivers effective clinical governance for doctors.

Action from last year: None.

All doctors work within the clinical governance framework of the Trust and fulfils all CQC patient safety, risk and quality improvement requirements. Clinical incident reporting monitored by the medical director and Quality & Governance committee to ensure any conduct and capability concerns are reported and acted on promptly. Evidence provided by Pals and Risk teams to doctors is for reflective practice purposes for appraisals.

Action for next year: we will continue to work with information teams to share information on compliments, complaints, involvement in incidents and similar items for the medical appraisal process.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None. Comments: Conduct and performance concerns reported via direct reports to the Medical Director, through patient and staff complaints, clinical governance, including audit and outcome measurement and incident reporting. The response monitored through annual appraisal and direct intervention by the RO where needed with additional support provided by the GMC Employment Liaison Officer if necessary. Action for next year: maintain current process.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practice, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practice concerns.

Action from last year: None. Comments: The Trust's approach to identifying and responding to concerns is set out in its policy based on the national 'Maintaining High Professional Standards (MHPS)' and GMC guidance. Last revised and ratified at Local Negotiating Committee in 2019. Due for review in September 2022 Action for next year: Continue to follow our agreed policies and procedures.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Actions from last year: None Comments: Responding to concerns is undertaken by the Medical Director, supported by the Director of Workforce and discussed with the GMC Employment Liaison Officer and PPA (NCAS) - NHS Resolution as required. Regular meetings with GMC Employment Liaison Officer take place at least 3 times per year. Any investigation conducted is overseen by a non-executive board member. Numbers and type of complaints are reported annually through this report. (see Figure 5.) In 2020/21 there were two open cases with the GMC. One was closed without investigation and the other is currently under investigation. There is one ongoing formal conduct case relating to a doctor's behaviour. Action for next year: Continue with current procedures.

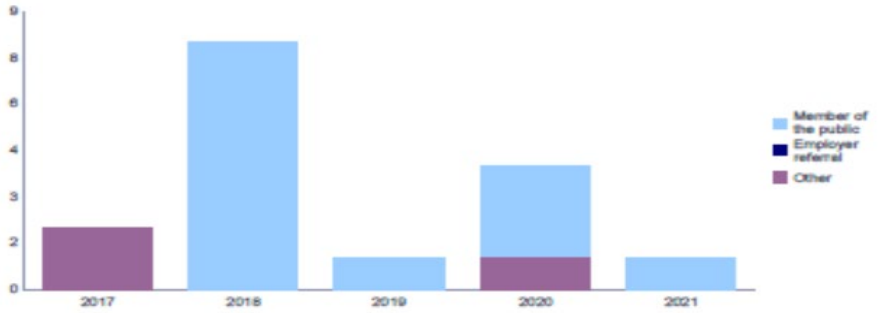
[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Complaints breakdown *(based on incident location by complaint received year)*
Showing data for your selected organisation

	2017	2018	2019	2020	2021
Complaints	2	8	1	4	1

Complaint Source

Member of the public	0	8	1	3	1
Employer referral	0	0	0	0	0
Other	2	0	0	1	0



Complaint Outcome

Closed at triage	2	7	0	2	0
Refered to employer	0	1	1	1	0
Investigations	0	0	0	1	0

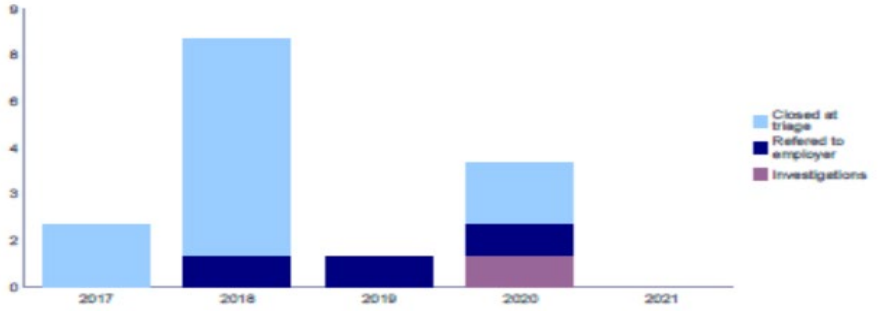


Figure 5. Complaints Breakdown

Action for next year: continue with current practise

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: None

Comments: Managed by the RO with support from the Appraisal & Revalidation administrator, timely transfers of information requests from other organisations are completed although challenging at times due to volume of requests.

A generic email address was published on the GMC website for all requests. Information transfers requests are supported by the PALS and Risk Teams who readily respond in a timely fashion. The RO reviews requests before sign off and release.

Transfers of Information requests are no longer provided as routine for previous HEE doctors instead sight of last ARCP outcome form for assurance purposes is required.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: Continue with current process and monitor compliance.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None.

Comments: The Disciplinary policy for medical and dental staff continues to adhere to national MHPS and GMC / NHSE guidance on managing concerns. Concerns managed by the RO and Medical Director, supported by Director of Workforce and OD, and the HR team as required.

Action for next year: Continue to follow agreed policies and procedures.

9. Section 5 Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None.

Comment: All doctors employed by QVH including the medical and dental Bank are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, via Trac recruitment system ensuring visibility and consistency. There is a local memorandum of understanding between Trusts within the STP where doctors are able to move more freely with the confirmation of checks confirmed by the previous substantive employer in place to avoid duplication and unnecessary checks.

In addition to the standard clinically based questions at interview, questions based on the Trust's values are included. Thereby ensuring applicants are able to converse and understand medical terminology at an appropriate level in English. Employment references follow a set format and include past employer and most recent Responsible Officer declaration.

For consultants, a more extensive assessment conducted including Stakeholder Panels with feedback presented to the Advisory Appointment Committee to provide assurance.

Action of next year; Continue to monitor compliance.

10. Section 6 – Summary of comments, and overall conclusion

In summary, despite the pandemic, good progress was achieved including improved communications, virtual peer networking sessions plus a focus on recruitment and retention of appraisers. Both appraisers and doctors positively received the new 2020 medical appraisal template aimed at reducing the previous administrative burden associated with medical appraisals.

Whilst a high volume of workload is expected because of the number of revalidation recommendations due in the upcoming year, it is anticipated the appointment of a new Medical Workforce Manager will provide support with this.

11. Section 7 – Statement of Compliance:

The Quality and Governance Committee of Queen Victoria Hospital NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of Queen Victoria Hospital NHS Foundation Trust

Chief executive)

Official name of designated body: Queen Victoria Hospital NSH Foundation Trust

Name: Mr Steve Jenkin Signed: _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date: _ _ _ _ _ _ _ _ _ _

Report cover-page					
References					
Meeting title:	**Business meeting of the Board of Directors**				
Meeting date:	**02 September 2021**		**Agenda reference:**	**140-21f**	
Report title:	**Research & Innovation Annual Report 2020-21**				
Sponsor:	Keith Altman, Medical Director				
Author:	Sarah Dawe, Head of Research				
Appendices:	1 - studies				
Executive summary					
Purpose of report:	To summarise R&I activity in 2020-21				
Summary of key issues	• R&I has faced unprecedented challenges in 2020-21 due to the Covid pandemic, but commitment and effort has enabled Research to perform better than expected. • All activity was suspended in Q1 following national guidance. In Q2 a restart programme was begun, with the reintroduction of participant recruitment where clinical services permitted. Patient pathways were adapted to ensure that participation in research remained safe and met national protocols. By Q4 all our research projects were successfully reopened and recruiting. • QVH worked with Public Health England on the high profile SIREN study. This study was prioritised ahead of all other research work. Early results from this study informed the government's roadmap for exiting lockdown, and the research was cited by the Chief Medical Officer Chris Whitty in his national televised Downing Street briefing. • One of our research nurses was seconded to run the Staff Testing Lab for most of 2020-21, to help with the Trust's covid effort. This, along with staff sickness, had an impact on our capacity to undertake research. • In 2020-21 we recruited **353** participants, of which **328** were to National Portfolio studies. This represents a drop of 54% in recruits over the previous year, reflecting the impact of the pandemic. • We are proud that three of our clinicians acted as Chief Investigators on National Portfolio studies (Charles Nduka, Raman Malhotra, Baljit Dheansa). • R&I has been working towards a cost-neutral position for the several years, and this year we are pleased to report that we made a £11K favourable contribution to the Trust's bottom line for the first time. We also ended the year ahead of Budget by £56K. We expect to be able to maintain a cost-neutral position throughout 2021-22.				
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):	KSO1: *Outstanding patient experience*	**KSO2: X** ***World-class clinical services***	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*

Implications				
Board assurance framework:	None			
Corporate risk register:	None			
Regulation:	All research at QVH is conducted under the UK Policy Framework for Health and Social Research			
Legal:	All research at QVH is conducted under the UK Policy Framework for Health and Social Research			
Resources:	None			
Assurance route				
Previously considered by:	R&I Governance Group			
	Date:	11/05/21	Decision:	Noted
Previously considered by:	Quality and Governance Committee			
	Date:	26/07/21	Decision:	Noted
Next steps:	NA			

Queen Victoria Hospital
NHS Foundation Trust

Holtye Rd
East Grinstead
RH19 3DZ

Queen Victoria Hospital NHS Foundation Trust
Research & Innovation Annual Report

Report covering the period from
April 2020 to March 2021

Document Control: Q&G Committee, R&I Governance Group
Executive sponsor: Nicky Reeves

Authors: Sarah Dawe

Date: May 2021

Type: Annual Report
Version: 1
Pages: 25
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1.	Executive Summary
	• R&I has faced unprecedented challenges in 2020-21 due to the Covid pandemic, but commitment and effort has enabled Research to perform better than expected. • All activity was suspended in Q1 following national guidance. In Q2 a restart programme was begun, with the reintroduction of participant recruitment where clinical services permitted. Patient pathways were adapted to ensure that participation in research remained safe and met national protocols. By Q4 all our research projects were successfully reopened and recruiting. • QVH worked with Public Health England on the high profile SIREN study. This study was prioritised ahead of all other research work. Early results from this study informed the government's roadmap for exiting lockdown, and the research was cited by the Chief Medical Officer Chris Whitty in his national televised Downing Street briefing. • We also took part in the Clinical Characterisation Protocol for Severe Emerging Infection Covid study. • One of our research nurses was seconded to run the Staff Testing Lab for most of 2020-21, to help with the Trust's covid effort. This, along with staff sickness, had an impact on our capacity to undertake research. We have now recruited a replacement, who will start work in April 2021. • In 2020-21 we recruited **353** participants, of which **328** were to National Portfolio studies. This represents a drop of 54% in recruits over the previous year, reflecting the impact of the pandemic. • We are proud that three of our clinicians acted as Chief Investigators on National Portfolio studies (Charles Nduka, Raman Malhotra, Baljit Dheansa). • Once the national picture allowed, we continued our work on commercial studies, and this year we undertook two such studies. • R&I has been working towards a cost-neutral position for the several years, and this year we are pleased to report that we made a £11,668 favourable contribution to the Trust's bottom line for the first time. We also ended the year ahead of Budget by £56K. We expect to be able to maintain a cost-neutral position throughout 2021-22.

3.	Service aim, objectives and expected outcomes
	Research & Development improves outcomes for patients both at QVH and in the wider NHS. This is achieved through research which gives meaningful, transparent and valuable information. As the new Director of Research & Innovation, it gives me great pleasure to introduce the annual Research and Innovation Report for 2020/2021. It has been a challenging year for clinical and ultimately research activity performance monitored by our local CRN. Research activity is tracked on a daily basis via an interactive performance system (Edge), to help provide guidance and initiatives. Our research team has continued to recruit patients into existing and new projects. Our efforts have been recognised over the past year by the National Institute of Health Research, which supported us with a 'Value For Money' (VFM) measure. This year, our VFM was impacted by the pandemic, with a cost-per-weighted-recruit of around £172. The drive to grow and support research continues to be a priority for the Trust. This year will see the introduction of our new Research Innovation strategy defining our vision for 2021 to 2023. The focus is to strengthen our position across the sector by seeking collaboration with organisations, both commercial and academic, in the region. I am also tremendously grateful for all the hard work put in by the research nurses, and by Sarah Dawe and Emma Foulds who oversee the managerial and governance arrangements. Mr Zaid Sadiq

4.	Activity analysis/ achievement

Research Activity

The number of patients receiving NHS services provided or sub-contracted by the Queen Victoria Hospital NHS Foundation Trust in 2020-21 that were recruited during that period to participate in research approved by the Health Research Authority was **353** of which **328** were recruits to National Portfolio studies. This represents a 54% decrease in National Portfolio activity over the previous year, reflecting the significant impact of the pandemic.

Participation in clinical research demonstrates QVH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

QVH was involved in conducting 30 clinical research studies in 2020-21, as per the tables below. We are particularly proud of our contribution to the national SIREN study, for which we recruited 201 participants. This study was key in forming the government's roadmap out of lockdown.

Since QVH was a 'covid-free' Trust, we were not able to participate in many national covid studies. Patient numbers were also reduced as the Trust curtailed normal elective work in order to focus on emergency treatment and cancer work. This meant that we were unable to recruit to many of our usual studies.

Study ref in appendix	Project Short title	Start date	Principle Investigator	National Portfolio study	Recruit-ment in 2020-21
1	DA VINCI activity 1a (citizen science)	20/10/2020	N/A	Yes	0

		2	SARS-COV2 immunity and reinfection evaluation (SIREN)	17/08/2020	Julian Giles	Yes	201
		3	The drivers for, and barriers to, radiographers reporting chest X-ray images in acute NHS Hospitals in England	28/05/2020	N/A	No	1
		4	NHS Work Communication & Impact of Covid19	22/05/2020	N/A	No	0
		5	The COVID-19 Resilience Project	22/05/2020	N/A	No	24
		6	COVIDA	06/05/2020	N/A	No	0
		7	GenOMICC	05/05/2020	Julian Giles	Yes	0
		8	National breastfeeding and anaesthesia survey	10/03/2020	N/A	No	0
		9	NEON - digital NErve, suture Or Not	18/11/2020	Rob Pearl	Yes	1
		10	MET-REPAIR	06/01/2020	Fiona Ramsden	Yes	30
		11	MET-REPAIR-FRAILTY	06/01/2020	Fiona Ramsden	Yes	30
		12	Leadership Styles and their effectiveness in the NHS. A study of Chief Executives in Acute Trusts	04/06/2019	N/A	No	0
		13	SPaCE Pilot	23/08/2019	Simon Booth	Yes	0

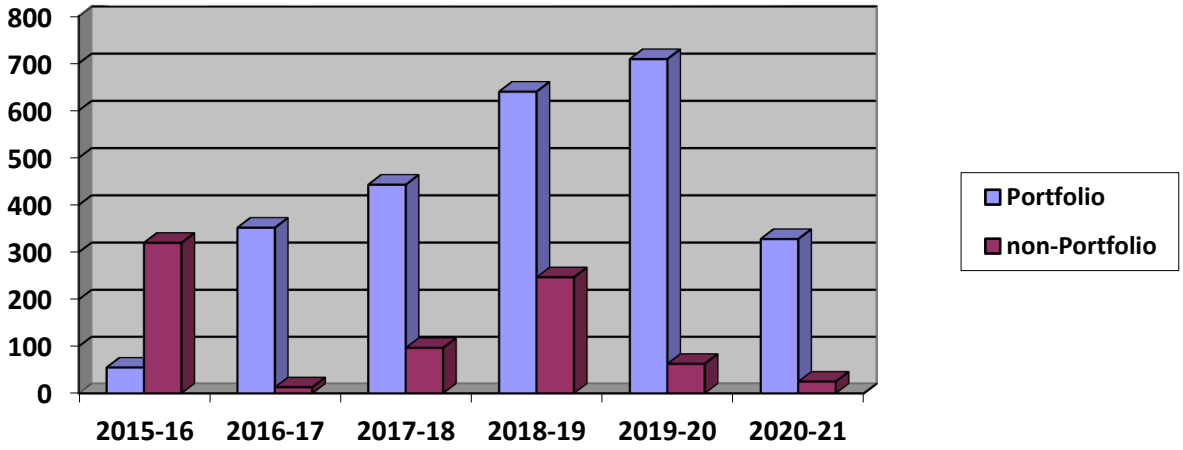
14	Are subjective pain scores related to facial muscle activity? - EMG pain scores	15/09/2020	Charles Nduka	Yes	3	
15	JaWPrinT	27/03/2019	Jag Dhanda	Yes	1	
16	FFFAP Falls Audit Evaluation	18/10/2018	N/A	Yes	0	
17	Allotex IntraStromal	08/02/2019	Samer Hamada	Yes	0	
18	The anatomy of flexor tendon repair-IRP student study	01/10/2018	Rob Pearl	No	0	
19	TEARS	12/11/2018	Raman Malhotra	Yes	25	
20	XEN45 in Angle Closure Glaucoma	22/11/2018	Gok Ratnarajan	Yes	0	
21	Haemostatic markers in ECMO (HAE) study	25/01/2018	N/A	Yes	0	
22	Smartmatrix SMA0217	10/09/2018	Baljit Dheansa	Yes	1	
23	Perioperative Quality Improvement Programme: Patient Study	03/05/2017	Julian Giles	Yes	6	
24	Validation of MIRROR application for facial paralysis	11/03/2020	Charles Nduka	Yes	0	
25	Investigation of Potential Biomarkers in the Role of Scar Formation	16/03/2016	Baljit Dheansa	Yes	0	
26	SUBMIT	21/09/2016	Asit Khandwala	Yes	0	

27	Molecular basis of chronic inflammatory and degenerative diseases	30/11/2015	Asit Khandwala	Yes	29
28	Clinical Characterisation Protocol for Severe Emerging Infection	03/02/2020	N/A	Yes	1
29	Is MGI or upper marginal entropion a contributing factor in the development of SLK	25/02/21	Raman Malhotra	No	0
30	Human factors knowledge in orthodontics		Sofia Ahmad	No	0

Our work on NIHR Portfolio studies

Recruitment to NIHR National Portfolio studies is recorded and monitored via a national database, and the level of CRN funding received by the Trust is partly determined by these accrual figures. In the past five years, the number of Portfolio participants recruited has greatly exceeded the number of non-Portfolio recruits, reflecting a strategic push to increase the proportion of Portfolio studies we undertake. This year activity was severely curtailed due to the COVID19 pandemic and QVH recruited **328** Portfolio participants – a **54%** decrease over the previous year.

Research Participant Recruitment 2015-2020



External Funding

Core funding

The CRN awarded the Trust **£187,643** core funding in 2020-21, plus £5000 contingency funding, £3750 Specialty Lead Funding, and £5000 funding for the SIREN study. The CRN determines its level of funding using an algorithm based on the number of patients recruited to Portfolio studies over the previous two years. This activity-based funding formula is a key driver for how research work is prioritized at QVH.

Funding was allocated according to CRN guidelines in the following way:

Resource	Allocation
Lead Research Nurse	31,824
Research Nurse B7	20,058
Research Nurse B6	41,900
Research Nurse B6	38,195
Bank Nurses	3416
Research Assistant	5048
SIREN study lab costs	2916
Director of Research & Innovation	1445
CRN Specialty Lead	3750
Head of Research	43,080
Research Governance Officer	7501
Training	0
Office/IT/Travel/consumables	2589
Overheads	10,558

The Trust also received **£2,822** from the Brighton and Sussex Medical School to support the IRP students who undertake fourth-year research projects at the hospital.

	R&I has been working towards a cost neutral position for the past few years, by reducing costs and increasing income. This year we for the first time we made a favourable contribution at year end, of £11,668. We also ended the year £56K ahead of budget. We expect to be able to maintain a cost-neutral position throughout 2021-22.

5.	Involvement & Engagement

Patient and Public Involvement and Engagement

QVH continues to work to find meaningful ways to involve patients and members of the public in its research activity. We are fortunate to have on our R&I Governance Group two very involved patient representatives, who take an active role in advising on and monitoring the research activities of the Trust. Patients are also sometimes involved in the early stages of research projects via focus groups, which feed into protocol development.

As in person clinic attendance was replaced with more telephone or video consultations, the opportunities for public involvement decreased, but we were still able to take part in the national anonymous PRES questionnaire, and received 42 completed questionnaires.

Data from PRES is reviewed regularly throughout the year and helps us better understand the experience of research participants and how we might improve their experience. The results are shared both internally and with our CRN. Action plans are in place to address the main PRES findings.

Comprehensive Research Network (CRN)

The Trust is a member of the Kent, Surrey, and Sussex Comprehensive Research Network (CRN). We work with the CRN to maximize opportunities for Portfolio studies, identify new studies the Trust may participate in, and implement new national systems and structures. The CRN distributes R&I resources amongst its members according to an activity-based algorithm. The CEO sits on the CRN Partnership Board, and the Head of Research and the Director of Research & Innovation regularly attend CRN finance and performance meetings, working closely with the CRN Link Manager and her team. Meeting CRN targets is a priority area for the Trust.

Our people

Clinical Research Staff

We are proud that two of our clinicians acted as Chief Investigators on National Portfolio research studies in 2020-21 (Charles Nduka, Raman Malhotra).

In 2020-21, the Trust supported one Lead Research Nurse (0.6WTE), one Burns Research Nurse (1WTE), two Research Nurses (1.89WTE), and one Research Assistant (0.2WTE). Our

Burns Research Nurse was seconded to the Staff Testing Lab throughout most of 2020-21 in order to support the COVID effort.

Some clinical departments also each have their own arrangements for Research Fellows. These are funded by the departments themselves and are not managed by the R&I Department. In addition, we have identified nurses within different clinical areas who have been trained up to support research in their own department.

Research Management and Governance

The R&I Department presently consists of one Director of Research & Innovation, one Head of Research (0.66WTE) one Research Governance Officer (13.8h/wk), and one Research Assistant (0.2WTE).

Funding was received from the Comprehensive Research Network (CRN) to support research management and governance. Other income to support the R&I infrastructure comes from commercial studies, which in addition to paying general Trust overheads, contribute a fee for R&I Department services in assessing applications, setting up contracts, and implementing and monitoring studies.

Intellectual property and Innovation

The Trust has engaged the services of NHS Innovations South East to assist with commercializing and developing its intellectual property.

Training and Development

Local Training
Individual support tailored to the individual is provided by the R&I Department to all new researchers who require guidance developing their protocols, navigating the approvals process and setting up their studies.

It is a legal requirement that all staff involved in clinical trials complete Good Clinical Practice (GCP) training, and the Trust has facilitated this for staff – either by enabling access to off-site courses at other Trusts, or by paying for staff to do an individual online course. Commercial companies also regularly run refresher GCP courses for staff involved in the clinical trials they run at the Trust.

This year our research staff also attended courses on phlebotomy, vaccinations, covid testing, psychological safety in teams, Nudge theory, and research capacity & capability.

CRN training
The Trust also has access to training provided by the CRN for any studies which are accepted onto the National Portfolio. A wide range of courses are offered, including GCP training.

Research Design Service
The NIHR Research Design Service South East provides a very good service in supporting staff making grant applications. They provide us with invaluable advice on study design and methodology.

Governance

R&I at the Trust is overseen by a Research & Development Governance Group. Its members include: Director of Research & Innovation, Chief Pharmacist/Clinical Trials Pharmacist, Anaesthetics Lead, Burns Lead, Corneoplastics Lead, Hand Surgery Lead, Maxillofacial Lead, Director of Nursing, Oncoplastics Lead, Healthcare Science Lead, Orthodontics Lead, Head of Research, Finance Department Representative, Designated Individual with Responsibility for Human Tissue Authority License, and External Academic Advisors from the University of Brighton. The Group also has two very active patient representatives who play a valuable role in advising on new projects.

The R&I Governance Group reports to the Quality and Risk Committee.

The Director of Nursing acts as the Trust's Nominated Consultee for research participants unable to consent.

***Trust policies which cover R&D*:** Adverse Event Reporting Policy, Research Fraud Policy, Code of Practice for Researchers, Pharmacy policy for Clinical Trials, Intellectual Property Policy.

R&I approvals and targets

QVH has effective, streamlined systems for managing R&I approvals in proportion to risk, and our turnaround times are generally swift, although this year approval times nationally were slower due to the service being reorientated towards the covid effort. The R&I Dept provides guidance with using the national IRAS applications system, and works with the Health Research Authority (HRA) to approve studies and ensure they meet national guidelines. We use the Edge online system to manage and monitor research here at the Trust.

Sponsorship status

Some research carried out at QVH is investigator-led ie designed and conducted by our own staff, and these require the Trust to provide structures to support pre-protocol work and peer-review, as well as the subsequent management of active projects. We currently have two Chief Investigators at the Trust who have initiated QVH-Sponsored National Portfolio studies, as well as one Chief Investigator for a non-Portfolio study.

No research study may begin in the NHS without a Sponsor being identified. The Trust continues to offer its researchers the benefits of providing Sponsor status for the studies they initiate. QVH believes that it is right to support its researchers in developing new projects, and to encourage the spirit of intellectual enquiry, and so continues to provide Sponsorship status for all single-site non-CTIMPs.

6. Learning from Experience

Research staff were very flexible in reconfiguring the service to meet the challenges of Covid, and supported each other in a rapidly evolving and challenging environment. R&I has maintained its financial stability, and indeed has made an £11K favourable contribution to the Trust's bottom line for the first time. This year we prioritized Covid research ahead of other research objectives, but this now needs to change in order to continue to guarantee future funding and make research opportunities more available to a wider group of patients again.

7.	Recommendations
	Research activity was hit by the pandemic this year, and we now need to focus on rebuilding our National Portfolio work in order to create a solid core of studies, so that we can return to our pre-pandemic levels of activity. This will entail a sustained focus on supporting and developing Portfolio studies.

8.	Future plans and targets
	Specific targets for 2020-21: • Continue to support the national focus on COVID19 studies • Build up recruitment to non-COVID19 Portfolio studies with the aim of getting back to our pre-pandemic level of activity Progress towards these targets will be monitored by the CRN and by the R&I Governance Group.

9.	Conclusions and assurance
	Research experienced a fall in activity in 2020-21 due to the COVID19 pandemic. The Trust was designated a cancer hub in the initial phase of the pandemic, and ceased elective work in order to focus on this and emergency work. This meant that we were unable to recruit to the majority of our studies for the first half of the year. Subsequent to this, staff sickness and staff redeployment also took its toll on research activity. Therefore our recruitment figures can only be taken to represent around 6 months full activity. Research staff responded well to the unprecedented challenges, and by Q4 all our research studies were open once again, the service having been reconfigured. We were also able to recruit a new research nurse to replace a member of staff who had been seconded. We will focus on rebuilding our non-Covid Portfolio research in 2021-22 as a priority. R&I maintained robust finances despite the challenging environment. We have been working towards a cost neutral position for several years, and this year we were able to make a £11,668 favourable contribution to the Trust's bottom line for the first time. We also ended the year £56K ahead of budget. We expect to maintain at least a cost neutral position in 2021-22. The CRN has confirmed that we will receive a 3% uplift in funding for 2021-22. We expect to return to our pre-pandemic levels of recruitment by the end of 2021-22.

10.	Appendices

Registered research projects (with HRA Approval) ongoing in 2020-21

1 DA VINCI activity 1a (citizen science)

People affected by dementia and some other forms of cognitive impairment in hospital settings face a range of risks that present important challenges in providing them with high-quality care. One possible intervention to support care is a visual identification system. A visual identification system includes an object placed on or near a patient (e.g. a different colour wristband or a sticker with a special symbol) that is paired with an appropriate care response. Such visual identifiers, as part of wider approaches to providing person-centred care for this group, help staff in recognising people with cognitive impairment quickly and easily, and adapt their care accordingly. Several such systems have been developed, but none has been subject to systematic development informed by design principles, nor has any system been rigorously evaluated. Some concerns have been raised about such systems, but these have not been systematically addressed. We propose to carry out a study on the use of visual identification systems for people with dementia and some other forms of cognitive impairment in hospital settings.

As an important first part of this wider study, we propose to undertake an exercise using a citizen science platform (Thiscovery, an online tool that allows people across the UK to contribute their views, experience and preferences) to ask staff using visual identification systems in acute hospitals across the UK to provide brief information on the systems they are using. The survey will be open for two months.

The results will feed into later stages of the programme, including a participatory process of identifying an existing system that might be developed further (or alternatively co-designing a new system based on the needs and preferences of patients, carers and staff), and to ensuring acceptability and workability in practice.

2 SARS-COV2 immunity and reinfection evaluation (SIREN)

This study aims to find out whether healthcare workers who have evidence of prior COVID-19, detected by antibody assays (positive antibody tests), compared to those who do not have evidence of infection (negative antibody tests) are protected from future episodes of infection. In this study, we will recruit healthcare workers to be followed for at least a year and study their immune response to the virus causing COVID-19, called SARS CoV2. We will do this by collecting data on their history of COVID-19 infection and any new symptoms. All NHS staff who deliver care to patients are being asked to have a nose and throat swab every other week in order to detect mild cases or cases who do not have symptoms. This is the main test that is currently used to detect and diagnose infection. It looks directly for the virus in the nose and throat. Once the infection is cleared, we cannot detect virus in samples. Therefore, we will also ask these individuals to have blood samples taken every other week to determine whether they have antibodies to the infection. These blood samples allow the previous infection to be detected as the response to infection in the body is to produce small particles in the blood called “antibodies”. It takes up to 4 weeks to make enough antibodies to fight the infection. But once someone recovers, antibodies stay in the blood at low levels– this is may help prevent us from getting infected with the same infection again. However, for SARS CoV2 infection we do not know yet if the detection of antibodies protects people from future infections. Through this study, we will provide this very important information which will help to understand the future impact of COVID-19 on the population.

3 The drivers for, and barriers to, radiographers reporting chest X-ray images in acute NHS Hospitals in England

This survey will seek to generate an overview of the current state of reporting radiographers (RR) reporting chest x-rays and future employment levels via training numbers. An electronic qualitative-style survey will be distributed to Radiology departments in 149 acute NHS trusts in England enquiring about their employment and training of chest xray reporting radiographers (CXR-RR). Thematic analysis with be undertaken using NVIVO 12 Plus.

4 NHS Work Communication & Impact of Covid19

The primary aim of this questionnaire study is to investigate the impact of work-related communication before and during COVID-19 pandemic on the work-life balance of healthcare workers.

A secondary aim is to explore what improvements can be made to communications to support work-life balance and to look at direct professional and patient related communication usage.

The study objectives are to ascertain: The volume of communication prior to the COVID-19 pandemic; The volume of communication during the COVID-19 pandemic; Changes in direct communication between patient and care professional due to COVID-19; Communication platforms used by healthcare workers and the frequency of their use during COVID-19 pandemic; Understanding the use of Teams recently made available to staff across the NHS ; Estimating work and off duty time spent on managing communications such as emails prior to and during the COVID-19 pandemic; Respondents' views of the impact of work-related communication on their work-life balance and the ability to switch off communications when needed.

5 The COVID-19 Resilience Project

It is vital that we explore the immediate and longer-term psychological impact of COVID-19 on NHS staff in order to better understand how to effectively support staff psychological wellbeing and mental health during this time.

This self-report questionnaire project will aim to: Evaluate the impact of COVID-related stressors on a range of mental health outcomes of interest, including anxiety, depression, post-traumatic stress, general well-being and compassion fatigue/burn-out; To investigate the effect of relevant psychological markers of risk and resilience that might aggravate or buffer the impact of COVID-related stressors on mental health and well-being outcomes; Evaluate impact of COVID-19 on post-traumatic growth and compassion satisfaction; Follow-up the impact over time, by inviting participants to re-complete the questionnaires after 4, 8, and 12 months; Gather follow-up qualitative data to further explore the above topics

6 COVIDA

An online questionnaire study to understand the psychological impact of the Covid-19 outbreak on the lives of health care professionals.

7 GenOMICC

The GenOMICC (Genetics of Susceptibility and Mortality in Critical Care) study will identify the specific genes that cause some people to be susceptible to specific infections and consequences of severe injury. Our hope is that identifying these genes will help us to use existing treatments better, and to design new treatments to help people survive critical illness. To do this, we will compare DNA and cells from carefully selected patients with samples from healthy people.

8 National breastfeeding and anaesthesia survey

Very few drugs make breastfeeding absolutely contraindicated. An evolving knowledge of pharmacology and breast milk physiology has led experts to suggest that mothers can resume breastfeeding following anaesthesia as soon as they feel able.

There is currently no national guidance on breastfeeding and anaesthesia. Supporting breastfeeding peri-operatively is essential to provide infant nutrition, maintain lactation and prevent breast engorgement & mastitis. Anaesthetist give a range of advice to breastfeeding mothers, which may cause distress to mother and infant and result in the premature end to their breastfeeding journey, depriving mother and baby of the health benefits. It is difficult to justify anaesthesia being a reason for women ceasing to breastfeed.

This project seeks determine current practice nationally through the use of a short online survey of currently practicing anaesthetists. The survey has been piloted in North Bristol NHS Trust, yielding 51 responses with grade of anaesthetist proportionally representing the department.

9 NEON - digital NErve, suture Or Not

Digital nerves are small nerves that pass along the side of each finger and provide sensation to the fingertips. These nerves can be accidentally cut when handling sharp objects like a knife or broken glass. The NEON study aims to find out whether sewing the ends of the cut nerve surgically is beneficial or even needed. Thoroughly cleaning the cut wound before closing the skin is a much simpler procedure, and may be satisfactory for patients.

There is some evidence that both treatments give good results. There is also some evidence that patients may not fully recover the feeling in their injured finger, even after the nerve has been sutured. Research so far has been conflicting and is of varying quality. For example, some studies do not directly compare treatments, or do not ask patients about their views of recovery.

NEON will compare surgical procedures for digital nerve repair, with or without stitches (also known as sutures). 478 patients with a single digital nerve injury will have one of these two treatment options by random allocation. Patients will complete questionnaires measuring fingertip sensation, quality of life and health resource use up to 12 months after the operation. They will also attend clinic visits at 3 and 12 months. Longer term follow up (12-24 months after randomisation) to determine re-operation rates will be collected using routine hospital data.

10 MET-REPAIR

This study seeks to investigate the prognostic value of estimation of a patient's exercise capacity prior to major noncardiac surgery. Current guidance from the European Society of Anaesthesia and European Society of Cardiology, American College of Cardiology and American Heart Association recommends that patients' exercise capacity should be estimated in terms of metabolic equivalents (METs). The number of METs reflects the increase in oxygen consumption during an activity compared to when at rest. For example, if 1 MET equates to a patient at rest and 4 METs is walking up two flights of stairs, the latter activity requires four times as much oxygen consumption. The primary objective is to determine whether the number of METs a patient can achieve, as estimated using a questionnaire, is associated with major adverse cardiovascular events or cardiovascular mortality around the time of surgery, and if so, what is the value for METs that can best predict whether a patient will suffer these complications?

In a substudy, the patient's NTproBNP (N-Terminal prohormone of Brain Natriuretic Peptide) level will be measured to determine whether NTproBNP improves prediction of perioperative cardiovascular events and cardiovascular mortality when added to clinical data and estimated

METs. If such associations exist, they will add to the methods available for establishing patients' risk of morbidity or mortality when they undergo major surgery.

11 MET-REPAIR-FRAILTY

See above

12 Leadership Styles and their effectiveness in the NHS. A study of Chief Executives in Acute Trusts

This research will focus on 5 main areas, these being the organisational structure of the NHS with emphasis on the executive tier within acute trusts, the historic development of the NHS chief executive as a substantive role, NHS leadership recruitment, development and education, leadership and followership theories and their application within the NHS and a critical examination of effectiveness when applied to leadership.

As this study does not have a pre-defined hypothesis it will utilise a grounded theory approach (Corbin and Strauss, 2015), allowing the researcher to explore the inner experiences of participants, explore how meanings are formed and transformed while exploring areas not yet thoroughly researched. This open-ended research will focus primarily on qualitative methods, however given the complexity of the subject and the need to compare a number of responses from NHS leaders, quantitative methods may also be utilised. The qualitative approach allows for greater study of the participants in this research, which in turn will allow for a more open and constructive dialogue.

To conduct this research a number of visits to NHS facilities shall take place. It is also important to visit the NHS leadership academy in Leeds or London. During these visits it is intended to interview current NHS chief executives to gather first hand descriptions of management styles within each setting. A semi-structured approach to the interviews will allow for a more fluid and descriptive dialogue.

13 SPaCE Pilot

The objective of this pilot study is to evaluate the technology that is intended to be incorporated into a SPaCE-swab sensor kit. The kit is intended to be a low cost, fast, near-to-patient method of assessing the infection state of a wound. It would rapidly indicate wound colonisation (onset of infection) by the four principal microbial wound pathogens: Staphylococcus aureus, Pseudomonas aeruginosa, Candida species, and Enterococcus faecalis.

14 Are subjective pain scores related to facial muscle activity? EMG pain scores

This study aims to discover if we can compare the pain felt by patients with a measurement of how their faces move. Facial movements will be assessed using muscle activity sensors worn like a pair of glasses/ goggles that measure underlying muscle activity. Past studies show facial expression is sensitive to the intensity of pain. Laboratory studies looking at pain in volunteers suggest facial electromyography (EMG) to measure muscle activity could be a useful tool to determine the pain an individual is suffering. This may have particular relevance to patients where communicationis limited eg dementia.

This is a small-scale study to validate an experimental model in the clinical environment. We propose studying at patients receiving a local anaesthetic injection before planned hand operation. Whilst they are receiving the injection we will record the facial muscle response non-invasively using specialized goggles containing muscle sensors. Simultaneously we will record the patients experience of pain using a self-reported visual analogue score (VAS). Importantly pain expectation will also be considered, and we will also be assessing participant anxiety traits and status prior to intervention.

50 adult patients requiring hand surgery under a local anaesthetic block at the Queen Victoria Hospital will be studied. The study will be the observation and recording of data from patients undergoing routine clinical care only. It will not involve any additional procedures. The study will run for 6 months and we will publish all the findings within 1 year

15 JaWPrinT

JaW PrinT is a 'real-world' prospective observational pilot study, evaluating the clinical effectiveness, usability and economics of two approaches to mandibular reconstruction surgery (figure 1). Patient participants will be recruited prospectively over a minimum period of 18 months (with observation of at least 10 participants in each treatment pathway). The figures are based upon the historical clinical practice of the research site, with both techniques in equal use; choice depending on resources, surgical training requirements and surgeon's clinical preference.

As a purely observational study, treatment choice will be made in the normal clinical manner and will in no way be influenced by the study itself. Participants will be followed up at their routine outpatient clinics (6 weeks, 6 months and 1 year postoperatively) with prospective outcomes data collection

16 FFFAP Falls Audit Evaluation

Audit and feedback is widely used within quality improvement initiatives as a strategy to improve professional practice. However, the use in practice of these tools needs to be carefully designed and adapted to the specific local context to be effective. Falls are the most frequent patient safety issue experienced by old patients during an acute hospital episode, resulting in over 2,000 hip fractures annually as well as considerably other injury, distress, and anxiety, plus increased healthcare expense.

This research will explore current use and opportunities of improvement of the National Audit of Inpatient Falls (NAIF), one of the work-streams of the Falls and Fragility Fracture Audit Programme (FFFAP), which is a national programme of quality improvement managed by the Royal College of Physicians (RCP) in the Clinical Effectiveness and Evaluation Unit (CEEU).

The purpose of this project is to provide a scientific evaluation to better understand the barriers and enablers to the use of the NAIF data by clinical services in their quality improvement work to reduce the incidence of inpatients falls. In particular in this research we aim to investigate technical, social and contextual factors, related to the audit and feedback process of the NAIF programme in order to explore how the audit data and reports from 2017 are perceived, received, and acted upon. The results of this research will be used to make recommendations as to how to improve the audit and wider programme 2018-2021 and more in general to inform future National Clinical Audits.

17 Allotex - IntraStromal

The objective of this clinical study is to evaluate the safety and effectiveness of intrastromal implantation of the Allotex TransForm corneal allograft (TCA) for improving near vision in presbyopic subjects.

The Allotex TCA is a piece of acellular cornea, sterilized with electron beam radiation and shaped to a particular shape using a laser. The availability of precise laser shaping systems and sterile corneas are the key factors that make the use of allogenic implants possible. One size of the TCA is available which has a +2.50 D power with a diameter of 2-3.5 mm and a

central thickness of 15-25 microns. The TCA is applied to the surface of the cornea at the layer known as Bowman's membrane, which is just underneath the epithelium.
The goal is to enhance the visual performance of the patient with a material that is 100% biocompatible and precisely shaped for the individual's needs.

18 The anatomy of flexor tendon repair

This study is a joint project with the Department of Anatomy and Queen Victoria Hospital and look at different methods of tendon repair in cadaveric hands. The study will be conducted by a student from BSMS.

Specifically, the volume of the knot and suture material as a proportion of the cross sectional area of the tendon, the circumference of the tendon repair site and the degree of shortening will be measured in cadaveric hands for different types of tendon repair.

19 TEARS Grading scale: grading the clinical severity of epiphora

Epiphora (watery eye) is a common presentation to the ophthalmology clinic, with most patients being amenable to surgical (61-69%) or non-surgical treatment. Surgically-amenable epiphora affects an estimated 16/100 000 persons rising to 100/100 000 in 75-84 year olds. While in some, the epiphora represents no more than a tolerable nuisance, in others it significantly affects their quality of life. At the more severe end of the spectrum, some cases require repeat medical attendances and hospital admissions for systemic infection. With ever-increasing financial constraints on healthcare providers, there is a need for clinicians and healthcare commissioners to better prioritise patients for surgical intervention.

The 'TEARS scale' was developed through extensive literature review, patient focus groups and consultation with an expert panel of consultant ophthalmologists. Disease severity is graded based on 4 subscales: symptom frequency, the effects on patients and healthcare providers, patients' functional status, and the compounding effect of ocular surface disease. This prospective study aims to validate the TEARS scale by recruiting adult patients presenting to oculoplastic clinics with epiphora. Two clinicians will complete the TEARS grading scale at the study entry point. Patients will complete two questionnaires: The Watery Eye Quality of Life score (WEQOL) and The Lacrimal Symptom Questionnaire (Lac-Q).
In a subset of patients who have previously agreed with their clinician to undergo either surgical or non-surgical intervention, the TEARS scale will again be completed at their clinical review by two clinicians between 3 and 6 months after their initial visit. Patients will again complete the WEQOL and Lac-Q, as well as the Glasgow Benefit Inventory (a measure of change in quality of life).

The scale's reliability will be evaluated through statistical testing of inter-rater agreement. Construct validity will be assessed by the scale's correlation with patient-reported outcome measures and by evaluating its responsiveness to surgical intervention.

20 XEN45 in Angle Closure Glaucoma

Glaucoma is an eye condition where the optic nerve is damaged by the high pressure of the fluid in the eye (aqueous humour). Aqueous humour is produced by a ring of eye tissue called the ciliary body, located behind the iris (coloured part of the eye). It flows through the pupil and drains out through a spongy network of holes called the trabecular meshwork (which sits in the angle formed where the iris meets the cornea). In Angle Closure Glaucoma (ACG), the outer edge of the iris and cornea come in contact, closing the drainage angle. This prevents the aqueous humour from draining and causes the pressure in the eye to build up.
Currently available treatment for ACG consists of procedures to reduce eye pressure, including laser treatment, lens extraction, eye pressure-lowering medications, and incisional surgeries. There are no minimally invasive glaucoma surgery options available for ACG.
XEN45 Glaucoma Treatment System (referred to as XEN) potentially alleviates this

unmet need. XEN comprises of the Gel Implant and the Injector. The Gel implant is a soft gelatinous implant, approximately 6 mm long and as wide as a human hair. After implantation in the eye, it acts as a conduit for the drainage of aqueous humour in the eye.

The current study, sponsored by Allergan, is a prospective, multicentre, single arm, open-label (the participants and study team will know which treatment the participant is assigned to) clinical trial in patients with ACG. Approximately 65 patients will be implanted with XEN in one eye and followed for 12 months to evaluate its safety and effectiveness. Participants will be enrolled at approximately 15 research sites in the Asia-Pacific and European regions

21 Haemostatic markers in ECMO (HAE) study

Multicentre, prospective cohort study of haemostatic activation markers and correlation with bleeding and thrombotic complications in patients receiving extracorporeal membrane

22 Smartmatrix SMA0217

This is a multi-centre, non-comparative, prospective study to demonstrate that the Smart Matrix dermal replacement scaffold has an acceptable safety profile and enables healing in full-thickness surgical wounds. Approximately 40 patients scheduled for elective surgical excision of suspected or histologically proven BCC or SCC lesions who meet the inclusion and exclusion criteria and provide written informed consent will be enrolled in the study.
The study will be conducted in 2 stages, with the first 12 patients (the safety cohort) reviewed by the Data Monitoring Committee (DMC) to assess the safety and performance of Smart Matrix.

When the safety cohort reaches the Week 6 post-operative time point, safety and the requirement for rescue therapy, in the opinion of the Investigator, will be assessed to decide if the study should continue to full enrolment.

23 Improving perioperative care through the use of quality data: Patient Study of the Perioperative Quality Improvement Programme (PQIP)

Over ten million operations take place in the UK NHS every year. The number of patients which are at high risk of adverse postoperative outcomes has grown substantially in recent years: this is attributable to a combination of an ageing population, the increased numbers of surgical options available for previously untreatable conditions, and the increasing numbers of patient presenting for surgery with multiple comorbidities. Estimates of inpatient mortality after non-cardiac surgery range between 1.5 and 3.6% depending on the type of surgery and patient related risks. Major or prolonged postoperative morbidity (for example, significant infections, respiratory or renal impairment) occur in up to 15% of patients, and is associated with reduced long-term survival and worse health-related quality of life; this signal has been consistently demonstrated across different types of surgery, patient and healthcare system.

Data from the US demonstrate wide variation in risk-adjusted mortality & morbidity rates between healthcare providers, suggesting that at least some complications after surgery could be avoidable if standards of care were improved. It is likely that the same is true in the UK; however, there is currently no unified national system for measuring complications or patient reported outcomes across different types of major surgery in the NHS. In order to address this gap, the National Institute for Academic Anaesthesia's Health Services Research Centre (NIAA-HSRC) has launched the Perioperative Quality Improvement Programme (PQIP) for the UK. PQIP will measure risk-adjusted morbidity and mortality, as well as process and patient-reported outcome data in adult patients undergoing major surgery (eg lower GI resection, upper GI resection, liver resection, cystectomy, major head and neck reconstructive surgery, thoracic resection).

24 Validation of the MIRROR facial expression tracking application in healthy subjects and facial paralysis patients

Facial paralysis (FP) presents from either a peripheral nervous abnormality (most commonly Bell's Palsy) or a central nervous lesion (usually a cerebro-vascular accident). Bell's Palsy accounts for 60% of cases of facial palsy, causing up to 24,800 new UK cases annually, leaving upwards of 100,000 people living with permanent disability. Of the 152,000 CVAs per year in the UK, many patients suffer resultant chronic facial movement problems. Current methods for tracking facial expression recovery include subjective measures, e.g. doctor-delivered grading systems, and objective measures, e.g. 2D / 3D imaging (photography and/or stereophotogrammetry) or videos of dynamic facial function. However, a consensus method for objectively measuring initial paralysis and monitoring progress towards normal facial expressions remains elusive. Gold standard treatment for FP includes daily rehabilitative exercises, but patients often fail to perform these regularly due to lack of feedback on exercise efficacy leading to demotivation and non-compliance with the prescribed physiotherapy. This in turn reduces patients' likelihood of recovery of normal facial function.

A new iPad-based non-invasive physiotherapeutic software application (MIRROR) has been developed, allowing FP patients to objectively track their paralysis / facial expressions in real-time via MIRROR's immediate feedback on exercise performance. To validate MIRROR, a study has been designed to analyse the facial movements of healthy and FP patients pre- and post-administration of Botulinum toxin (BT). Each subject's response to BT over the period of action of the injected BT will be assessed. Subjects will have their facial expressions quantitatively analysed via subjective grading scales validated for use in FP analysis, 2D / 3D imaging, via surface-electromyography and using MIRROR

25 Investigation of Potential Biomarkers in the Role of Scar Formation

The reason for the development of a scar is not clearly understood and the causes are multi-factorial. In simple terms, scarring may be a direct consequence of evolutionary changes that have lead to a rapid healing of the wound site in order to prevent infection. As a consequence of this speed of wound epidermal closure, the cells in the dermis of the skin are prone to produce inappropriate amounts of extracellular matrix molecules. It is this over production that leads to the formation of a scar.

The only example of scar-free healing is in utero. Surgery performed on a foetus in the third trimester (and these often save lives of unborn children) do not leave any traces of surgical intervention. A child is born without a scar. This amazing ability is lost shortly after birth and for the rest of adulthood, any post-traumatic event to the skin results in the production of a scar. The Queen Victoria Hospital (QVH) is a regional centre for burns and plastic surgery. The hospital treats patients with acute wounds and those undergoing surgical reconstruction or scar revision. As part of this treatment scar tissue will often be removed and disposed of as clinical waste. This redundant scar tissue offers the possibility of developing a clearer understanding of the mechanisms of scar formation.

26 SUBMIT

Metacarpal fractures are common, accounting for 40% of all hand injuries and many can be treated non-operatively. However, surgery is reserved for cases in which an adequate reduction of both angular and rotational deformity cannot be maintained or where an adjacent ray is damaged.

A variety of surgical strategies exist, including percutaneous kirschner wiring, intramedullary fixation, and fixation with plate and screw construction. A plate secured along the dorsal midline of the metacarpal has been shown to be the best biomechanical method of fixation, and allows early aggressive hand therapy post-operatively.

Traditionally, bicortical fixation is the standard practice, where both dorsal and palmar cortices of the metacarpal are drilled though. However, such practice is not without risk. In this method, the flexor tendons and neurovascular bundles at risk from over-zealous drilling through the palmar cortice. Correct screw size selection is also critical as overly long screws can irritate and cause rupture of flexor tendon. More recently, with the advent of a new generation of locking plates, unicortical fixation, where only the near cortex is drilled, has been used to treat fractures. Unicortical fixation is a surgically less complex operation, can theoretically cause less damage to surrounding soft tissues and avoids the complications associated with incorrectly sized screws.

This trial aims to compares the functional outcomes and complications of patients having unicortical versus bicortical fixation for diaphyseal metacarpal fractures.

27 Molecular mechanisms and pathways of chronic inflammatory and degenerative diseases

Using synovial tissue in explant cultures obtained from rheumatoid arthritic patients undergoing joint replacement surgery, the Kennedy Institute was the first research laboratory in the world to identify the pathogenic role of the inflammatory cytokine tumour necrosis factor alpha (TNF) in Rheumatoid Arthritis (RA). Biological therapies that block the function of TNF are now clinically proven and over one million people worldwide have been treated successfully with this drug. However, this is not a cure for RA, so current research activities at the Kennedy are aimed at understanding those events that trigger RA, and developing better therapies for this disease.

Patients scheduled to undergo a surgical procedure as a result of arthritis or other inflammatory diseases, will be given the option to take part in our study. In addition, waste tissue will be obtained from an amputation as a result of a traumatic injury and adipose as a result of an abdominoplasty. A qualified clinician / GCP trained team member will take written, informed consent prior to surgery. Waste tissue from surgery is collected in a sample pot and couriered to the Kennedy Institute. This waste tissue includes joints (cartilage and bone), periarticular tissue, connective tissue (muscle and fascia) and other soft tissue such as skin.

The tissue will be processed ex vivo to liberate single cell suspensions, which will then be cultured for up to 5 days or long term lines will be derived. Cell supernatants will be analysed for cytokine, MMP and other inflammatory mediators by ELISA and cell phenotype determined by Flow cytometry. In addition, mRNA will be harvested and gene expression determined by TaqMan PCR. The histopathology of the tissue will also be looked at.

28 Clinical Characterisation Protocol for Severe Emerging Infection

This is a standardized protocol for the rapid, coordinated clinical investigation of severe or potentially severe acute infections by pathogens of public health interest. Patients with a spectrum of emerging and unknown pathogens will be enrolled. This protocol has been designed to maximize the likelihood that data and biological samples are prospectively and systematically collected and shared rapidly in a format that can be easily aggregated, tabulated and analysed across many different settings globally. The protocol is designed to have some level of flexibility in order to ensure the broadest acceptance and has been initiated in response to the recent cases of novel coronavirus (nCoV) in 2012-2013, Influenza H7N9 in 2013 and viral haemorrhagic fever (Ebolavirus) in 2014. Information will be circulated by the Investigators and disseminated by the NIHR Clinical Research Network to clarify the eligibility criteria in the event of the emergence of a pathogen of public health interest. The study is now recognised by the NIHR as being an Urgent Public Health Research study

29 Is MGI or upper marginal entropion a contributing factor in the development of SLK

The Corneoplastic Unit at the Queen Victoria Hospital often manages patients with superior limbic keratoconjunctivitis (SLK). We hypothesise that meibomian gland inversion (MGI)

and/or upper marginal entropion is a major contributing factor in the development of SLK, and is currently under-recognised. This prospective observational cohort study aims to answer the research question: "Is MGI or upper marginal entropion a contributing factor in the development of SLK?". This study will take place over six months, within the Ophthalmology department of an NHS site, and include all patients identified as possessing features of SLK.

30 Human factors knowledge in Orthodontics Team

Student project

New projects which are expected to start in 2021-22

- SAVER - maxfacs
- Burn-code: multicentre review of burns patients
- GRRAND-F – physiotherapy for H&N patients
- LOOC – lymphatic mapping of oropharyngeal cancer

11.	Report approval and governance

	This annual report has been reviewed by our R&I Governance Group, as well as by the Quality and Governance Committee.