NHS
Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 3 March 2022

Session in public
11:00 – 13:00

MEMBERSHIP
BOARD OF DIRECTORS
March 2022

Members (voting):

Trust Chair	-	Anita Donley
Senior Independent Director	-	Gary Needle
Non-Executive Directors	-	Paul Dillon-Robinson
	-	Kevin Gould
	-	Karen Norman
Chief Executive:	-	Steve Jenkin
Medical Director	-	Tania Cubison
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
Director of Workforce (interim)	-	Lawrence Anderson
Deputy Company Secretary	-	Hilary Saunders

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.	Other
Non-executive and executive members of the board (voting)								
Anita Donley Trust Chair	Director, Anita Donley Associates Ltd	Nil	Nil	Trustee, Imperial Health Charity. Chair, Grants Oversight Committee	Principal Advisor, Academic Health Solutions Senior Associate, Good Governance Institute Independent Advisor, Visionable Ltd	Nil	Nil	Nil
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.	From 1/6/21 : Chair of the Audit Risk and Assurance Committee for one of the MoD's Top Level Budget organisations. From 8/11/21 : Non-Executive Director Chair of ARAC, and member of Agency Management Board for Rural Payments Agency, ex-officio member of Defra ARAC Already : Non-trustee member of Finance Risk and Audit Committee of Farm Africa. Shadow governor of Hurst Education Trust. Trustee of the Association of

							Churchwarden for Parish of Buxted & Hadlow Down, trustee of Friends of St Margaret, and St Marks House School trust.	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. Director and Chair 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	Nil
Gary Needle Acting Trust Chair and SID	T&G Needle Property Development Ltd	Nil	Nil	Chair of Board of Trustees, East Grinstead Sports Club.	Nil	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	Nil
Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Tania Cubison Medical Director	Nil	I undertake private practice at the McIndoe Centre and also I am a Medio legal expert. This	Nil	National Chair of the Emergency Management of severe burns senate (part of	Nil	Nil	Spouse (Ian Harper) is the director of welfare for BLESMA (the military charity for	Nil

		is as a sole trader, not a limited company.		the British Burn Association)			amputees). He is in a salaried post and does signpost people to QVH.	
Michelle Miles Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Nicky Reeves Director of Nursing	Nil	Nil	Nil	Trustee of McIndoe Burns Support Group	Nil	Nil	Nil	Nil
Other members of the board (non-voting)								
Abigail Jago Director of operations	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Lawrence Anderson Director of HR & OD	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Clare Pirie Director of Communications & Corporate Affairs	Nil	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)							
Anita Donley Trust 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 Acting Trust Chair and SID	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
Tania Cubison 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

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Agenda: session held in public			
WELCOME			
32-22	**Welcome, apologies and declarations of interest** *Anita Donley, Trust Chair*		
STANDING ITEMS		**Purpose**	**page**
33-22	**Draft minutes of the public meeting held on 6 January 2022** *Anita Donley, Trust Chair*	*approval*	1
34-22	**Matters arising and actions pending** *Anita Donley, Trust Chair*	*review*	-
35-22	**Chair's report** *Anita Donley, Trust Chair*	*review*	11
36-22	**Chief executive's report** *Steve Jenkin, Chief executive*	*assurance*	13
TRUST STRATEGY			
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
37-22	**Board Assurance Framework** *Nicky Reeves, Chief nurse and* *Tania Cubison, Medical director*	*assurance*	24
38-22	**Quality and governance assurance** *Karen Norman, Non-executive director*	*assurance*	-
39-22	**Corporate risk register (CRR)** *Nicky Reeves, Chief nurse*	*review*	26
40-22	**Quality and safety report** *Nicky Reeves, Chief nurse, and* *Tania Cubison, Medical director*	*assurance*	41
41-22	**Approval of updated corporate risk strategy** *Nicky Reeves, Chief nurse*	*approval*	53
42-22	**Health care worker flu vaccination Information** *Nicky Reeves, Chief nurse*	*review*	72
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
43-22	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*assurance*	76
44-22	**Financial, operational and workforce performance assurance** *Paul Dillon-Robinson, Committee chair*	*assurance*	78
45-22	**Operational performance** *Abigail Jago, Director of operations*	*assurance*	81

46-22	**Financial performance** *Michelle Miles, Director of finance*	*assurance*	97
47-22	**2022/23 Planning Update** *Michelle Miles, Director of finance*	*information*	106
Key strategic objective 5: organisational excellence			
48-22	**Board assurance framework** *Lawrence Anderson, Interim director of workforce and OD*	*assurance*	109
49-22	**Workforce monthly report** *Lawrence Anderson, Interim director of workforce and OD*	*assurance*	110
GOVERNANCE			
50-22	**Board effectiveness review** *Clare Pirie, Director of communications and corporate affairs*	*review*	123
51-22	**Changes to Trust constitution** *Clare Pirie, Director of communications and corporate affairs*	*approval*	154
52-22	**Annual report on use of Trust seal** *Clare Pirie, Director of communications and corporate affairs*	*information*	158
53-22	**Nomination & remuneration assurance update** *Anita Donley, Trust Chair*	*assurance*	160
ANY OTHER BUSINESS (by application to the Chair)			
54-22	*Anita Donley, Trust Chair*	*discussion*	-
MEMBERS OF THE PUBLIC			
55-22	*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.* *Anita Donley, Trust Chair*	*discussion*	-
56-22	*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 confidential or sensitive nature. Any decisions made in the private session of the Trust Board will be communicated to the public and stakeholders via the Chair's report.* *Anita Donley, Trust Chair*	*approval*	-

Document:	Minutes (Draft & Unconfirmed)	
Meeting:	**Board of Directors (session in public)** **Thursday 06 January 2022 11:00 via videoconference**	
Present:	Anita Donley (AD)	Trust Chair (voting)
	Gary Needle (GN)	Senior Independent Director (voting)
	Keith Altman (KA)	Medical Director (voting) **[13-22 to 24-22]**
	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)
	Abigail Jago (AJ)	Director of operations (non-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)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
In attendance:	Hilary Saunders (HS)	Deputy company secretary (minutes)
	Peter Shore (PS)	Lead governor
Apologies:	None	
Members of the public:	Eleven, including two members of staff.	

Welcome	
01-22	**Welcome, apologies and declarations of interest** The Chair opened the meeting. There were no apologies and no additional DoIs to those already recorded on the register. All Board members had read reports in advance. The Chair reminded those present that since moving to online meetings and in order to make most efficient use of the time available, the Board now submitted questions in advance, although this did not preclude additional questions being raised. The Chair went on to welcome those members of the public in attendance today. Some questions had been raised in advance by members of the public; for some the answer will be addressed during the main discussion whilst others will be addressed at the end of the meeting, with a full record included in the minutes.
Standing items	
02-22	**Draft minutes of the meeting held on 04 November 2021** The draft minutes were **approved** as a correct record subject to changes to item 166-21 as follows: • The Trust had delivered 62 day, 31 day and FDS standards in the reporting month. Trust performance was behind plan for 2ww. • Late referrals were a challenge for both the 62 day backlog and patients waiting over 104 days.
03-22	**Matters arising and actions pending** The Board **received** the latest matters arising update. There were no matters outstanding this month.
04-22	**Chair's report** The Board received the Chair's report. In response to a question around publication of the independent review report, it was noted that the full report would be confidential in recognition of the need to ensure that parties approached by the Reviewer were able to discuss confidential or sensitive issues as necessary. The Reviewer will also produce an executive summary report containing the key findings, conclusions and recommendations without confidential information in such a way that this can be shared with relevant parties more widely.
05-22	**Chief Executive's report** The Board **received** the latest report from the Chief Executive which included the overall board assurance framework, dashboard and media update. SJ highlighted in particular:

	• The potential impact of the Omicron variant and the role QVH was taking within the Sussex system in stepping up as a cancer hub once again. The most significant challenge for all trusts, (including QVH), was managing staff sickness. • The results of the CQC 2020 National Children and Young Person Experience Survey; it was a testament to front line teams for maintaining this progress during a difficult 12-month period. • The timeline for possible merger with University Hospitals Sussex; whilst we had hoped to progress work on the full business case sooner, the operational pressures which both organisations were experiencing mean this is not possible. In the meantime, work will proceed to bring the Patient First improvement methodology to QVH. • NHS Specialised Commissioning is leading on an options appraisal aimed at seeking a provider meeting the requirements to deliver the high quality burns service currently provided at QVH. The CEO report made reference to an allocation from the NHSEI Targeted Investment Fund (TIF) for modular theatres. Discussion by the Board had taken place during a private session for reasons of commercial sensitivity. The additional modular buildings would be a significant improvement and increase activity. The additional resilience would ensure the new facility could remain operational throughout the year. The CEO report also referenced the Board's formal approval in November for the residency requirement for the interim chair to be waived. The Board considered the report and received the following additional information: • That NHS Specialist Commissioning were leading on the burns options appraisal. An outline plan had been submitted to Health Overview and Scrutiny Committees (HOSC) in December. A peer review would take place in early 2022 which would inform the option appraisal. Specialist Commissioning anticipate this to be completed by the end of the financial year. • The medical director will be the QVH lead on the clinical service reviews, working alongside their equivalent at University Hospitals Sussex (UHSx). • The Executive Management Team (EMT) will discuss implementation of the Patient First quality improvement methodology shortly, considering the level of additional resource that will be required. • QVH and UHSx are both committed to the timescales given for completion for service reviews and the full business case (FBC); however, the timeline has been amended before and QVH will not shy away from the need to flex priorities based on operational pressures. • The planning guidance was published on Christmas Eve and included ten priorities for systems to deliver. There would be some challenges for QVH, possibly reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by 2023, and going further where possible. On a more positive note, the successful TIF bid for two modular theatres will offer the Trust the opportunity to tackle its elective backlog. The project was due to complete mid-summer, provided all milestones were achieved, and that there were no significant supply issues. • The establishment of integrated care boards (ICBs) has been deferred from April to July 2022. • Current sickness levels at QVH are around 5%, including both self-isolation and COVID; whilst this was not exceptional for the time of year, we are aware that this may increase in the coming days. There were no further comments and the Board **noted** the contents of the report.
Trust strategy	
06-22	**Green Plan** SJ introduced his report. In October 2020, the Greener NHS National Programme published its strategy, 'Delivering a 'Net Zero' National Health Service', which committed to becoming a net zero-carbon health service by 2040 for emissions it controls directly and 2045 for emissions it can influence. In 2021, Trusts were tasked with submitting a green plan (Part I) to their Integrated Care System (ICS) by January 2022. Part II will be the detailed delivery and how we intend to work with stakeholders to develop this. There has been great engagement and commitment to date and SJ commended in particular the input of the anaesthetics team. However, additional resources would be needed for further development.

	The Board commended the report and sought the following additional information: • That there would be a need for additional resources to ensure delivery; these will be mapped out during the second phase of planning. • That the targets set in the Green Plan were in line with the national targets (2040 for Net Zero Carbon for direct emissions and an interim target of 80% reduction by 2028-2032). The 2025 target is based on a straight line trajectory to the mid-point of the interim target (i.e. reaching 80% reduction by 2030). • To date, the Trust has reduced its carbon footprint by 30%; some of this is as a result of energy efficiency projects, but a significant proportion is due to the reduction in the carbon intensity of grid electricity. There were no further questions and the Board **approved** the report for submission to the ICS.
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services	
07-22	**Board Assurance Framework** The Board **received** the BAFs for KSOs 1 and 2 **noting** that there were no changes this month.
08-22	**Quality and governance assurance** KN summarised her report highlighting: • An overview of the November seminar and future priorities identified by the Committee. • Issues of concern which included workforce availability, capacity resilience, service pressures from COVID and clinical fragilities. • That the Committee had taken significant assurance from the Care Quality Commission (CQC) report on the quality of the paediatric patient experience at QVH. In response to questions from the Board, KN noted that: • Further work was needed before a timeline for implementation of the quality improvement methodology could be confirmed. Proposals will be discussed at the February seminar prior to the Executive drawing up a final paper. • KN was meeting with SJ next week to progress issues of concern highlighted in the report. There were no further questions and the Board **noted** the contents of the assurance report.
09-22	**Corporate risk register (CRR)** NR presented the corporate risk register, noting that the front sheet highlighted recent changes. The Board sought additional clarification as follows: • Following the NHS Digital Cyber Security Alert in December, IT had identified those assets vulnerable to this security threat. The issue relates to both clinical and non-clinical systems and could not be managed independently by our IT team. Accordingly, additional support was provided by the Information Asset Administrator and suppliers. Whilst in some cases no further action was required, in other where a risk remained downtime was scheduled to apply the security patch. The Trust is now considering if we can reduce the risk, in which case this will be reflected in the CRR for the next reporting cycle. As a global threat, the Trust was working with both national and NHS cyber security. • Staffing levels in Canadian and Peanut wards is reviewed on a daily basis, with staff moved around the organisation to maintain safety. The Trust amalgamates wards to maintain safety when numbers are challenged, however, the Trust is able to manage some cases remotely and bring other patients in at a later date. Cancellation of activity would be the last resort. The Board noted that at present this was being managed well on a short term basis, however a different approach would be necessary for the longer term. There were no further comments and the Board **noted** the latest update.
10-22	**Quality and safety report** NR presented the latest report highlighting in particular the seasonal flu vaccination campaign currently underway, completion of the COVID booster campaign, and the appointment of the new Deputy Director of Nursing (who had joined today's meeting as a member of the public).

	Several members of the Board had asked for further clarification around implications of the upcoming mandatory vaccination requirement, as follows: • At QVH around c8% of staff are currently not recorded as double vaccinated; this includes a small number of clinical staff where vaccination status is still being confirmed. In addition, fewer than 10 clinical staff are either unable to be vaccinated for clinical reasons, or have declined the vaccine at this time. As these numbers are so small the staff group detail is not published to ensure individuals cannot be identified; however, none of these are doctors. • The Trust aims for all staff to be vaccinated in time to achieve the April national target. In order to protect our patients and staff, those staff coming to site are required to lateral flow test at least twice a week and all are fully aware of requirement to stay home if symptomatic until PCR tested. • The Trust is not currently restricting any unvaccinated individual from working, and safety is maintained through the testing regime. This reflects the practice within the region. • National terms and conditions determine that unvaccinated staff members who contract COVID would still receive sick pay. • Data around the booster vaccination programme is as accurate as it can be, and reviewed on a daily basis; the Board was reminded that not everyone is eligible for a booster due to the time lag. • Benchmarking data from other organisations shows that QVH is at the top of the league for seasonal flu and COVID vaccination rates. The Board also sought assurance around anti-microbial prescribing. The group already established to oversee compliance was to be expanded and further consideration would take place at the next consultants meeting. The Quality and governance committee was responsible for corporate oversight. There were no further questions and the Board **noted** the contents of the latest report.
11-22	**6-montly nursing workforce review** The Board received the bi-annual nursing workforce report; this reviewed the level of nurse staffing required to provide safe, high quality and cost efficient care. NR commended the Deputy director of nursing who had produced the report. NR provided additional assurance around staffing levels, and advised that the Trust was working hard to avoid declaring a critical incident. The Trust's specialty status and lack of A&E and maternity services helps to mitigate this risk; however, the Board was cognisant that this could become an issue should COVID sickness and self-isolation rates increase. There were no further questions; the Board **noted** the contents of the report, commended its quality and level of detail, and thanked all those who contributed.
12-11	**Paediatric inpatient survey results** The Board **received** the findings of the CQC Children and Young People's Survey report (2020). NR noted these were particularly satisfying given that the survey took place at the height of COVID. It was a credit to those who had worked hard to deliver excellent care despite the challenges, including relocation of the paediatric department to a non-purpose built area. Whilst commending the report, the Board also sought assurance as to what action would be taken to address the lower scores. It noted that an action plan was in development to support areas of decline and that a new matron would be joining shortly to support progress. Oversight was through the Patient Experience Group. There were no further comments and on behalf of the Board, the Chair congratulated NR and the whole team for the very positive outcome.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
13-22	**Board assurance framework** The Board **received** the BAFs for KSOs 3 and 4 **noting** that there were no changes this month.
14-22	**Financial, operational and workforce performance assurance** The Board received an assurance report on matters discussed at the meeting in November, with PDR providing a verbal update on the meeting which had taken place earlier this week.

	PDR noted that a question had been raised by a public governor on actions which the organisation had taken to reduce costs in non-essential spending for the coming 12 months. He assured the meeting there was very little "non-essential" expenditure (external audit review) and that charitable funds tend to be used for "non-essential" items, rather than revenue. In particular, he asked the Board to note that: • Traditionally the Trust is required to find 'efficiencies' every year, and this has been a problem, given its size, with the majority coming from procurement areas. Efficiencies are a wider definition than just removing costs (former cost improvement programmes) as they can also cover income generation and efficiency • The planning process for 22/23 will be where the Trust develops its plans for savings, particularly through the budget setting process and the challenge involved. The challenge to budgets is an absolutely critical element to the need for expenditure. • The 2022/23 planning guidance includes efficiencies and productivity requirements, including • the ambition in 2022/23 for systems to deliver over 10% more elective activity than before the pandemic and reduce long waits. In the longer-term this is around 30% more elective activity by 2024/25 than before the pandemic. • F&PC has been looking at productivity (for instance in theatre utilisation and now outpatients), it also has the efficiency programme, when developed, as part of its work programme to oversee its delivery. It has also looked at service reviews in specific areas.. • Responsibility for delivering efficiencies rests with the individual budget holder/director. • There are plenty of tools around to help in this area; such as GIRFT, model hospital, etc • It is important that the system's financial balance will be a key driver, and we will get additional scrutiny from the ICS and partners Noting that this was a lengthy answer, PDR hoped this provided the assurance that costs were reviewed in detail, alongside the push to deliver on activity. The Chair thanked PDR for such a comprehensive response. There were no further comments and the Board **noted** the contents of the report.
15-22	**Operational performance** The Board **received** the latest operational performance report , noting that: • The organisation continued to deliver against key cancer standards, meeting the 62-day target for 12 consecutive months, (the only provider within the ICS to achieve this). • Performance remained behind plan for 2-week waits (2-ww) and related primarily to clinic capacity and patient choice, although there had been some improvement since last month. Challenges continued within the sleep service due to staffing gaps. • The report highlighted the deep dive into the health inequalities programme at both national system and organisational level. The Board sought and received the following clarification: • The first step in the health equalities programme of work was to ensure that robust data processes were in place, with ethnic coding a key focus. The Trust was keen to prioritise long wait patients, those on cancer pathways and those with learning disabilities; it will consider what adjustments might be needed to ensure equitable provision of service. • In stepping up once again as a regional cancer hub, QVH will continue to manage its waiting list through the national clinical prioritisation/risk stratification coding as set out by NHSE, which informs theatre allocations. Further work is also planned at system level to consider how we might be able to align validation, the harm review process, and how patients can be supported to wait well. The first phase will result in a net loss of 10 theatre sessions per week. The team has modelled the potential impact and believe the Trust should achieve the year end trajectory for long waiters, although this will inevitably mean delaying some patients. Further consideration should also be given to the wider context of all service pressures, (eg. higher levels of cancellations due to COVID at present). Negotiations are currently underway between commissioners and The McIndoe Centre with regard to additional theatre capacity. • Whilst waiting lists include age and gender breakdown, ethnicity data is not complete and a data collection exercise is currently underway. • Patients with learning disabilities are within the cohort of priorities, and the Trust remains confident that our paediatric service is robust in this area. The challenge is more at point of referral and the Trust is working hard to ensure these are clearly identified to ensure consistency.

	• As the system's Senior Responsible Officer for Clinical Harm Reviews, AJ updated on the cross system work underway, including standardisation of Clinical Harm Review tools. Each organisation was taking stock and a more systematic review process was anticipated in the future. The Director of Nursing confirmed that a learning disability patient peer review was pending as a result of COVID but would proceed as soon as possible. Membership of the Sussex clinical harm review group informed what was happening at regional level. At QVH, the Clinical harm review agenda was monitored closely through the Quality and governance committee. The Chair thanked AJ for her report. There were no further comments and the Board **noted** the contents of the update.
16-22	**Financial performance** MM presented the latest financial report, noting that year to date (YTD) figures appeared anomalous due to the planning round. The Trust was working with NHSEI to rectify and the Board was assured that the Trust was planning to break-even (not report a deficit). The Board also noted the Trust was reporting a small £400k surplus as a result of an increase in capital. The Board sought the following clarification: • That considerable work had been undertaken to resolve historical issues relating to the Better payment practice code (BPPC) and we were close to achieving full compliance in this area. • Due to a timing delay, there was still no indication as to whether the system had achieved Elective Recovery Funding (ERF) but it was hoped this information would be available shortly. There were no further comments and the Board **noted** the latest update.
Key strategic objective 5: organisational excellence	
17-22	**Board Assurance Framework** The Board **received** the BAF for KSO5, **noting** one additional risk in relation to staffing levels over winter period.
18-22	**Workforce monthly report** LA presented the latest report, asking the Board to note in particular that when this year's staff survey had closed in November there had been an overall response rate of 62.1% which was an encouraging increase from 2020. LA also highlighted sickness absence levels of around 5% at present. This was not unusual for the time of year but this was being closely monitored. The Board sought and received additional clarification around the work-related stress indicator tool (WRSIT) project. This should identify themes for the HR teams to use to develop targeted communications and action plans. These themes will also inform our Health and Wellbeing Calendar and action plan for the next financial year. They will also support work with the Trust's Employee Assistance Programme (EAP) and Occupational Health (OH) providers. There were no further questions and the Board **noted** the contents of the report.
19-22	**Workforce Diversity Annual Report 2020-2021** LA presented the annual workforce diversity report for approval. This is the overarching report which enables QVH to publish information demonstrating our commitment to eliminate discrimination and harassment, promote equality of opportunity and foster good relations between different groups within our workforce. Improvements had been seen in a number of areas. The Trust remained cognisant of the challenges as set out in the WRES, WDES and Gender Pay reports (previously presented to Board). The Board was asked to note in particular: • Data contained in the report was from the previous financial year, ie. April 2020 to March 2021 at the height of the pandemic. • The report indicated an increase in workforce diversity. • An increase in levels of staff engagement. • The introduction a network of BAME panel members to participate in all Band 8a (and above) and consultant interviews.

	• As in previous years, due to the size of the organisation some percentages were not as statistically robust as they might be in larger organisations. LA highlighted in particular areas within Section 3 of the report (Diversity). • There had been a significant reduction in the number of candidates being shortlisted which reflected the drop in recruitment during the pandemic. The Board sought and received additional assurance as follows: • That the Trust would anticipate a higher number of female than male staff being managed for sickness/absence attendance due to the gender mix across the organisation. (The 75% female and 25% male mix is naturally reflected in the figures). • That just under 9% of employee relations cases for attendance involved those with a declared disability. However, as highlighted within the report it is important to note that policy management is not designed to be punitive but is there to provide a formal support framework, appropriate adjustment and independent advice to both managers and staff members concerned. • Whilst there is always more an organisation can do to improve diversity on interview panels, QVH has made good progress over the last 12 months in staff engagement and the BAME network. Steps have included growing diversity networks and the pool of individuals who can take part in diverse interview panels. It is now mandatory that all senior roles have a diverse interview panel. • That higher disclosure levels demonstrate increased confidence in staff feeling able to make a disclosure without suffering a detrimental impact as a result. A huge amount of work had been undertaken to increase declaration rates, which in turn had increased confidence in reporting. It was agreed that the Board could review effectiveness of policy interventions at a future seminar. • That for a number of years, fewer female consultants have applied and received CEAs at the Trust; this has resulted in a disproportionate outcome due to the gender mix amongst the consultant body. The action plan includes steps to encourage more female consultants to apply for CEAs; moreover, the national CEA framework has been updated since the pandemic and now provides an equal distribution to all eligible consultants. There were no further questions and the Board **approved** the report for formal submission.
Governance	
20-22	**Audit committee assurance update** The Board received an update from the Chair of the Audit committee on the recent meeting. In response to a question around compliance levels with the Standards of Business conduct policy, CP confirmed that a small number of doctors have still not yet complied but all other staff, including all consultants, were now compliant. KG noted that this was a better position than in previous years and thanked the management team for the significant progress made. There were no further questions and the Board **noted** the contents of the report.
Any other business (by application to the Chair)	
21-22	The Chair reminded those present that this meeting had been held in line with national guidance on reducing the burden of reporting and releasing capacity to manage COVID-19 pandemic. She went on to thank board members for presenting clear reports which had contained the right level of detail for NEDs to undertake robust questioning and receive appropriate assurance.
Members of the public	
23-22	**Questions from members of the public** Peter Shore, public governor asked the following: • With reference to agenda 10-22, regarding the 8% of staff reported as not double vaccinated for COVID, is it known if any of these staff are doctors or nurses? If so, what are the numbers in each category? • Will any doctors or nurses who are known not to be double vaccinated be restricted in any way in respect of their contact with and treatment of patients between now and 31 March 2022? • If a member of staff who has declined to be double vaccinated is off sick between now and 31 March 2022 because of contracting COVID, will they still be entitled to receive full contractual sick pay for the duration of their absence?

CP reminded the meeting that all aspects of these questions had been addressed by the Director of Nursing under item 10-22.

Julie Holden, stakeholder governor East Grinstead Town Council asked:

- Given the financial position of QVH and the deficit which has grown, is it the view of the board that there is no realistic proposition to be able to satisfactorily recover this position for the future, while retaining standards, staff and reputation. Therefore making a partnership or merger of some kind the best possible option for the sustainability of the hospital in East Grinstead?

  If yes, in reaching that decision, is the board satisfied that all the financial evidence of the current position and forecasts for the future have been presented to them to allow that decision to be confidently made?

  I do caveat the above that I am not asking if the board has decided to merge, this has not happened, however I am asking for a clear expression of opinion that the route being followed is that which the board are satisfied give the trust the best opportunity for the sustainable future of the QVH in East Grinstead retaining the reputation and standards of the hospital

CP responded on behalf of the Board that:

- QVH is an excellent hospital, with dedicated and skilled staff, getting patient feedback that is amongst the very best in the country. In NHS terms we are a very small organisation and as described previously that brings significant challenges. As a small specialist mainly surgical hospital, we have issues of compliance with national specifications as well as the bureaucracy of service agreements with other organisations for all the services we can't provide for ourselves. In a number of areas there is just one person who is responsible for a role in the organisation, which we know from our staff means work pressure and difficulties taking annual leave, as well as a lack of career progression. And we have a significant underlying financial deficit.

  When the Board considered the strategic case for merger in August 2021, the unanimous decision proceed to develop to development of a full business case was taken with the view that this will give the hospital the best opportunity to secure a sustainable future.

  As stated in the Board meeting, the process of FBC development will include listening to the hopes and concerns of staff, patients and other key stakeholders; and seeking assurance regarding the position of UHSussex in relation to operational performance, clinical safety, quality and finances to ensure that QVH staff and services would be joining a sustainable and high quality organisation.

  The board believes that the 'five tests' previously described remain relevant and will be an important focus in developing the FBC, supporting the Board to consider whether merger would help to:
    - further develop and invest in services
    - maintain and build on QVH's excellent record for patient experience, clinical outcomes and safety
    - continue to provide services to patients from the wide area covered currently (including Kent and Surrey as well as patients who travel much further for our care)
    - continue to deliver world class research and innovation
    - secure the future of the hospital in East Grinstead.

Tim Butler, public governor asked

- What specific actions have been agreed by the Board to reduce costs in non-essential spending areas for the coming 12 months? What is the timeline and the person responsible for execution for each of these actions?

CP reminded the meeting that a detailed response to this question had been provided by the Chair of the Finance and performance committee under item 14-22.

Tim Butler, public governor asked

- Did the Board discuss the gifting of 0.5 day of holiday to all 'substantive staff' prior to the CEO announcement of this?

- Did the Board not consider the elimination of 0.65% of total staff capacity (in the period) inappropriate given the level of absence suffered by the hospital this year during COVID?
- Did the Board make any attempt to delay or reverse the internal decision before it was announced given the fact that the CEO announced the 'gift' after it was public knowledge that a new, highly mutated variant of COVID had been discovered?

CP responded on behalf of the Board that:

- in common with other NHS staff, QVH staff have worked under a great deal of pressure and facing multiple challenges through the two years of the pandemic. The executive director team have discussed staff morale, recruitment and retention, and how to ensure continued high levels of staff performance; one of the operational decisions coming out of this was to recognise and thank staff through an additional four hours of leave for Christmas shopping, a long winter walk or whatever each member of staff chooses to do with the additional time to support their wellbeing. QVH is not unusual within the NHS in having granted additional leave to staff in recognition of the exceptional working pressures. This was an executive director decision, which was also discussed with non-executive Board members.

- Staff were informed on 25 November of the four hours additional leave to be taken by 31 March 2022, with direction about ensuring this does not impact on planned patient care. The WHO designated the variant B.1.1.529 (later called Omicron) as a variant of concern on 26 November. The Prime minister's announcement re boosters was made on 12 December. The pressures of covid are ongoing and all leave is managed around the requirements of services; there is no plan to delay or remove the additional leave and feedback from managers suggests it is being implemented with the care and consideration for patients and colleagues that we would expect from QVH teams.

<u>Caroline Migo, public governor asked:</u>

- Since the announcement that QVH has been chosen to set up as a community diagnostic centre, very little information has been shared. Can you tell us if decisions have been made regarding who will be our investment partners/service providers and if so who they are? What is the timescale for this project?

CP responded on behalf of the Board that:

- QVH is an early adopter for the community diagnostic centres, an initiative to establish services on (largely) non-acute sites to support challenges around diagnostics. The first phase is around early direct access for CT, ultrasound and MRI (which is in place). The second phase is looking at physiology testing and support for breathlessness and abdominal pain pathways.

- QVH is working with multiple NHS partners including commissioners, NHSE, the ICS and primary care. Discussions feed into the system planned care board. The only non NHS partner currently is a pilot that is taking place to enable a communication platform between referrers and QVH. Progressing the pilot was discussed through EMT and Finance & Performance Committee.

- In terms of timescales a 5 year plan is under development in line with the national ambition.

- A high level update of progress is included within the monthly Operational Report which is shared with the trust Hospital Management Team and included within F&P and Board Papers.

<u>Caroline Migo, public governor asked:</u>

- What was the HR advice to the Board and Management regarding potential discrimination claims from fulltime staff for gifting a full half day to all 'substantive staff'?

As described in answer to previous question, CP reiterated that:

- QVH staff have worked under a great deal of pressure and facing multiple challenges through the two years of the pandemic. This was not a contractual entitlement and for reasons of practicality, efficiency and to achieve the intended impact this had not been proportionally reduced for part time staff.

24-22	**Exclusion of members of the public** Aligned to paragraph 39.1 and annex 6 of the Trust's Constitution, members of the public and representatives of the press were excluded from the remainder of the meeting for the purposes of allowing the board to discuss issues of a confidential or sensitive nature. There were no further comments and the Chair closed the public session of the meeting.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**3 March 2022**		**Agenda reference:**	**35-22**	
Report title:	**Chair's report**				
Sponsor:	Anita Donley, Chair				
Authors:	Anita Donley, Chair and Clare Pirie, Director of communications and corporate affairs				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on Chair, NED and governor activities since the last Board meeting.				
Summary of key issues	Independent Review of the Trust's handling of the challenges it has encountered in progressing the merger with University Hospitals Sussex				
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
Agenda item:	35-22
Date of meeting:	3 March 2022
Report from:	Chair of the Board
Report author:	Anita Donley
Date of report:	23 February 2022
Appendices:	none

Chair's Report to the Board

Much of the time since my last report has concerned the independent review commissioned by NHSEI SE and myself as interim chair as part of the additional licence conditions imposed on the Trust by the regulator.

The Report concerned the Trust's handling of the challenges it has encountered in progressing the merger with University Hospitals Sussex. Trust Board members received the report on 2 February and at an extraordinary Board meeting on 3 February welcomed the report and pledged to implement all the recommendations of the report through a broader strategic approach which will strengthen engagement with our stakeholders, improve our governance in line with best practice, and define, through development of a Clinical Strategy, the sustainable future of QVH as a specialist tertiary centre; as a hospital for the local population; and as a provider partner in the Sussex ICS.

Our Council of Governors received the report on 3 February 2022 and considered the report at an extraordinary meeting of CoG on 21 February 2022. It is clear that there is some hard work ahead to reform and improve the ways that we enable our governors to perform their important oversight and scrutiny role. The NEDs, led by Gary Needle as senior independent director, have opened discussion with governors on how we might co-develop an improved process allowing governors insight into the work of the NEDs.

Since the last Board meeting as part of getting to know the Trust I have spent some time with staff in the minor injuries unit. The chief executive and I have also met with two local MPs, Mims Davies (MP for Mid Sussex) and Jeremy Quin (MP for Horsham).

Non-executive directors have continued to participate in a range of hospital and system meetings in order to seek assurance and triangulate information. Activity since the last public Board meeting includes chairing the appointment panel for the director of operations, attending clinical and corporate department performance review meetings, attending quality and governance sub-committees, meeting the new Chair of the Sussex ICS, meeting with the Chief Nurse of the Sussex ICS.

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

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

KSO 1&2 were reviewed at the Quality and Governance Committee, 28/02/2022. KSO 3, 4 and 5 were reviewed at the Finance and Performance Committee on 28/02/2022. Due to the Omicron surge the Trust has continued to "step up" as a cancer hub since 10th January 2022. The trust finances continue to be break even and we await further national /regional instruction regarding the financial flows. The trust is proactively managing the new and emerging risks identified as part of the restoration and recovery phase. Workforce challenges continue to be referenced in individual BAS's

	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Target risk
KSO 1	12	12	15	15	9
KSO 2	16	16	16	16	8
KSO 3	16	16	16	16	9
KSO 4	20	20	20	20	16
KSO 5	16	16	16	16	9

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/03/2022**		**Agenda reference:**	**36-22**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	1) QVH media update				
Executive summary					
Purpose of report:	To update the Board on progress and to provide an update on external issues that may have an impact on the Trust's ability to achieve its internal targets.				
Summary of key issues	• Director appointments • Elective Recovery Plan • Chief Executive appointment at University Hospitals Sussex				
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:	28/02/22	Decision:		
Next steps:					

CHIEF EXECUTIVE'S REPORT
MARCH 2022

TRUST ISSUES
Director of Operations
Abigail Jago joins East Sussex NHS Healthcare Trust on 7 March after nearly four years in the post of Director of Operations at QVH. Abigail joined QVH in May 2018 from Barts Health NHS Trust, bringing with her a wealth of experience in a range of senior operational, programme and strategic hospital roles. She has played a key role in our pandemic response and led a number of improvement programmes looking at our waiting lists and theatre productivity.

Shane Morrison-McCabe will take over from Abigail joining QVH on 21 March. Shane qualified as a nurse and lives in Bexhill-on-Sea. Currently she is deputy chief operating officer at Medway NHS Foundation Trust, where she has oversight of urgent and emergency care. She has been at Medway since April of last year. Prior to this, she held a similar role for around two years at East Sussex Healthcare NHS Trust.

Medical Director

Tania Cubison, our consultant plastic surgeon and deputy medical director, has been appointed as our new medical director. Keith Altman stepped down from the role a few months before the end of his three-year term so that we can have continuity of medical leadership as we work towards creating the full business case for our possible merger with University Hospitals Sussex. Tania joined QVH in 1996 as a senior house officer, progressing to consultant, and is the safeguarding lead for the Trust as well having been our deputy medical director.

Chief Nurse

Nicky Reeves has been confirmed as Chief Nurse. Nicky has worked at QVH for over 16 years starting as Unit Manager for the Burns ward. Prior to taking on the interim Director of Nursing role when Jo Thomas retired in November 2020, Nicky had held the role of Deputy Director of Nursing and Quality for five years.

She trained at the Hammersmith Hospital and has 35 years of nursing experience, in a range of senior posts both at QVH and in trusts around Surrey and Kent.

Nicky has been reviewing the nursing leadership within the trust.

Claire Hayward and Emma Alldridge will join David Johnson to make up our heads of nursing team. David is also our new Adult Safeguarding lead, so will split his time between the two roles.

Pictured from left: Emma Alldridge: Head of Nursing – responsible for site practitioners, Canadian Wing, and main outpatients. Claire Hayward: Head of Nursing – responsible for critical care unit, head & neck ward, burns unit, and corneo outpatients. David Johnson: Head of Nursing – responsible for Peanut ward, OMFS outpatients, and adult safeguarding. Liz Blackburn, deputy director of nursing, has management responsibility for specialist nurses including Macmillan, and the minor injuries unit.

Top awards

Danny Favor, our ophthalmic clinical nurse specialist, has been awarded The Pamana ng Pilipino Award for exemplifying the talent and industry of the Filipino overseas. The award is given to Filipinos overseas who have brought the country honour and recognition through excellence and distinction in the pursuit of their work or profession. Maribel Favor, who is also an ophthalmic clinical nurse specialist, was recognised too as part of the Filipino Nurses Association UK with the Lingkod Kapwa Pilipino Award.

Danny and Maribel

QVH chosen for Community Diagnostic Centre pilot scheme

Our hospital has been chosen to become the first Community Diagnostic Centre (CDC) in the South East of England. Commissioned by the Sussex Integrated Care System, our hospital will run a pilot scheme, starting next month, designed to provide patients with access to diagnostic tests nearer to home. The pilot scheme will start with Moatfield Surgery in East Grinstead, giving the GPs there rapid access to tests they are unable to offer in the practice and reduce the need for their patients to go to A&E.

By coming to QVH patients will be able to have a series of relevant tests or investigations, ideally all in the same day, reviewed by our multidisciplinary team, before referral back to the GP for treatment/management or on to specialists if needed. These can include a range of both scans (like CT) and physiological testing (like spirometry, a test used to see how well your lungs work by measuring how much air you exhale). The CDC will offer rapid access to a whole pathway of tests

and scans to help speed up diagnosis and treatment plans. As the CDC pathways are separate from urgent diagnostic scans and tests offered by other hospitals it will means shorter waiting times and a reduced risk of cancellation which can happen when more urgent cases take priority. This will help improve patient experience and reduce waiting lists for diagnostic tests.

MPs

The chair and chief executive recently met virtually with two local MPs, Mims Davies and Jeremy Quin, on 14 February to discuss our potential merger discussions with University Hospitals Sussex. In a subsequent blog, Jeremy Quin wrote that he "….was reassured that the Hospital's fundamental focus is on how they continue to provide the very best healthcare to local people and maintain their international reputation over the long term. Every part of the NHS needs to consider on an ongoing basis how best to manage themselves to support the frontline and provide patient care."

Integrated Performance Dashboard Summary

Unfortunately due to the data being unavailable at the time of going to print, the dashboard is not available this month.

Board Assurance Framework (BAF)

The entire BAF was reviewed at executive management meeting (21/02/2022) alongside the corporate risk register. KSO 1 and 2 were reviewed at the Quality and Governance Committee, 28/02/2022. KSO 3, 4 and 5 were reviewed 28/02/22 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 1) during December 2021 and January 2022, including coverage of QVH's very positive results in the Care Quality Commission Children and Young People's Patient Experience Survey, and QVH's role as a cancer surgery hub.

SUSSEX SCENE

Chief Executive appointed to University Hospitals Sussex

University Hospitals Sussex NHS Foundation Trust has appointed a new Chief Executive, Dr George Findlay. He will succeed Dame Marianne Griffiths, who is retiring after almost 14 years in charge across UHSussex and its predecessor organisations Western Sussex Hospitals (WSHT) and Brighton and Sussex University Hospitals (BSUH).

Dr Findlay has been interim Chief Executive at Medway NHS Foundation Trust since May 2021. Before joining Medway, Dr Findlay spent seven years at Western Sussex Hospitals (WSHT) in roles including Medical Director, Chief Medical Officer and Deputy Chief Executive.

NATIONAL SCENE

Delivery plan for tackling the COVID-19 backlog of elective care

NHS England published their Delivery Plan for Tackling the COVID-19 Backlog of Elective Care on 8 February. It sets out a clear vision for how the NHS will recover and expand elective services over the next three years. It details ambitions, guidance, and best practice to help systems address key issues, fit for the future.

A central aim is to maximise NHS capacity, supporting systems to deliver around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance.

The plan will require significant investment in the capacity and skills of our staff while ensuring that our workforce is supported to deliver the task ahead.

The plan requires a collective focus to:

- Increase capacity and separate elective and urgent care provision, while freeing clinicians' time for new patients and those with the greatest clinical need
- Prioritise diagnosis and treatment for those with suspected cancer or an urgent condition, and offering alternative locations with shorter waiting times for those waiting a long time
- Transform the way we provide elective care, including streamlined care and fewer cancellations, and more convenient access to surgical and diagnostic procedures, using digital tools and data to drive the delivery of services
- Better information and support to patients, providing personalised, accessible support to patients whilst they wait, improving outcomes and reducing inequalities in health outcomes.

Crucially, the plan has a strong focus on improving patient outcomes and their experience of NHS services. NHS England want to work with providers to:

1) Make progressive improvements on long waits, with a goal to eliminate waits of over one year by March 2025, and waits of over two years by July 2022. We know that some patients will still choose to wait longer, and there will be challenges in particular specialties, as before the pandemic.
2) Reduce diagnostic waiting times, with the aim of least 95% of patients receiving tests within 6 weeks by March 2025.
3) Deliver the cancer faster diagnosis standard, with at least 75% of urgent cancer referrals receiving a diagnosis within 28 days by March 2024, and return the 62 day backlog to pre-pandemic levels by March 2023.
4) We will work with patient groups and stakeholders to better monitor and improve both waiting times and patients' experience of waiting for first outpatient appointments over the next three years.

Although we are on target for eliminating patient waits of over two years by 31 March 2022, one of the most significant challenges for next year will be reducing outpatient follow-ups by 25% by 31 March 2023.

Integration plan

This paper sets out our legislative proposals for a Health and Care Bill. It aims to build on the incredible collaborations that have been seen through COVID and shape a system that's better able to serve people in a fast-changing world. Outlining steps to support everyone who works to meet people's health and care needs:

1. By removing the barriers that stop the system from being truly integrated.
2. The use of legislation to remove much of the transactional bureaucracy that has made sensible decision-making harder.
3. Proposals will ensure a system that is more accountable and responsive to the people that work in it and the people that use it.


Department of Health & Social Care

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

Published 11 February 2021

The Department of Health and Social Care's legislative proposals for a Health and Care Bill

CP 381

Steve Jenkin
Chief Executive

QVH media update – December 2021

Potential merger update
The HSJ (behind the paywall) ran an article explaining how the timeline for the development of a full business case for the potential merger of Queen Victoria Hospital and University Hospitals Sussex has been delayed to focus on operational pressures. It has been agreed that the focus for the next 4-6 months will be on clinical leads in both organisations working together to identify what improvements a joined up service could bring for patients and staff.

Children and Young People highly rate Queen Victoria Hospital
The news that Queen Victoria Hospital received some of the best results in the country from its youngest patients in the latest Care Quality Commission Children and Young People's Patient Experience Survey, was featured on the InYourArea website. The hospital was one of only three trusts in the country to score 'much better than expected' for patients aged 8 to 15 years old, the top band of the survey, and one of only eight trusts to score 'better than expected' for patients aged 0 to 7 years old.

Funds to support the NHS
A press release on the Government's website talks of how £700 million is being given to support the NHS this year, funding initiatives and projects to help tackle waiting lists and improve care. Queen Victoria Hospital is listed in a table, under South East NHS organisations, who will be allocated money. The investment will be used towards providing two new modular theatres situated alongside the see and treat clinic (Location 26), replacing two old day surgery theatres. They will be suitable for a wider range of surgery and will enable us to increase our elective activity.

Targeted Muscle Reinnervation surgery
An article in the Autumn/Winter issue of Blesma Magazine, the members' magazine for Blesma, the limbless veterans charity, featured an article about Lexi Chambers and Tania Cubison, our consultant plastic surgeon. In the piece written by Lexi, she explains how she had eight unsuccessful operations in eight years to try and "calm the chaos" of complex regional pain syndrome (CRPS) before she was referred to Tania. She says "Tania literally changed my life... before the surgery I could only focus on the daily battle with the pain."

Lexi is one of around only 60 people in the UK to have had Targeted Muscle Reinnervation (TMR) surgery that attaches nerve endings to other nerves to minimise the pain they cause in amputated limbs. Tania performed a four hour operation at Queen Victoria Hospital in June.

Call to increase cancer surgery capacity
An article in the HSJ on 21 December (behind the paywall) explained how charity Cancer Research UK is calling for the rapid reopening of cancer hubs, which saw independent hospitals used by the NHS to protect urgent surgery during previous Covid waves. This comes as hospital intensive care units are under strain from both Covid and normal winter emergency care pressures.

The piece says that the HSJ "understands there are discussions about restarting a hub at Queen Victoria Hospital" and at that stage no decision had been announced. QVH has been working as a cancer hub again from 10 January 2022.

Virtual assessment in hand trauma
The docwirenews website listed an article entitled "Accuracy of virtual assessment in hand trauma" as its news featured reading. The article, originally published by JPRAS, was written by Queen Victoria Hospital clinicians Suzanne Westley, Rikki Mistry and Baljit Dheansa, about how the hospital developed a virtual clinic, based on an existing telemedicine system, to manage hand trauma during the first wave of the pandemic.

McIndoe mentions
Following on from the article in The Spectator last month about the creation of a musical about Sir Archibald McIndoe, Sam Gallop CBE, chairman of the Guinea Pig Club, wrote a letter entitled "McIndoe, my hero." Rob Kendrick also wrote to The Spectator asking that creator of the McIndoe musical, includes Rauceby in his research (Fenton Braithwaite undertook surgical work there before being asked by McIndoe to join him after the war at Queen Victoria Hospital).

Ad hoc mentions
One of Queen Victoria Hospital's patient information leaflets was cited in the Daily Mail this month in a story about how a 38 year old man from New York found a tooth in his nose. The rare case of an 'ectopic tooth' was affecting his ability to breathe. The article quoted part of a patient leaflet about ectopic teeth. The article was also featured on the nation.lk website.

KentLive ran an article about Freddie Shaw, a 21 year old, who fell whilst ice skating for the first time and came to Queen Victoria Hospital for facial stitches. In the piece, Freddie's dad is calling for better health and safety information and the provision of helmets. InYourArea also covered the story.

The hospital was also mentioned in an article in Livingetc magazine about how to sleep better. As well as discussing good bedroom design and sleep hygiene, it talks about how Queen Victoria Hospital is one of a handful of sleep clinics to offer CBTi, or cognitive behavioural technique for insomnia. The technique works by removing the negative associations of the bedroom and replaces them with new, positive connections. Eventually, your body recognises that when in bed, its only job is to sleep.

Press releases
In December we published the following press releases:

- Formula 1 donates film prize, awarded for footage of Romain Grosjean's fireball escape, to QVH
- QVH gets a thumbs up from its youngest patients

In December we published the following information on our website

- What's happening about the possible merger?
- Coronavirus information and advice for our patients and visitors – update of standing item
- Looking after yourself this winter

QVH media update – January 2022

Stepping up as a surgical cancer hub
Queen Victoria Hospital's role as a surgical cancer hub was featured in The Argus as part of an article explaining NHS Sussex's 'surge plan' to ensure patients across the county are cared for and staff are supported amid significant pressures due to high rates of Covid-19. The hospital has been working as a cancer hub again since 10 January 2022. This was also mentioned in the news bulletins on Heart South News radio station on Sunday 16 January, and in an article on the Sussex World website as part of a request for Eastbourne residents to 'play their part' in the fight against Omicron.

At the start of the month Sussex Live did a roundup of the number of people in hospital in and around Sussex with Covid-19 and referenced Queen Victoria Hospital as having zero, hence our role as a surgical cancer hub.

Independent review
The HSJ ran an article (behind the paywall) about the launch of an independent review commissioned by NHS England and NHS Improvement South East Region and Anita Donley the newly appointed interim Chair of Queen Victoria Hospital to explore QVH's handling of challenges encountered in progressing a merger proposal with University Hospitals Sussex NHS Foundation Trust. The review will be conducted by management consultants Carnall Farrar.

Immediate image access to enhance patient care
News that a consortium of five NHS trusts across Surrey and Sussex, including Queen Victoria Hospital, have chosen company Sectra to deploy a new picture archiving and communication system (PACS), received a series of media mentions. The project will introduce a cloud-based solution designed to help professionals to make faster and better informed decisions to provide enhanced care to their patients. Outlets to feature the news include PR Newswire; DigitalHealth; The Health Guild; and UKAuthority.

£1 million grant for the future of surgical training
Professor Jag Dhanda, a Consultant Maxillofacial/Head and Neck Surgeon at the Queen Victoria Hospital and Honorary Professor of Surgery at Brighton and Sussex Medical School has received a £1m grant from Health Education England to develop virtual reality and augmented reality surgical training resources. The news was featured on the BSMS website.

Amanda Redman shares memories of being a patient
To coincide with the start of the new series of medical drama Good Karma Hospital, actress Amanda Redman was interviewed by The Sun about the burns on her arms. She explains that she pulled a vat of boiling soup over her as a young child and received treatment for many years at Queen Victoria Hospital. Amanda explained: "Even though 90 per cent of my body was burned, the worst scars are on my [left] arm, but that's it and that's thanks to the amazing work of the hospital." The article also featured in The Scottish Sun.

Here for you this winter
Our Minor Injuries Unit received a full page article in the Winter edition of Community News, a free publication distributed to 4,000 local homes. It outlined the injuries and illnesses the team can see, diagnose and treat and its role as an alternative to A&E for conditions that are not severe or life

threatening.

Ask our ambassador
The January issue of East Grinstead Living magazine featured a full page Q&A with Will Bayley MBE, QVH Charity's latest ambassador. Will explains how the role is his way of being able to give something back having spent a lot of time in NHS hospitals as a child, and how it has given him an appreciation of the difference charity funding can make in purchasing the extra equipment and items that make an impact when you are staying or being treated in hospital.

Ad hoc mentions
Queen Victoria Hospital also received a mention in a series of ad hoc media pieces this month, including in a 90 seconds with article on the Dentistry Online website where interviewee Annika Patel explains how she had specialist training in orthodontics here and at Guy's Hospital. The BMJ ran an obituary for Jean Horton who did her junior anaesthetics training at Queen Victoria Hospital and other hospitals. The Brighton and Hove News website ran a story regarding a patient due to come to Queen Victoria Hospital for an appointment being charged after attacking an ambulance driver.

Press releases
In January we did not publish any press releases or update news on our website.

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed 16th February 2022

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 and patient safety. When patient experience is in conflict with providing a safe service, safety will always be the highest priority

Initial Risk 4(C) x 2(L) = 8 low
Current Risk Rating 3(C) x 5 (L) = 15 mod
Target Risk Rating 3(C) x 3(L) = 9 low

Rationale for risk current score
- Compliance with regulatory standards
- Meeting national quality standards/bench marks
- Very strong FFT recommendations
- Sustained excellent performance in CQC 2020 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
- Increasing challenge with recruitment, particularly Head and Neck unit and paediatrics. Risk register have been updated to reflect these challenges

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
- 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
- Red, 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 mandated via "Trac 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: 18th February 2021

Strategic Objective
We provide world class services, evidenced by clinical and patient outcomes. Our clinical services are underpinned by our high standards of governance, education research and innovation.

Risk

1. Potential for harm to patients due to long waits for surgery
2. Maintaining safe & effective clinical services evidenced by excellent outcomes & clinical governance

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

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

Rationale for current score

- Adult burns ITU and paediatric burn derogation
- Paediatric inpatient standards and co-location
- Compliance with 7 day services standards
- Spoke site clinical governance.
- Consultant medical staffing of Sleep Disorder Centre & Histopathology
- 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
- Antibiotic stewardship

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 University Hospitals Sussex

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
- ~~Antibiotic task & finish group~~
- Senior clinicians meetings to review Microguide and appoint specialty antimicrobials champions

Gaps in controls and assurances:

- Link between internal data systems & external audit requirements & programs
- Limited data from spokes/lack of service specifications
- Achieving sustainable research investment
- Sleep disorder centre sustainable (~~medical~~) staffing model & network
- Antimicrobial prescribing (CRR 1221)
- Repeat prescriptions in Sleep (CRR 1164)

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**3 March 2022**		**Agenda reference:**	**39-22**	
Report title:	**Corporate Risk Register: to February 23rd 2022**				
Sponsor:	Nicky Reeves, Chief Nurse				
Author:	Karen Carter-Woods, Head of Risk, Clinical Quality & Patient Safety				
Appendices:	None				
Executive summary					
Purpose of report:	For assurance that the Trust risk management process is being followed; new risks identified and current risks reviewed and updated in a timely way.				
Summary of key issues	The Corporate Risk Register reviewed at two subcommittees of the Board: Quality & Governance (Patient Safety Risks) and Finance & Performance (remaining Risks) The full corporate risk register is bought to board for review and discussion Key changes to the CRR this period (Jan to Feb 2022): • Eight new corporate risks added • One corporate risk closed • One corporate risk 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:** *Outstanding patient experience*	**KSO2:** *World-class clinical services*	**KSO3:** *Operational excellence*	**KSO4:** *Financial sustainability*	**KSO5:** *Organisational excellence*
Implications					
Board assurance framework:	The entire BAF has been reviewed by EMT alongside the CRR, The corresponding KSOs have been linked to the corporate risks.				
Corporate risk register:	This document				
Regulation:	All NHS trust are required to have a corporate risk register and systems in HMT place to identify & manage risk effectively.				
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.				
Resources:	Actions required are currently being delivered within existing trust resources				
Assurance route					
Previously considered by:	Finance and performance committee:				
	Date:	28/02/2022	Decision:	All risks except ID1255 noted	
Previously considered by:	Quality and governance committee				
	Date:	28/02/22	Decision:	All patient safety risks except ID1251 & ID1253 noted	
Next steps:	NA				

Corporate Risk Register Report
January and February 2022 Data

Key updates

Corporate Risks added between 01/1/2022 and 23/2/2022: eight

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x4=12	1245	Junior Doctor Rota Management: Plastics	GM & Service Manager
3x4=12	1247	Lost first appointments from tertiary referrals: Plastics skin	GM & Service Manager
4x4=16	1248	Reduced staffing levels: Covid testing laboratory	GM & Laboratory Services Manager
3x4=12	1249	Sentinel Lymph Node Biopsy (SNLB) Wait List: capacity issues	GM & Service Manager
4x4=16	1250	Additional licence conditions	CEO and DoC&C
3x4=12	1251	Untracked Oncology Patients	GM & Service Manager
3x4=12	1253	Patients not added to Waiting List: Plastics	Service Manager
3x4=12	1255	Sterile Services provision failures	Deputy Theatre Manager

Corporate Risks closed this period: one

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x4=12	1241	SG named Nurse and MCA lead Post vacancy	R/V: Chief Nurse Adult Safeguarding and MCA lead now in role

Corporate Risks rescored this period: one

Risk ID	Service / Directorate	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore
1242	IT	Cyber Security Vulnerability - Apache Foundation Log4j 2	5x5=20	5x3=15	Review: DoF&P and CIO Potential impact reduced • Probability of an attack has reduced as less endpoints are vulnerable • We have more knowledge and understanding of the exploit • local remediation plan created and updated by IT

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 70 risks on the Trust Risk Register as at 23rd February 2022, of which 30 are corporate, with the following modifications occurring during this reporting period (January to February 23rd incl):

- Eight new corporate risks added
- One corporate risk closed
- One corporate risk 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 below shows the 30 corporate risks open on the trust risk register as at the 23rd February 2022.
Three corporate risks are within the higher grading category:

	No harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2			**4**	**3**	**2**
Possible 3		**4**	**25**	**5** ID: 834, 968, 1192, 1210, 1226,	**1** ID:1242
Likely 4		**1**	**12** ID: 1040, 1077, 1217, 1235, 1236, 1240, 1245, 1247, 1249, 1251, 1253, 1255	**2** ID1250, 1248	**0**
Certain 5		**1**	**9** ID1140, 1189, 1198, 1199, 1221, 1225, 1231, 1238, 1239	**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	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1255	17/02/2022	Sterile Services provision failures	Our off site sterile services provider STERIS IMS is in business continuity due to severe staff shortages.□ The risk is not being able to deliver any services relating to theatres and outpatient clinics that require sterilized equipment	The sterile services equipment team leader meets daily with the customer service manager of STERIS IMS to ascertain what is required to deliver the service on a daily basis.□ There are weekly meetings with the decontamination lead, sterile services equipment team leader and general manager from STERIS IMS	Abigail Jago	Malcolm Dorman	Compliance (Targets / Assessments / Standards)	12	9		KSO2 KSO3 KSO4 KSO5
1253	15/02/2022	Patients not added to Waiting List: Plastics	Patients not added to the Waiting List on Patient Centre.□ □ Patients can be missed as by not being added onto the waiting list on patient centre, there is no way of knowing that they have been "added" to the wait list. They are not therefore tracked on the PTL. □ Several incidents have been raised within plastics.□	1. All med secs have now been asked to ensure that when typing clinic letters, they automatically search in patient center to ensure that an "addition" to wait list is not missed.□ 2. Evolve have developed a waiting list report that will be distributed weekly to cross check the PTL to ensure no patients are missed. Unfortunately, this cannot be done retrospectively	Abigail Jago	Barbara Raine	Patient Safety	12	6		KSO1
1251	01/02/2022	Untracked Oncology Patients	Patients on an 18 week pathway who have a routine or urgent referral outpatient appointment/ or triage who does not have an appropriate consultant oncology upgrade implemented when cancer is suspected.	SOP distributed to Admin Team (August 2020) outlining the correct management of this process.□ RTT Training planned on 15 Feb 2022 for medical secretaries.□ Future COMS planned by Head of Access and Performance to Consultants about the correct process of upgrading patients onto the Consultant Upgrade pathway.□ Validation work underway to identify patient cohorts for escalation.□ Service manager meeting with skin lead consultant to discuss processes in place and future mitigation of risk.□ Patients coded by consultants as P2 regardless of failure to upgrade.	Abigail Jago	Phillip Connor	Patient Safety	12	9	**February 2022**: escalated to Skin Lead Consultant, service manager and skin lead met to discuss Skin lead requested to review list of 51 patients identified as untracked oncology patients between 27.1.22 and 11.2.22 January 2022: Service Manager actioned data capture process with schedulers to help fully understand level and volume of risk and circulated Consultant Upgrade SOP to Plastics medical secretaries. Following escalation by the Patient Safety and Governance Facilitator themed incidents around untracked oncology, Service Manager escalated to Head of Access and Development and General Manager and commenced initial investigation to establish level of risk	KSO1

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1250	24/01/2022	Additional licence conditions	Breach of additional licence conditions.	Interim Chair in post□ Independent review jointly commissioned by NHSEI and QVH to make recommendations which will help resolve conflict and to build a consensus□ Communication of the change in licence conditions to all relevant stakeholders and discussion about the implications. □ Remedial action will be taken once the results of the review are published. □ Discussion at Board and CoG and development of an action plan that will be monitored by the regulator.□ □ The objective (target risk) - removal of the licence conditions by regulator□	SJ	Clare Pirie	Compliance (Targets / Assessments / Standards)	16	12	**February 2022** - Independent Review document being discussed and action plan being compiled	KSO3 KSO5
1249	17/01/2022	Sentinel Lymph Node Biopsy (SNLB) Wait List: capacity issues	Rise in demand to perform Sentinel Lymph Node Biopsy for skin cancer□ Not enough capacity in theatres & clinics to undertake them all□	Escalation protocol in place to Service Coordinators to increase capacity.□ Weekly Review by Service Co-ordinators and Cancer Pathway Trackers□ Extra Clinics added where possible	Abigail Jago	Phillip Connor	Patient Safety	12	6	**22 February 2022** - scoping out scale of demand and organising additional capacity to even out peak in demand. It is expected that periodically and responsively introducing extra capacity will help to even out the peaks in demand. We will need to confirm this, however, once we have better data. PC	KSO1
1248	04/01/2022	Reduced staffing levels: Covid testing laboratory	Infection with Covid-19□ □ Delays or cancellations of procedures and operations leading to patient harm□ □ Loss of income to Trust	Scientific staff on short term contracts - minimally trained; staffing numbers being explored to provide ongoing resilience.	Abigail Jago	Sue Aston	Patient Safety	16	8	26.01.2022 - POAP resubmitted to EMT, staffing model approved, to be placed into BP for 2022/23. Senior team advised to begin recruitment process for the approved staffing model. 20.01.2022 - POAP for increasing staffing model to ensure stability. Requires further work as proves to be a significant cost pressure for the Trust. To update following further discussions and to return to EMT once further information available.	KSO1 KSO2 KSO3 KSO4 KSO5
1247	10/01/2022	Lost first appointments from tertiary referrals	Lost first appointments from referral to QVH.	Review underway of processes in place for the management of PTL.□ □ PTL being validated from 22nd January□	Abigail Jago	Phillip Connor	Patient Safety	12	9	**February 2022:** (Service Manager review)□ Improved processes designed by working group led by service manager.□ New paperless process in place for whole trust.□ Service Manager has drafted a temporary Referral Management SOP for approval at DEC on 23.2.22.□ Development of referral/triage process on Evolve in development for roll out in March/April - Service Manager leading development.□ Validation work on PTL - extra support in place with weekend validation	KSO3

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1245	10/01/2022	Junior Doctor Rota Management: Plastics Surgical	Rota manager on long term sick leave. □ No substantive post holder to cover that work and no clear processes/SOP in place. □ □	1. Service co-ordinator is managing rota with assistance of admin support□ 2. Manual process now improved rota management to 6 weeks in advance - remains dependant on staff with competing duties & completion of consultant job plans in order to inform rota□ 3. Draft SOP initiated□ □ PROPOSED ACTION□ □ 1.□Management of Rota further in advance and formalise processes□ 2.Create Standard Operating Procedures SOP□ 3.□Band 4 admin support to undertake band 5 role as rota manager for 3 months as of Jan 2022 and support Rota Manager's phased return from long term sick leave□ 4.□Migration to Healthroster planned for early 2022□ 5. Review of WTE requirement in department to manage workload□	Abigail Jago	Phillip Connor	Compliance (Targets / Assessments / Standards)	12	9	**22/02/2022** - rota SOP authored and awaiting approval; Band 5 and 6 supporting with rota (greater investment of resource to support the process); JCST being retrospectively audited by trainee lead; recruitment practices adjusted to improve stability and far-sightedness; transition to manage rota via Healthroster (programme entitled 'Activity Manager') (proposal written and conveyed to Executive Director for HR to agree next steps); employment of two further trainees to fortify the rota; employment of trainee lead to facilitate clinical oversight of rotas. Rota Task and Finish Group set up. Improved processes in place. □ □	KSO3
1242	24/12/2021	Cyber Security Vulnerability - Apache Foundation Log4j 2	A security vulnerability has been found within "Log4j". □ This vulnerability is already being exploited by some cyber attackers internationally, though not yet here in the UK. □ Cyber criminals are actively scanning for this vulnerability on systems worldwide and in the UK. □ Scanning has been detected on some NHS systems. □	Communication Plan (cyber security reminders to staff, system downtime)□ Initial Mitigation/ Prevention Plan (Anti Virus Software, Firewall, IPS, Windows updates, on going cyber security scanning for vulnerabilities)□ Detailed Remediation Action Plan□ Identify all vulnerable systems □ Engagement with Information Asset Administrators (IAA) and Suppliers□ Control Centre□ Provide regular and timely updates on progress via the NHS Digital 'Respond to' and NHS Cyber Alert portal □	Michelle Miles	Nasir Rafiq	Information Management and Technology	15	4	Update 07/01/2022: ongoing weekly meetings to identify Information Assets (IT Devices / Medical Devices / PACS Modalities)with the Log4j security vulnerability. Engagement with suppliers of applications, system and hardware to provide mitigation and remediation. work is ongoing and considerable work has been achieved with to reduce the cyber security risk.□ □ Update 14/01/2022: Potential Impact has reduced as no device has the specific high carecert (CVE) vulnerability however, we have 22 instances of the Log4J installed on servers/PC's that are unaffected by the HIGH carecert but require upgrading to the new version.□ •Single Medical device asset list is not captured, work is being completed by KS/NR to pull together this list and work is ongoing to contact suppliers about their devices to know if they are impacted □ •Probability of an attack has reduced as less endpoints are vulnerable□ Additional controls have been put in place on our network boundary and firewalls (additional control being added to firewall / IPS – 14th Jan (subject to RFC approval)) □ •We don't have control over third parties and their timescales to get these patches installed / tested for their systems (the 22)□ •We have more knowledge and understanding of this exploit and run multiple scans which is monitored□	KSO1 KSO2 KSO3 KSO4 KSO5

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1240	19/11/2021	Unregulated use of data sharing apps	IG and IT are aware that there is use of data sharing apps at the Trust which could pose significant data security risks if unregulated or used for business purposes on personal devices	Trust owned devices have a strict AD and policy security group profile installed. This does not allow any unapproved data sharing apps unless agreed at local level.	Michelle Miles	Dominic Bailey	Information Governance	12	6	**17/02/22**: PC's and laptops have AD and group policies in place to prevent users from installing software.□ Mobile devices, (e.g. IoS and android) are managed by Trust mobile device management, (MDM) controls.□ Only software that has been approved by the Trust IT Working Group is permitted upon submission of a formal request.□ No controls in place for staff personal devices.□ MDM policy will be reviewed at Information Governance Group, (IGG) 03/05/22□ Communications to all staff regarding use of apps will be reviewed by IGG 01/03/22 - subsequent dissemination.	KSO3
1239	02/11/2021	Canadian Wing Staffing	Unable to fulfil the rota requirement	management of activity	Nicola Reeves	Liz Blackburn	Patient Safety	15	6	**February** - Evidence that incentives are having positive impact on uptake of bank shifts. International Recruitment options being considered.□ November - EMT have approved a paper to address staffing challenges using a range of incentives to encourage applicants	KSO1 KSO2 KSO3 KSO4 KSO5
1238	02/11/2021	Peanut Ward Staffing	Lack of staff to fulfil the rota requirements	Control of activity at night to maintain safety□ TDS review of staffing	Nicola Reeves	David Johnson	Patient Safety	15	6	**February 2022** - Ongoing review. Consideration of international Recruitment to address staffing shortfall.□ January - New matron due to start March. Enhanced bank rates now in place. Welcome bonus being introduced. Vacancy rate 20%□ November - New Matron appointed, pending start date. EMT have approved a range of measures to encourage recruitment	KSO1 KSO2 KSO3 KSO4 KSO5
1236	26/10/2021	Inappropriate generic Inbox Info@qvh.nhs.net	Historically and possibly inappropriately, the Patient experience manager was responsible for this inbox. The volume of emails is significant and many are including patient's identifiable information, imagers, referral etc. There is a significant risk of loss of information, missed referrals, IG breaches.	Inbox being managed by Risk team currently	Nicola Reeves	Karen Carter-Woods	Patient Safety	12	6	**February 2022** - Continues to be managed with additional admin resource. Consider re assessing with a view to this becoming a local risk□ January 2022 - admin employee assigned to oversee inbox, back up in the event of absence being progressed□ November - QVH website has been updated with a list of email contacts to support patients emailing the appropriate department. Temporary solution to cover the workload being explored.	KSO1
1235	22/10/2021	Head & Neck Unit Roof	Roof in H&N leaks when there is heavy rainfall. The leaks occur in patient rooms and the nurses station area. This poses a potential safety risk to staff and patients. It also poses a risk to reputational damage if patients post videos to social media or share with the press.	Estates have made some minor fixes but this hasn't stopped the leaking. Estates are attempting to source contractors to repair/replace the roof. □ There are discussions about having to relocate the H&N ward until it is repaired/replaced.	Michelle Miles	Phil Montague	Estates Infrastructure & Environment	12	3	14/01/22 Velux windows which is felt to be a cause of a lot of the water ingress set for replacement late January with roof replacement captured as part of 22-23 capital plan	KSO1 KSO2 KSO3 KSO4

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1231	04/10/2021	Late tertiary cancer referrals	The trust is receiving up to 26 late cancer referrals a month and around 45-50% are past 62 days. □ The trust is treating around 90% of patients within 24 days however these patients are on our PTL and in our weekly PTL reported numbers.	unable to control externals late referrals, however:□ Weekly national/regional reporting. □ Twice weekly cancer PTL meetings which goes through each individual patient ensuring they have a next step booked within time. Escalations are sent out after each meeting. □ PTL is widely distributed across the trust, including admin and clinical staff. □ □ The responsible Committee should be the Cancer Board who meet monthly.	Abigail Jago	Victoria Worrell	Compliance (Targets / Assessments / Standards)	15	9	27.01.2022 - challenges continue, number of patients referred over 104 remain high. Update ICS on weekly cancer managers call, continue to have weekly calls to monitor with providers.□ November: ongoing challenge' level of mitigation via weekly escalation calls with key referring providers	KSO3
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	Tania Cubison	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	8	**February 2022** - Specialised Commissioning continuing to work on case for change and options appraisal for provision of a compliant burns service□ 15/12/21: NHSE Specialised Commissioning leading work on Case for Change and Options Appraisal	KSO1 KSO2 KSO3 KSO5
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	Claire Hayward	Patient Safety	15	6	**February 2022::** International Recruitment being considered to address staffing shortfall. January - Enhanced bank rate in place. Welcome bonus due to be introduced. Significant vacancy remains with 47% of posts remaining vacant. November - EMT have approved plans to increase recruitment October - Update 26.10.21 Re-templated the establishment to incorporate a Band 7 Matron (0.60WTE) and staffing of 2+1 on day shifts. Currently a clinical vacancy rate of 44% August - Update 17/08/2021 Establishment remains at 6.82 WTE. However some staff are leaving. Full details below: B6 = 4.75 WTE in post B5 = 1.0 WTE in post. 1 WTE is applying from C-Wing to join but the current B5 is interested in applying for CCU. B 4 = 1.07 in post – both will be leaving as above for CCU as a split role between HNU and CCU. It is anticipated that establishment will reduce to 5.75. HNU jobs are now being advertised after a delay from finance sign off, also going out for 2.0 WTE Nurse associates. July - still awaiting formal upload of budget to allow further recruitment to be undertaken. Flexible workforce being used as available. Activity continues to fluctuate. October - Update 26.10.21 Re-templated the establishment to incorporate a Band 7 Matron (0.60WTE) and staffing of 2+1 on day shifts	KSO1 KSO2

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
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.	Tania Cubison	Judy Busby	Patient Safety	15	9	**February 2022**: Incoming MD working collaboratively with Clinical Leads□ July: anti-microbial stewardship group formed, to meet fortnightly - MD to chair	KSO1 KSO2
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	Clare Pirie	Compliance (Targets / Assessments / Standards)	12	6	**February 2022**: Reported to Board, shared with Council of Governors, and published on public website 22 February 2022. Board confirmed commitment to ensuring the recommendations are implemented□ 15/12/21: Independent review jointly commissioned by NHSEI & QVH looking at engagement of stakeholders during the past twelve months. Will report to Chair and NHSEI in January 2022	KSO3 KSO5
1210	09/02/2021	Pandemic Flu Covid-19 Clinical Challenges	Staff required to work in different ways□ National guidance being updated on regular basis□ Adverse impact on patient experience - particularly linked to restricted visiting and infection control recommendations□ Potential Covid-19 outbreaks in either workforce or patient cohorts	R&R governance meetings weekly□ Open door IPACT policy□ Generic email address for queries or concerns □ Case by case management regarding visiting restrictions□ Asymptomatic staff testing both via Lateral Flow and Optigene□ Patient screening pre admission□ Optigene screening for trauma patients□ Management of "accompanying" carers with patients coming to OPD□ Remote check in to avoid numbers in waiting rooms□ Virtual clinics when possible □ □	Nicola Reeves	Karen Carter-Woods	Patient Safety	12	8	**February 2022** - All national guidance reviewed and changes made to policy as required. This is then managed via the IAPCT governance routes. IPACT BAF reviewed and presented at Q&G. □ November - QVH continues to apply rigorous IPACT precautions and use Optigene and lateral flw to manage the staff risk. PPE and social distancing are maintined□ 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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
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	Claire Hayward	Patient Safety	15	9	January - Enhanced bank rate in place. Welcome bonus due to be introduced. Recently lost 4 Band 6 SSN's. 26% of posts remain vacant including 50% of Band 5 SN posts.□ November - EMT have approved a range of measures to encourage increase in bank uptake and to support recruitment□ October - Update 26.10.21□ Current clinical vacancy of 23%. Three new Band 5's due to start (2.53 WTE) however they have limited/no ITU experience. There is also 4 Band 6's (3.67WTE) due to leave in the next few months after achieving promotion. It is important to note that we will be losing 4 experienced ITU nurses who are able to look after ventilated patients and take charge of the unit. This has the potential to impact on our ability to accept patients if we are unable to safely staff the unit. Recruitment is ongoing but remains a challenge. Attracting temporary workforce is also proving a challenge and work has been started to ensure we are offering the same hourly rates as our surrounding trusts.□ August - □ B2 = 1.81 WTE vacancy with another 1.0 WTE leaving for TNA role. □ B4 = 0.11 WTE vacancy, with both in post leaving to do nurse training (one finishes 22nd August, another 27th September leaving a 1.03 WTE vacancy. □ B5 = 3.58 WTE vacancy. Currently have 1.0 WTE band 5 seconded to HNU. Now on a rolling advert, last advert had 50 applicants all of which were	KSO1
1198	09/03/2021	Medical Workforce Sleep Unit	Risk to long-term stability of diagnosis and prescribing for patients in Sleep Unit due to age profile >60 years and retired status of majority of existing substantive medical workforce. Requires succession planning.□	Current Workforce <60 years old/not retired:□ 1 PA - respiratory and sleep disordered breathing - locum/bank□ 8 PA - Associate Specialist Registrar sleep disordered breathing and sleep - bank/locum >2 years.□ Succession/strategy planning underway.□ □	Tania Cubison	Philip Kennedy	Patient Safety	15	9	**22/2/22**: New clinical lead appointed for Sleep Unit. Continued use of locums from 2021 and additional medical capacity sourced via new locum/bank arrangements. Joint post established with Epsom St Helier (3PA) and business case underway to recruit to a full time post shared with EStH. 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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1192	09/10/2020	Inability to provide full pharmacy services due to vacancies, sickness and covid vulnerable pharmacist	Delays to indirect clinical services (e.g. updating policies / guidelines / audit/ training)□ Unable to move forward with non-clinical initiatives e.g compliance with falsified medicines directive, EPMA introduction□ □ Delays in projects e.g. EPMA and supporting new services□ Pharmacist vacancy rate increasing and inability to recruit□ □ Loss of long established staff□ □ Unable to support any new work elsewhere in Trust	1. All technical staff in post apart from 0.2WTE band 2 assistant. Vacancy money used for bank staff.□ 2. Pharmacy clerk new to post but is progressing well.□ 3. Pharmacist assistants have completed apprenticeship and could dispense if needed to help reduce pharmacist to cover technicians.□ 4. Long term locum in post along with part-time bank pharmacists□ 5. Chief Pharmacist working addition bank hours.□ 6 Retired bank technician helping cover some vacancies and leave. Medicines management technician working on wards supporting pharmacist when possible.□ 7. Recruited new bank pharmacist who can work 1 day a week□ 8. Direct clinical work a priority.□ 9 Second locum pharmacist in place and working well covering wards and dispensary □	Abigail Jago	Judy Busby	Patient Safety	12	8	**16/2/22** Band 8a clinical lead due to start 4 Apr22 (no cover in March). Band 7 pharmacist started 1feb22 - has not hospital experience so needs more support. Band8a MSO job description reviewed and sent to evaluation panel. Recruitment for bank assistant progressing. Locum left as offered homeworking post. Lost 1 bank pharmacist, other restricted hours due to sickness.□ 25/1/22 Appointed band 8a clinical lead - looking to start in April. Awaiting HR confirmation of start date for band 7. Shortlisted bank band 2 assistant. Band 8a MSO post to go out to recruitment shortly. Bank band 8a pharmacist not currently available.□ 29/12/21 Shortlisted for band 8a clinical lead - to interview within next 2 weeks. 20/12/21 Antimicrobial Pharmacist 8a now in post, Clinical Pharmacy lead 8a out to internal advert. Part-time bank pharmacist assistant out to advert. Struggling with increased sickness of all staff and covid household isolation. 26/11/21 1wte band 7 pharmacist post offered and accepted, cannot start before 1 Feb 22. 12/11/21 Locum started working 4 days a week, but now only wants to work 3 days. 2 day a week bank pharmacist unavailable end Nov. Interviewing for potential band 7. Oct MMOGG cancelled due to staffing / resources. 12/10/21 Sleep pharmacist started. Still unable to get any locums. Still not able to recruit into B7 advertised posts. One bank pharmacist due to have operation, other currently unable to work. Staff struggling with holidays. Pharmacists limited to working clinically.	KSO1 KSO2 KSO3 KSO4 KSO5
1189	08/12/2020	Workforce succession planning: radiology	- 50% of the workforce at / approaching retirement age□ - difficulties recruiting: Lack of ultrasound / radiographer/Radiologist workforce nationally□ - multiple failed recruitment drives previously and currently	-Bank staff/ agency □ □	Abigail Jago	Sarah Solanki	Compliance (Targets / Assessments / Standards)	15	9	20-01-2022 - 1 person on apprenticeship. Start date February. For business planning, going to do a combined POAP/plan with other depts. in CSS for a combined apprenticeship longer terms bid. Also for business planning, we need a training ultrasound post to support the impending shortage there. Bank CDC sonographer ready for start date. Return to practice post - ECF approved. JD needs approval from panel - next one 1st March. 2 new starters (both band 6). Next one starting on the 1st Feb. As of Sept going to support Sussex Uni with more placement spaces to try and attract more students here.□ 23-12-2021 - have 1 person approved for apprenticeship and will factor this into business planning moving forward. Bank CDC sonographer interview complete yesterday and paperwork sent to HR. Developing a return to practice post for a radiographer who has fallen off the HCPC register but previously was experienced CT radiographer. New staff members starting on 16th Jan and 1st Feb.□ 19-11-2021 - interviews for remaining band 6 on 24th. Proposed start date for other band 6 role is 17 January 2022. Bank CDC sonographer role on TRAC awaiting authorisation. □ Apprenticeship POAP submitted for approval - to EMT 29th Nov.□ Apprentice JD- signed off. HEE confirmed additional funding and Candidate suitable and ready. □ 18-10-2021 - Band 5 ready for start date. Hoping for 1st November. Band 6 - 1 individual pulled out so the	KSO1 KSO2 KSO3 KSO5

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1140	19/03/2019	Current PACS contract ending in June 2020	QVH is in a consortium for PACS/RIS/VNA with 5 other trusts from Surrey & Sussex. □ Philips provide a managed PACS/RIS/VNA (Vendor neutral archive) service to QVH and the other 5 trusts. The current contract was extended in 2016 to allow the contract to run until June 2020 under the 5+2 terms of the original contract. □ All 6 trusts have stated they want to remain in this consortium and potentially expand it to include another Surrey trust.□ There is now limited time available to re-procure PACS/RIS/VNA before the current contract runs out; without which there will be no PACS system.□ There is currently no project board or business case aligned to this procurement process. □ ESHT has said they are happy to lead on the project, with input from all trusts as and when requested.□ The data in the VNA is known to be incorrect across all sites, and if the S&S PACS consortium approve a plan to move PACS providers then	ESHT have said they will lead on a re-procurement process for the consortium. □ Philips have said they will extend the current contract - costs will need to be agreed as hardware will need replacing.	Michelle Miles	Sarah Solanki	Information Management and Technology	15	4	20-01-2022 - PACS project moving forward at pace. Hardware being ordered for both IT data centre and Radiology dept. Wellbeing RIS will no longer be hosted by phillips as of 12th Feb. Wellbeing data being migrated and cut over happening (that weekend) - RIS downtime for 12 hours. IT aware. Comms to go out nearer the time. PACS workflow meetings ramping up. RSM to do EPF and briefing paper for short term PACS project support. Longer term - role to be factored into BP for 2022/2023. VNA - S&S consortium have sought legal advice to end the contract with hyland due to non-delivery. Being worked through currently re strategy. □ □ □ 23-12-2021 - PACS project team being worked out with dept and working through support required. RIS Test environment changes still not fully working at QVH. Issues being worked on with a planned change over in the live environment for 12h Feb 2022. VNA - Hyland, legal advice with SROs approving letter of termination with Hyland. This needs to be worked through. have copied status update into documents re this. □ 19-11-2021 - VNA - hyland sent dispute letters re non-payment of invoices and said all support would stop from 17th. Legal advice sought from Shoe lane solicitor. Reply letters devised and sent on the 17th. PACS and RIS all fine - finalizing PID for PACS for contract and RIS - minor changes to test environment next week - both moving forward. Trust project teams being devised for PACS go live. □	KSO1 KSO2 KSO3 KSO4
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	Claire Ziegler	Patient Safety	12	4	**04.02.2022** Update for January 2022. Recovery - appointed B7 one year fixed term mat leave cover, still awaiting B5 sponsorship. Day Surgery recruited B6, B2 - risk in periop admin due to low uptake on adverts - recruited 1 and interviewing X 2 Theatres rolling B5 with leavers X 3□ □ □ 21.12.2021 Update for December 2021. current vacancy being reviewed in periop PR. out to advert for B5 theatre practitioner/anesthetic practitioners, on a rolling advert due to lack of suitable applicants, recruited into B6 and out to advert for Mat Leave cover B7 recovery. POAP for 2022 ODP Apprenticeship □ □ 04.10.2021 - update for September 2021. 3 X RN's for Recovery are in the onboarding process and have been given start dates for the end of October 2021. 1 X RN for Day Surgery in the onboarding process and given a start date for the end of October 2021. 3 X HCA in the onboarding process and aiming to start end of October 2021. Adverts out for theatre practitioners Band 5 and Band 6. Day Surgery Band 6 and periop receptionists band 2. 2 ODP Apprenticeship students have commenced their year one training. □ □ 25.08.2021: International recruits still being supported in theatres due to specialties not previously worked in. Weekend bank shifts still hard to fill due to holidays, isolation and skill mix. Staffing reviewed daily as	KSO1 KSO2

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1040	13/02/2017	Age of X-ray equipment in radiology	Significant numbers of Radiology equipment are reaching end of life with multiple breakdowns throughout the last 2 year period.□ □ No Capital Replacement Plan in place at QVH for radiology equipment	All equipment is under a maintenance contract, and is subject to QA checks by the maintenance company and by Medical Physics.□ □ Plain Film-Radiology has now 1 CR x-ray room and 1 Fluoroscopy /CR room therefore patients capacity can be flexed should 1 room breakdown, but there will be an operational impact to the end user as not all patients are suitable to be imaged in the CR/Flouro room. These patients would have to be out-sourced to another imaging provider.□ □ Mobile - QVH has 2 machines on site. Plan to replace 1 mobile machine for 2019-2020□ □ □ Fluoroscopy- was leased by the trust in 2006 and is included in 1 of these general rooms. Control would be to outsource all Fluoroscopy work to suitable hospitals during periods of extended downtime. Plan to replace Fluoro/CR room in 2019-2020□ □ Ultrasound- 2 US units are over the	Abigail Jago	Sarah Solanki	Patient Safety	12	2	20-01-2022 - tender document evaulation were finalised by 23rd December. The phase 1 presentations are complete and 1 set of moderation meetings held for presentations. 1 more moderation meeting occurring on 21st Jan. Legal team need to formally review phase 1 documents. This is going to happen within the next month. OBC being written and MES to be added as an agenda item for EMT. We need trust approval to move to phase 2 of MES which takes around 12 weeks. As a precautionary measure, RSM has added MRI and xray kit to the BP template for capital in case trust do not progress to phase 2. □ 23-12-2021 - Phase 1 - evaluators scoring phase 1 documents and creating questions for vendors. Presentations provisionally booked for January 2022. Financial evaluation is needed to demonstrate to DOF differences from initial BC from 2019 to now. □ 19-11-2021 - Vendor clarification questions sent back via supply chain framework. Awaiting bids to come back to trust.□ 18-10-2021 - Now in Phase 1 of the procurement process to work up spec and full costings with the framework. 3 Suppliers want to complete site visits this week. Some dates in November in diary for going through bids from Vendors.□ 22-09-2021 - Ground survey received which identified parts of the proposed location for the MRI overlie an uncharted Quarry - which would mean Piling needed. We have moved to phase 1 of the project with the framework as this will provide likely costs. We can then	KSO1 KSO2 KSO3
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 cover: 24/7 telephone advice & 3 sessions per week on site at QVH	Tania Cubison	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	4	**February 2022** - nit to report - risk reviewed□ November 2021 - nil to report□ 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	KSO2 KSO3 KSO5

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
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	JMCI	Finance	20	16	January 2022: H2 has been submitted. A forecast breakeven position for 21/22 is planned subject to normal working assumptions.□ Business planning for 22/23 is underway to achieve national deadline.□ October 2021: H2 Financial regime has now been issued to the Trust (1st October) work is underway to review the financial envelop for the Trust and also the implications of the revised Elective Recovery Funding arrangements which have changed from H1.□ 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□	KSO4
834	09/09/2015	Non compliance with national guidelines for paediatric care.	Unavailability of a Paediatrician to review a sick child causing □ 1. Harm to child□ 2. Damage to reputation□ 3. Litigation	1. Service Level Agreement with BSUH providing some Paediatrician cover and external advice. □ 2. Consultant Anaesthetists, Site practitioners and selected Peanut Ward staff EPLS trained to recognise sick child and deal with immediate emergency resuscitation.□ 3. Policy reviewed to lower threshold to transfer sick children out □ 4. Readmission of infected burns criteria reviewed to raise threshold for admission□ 5. Operating on under 3 year olds out of hours ceased unless under exceptional circumstances□ □ With regards to SLA for paediatrician cover, □ 1. Continuous dialogue with consultants and business managers□ 2. Annual review meeting - Sept/October 2015□ □ Forward plan: to address areas of highest risk of complications with improved collaboration with BSUH to deliver inpatient Burns care to children in the Royal Alex hospital in Brighton. Aiming for Sept 2016□	Tania Cubison	Dr Edward Pickles	Patient Safety	12	4	**February 2022**: HoN reviewing SLA - nil other significant update□ 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:	**3 March 2022**		**Agenda reference:**	**40-22**	
Report title:	Quality & Safety Board Report				
Sponsor:	Nicky Reeves, Director of Nursing and Quality				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:					
Executive summary					
Purpose of report:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Summary of key issues	The Board's attention should be drawn to the following key areas detailed in the reports: • New Chief Nurse appointed • Sleep Services external review process complete and an action plan is being implemented • Funding has been approved by HEE to support Plastic Surgery trainees following the impact of the pandemic on training • Ongoing challenges with recruitment in a number of clinical areas				
Recommendation:	The Board is asked to note that the contents of the report reflect the quality and safety of care provided by QVH during this time				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	The Quality Report contributes directly to the delivery of KSO 1 and 2, elements of KSO 3 and 5 also impact on this.				
Corporate risk register:	CRR reviewed as part of the report compilation –and the workforce and RTT18 risk impact the most on quality, safety and patient experience.				
Regulation:	The Quality Report contributes and provides evidence of compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's Essential Standards of Quality and Safety.				
Legal:	As above The Quality and Safety Report uphold the principles and values of The NHS Constitution for England and the communities and people it serves – patients and public – and staff.				
Resources:	The Quality and Safety Report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	28/02/22	Decision:	Noted	
Next steps:					

Executive Summary - Quality and Safety Report, March 2022

Domain	Highlights
Chief Nurse	Safety of our patients and staff continues to be the primary focus for the Trust whilst also maintaining a positive patient experience. The interim Director of Nursing has been successful in being appointed to the substantive role of Chief Nurse here at QVH. The Covid update and IPACT BAF are included in appendix 1.
Medical Director	**Sleep Services** We have undertaken an external review process of the sleep service as there have been considerable staffing challenges in a number of staff groups. This review has informed an action plan that is being implemented with the oversight of the Medical Director and the Chief Nurse. **Antimicrobial stewardship** The antimicrobial stewardship programme continues and our antimicrobial pharmacist is working with the medical and nursing colleagues to look at implementation. We are considering approaching middle grade medical staff within the main specialties to champion this work. **Clinical harm reviews** The clinical harm reviews continue and we are working to change some of our pathways to incorporate harm review within the routine working of the waiting list process. We have now embedded the harm review reports in to the Evolve Medical record and hope to link this into the Patient Centre administrative system to ensure good visibility of the patient moving along the clinical harm review process.

Report by Exception - Key Messages

Domain	Issue raised	Action taken
Responsive: Safe Staffing	Staffing Challenges	Ongoing challenges with recruitment in a number of clinical areas. Recorded on the corporate risk register. A range of measures are being taken to address these challenges.

Safe - Performance Indicators

Metric Description	Target	Q4 2020/21		Q1 2021/22			Q2 2021/22			Q3 2021/22			Q4 2021/22	12 month total/ rolling average
		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
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
Clostridium Difficile acquired at QVH post 72 hours after admission	0	3	4	0	0	1	0	0	0	0	0	0	0	5
Gram negative bloodstream infections (including E.coli)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA screening - elective	95%	94%	95%	94%	95%	96%	86%	84%	96%	95%	96%	98%	95%	94%
MRSA screening - trauma	95%	96%	94%	97%	96%	98%	97%	97%	97%	98%	99%	99%	99%	97%
Incidents														
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Serious Incidents	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Theatre metrics														
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	0	5	2	8	5	7	5	2	3	2	3	3	45
Paediatrics under 3 years: Induction of anaesthetic was between 18:00 and 08:00	0	0	0	0	0	1	0	0	0	0	0	0	0	1
WHO quantitative compliance		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Non-clinical cancellations on the day		0	2	5	3	8	5	9	10	8	23	7	4	107
Needlestick injuries	0	3	3	2	1	3	2	2	1	2	3	2	1	22
Pressure ulcers (all grades)(Theatre metric)		0	1	0	0	0	1	1	0	2	0	0	0	5
Paediatric transfers out (<18 years)		1	0	1	0	0	1	0	0	0	0	2	nc	4
Medication errors														
Total number of incidents involving drug/ prescribing errors		9	10	3	9	8	10	9	3	11	5	6	4	78
No & Low harm incidents involving drug/ prescribing errors		8	8	3	9	5	8	8	2	6	4	5	4	62
Moderate, Severe or Fatal incidents involving drug/ prescribing errors		0	0	0	0	0	0	0	0	0	0	0	0	0
Medication administration errors per 1000 spells		0.7	1.1	0.0	0.0	1.7	1.1	0.6	0.6	3.0	0.6	0.6	0.0	0.8
Pressure Ulcers Hospital acquired - category 2 or above		1	0	2	0	0	0	2	0	2	1	0	0	7
VTE initial assessment (Safety Thermometer)	95%	100%	100%	100%	97%	96%	96%	100%	100%	100%	100%	96%	100%	99%
Patient Falls														
Patient Falls assessment completed within 24 hrs of admission	95%	100%	93%	100%	100%	93%	100%	95%	100%	100%	96%	100%	95%	97%
Patient Falls resulting in no or low harm (inpatients)		6	2	1	3	3	4	5	2	1	7	1	1	30
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	0	0	0	1	0	0	0	0	0	0	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

*Nov 21 - non clinical cancellation on day. Variation due to cancellations for trauma and a member of the surgical team with a +PCR, excluding these exceptional circumstances would show cancellations at around 8-10 in the month.

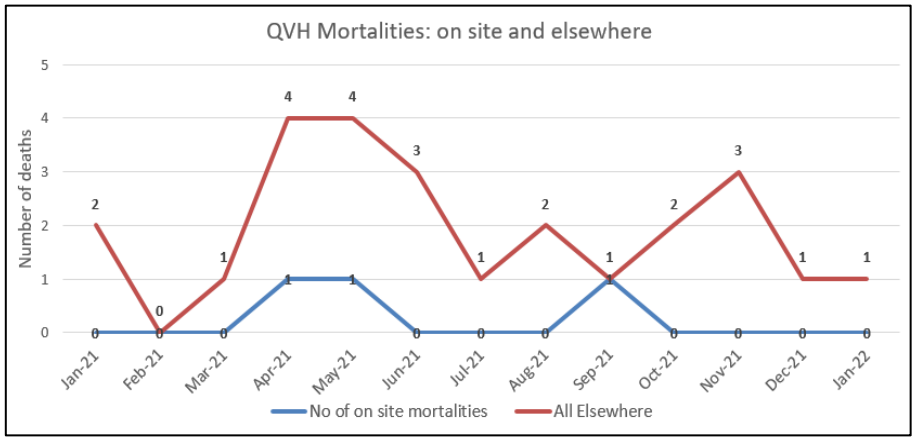
nc = not collected or not reported

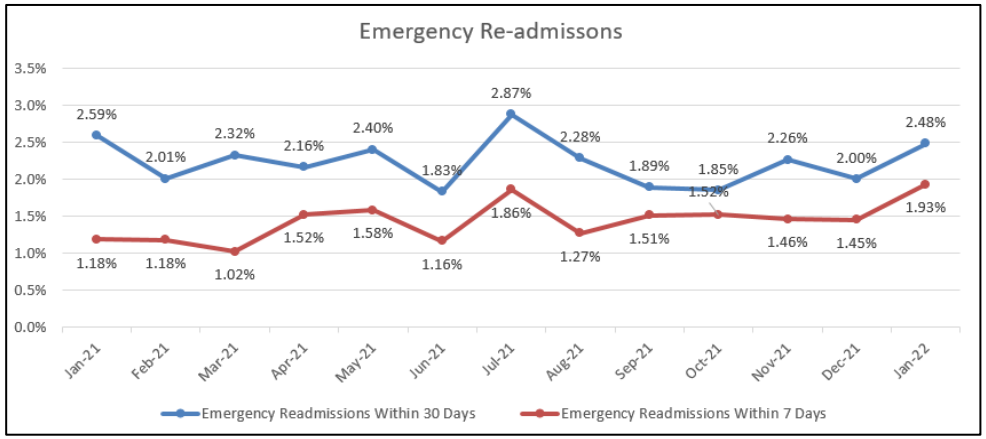
Safe - Performance Indicators

KPI	Target	Average	Jan-22	Variation Jan-22	Assurance Jan-22	Comments for the latest period shown for each metric
MRSA - Elective	95%	97%	95%			Current performance is within normal variation There is no assurance that the current processes will achieve our target
MRSA - Trauma	95%	96%	99%	H		Current performance is improving, it is significantly higher. There is no assurance that the current processes will achieve our target
Serious Incidents	0	0	0.0	L		There has been an improvement and the measure is significantly lower. There is no assurance that the current processes will achieve our target
Total no of incidents involving drug/prescribing errors	0	13	4.0	L	F	Current performance appears positive due to lower level, but this could be due to staff shortages and lack of reporting as seen previously. However the system is still not capable. It will fail the target without system change.
Falls per 1000 bed days	0	3	1.1			Current performance is within normal variation There is no assurance that the current processes will achieve our target
Pressure ulcers per 1000 bed days	0	0	0.0			Current performance is within normal variation There is no assurance that the current processes will achieve our target
Complaints	0	5	5.0			Current performance is within normal variation There is no assurance that the current processes will achieve our target
Mortalities	0	1	1.0			Current performance is within normal variation There is no assurance that the current processes will achieve our target

Variation			Assurance		
	H L	H L		P	F
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

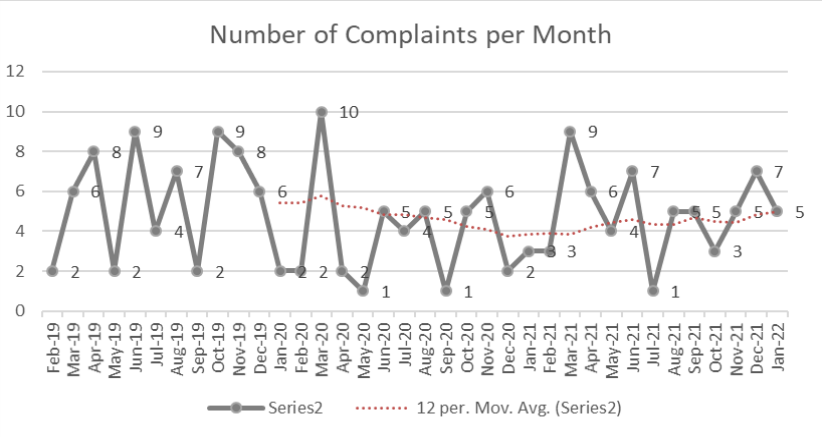
Effective - Performance Indicators

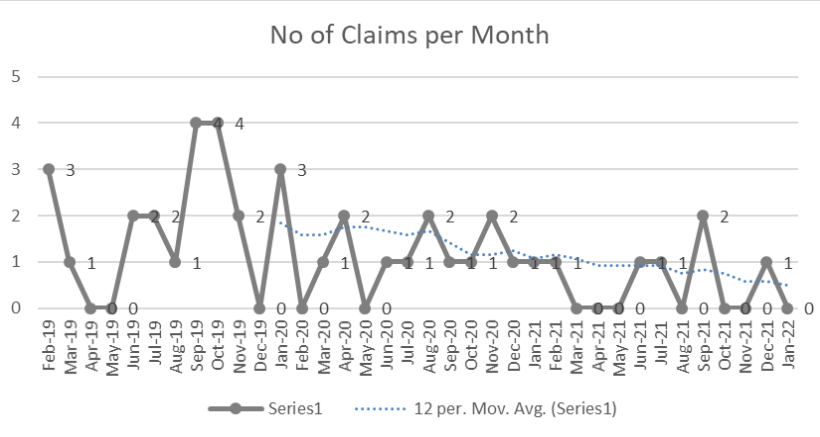




Mortalities Report			Q4 2020/21		Q1 2021/22			Q2 2021/22			Q3 2021/22			Q4 2021/22
			Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Mortalities within 30 days of an inpatient episode or outpatient procedure	Inpatient	No of on site mortalities	0	0	1	1	0	0	0	1	0	0	0	0
		No of mortalities elsewhere	0	0	1	3	3	1	1	1	0	3	1	1
	Outpatient		0	1	3	1	0	0	1	0	2	0	0	0
	All Elsewhere		0	1	4	4	3	1	2	1	2	3	1	1
Reviews		Completed Preliminary Reviews	0	0	1	1	0	1	2	0	0	2	nc	1
		No of deaths subject to SJR	0	0	1	3	3	3	0	1	0	0	nc	0
No of mortalities in patients with learning difficulties (inpatients only)			0	0	0	0	0	0	0	0	0	0	0	0

Caring - Current Compliance - Complaints and Claims





	Q4 2020/21		Q1 2021/22			Q2 2021/22			Q3 2021/22			Q4 2021/22
	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Number of complaints	3	9	6	4	7	1	5	5	3	5	7	5
Complaints per 1000 spells	0.2	0.50	0.31	0.21	0.34	0.05	0.28	0.25	0.16	0.25	0.41	0.28
Number of claims	1	0	0	0	1	1	0	2	0	0	1	0
Claims per 1000 spells	0.1	0.00	0.00	0.00	0.05	0.05	0.00	0.10	0.00	0.00	0.06	0.00
Number of cases referred to PHSO	0	0	0	1	0	0	0	0	0	0	0	0

Nursing Workforce - Performance Indicators, Safe staffing data

Peanut ward - Staffing challenges continue. A new matron will join the team in March 2022. In December there were 9 overnight cases on 6 occasions, there were 13 nights when the ward was staffed but there were no inpatients and there were 12 occasions when the ward was unable to accept an inpatient overnight. In January there were 11 patients overnight on 8 occasions, there were 7 occasions when the ward was not able to accept an inpatient. There were 16 nights when the ward was staffed but there were no inpatients.

December safe staffing data demonstrates challenges with staffing and the average was just under the 95% threshold at 94.3% on day shifts. On these occasions, clinical educators and support staff are utilised to maintain safety. Staffing levels are reviewed on a regular basis and as a minimum three times a day. Use of the Safe Care Live module is also supporting the team to make real time staffing decisions.

Combined Staffing exc. Site — *Target 95%*

	Planned staff			Actual staff			Dec-21		Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA			RN	NA	HCA	RN	NA	HCA
DAY	5003	230	2576	4669	230	2461	*Total Hrs Planned and Actual*	NIGHT	3945	92	1311	3795	92	1196
				93.3%	100.0%	96%	*% Planned Hrs Met*					96.2%	100.0%	91.2%
			7809			7360	*Total Hrs Planned & Actual - Combined reg & support*				5348			5083
						94.3%	*% Planned Hrs Met - Combined reg & support*							95.1%

January safe staffing data demonstrates compliance across all the bands with staffing levels at or 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.

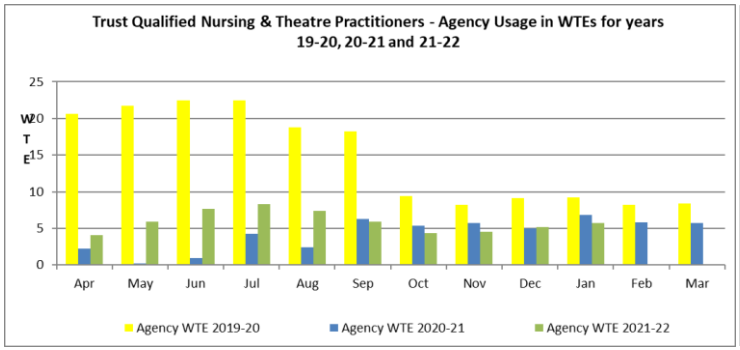
Combined Staffing exc. Site								Target 95%						
	Planned staff			Actual staff			Jan-22		Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA			RN	NA	HCA	RN	NA	HCA
DAY	5072	322	2553	4997	322	2507	*Total Hrs Planned and Actual*	NIGHT	4025	172.5	1219	3979	172.5	1196
				98.5%	100.0%	98%	*% Planned Hrs Met*					98.9%	100.0%	98.1%
			7947			7826	*Total Hrs Planned & Actual - Combined reg & support*				5417			5348
						98.5%	*% Planned Hrs Met - Combined reg & support*							98.7%

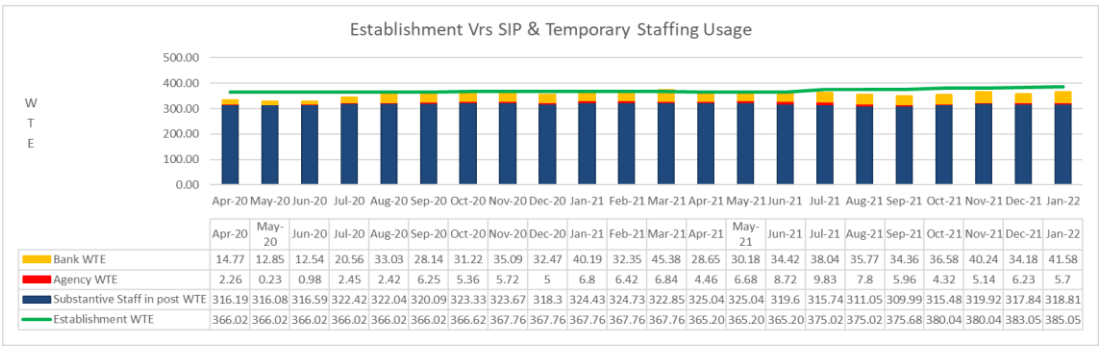
Nursing Workforce - Performance Indicators

ALL QUALIFIED & UQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2020-21 & 2021-22	Jan-21	Feb-21	Mar-21	Apr-21	????	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)		367.76	367.47	367.47	365.20	365.20	365.20	375.02	375.02	375.68	380.04	380.04	383.05	**385.05**	▲
Staff In Post WTE		324.43	324.73	322.85	325.04	325.04	319.60	315.74	311.05	309.99	315.48	319.92	317.84	**318.81**	▲
Vacancies WTE		43.33	42.74	44.62	40.16	40.16	45.60	59.28	63.97	65.69	64.56	60.12	65.21	**66.24**	▲
Vacancies %	>18% 12%<>18% <12%	11.78%	11.63%	12.14%	11.00%	11.00%	12.49%	15.81%	17.06%	17.49%	16.99%	15.82%	17.02%	**17.20%**	▲
STARTERS WTE (Excluding rotational doctors)		11.56	1.00	1.00	6.15	2.00	3.43	0.00	1.41	3.93	4.68	9.97	6.56	**2.95**	▼
LEAVERS WTE (Excluding rotational doctors)		4.18	0.00	2.88	3.80	0.87	7.62	3.21	6.76	1.12	1.60	3.61	4.41	**3.48**	▼
Starters & Leavers balance		7.38	1.00	-1.88	2.35	1.13	-4.19	-3.21	-5.35	2.81	3.08	6.36	2.15	**-0.53**	
Agency WTE [Data from Healthrosters]		6.80	6.42	6.84	4.46	6.68	8.72	9.83	7.80	5.96	4.32	5.14	6.23	**5.70**	▼
Bank WTE [Data from Healthrosters]		40.19	32.35	45.38	28.65	30.18	34.42	38.04	35.77	34.36	36.58	40.24	34.18	**41.58**	▲
Trust rolling Annual Turnover %	>=12% 10%<>12% <10%	8.90%	8.93%	9.34%	9.33%	8.58%	10.91%	11.36%	12.52%	12.62%	13.32%	12.89%	12.81%	**12.82%**	▲
Monthly Turnover		1.14%	0.00%	0.95%	1.26%	0.29%	2.58%	1.09%	2.14%	0.38%	0.53%	1.13%	1.46%	**1.15%**	▼
Sickness Absence %	>=4% 4%<>3% <3%	4.48%	3.13%	3.30%	2.30%	3.70%	3.81%	3.21%	3.61%	3.98%	4.69%	5.12%	**5.29%**	*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	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
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	35.77	34.36	36.58	40.24	34.18	41.58
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	7.8	5.96	4.32	5.14	6.23	5.7
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	311.05	309.99	315.48	319.92	317.84	318.81
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	375.02	375.02	375.68	380.04	380.04	383.05	385.05

Medical Workforce - Performance Indicators

Metrics	Q4 2020/21		Q1 2021/22			Q2 2021/22			Q3 2021/22			Q4 2021/22
Medical Workforce	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Turnover rate in month, excluding trainees	0%	3%	30%	1%	1%	0%	1%	1%	4%	0%	1%	1%
Turnover in month including trainees 9%	3%	7%	8%	0%	2%	0%	18%	18%	5%	1%	1%	1%
Management cases monthly	0	0	0	0	1	0	0	0	0	0	0	0
Sickness rate monthly on total medical/dental headcount	1%	2%	1%	2%	2%	2%	1%	3%	3%	2%	2%	Not Available
Appraisal rate monthly (including deanery trainees)	78%	84%	62%	67%	67%	69%	70%	65%	52%	61%	57%	61%
Mandatory training monthly	82%	81%	83%	85%	84%	82%	82%	80%	79%	81%	82%	82%
Exception Reporting – Education and Training	0	1	0	2	1	1	10	5	1	1	1	0
Exception Reporting – Hours	3	1	2	2	1	5	10	2	3	3	0	1

Medical & Dental Staffing

During 2021/22 we have moved forward on a large number of locum and substantive consultant posts, some new and some to replace leaving staff, and appreciate the huge team effort from clinical teams, Ops and HR to achieve some rather complex arrangements. As always the QVH has excelled in innovative solutions and this is only possible due to integrated working between many members of the trust. In February QVH hosted the first doctors' induction of the year, welcoming 19 new trainees and trust doctors in Corneo Plastics, Plastic Surgery and OMFS. Medical Education have worked hard with the departments to ensure an interesting and safe programme of training, and we are very grateful for the efforts of all the QVH teams who contribute to ensuring that the inductions run smoothly. Potential changes in the plastic surgery deanery rotations means that there is an opportunity for extra deanary trainees to come to the QVH and the Medical Education team are following this up enthusiastically. We have always had more training opportunity at the QVH than we have trainees and this initiative is strongly supported by the consultants.

Additional funding has been approved by HEE to support the trainees in Plastic Surgery with recovery following the impact of Covid on their training. The funding will be used for locum shifts to allow trainees access to lists that provide additional teaching opportunities.

	The renovation of the facilities in A Wing Lecture Theatre, funded by HEE is well underway, with a new touchscreen TV being installed and other facilities also upgraded. The plastics monthly teaching timetable is in place for the first nine months of 2022, with excellent sessions planned and the opportunity to use two separate rooms being taken on some occasions to allow dedicated sessions for core and higher trainees.
Education	The latest round of Local Faculty Group meetings are underway, to ensure continued educational governance in all specialties. The Medical Education Manager has joined a new Education Development Group, bringing together interested members from around the Trust to look at ways to encourage multi-professional learning, ensure the best possible use of funding received, and encourage staff retention.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	03/03/2022	**Agenda reference:**	**41-22**		
Report title:	**Updated Corporate Risk Strategy**				
Sponsor:	Nicky Reeves, Chief Nurse				
Authors:	Nicky Reeves, Chief Nurse Kelly Stevens, Head of Quality and Compliance				
Appendices:					
Executive summary					
Purpose of report:	To approve the QVH Corporate Risk management Strategy				

Summary of key issues	• Reviewed and updated following Board Seminar in December 2021 to reflect feedback and comments
	• Additional information in section 3 on the management of the three overarching risks to delivery
	  ◦ Unable to keep our staff engaged, motivated and supported during a time of great change
	  ◦ Unable to maintain patient and staff safety through the pandemic
	  ◦ Unable to secure a sustainable future for QVH
	• Inclusion of Good Governance institute 6 principles of risk management				

Recommendation:	Board is asked to **approve** this strategy				
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:	Any risks to achievement of the targets will be noted on the relevant BAF				
Corporate risk register:	Reviewed during the creation of this document				
Regulation:	Required to meet the CQC regulations				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	28/02/2022	Decision:	Outcome not available due to timing of Q&GC meeting and board reporting deadline. A verbal update will be provided at the board meeting.	
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Corporate Risk Management Strategy

Trust Strategic Objectives:


Outstanding patient experience


World-class clinical services


Operational excellence


Financial sustainability


Organisational excellence

1. Introduction

The Good Governance Institute references the following 6 principles of risk management:

Principle One - An engaged board focuses the business on managing the things that matter

Principle Two - The response to risk is most proportionate when the tolerance of risk is clearly defined and articulated

Principle Three - Risk management is most effective when ownership of and accountability for risks is clear

Principle Four - Effective decision-making is underpinned by good quality information

Principle Five - Decision-making is informed by a considered and rigorous evaluation and costing of risk

Principle Six - Future outcomes are improved by implementing lessons learnt

(National Audit Office, 2011)

1.1. The Board of Queen Victoria NHS Foundation Trust (QVH) is committed to ensuring that risks to the quality, safety, effectiveness and sustainability of it services are identified and managed so that they are reduced to an acceptable level or eliminated as far as reasonably practicable. This Corporate Risk Management Strategy sets out the Trust's intentions and approach to risk management. It should be read in conjunction with the Trust's Risk Management Policy which sets out the methods and responsibilities for delivering this strategy.

1.2. The successful management of risk in all aspects of the Trust's business and by all those working within the Trust is fundamental to delivering the Trust's strategic and operational objectives. It also ensures the Trust is resilient and able to deal with unanticipated exposure to risks that could threaten our success. Therefore, the Trust will ensure that effective risk management is an integral part of everyday working practice in all aspects of the Trust's business as part of its overarching strategy and approach to delivering its strategic objectives.

1.3. The Trust is committed to an integrated risk management system, which incorporates all aspects of risk including strategic, clinical, financial, workforce, infrastructure, health and safety, operational, compliance and reputational risk.

1.4. The Trust's governance framework relies on a robust system for managing risk. This strategy describes how the Trust's risk management structures, systems and processes will ensure that the Trust meets its strategic and operational objectives and delivers safe, sustainable, high quality care. This will involve maximising opportunities to achieve objectives, as well as reducing risks.

1.5. The strategy sets out the Trust's approach to risk management which will include the identification assessment, reporting and management of risk. It defines the contribution to be made by key parts of the Trust's governance structures. The Corporate structure is seen at every public board meeting. Corporate risks relating to KSO1&2 are reviewed at the Quality and Governance Committee and KSO 3, 4 & 5 risks are reviewed at Finance and Performance Committee. By managing risk effectively, the Trust aims to:

- ensure that risk management is an integral part of open culture
- identify risks to achieving the Trust's objectives requiring intervention, and
- drive a standardised, strategic, and accessible approach to risk management

1.6. In addition to this Corporate Risk Management Strategy there are a range of policies that support the identification and management of risk within the Trust. These include the following policies:

- Risk Management Policy
- Incident Reporting and Investigation Policy
- Handling Complaints & Concerns Policy
- Health and Safety Policy

2. Scope

2.1. The risk management approach described in this strategy applies to all areas and activities of the Trust and to all individuals working within the Trust. The Trust will work in partnership with its staff, service users and stakeholders to ensure it takes a comprehensive approach to risk management and that all opportunities for the identification and management of risk are fully exploited including risk management approaches that can only be delivered in partnership with others.

3. Risk Management approach

3.1. Following a Board seminar in December 2020, three overarching risks to delivering the Trusts corporate objectives and the ongoing safe delivery of clinical services were identified. These are as follows:-

- Unable to keep our staff engaged, motivated and supported during a time of great change
- Unable to maintain patient and staff safety through the pandemic
- Unable to secure a sustainable future for QVH

These are reflected in all the KSO BAF's and reported through the CEO report to Board bi-monthly and these are reviewed when preparing board papers for each KSO. The CEO is accountable for leading on the management these risks.

These risks broadly mirror the three challenges reflected in the 2020 document "Securing the long term future of Queen Victoria Hospital"

- Reliance on key individuals
- Synergies between services
- Getting value for money

3.2. Risk is inherent in all the Trust's activities: for example, treating patients, determining service priorities, project management, record-keeping, communication, staffing, service design, and setting strategy. Equally, there is also risk associated with acts of omission.

3.3. The Trust supports a dynamic and proactive approach to risk management, with the aim of identifying and managing potential threats and hazards before adverse events occur. The identification and assessment of risk should be seen as an opportunity to improve care quality.

3.4. The Trust's strategy for the management of risk is to integrate the identification, assessment, and control of risk into all areas of the Trust's business so that risk is routinely identified by all staff and appropriate action is taken to reduce risks to acceptable levels. The Trust will support all staff in taking an active role in the identification and management of risk and to take responsibility for the health, safety, and wellbeing of patients, visitors, staff and others accessing and using the Trust's facilities and services. This approach will also enable staff to make an active contribution to the management of risks associated with the delivery of services in line with the NHS Constitution, and with the delivery of the Trust's objectives.

3.5. While the Trust Board carries overall responsibility for risk management, the key to success is local leadership. The Trust's business unit structure is fundamental to the risk management system, and business unit leaders and their teams will work with colleagues holding specialist Trust- wide governance remits, and the Trust's Executive directors to ensure it is successfully implemented.

3.6. It is the responsibility of all staff to identify risk and report concerns that may affect the quality, safety and effectiveness of service provision. The Trust aims to work in partnership with staff and support them with their responsibilities by creating a culture of openness and willingness to admit mistakes. The Trust is committed to learning from mistakes, incidents, near misses, complaints and claims and using this learning to improve systems. The Trust is committed to a just culture where the reporting of incidents and concerns is encouraged and staff are supported in delivering their responsibilities for safe care.

3.7. This strategy sets the objectives for risk management within the Trust as follows:

- to take all reasonable and appropriate steps in the management of risk in order to protect patients, staff, the public, its assets and reputation
- to meet statutory, regulatory and legal obligations
- to develop and maintain an effective system to identify, assess, manage and review risks across the Trust
- to offer staff appropriate training and support in the principles and practice of risk assessment and management
- to provide assurance to the Board (via the Audit Committee) regarding the effectiveness and robust implementation of the Risk Management Policy and its associated systems and processes
- to manage risk within the risk appetite that has been agreed by the Trust Board

4. Risk Management System

4.1. The risk management system will be an integral part of the Trust's framework for assuring and delivering good governance. It will enable the Trust to identify and monitor risks to its strategic objectives, support the appropriate management and escalation of these risks and inform the Board whether the systems and process in place are providing effective controls and assurances.

4.2. The key components of the Trust's risk management system will be the risk appetite statement, the Board Assurance Framework, the Corporate Risk Register and local risk registers (Business unit). The production of these components is supported by the Trust's risk management processes

5. Risk Appetite Statement

5.1. Risk appetite sets out the levels of risk we are prepared to accept / not accept for each type of risk in achieving objectives. Risk appetite therefore is at the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, external agencies and the public.

5.2. The amount of risk an organisation is willing to accept can vary from one organisation to another and between one type of risk and another depending upon the specific organisational and risk circumstances. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

5.3. In order to transfer, treat, terminate, or tolerate risks those staff undertaking risk assessments and making decisions will need to understand what level of risk is acceptable to the Trust's Board

5.4. The risk appetite of the Trust will be defined by the Board. The Board will decide on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, the Trust's risk appetite will address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

5.5. Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk and should be used to determine the target risk rating throughout the risk management process.

6. Risk Appetite

6.1. The following risk appetite levels, adapted from those developed by the Good Governance Institute[1] (see Appendix 1), form the background to the Board's discussion and decision when defining the Trust's risk appetite. Using this model as guidance the Trust Board will agree an appetite statement that aligns to the Trust's strategic aims. The statement should then be considered when assessing risk targets and tolerances in the Board Assurance Framework, Corporate Risk Register and Local (Business unit) Risk Registers.

Appetite Level	Risk level:
None	**Avoid**: There is a requirement to avoid risk and uncertainty to deliver an agreed organisational objective
Low	**Minimal**: There is a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious**: There is a preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for reward.
High	**Open**: There is a willingness to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement and/or value for money.
Significant	**Seek**: There is a preference to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk **Mature**: There is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.

7. Risk Appetite Statement

7.1. The Boards of NHS Trusts are accountable for ensuring the quality, safety and sustainability of the services they provide to patients. Queen Victoria Hospital NHS Foundation Trust sets clear expectations for the Trust through strategic objectives.

[1] Good Governance Institute: *Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking*

7.2. The Trust operates in a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a moderate appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

7.3. Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients. We have defined our appetite for risk in relation to our strategic objectives as follows:

	Strategic objective	Risk appetite
	Outstanding patient experience	Low to moderate
	World-class clinical services	Low to moderate
	Operational excellence	Low
	Financial sustainability	Moderate
	Organisational excellence	Low to moderate

7.4.  Outstanding patient experience:
We make delivering an excellent care experience for our patients our highest priority. However, we will accept **moderate risks** to patient experience if this is required to achieve improvements in patient safety and quality improvements.

7.5. We have a **low risk appetite** for actions and decisions that, whilst taken in the interests of ensuring quality, safety and sustainability, may affect the reputation of the Trust or of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Board.

7.6. We have a **low appetite** for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

7.7. We have a **low appetite** for risks that may jeopardise patient safety.

7.8.  World-class clinical services:
We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards. Overall, our **risk appetite for safety is low**. Specifically:

7.9. We have a **low appetite** for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

7.10. We have a **low appetite** for risks that may jeopardise patient safety.

7.11. We have a **moderate appetite** for risks relating to the increase in waiting times as a consequence of Covid-19. . We expect that the Trust's resources will be prioritised based on the clinical need and urgency of the patient and not only the length of time on the waiting list.

7.12. We have a **moderate appetite** for some individual patient care and treatment risks in order to achieve the best outcomes. We will support our staff to work in collaboration with the people who use our services to develop appropriate and safe care and treatment plans based on assessment of need and clinical risk.

7.13. We will apply strict safety protocols for all clinical and non-clinical activity, when and wherever possible. We will report, record and investigate all clinical incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.

7.14.  Operational excellence:
We will collaborate with commissioners, local authorities, other partners and care providers to prevent ill health, plan and deliver services that meet the needs of our local population and operational and NHS constitutional standards. Overall, we have a **low appetite** for risks relating to this objective.

7.15.  Financial sustainability
We strive to use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall, we have a **moderate appetite** for risk in this area.
Specifically:

7.16. We have a **moderate appetite** for some financial risks where these are required to mitigate risks to patient safety or quality of care. We will ensure that all such financial investments and resources deliver optimal value for money.

7.17. We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a **moderate appetite** for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance

7.18. We have a significant appetite for financial risks required to ensure the delivery of our objectives. Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board.

7.19. We are prepared to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. Value and benefits will be considered and resources allocated in order to capitalise on opportunities.

7.20.  Organisational excellence:
We value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles. We will rarely accept risks that limit our ability to achieve this objective and the Trust's overall risk appetite for workforce related risks is low. Specifically:

7.21. We have a **low appetite** for risks related to the recruitment, retention and training of staff to deliver safe, high quality services and good patient experience.

7.22. We have no appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents or circumstances which may compromise the safety or wellbeing of any staff members and patients or contradict our values.

7.23. We have a **moderate appetite** for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.

7.24. We have **no appetite** for any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.

7.25. We have **no appetite** for any risk that could result in us being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment rights.

8. Board Assurance Framework

8.1. The Board Assurance Framework (BAF) will set out the strategic and operational risks which may threaten the achievement of the Trust's strategic objectives. It will enable the Board to monitor progress in achieving the strategic objectives, attend to key accountability issues, ensure the right issues are debated and that remedial actions are taken to reduce risk, strengthen controls and assurances. All NHS bodies are required to sign a full Annual Governance Statement and provide evidence of compliance. The BAF brings together a significant part of this evidence.

8.2. The BAF will be designed to assess the strength of the internal control measures that are intended to prevent these risks occurring and to identify and evaluate sources of assurance. It supports the identification of gaps in control and assurance and enables the Board to monitor progress on the actions being taken to address these gaps.

8.3. The BAF will also describe the assurances and sources of assurance the Board has agreed are necessary to assess the achievement of the Trust's strategic objectives, and will thus drive the cycle of Board and Board Committee work and reporting to the Board.

8.4. The BAF also describes the controls that the Trust's Executive must ensure are effective in order to manage strategic and operational risks and to assess that the adequacy and strength of these controls are aligned to the Board's risk appetite for individual strategic risks.

8.5. The BAF will be regularly review by the Board and Board Committees as determined by their roles and responsibilities set out in Section 7 and defined in the Risk Management Policy.

8.6. The assurance alignment within the Trust is shown diagrammatically by Good Governance Institute, see Appendix 1.

9. The Corporate Risk Register (CRR)

9.1. The corporate risk register (CRR) will be comprised of all risks with a residual score of 12 or above and will be compiled from business unit and corporate directorate risk registers. It will be the key tool for the management of risk and will be informed by the Trust's risk escalation process.

9.2. The CRR will be routinely reviewed by the Trust Board and appropriate Board sub-committees and management groups as determined by their roles and responsibilities as set out in their Terms of Reference. This will ensure:

- the right risks are being reported and escalated
- actions are being taken to mitigate risk
- these actions have been effective in reducing the risk level
- risks to strategic objectives are identified
- gaps in control are identified and included in the BAF
- the ongoing integrity of the risk management system

9.3. In addition, the CRR will be routinely reviewed by the Audit Committee in order to assess the adequacy and effectiveness of the Trust's risk management systems and processes so that the Committee can provide the relevant assurance to the Board.

9.4. The Audit Committee will also assess whether the linkages between the CRR and the BAF are robust and enable the Board to effectively identify gaps in control and assurance. Risks on the CRR may indicate a gap in control or identify that the Board is receiving inadequate, insufficient or incomplete assurances.

10. Local Risk Registers

10.1. The local Risk Registers (RR) will be held at business unit level and are the mechanism and management tool through which identified risks, controls and actions to mitigate or manage risks are recorded, monitored and managed. RR will follow the same format as the CRR.

10.2. Local Risk Registers will be routinely reviewed and monitored through the business unit governance structure. Corporate directorate RR will be routinely reviewed and monitored by Executive Directors and their teams.

10.3. In addition, the CRR and LRR will be reviewed as required by Trust's committees and management groups to ensure consistency between all RRs in the identification, assessment and rating of risks and to ensure effective management action is being taken to mitigate and control risks.

11. Risk management processes

11.1. The Trust's risk management processes will be described in the Risk Management Policy and will be determined in line with NHS and regulatory requirements and best practice. They will govern how risk is contextualised, identified, analysed for likelihood and impact, prioritised and managed and how risks will be communicated, reported, recorded, monitored and reviewed.

11.2. The Trust's risk management processes will ensure that risk is identified from a wide range of sources both proactively (for example through audit or assessment of provision against clinical guidelines) and reactively (for example through complaints, incidents and claims).

11.3. The Trust will manage identified risk and opportunities through one of the following approaches and when reviewing BAF's, these should be reflected when appropriate:

- Treat: control or reduce by taking action
- Terminate: remove altogether by stopping practices, or
- Tolerate: accept where appropriate and in line with risk appetite
- Transfer: move to another organisation or service

12. Governance Structure

12.1. The Trust's governance structures will support the ward to Board management of risk throughout the organisation. The Trust's Governance structure is set out in Appendix 2.

12.2. The Board is responsible for the risk management strategy and objectives, confirming the Trust's risk appetite and assessing the outputs and outcomes of the Trust's Risk Management Systems to ensure that they deliver appropriate levels of assurance and demonstrate that the risks to the Trust's strategic objectives are being effectively managed and controlled. This will be reported in the annual risk management report and will form the basis of the annual report to the audit committee. The Board delegates some of its responsibilities to the Committees described later in this Strategy. The individual BAF's are used by Board to offer a high level summary of the risks to the delivery of the KSO's tool used by the Board in to monitor how it is fulfilling these responsibilities. Both Quality & Governance and Finance & Performance Committees provide an annual report to the Audit committee which is then taken forward to Board for sign off via Audit committee. In addition, these feed into the annual account and quality report for further review and assurance.

12.3. The Trust's management structures will have the responsibility to ensure risk is managed and controlled in line with the Trust's Corporate Risk Management Strategy and Policy. Gaps in control will be identified through the management structures, and actions to strengthen controls or address gaps in control will be defined and monitored.

12.4. The Trust Board is the principal governance forum for the management of risk and will delegate some of its responsibilities to other management groups in order to ensure appropriate levels of scrutiny and action to manage risk. The Risk Management Policies, Corporate risk register (CRR) and local risk register (LRR) will be the key tools used by the Executive and Trust managers in fulfilling their responsibilities.

13. Risk escalation

13.1. In order to successfully monitor and manage operational and strategic risk, it is essential that high risks, areas of escalating risk, gaps in control and delays in implementing actions to strengthen controls or address control gaps are escalated through the risk management governance structure. The risk escalation process will be described in the Risk Management Policy. In addition to regular reporting to provide assurance it is expected that all component parts of the Trust's risk management governance structure will identify and escalate risks in a timely manner, reporting concerns to ensure awareness and the implementation of strengthened actions.

14. Learning from the management of risk

14.1. The Trust is committed to continuously developing as a learning organisation and ensuring that it can learn from the outcomes and processes of its risk management system. Learning will include the identification of improvement actions that will enable incremental improvement in the effectiveness of the risk management system, the implementation of effective controls and risk mitigations and the development and delivery of assurance. Learning opportunities will be identified throughout the Trust's risk management process and highlighted to the Board. Plan for risk management improvement will be incorporated into the Corporate Risk Management Strategy, Policy and practice.

15. Organisational responsibilities

15.1. In line with the governance structure illustrated in Appendix 2 below describes the key responsibilities of the Board and its Committees. Appendix 3 describes the roles and responsibilities of the Trust's key management groups for the delivery of the Trust's risk management systems and processes and the development of assurances in relation to the management.

15.2. The Terms of Reference for the Board Committees and groups reporting to the Board subcommittees are available on QNet

16. Strategy Implementation and monitoring

16.1. The Trust's Corporate Risk Management Strategy will be implemented through the mechanisms described within the Risk Management Policy. The Board will review the Corporate Risk Management Strategy annually making any changes required in year to reflect national and regulatory standards, best practice and learning and improvement opportunities identified by the Trust including through internal or external reviews the of risk management systems.

Appendix 1: Good Governance Institute: *Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking*

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels / Key elements	0 Avoid Avoidance of risk and uncertainty is a Key Organisational objective	1 Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

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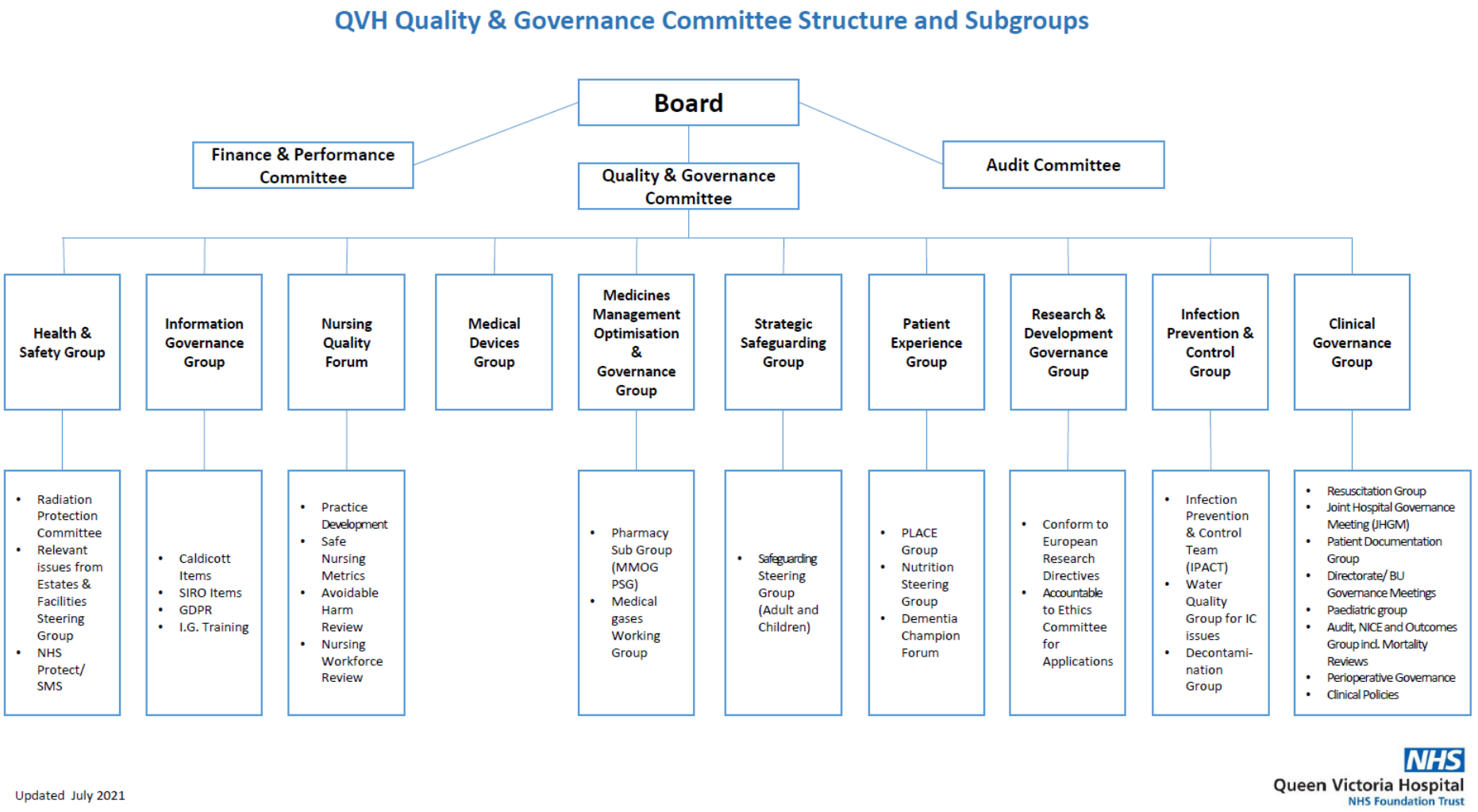
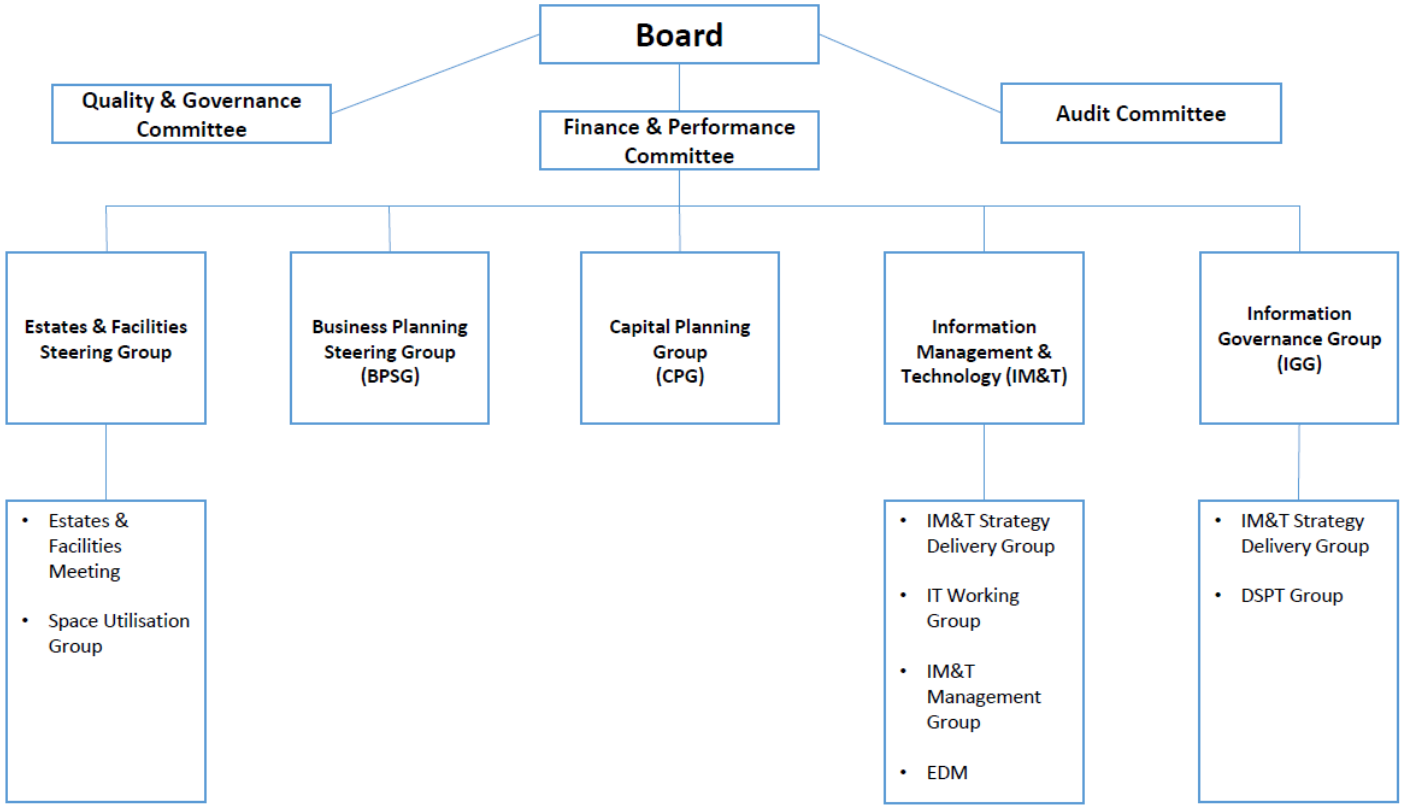
Appendix 2: Trust's Quality and Governance Structure



FINANCE & PERFORMANCE COMMITTEE STRUCTURE AND SUB-COMMITTEES



Updated April 2021 – Michelle Miles

NHS
Queen Victoria Hospital
NHS Foundation Trust

17. Appendix 3: Responsibilities of the Board and Board committees

The Trust Board is accountable for

- Agreeing the Trust's Corporate Risk Management Strategy
- Agreeing the key risks to the achievement of the Trust's strategic objectives
- Agreeing the Trust's risk appetite in relation to the strategic objectives and the types of risk the trust is managing
- Agreeing the BAF, defining the controls, assurances and gaps in control and assurance for each of the key risks that will be the focus of the Board's assurance assessment activity
- Ensuring the BAF informs the business of the Board and drives the Board agenda
- Scrutinising and testing the assurances received on the effectiveness of controls and actions to address gaps in control through the annual cycle of business
- Challenging the risk controls and sources of assurance described within the BAF to ensure they are effective and robust
- Considering the wider strategic implications of the risks identified, and making recommendations to improve management of risk by taking a strategic corporate approach

The Board delegates responsibility to the **Audit Committee** for

- Assessing the quality and strength of the assurances received on the Trust's risk management, quality and financial governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of governance, risk management and internal controls, across the whole of the Trust's activities (both clinical and non-clinical) and that this supports the achievement of the Trust's objectives
- Testing the integrity and completeness of the risk management system through reviewing the strength of operational and strategic risk management and internal control.
- Assessing the accuracy, adequacy of the assurances provided on the effectiveness of controls and the actions being taken to address gaps in control processes that indicate the effectiveness of the management of principle corporate and clinical risks.
- Identifying gaps in assurance, assessing the adequacy and robustness of the actions being taken to address these gaps and the progress being made to close them
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the above responsibilities
- Regularly reviewing and testing the contents of the Trust's Corporate Risk Management Strategy, Risk Management Policy and associated policies in pursuit of the above responsibilities.
- Ensuring there is independent scrutiny of the Trust's risk management and governance systems and processes and of the strength and adequacy of related assurances through internal and external audit work programmes
- Making recommendations to the Trust Board on the development and implementation of the Corporate Risk Management Strategy and Policy
- Reviewing and testing all risk and control-related disclosure statements (e.g. the Annual Governance Statement) to provide assurance to the Board that they are accurate and adequate.
- Reviewing the Trust's Risk Management Annual Report, and agree recommendations on actions for improving the Trust's risk management systems and processes

The Board delegates responsibility to the **Quality and Governance Committee** for

- Assessing the quality and strength of the assurances received on the Trust's quality and clinical governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of quality and clinical governance across the whole of the Trust's activities and that this supports the achievement of the Trust's objectives
- Testing the integrity and completeness of the quality governance system through reviewing the strength of operational and strategic management and internal control of quality and clinical risks.
- Assessing the accuracy and adequacy of quality reporting and the assurances developed through the Trust's quality management system; identifying gaps in assurance and overseeing the actions being taken to address these gaps and ensure assurances are focused on the key risks to achievement of the Trust's strategic;
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Assessing the effectiveness of the controls implemented through the Trust's quality management system; identifying gaps in control and overseeing the actions being taken to address these gaps and ensure controls are focused on managing the key risks to achievement of the Trust's strategic objectives`
- Escalating concerns about areas of inadequate control to the Board
- Monitoring delivery progress on actions to address gaps in control or assurance and agreeing recommendations on actions for quality improvement
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the above responsibilities
- Reviewing and testing all clinical and quality related statements (e.g. the Quality Account) to provide assurance to the Board that they are accurate and adequate.
- Making recommendations to the Trust Board on the development and implementation of the Quality Strategy
- Regularly reviewing and testing the contents of the quality improvement plans, clinical governance annual reports and associated policies in pursuit of the above responsibilities.

The Board delegates responsibility to the **Finance and Performance Committee** for**:**

- Assessing the quality and strength of the assurances received on the Trust's financial and operational performance governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of financial and operational performance governance across the whole of the Trust's activities and that this supports the achievement of the Trust's objectives
- Assessing the accuracy and adequacy of financial reporting and the assurances developed through the Trust's financial management system; identifying gaps in assurance and overseeing the actions being taken to address these gaps and ensure assurances are focused on the key risks to achievement of the Trust's strategic objectives
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Assessing the effectiveness of the controls implemented through the Trust's financial management system; identifying gaps in control and overseeing the actions being taken to address these gaps and ensure controls are focused on managing the key risks to achievement of the Trust's strategic
- Escalating concerns about areas of inadequate control to the Board
- Monitoring delivery progress on actions to address gaps in control or assurance and agreeing

- recommendations on actions for financial improvement
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the above responsibilities
- Reviewing and testing all financial statements (e.g. the Financial Accounts) to provide assurance to the Board that they are accurate and adequate.
- Reviewing and testing the reported performance of the Trust to provide assurance that the information reported is accurate and adequate.
- Making recommendations to the Trust Board on the development and implementation of the Trust's Financial Strategy.

The **Trust Executive Management Team** is responsible for**:**

- Ensuring the effective identification, evaluation and management of operational and strategic risk in all aspects of the Trust's business and providing effective and proactive leadership of risk management within the Trust by implementing the Trust's Corporate Risk Management Strategy and Policy and the associated framework of processes, procedures and controls that enable risks to be managed directly and through delegated powers and ensure the Trust meets its strategic objectives
- Ensuring the Trust's Corporate Risk Management Strategy and Policy and the annual risk management improvement plan are developed, regularly reviewed and updated taking into account recommendations for improvement arising from internal and external scrutiny and recommending these to the Board for approval.
- Developing and providing assurance to the Board and its Committees on the effectiveness of the Trust's risk management systems
- Reviewing the local RR, CRR and Board Assurance Framework routinely to ensure risks and controls are described clearly and accurately, rated consistently, and managed appropriately to reduce risks to the agreed target level. Recommending the BAF to the Board for approval.
- Identifying gaps in assurance or control and ensuring actions to address these gaps are agreed and delivered in a timely fashion to make the necessary improvements, taking action as required to address delays and enable and support successful delivery
- Escalating risks, gaps in control or gaps in assurance to the Board
- Promoting continuous quality improvement with regard to the management of clinical and non-clinical risk and the control environment throughout the Trust by examining and challenging action plans developed to control risks and assessing their wider impact.
- Assessing the quality and strengths of the assurances developed through the Trust's quality management system and its sub-groups to provide evidence of the effectiveness of quality risk management within the Trust, taking action to strengthen assurances as required
- Assessing the quality and strengths of the assurances developed through the Trust's performance management system to provide evidence of performance risk management within the Trust, taking action to strengthen assurances as required
- Assessing the quality and strengths of the assurances developed through the Trust's financial management system to provide evidence of financial risk management within the Trust, taking action to strengthen assurances as required
- Considering the wider strategic implications of risks and themes arising, and opportunities to improve management of risk by taking a corporate approach
- Delegating powers for the management of risk to the appropriate management groups as set out in their approved Terms of Reference.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	03/03/2022		**Agenda reference:**	**42-22**	
Report title:	**Health care worker flu vaccination information**				
Sponsor:	Nicky Reeves, Chief Nurse				
Author:	Nicky Reeves, Chief Nurse				
Appendices:					
Executive summary					
Purpose of report:	To provide assurance and update regarding the QVH 2021/22 seasonal flu campaign				
Summary of key issues	• Overall increase in vaccination numbers across the workforce • Decrease in seasonal flu vaccination uptake in some staff groups • Plans to address challenges for the 2022/23 campaign				
Recommendation:	Board is asked to **note** the contents of this 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:	Any risks to achievement of the targets will be noted on the relevant BAF				
Corporate risk register:	None at this stage				
Regulation:	CQUIN applicable to the numbers of relevant staff vaccinated which is monitored by NHSE/I				
Legal:	None				
Resources:	Resources required to incentivise the vaccination uptake and to deliver the required levels				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	28/02/22	Decision:	Outcome not available due to timing of Q&GC meeting and board reporting deadline. A verbal update will be provided at the board meeting.	
Next steps:					

Report to: Board of Directors
Agenda item: 42-22
Date of meeting: 3 March 2022
Report from: Nicky Reeves, Chief nurse
Report author: Nicky Reeves, Chief nurse
Date of report: 23 February 2022
Appendices: none

Health care worker flu vaccination Information

1. Purpose

To **inform** the Board of the evaluation of the QVH 2021/22 seasonal flu campaign.

2. Introduction

Prior to starting the 2021/22 flu campaign a detailed review of the effectiveness of the previous year's plan was undertaken including consideration of the comments and feedback.

The 2021/22 Flu programme requires QVH to report nationally to Public Health England via their IMMFORM platform. This year's figures are not readily comparable to previous data due to the increase of the denominator as reporting had to mirror the Covid 19 vaccination denominators, all bank staff were included which in previous years have not counted in the figures.

3. Summary

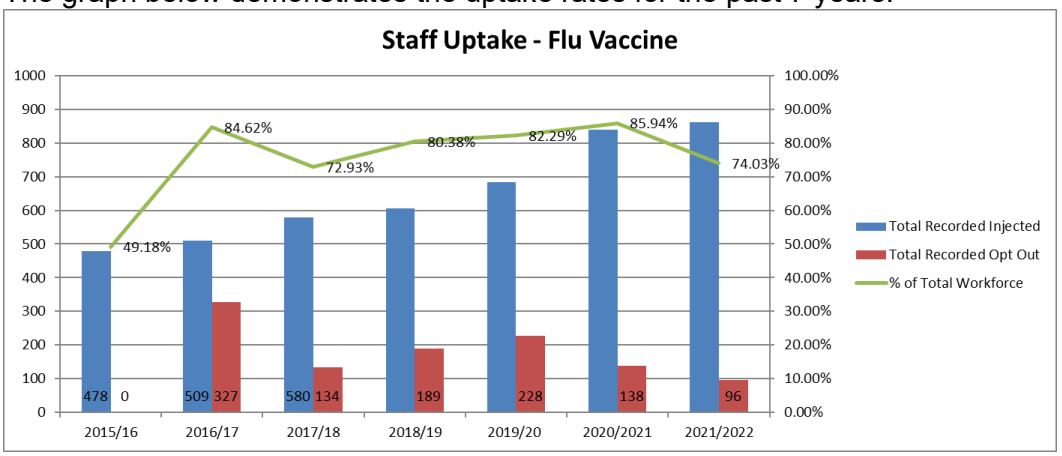
As in previous years, QVH adopted a mixed approach to encourage staff to be vaccinated Occupational health provided drop in clinics and there were a number of peer vaccinators trained who were based in clinical areas and who carried out roving vaccination clinics.

Monthly review of staff unvaccinated was undertaken and line managers were contacted to encourage staff to access a drip in clinic.

Of note, overall, QVH was able to vaccinate more individuals than previous years.

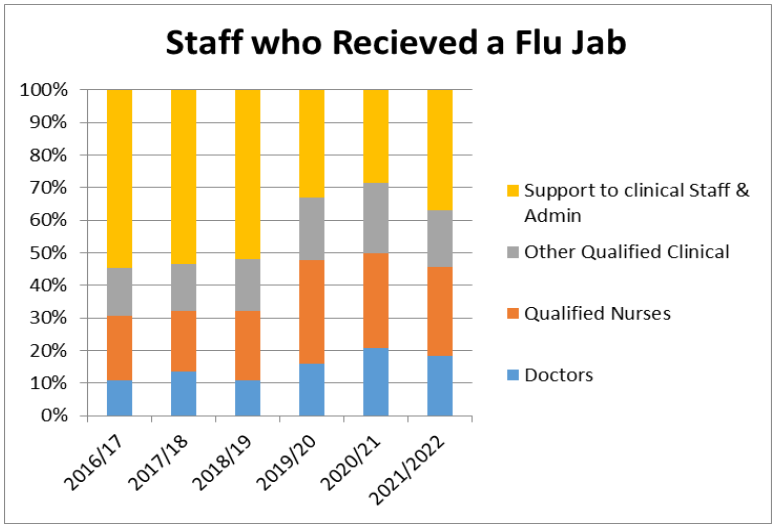
As in previous years, QVH reviewed the best practice checklist (**Appendix 1**)

The graph below demonstrates the uptake rates for the past 7 years.

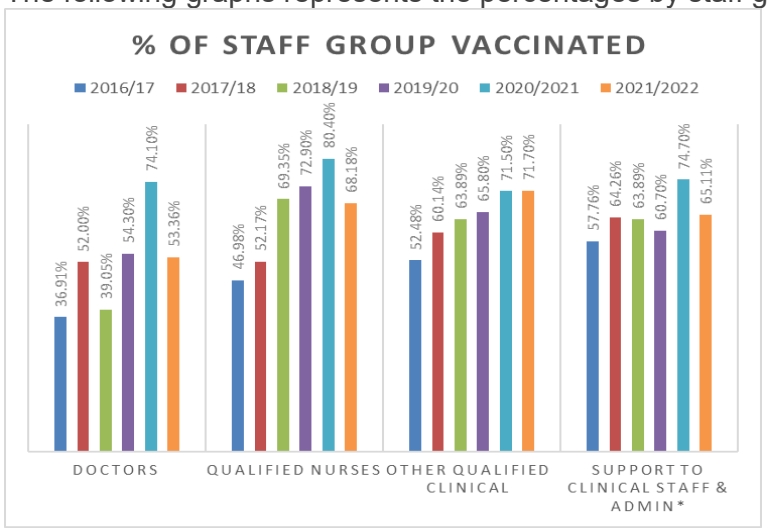


*Total Workforce 2021/22 now includes all bank staff in line with reporting for Covid 19 vaccination. This chart includes all staff not just those reported to IMMFORM.

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



The following graphs represents the percentages by staff group



The above graphs identify that IMMFORM reportable staff vaccination uptake has seen a decrease in some groups, of note medical and nursing.

There is some anecdotal evidence that staff prioritised Covid 19 vaccine over the seasonal flu vaccine.

To date over 860 staff have vaccinated against seasonal flu.

4. Next steps

- Fewer staff provided formal “opt out” information which will be addressed in 2022/23 planning
- Prior to the 2022/23 Seasonal Flu campaign commencing a targeted piece of work will be undertaken to address the reasons for decrease in uptake within the medical and nursing workforce
- Early identification of Seasonal Flu champions to support the communication of the campaign
- Continue to incentivise the uptake of Seasonal Flu vaccine

5. Recommendation

The board is asked to **note** the contents of this report.

Appendix 1

Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	✓
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	✓
A3	Board receive an evaluation of the flu programme 2020/21, including data, successes, challenges and lessons learnt	✓
A4	Agree on a board champion for flu campaign	✓
A5	All board members receive flu vaccination and publicise this	✓
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	✓
A7	Flu team to meet regularly from September 2021	✓
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	✓
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	✓
B3	Board and senior managers having their vaccinations to be publicised	✓
B4	Flu vaccination programme and access to vaccination on induction programmes	✓
B5	Programme to be publicised on screensavers, posters and social media	✓
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	✓
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	✓
C2	Schedule for easy access drop in clinics agreed	✓
C3	Schedule for 24 hour mobile vaccinations to be agreed	✓
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	✓
D2	Success to be celebrated weekly	✓

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed : 23 February 2022

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 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
- Vacancy levels in sleep [CRR 1116]
- 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
- Reduced IS provision for corneo plastics to inability to access Horder Healthcare capacity
- Increased demand in immediate breast reconstruction referrals

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 ongoing
- 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 23/02/2022**

Strategic Objective
We maximize existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services

Risk
Loss of confidence in the long-term financial sustainability of the Trust due to a failure to create adequate surpluses to fund operational and strategic investments

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

Initial Risk 3 (C) x 5 (L) = 15, moderate
Current Risk Rating 4 (C) x 5 (L)= 20, High
Target Risk Rating 4 (C) x 3 (L) = 12, moderate

Rationale for current score (at Month 10)

- The Trust submitted a breakeven plan for H2 in line with ICS. As at Month 10 the Trust is reporting a £0.7m surplus on actuals & forecasting a surplus position of £1.2m including technical adjustments at year end.
- ERF changes in H2 to clockstops, no income achievement in month 10.
- 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 in calendar year, business planning will need to continue based on assumptions of current cost base.
- Capped expenditure process
- Single Oversight Framework
- Commissioning intentions – Clinical effective commissioning
- NHSI/E control total expectation of annual breakeven within the LTFM trajectory (2020/21-2024/25)
- Central control total for the ICS which is allocated to organisations
- Unknown Brexit risks for increased costs for such items as drugs and procurement and staffing implications
- Significant work to develop the LTP in line with potential merger
- Lack of relevant resource to deliver BAU, develop required efficiencies and Business Cases
- Development of compatible IT systems (clinical and non clinical) & back office functions will be part of the longer term plan to ensure in medium term efficiencies may be achieved.

Future Opportunities

- New workforce model, strategic partnerships; increased trust resilience / support wider health economy
- Develop the significant work already undertaken using IT as a platform to support innovative solutions and new ways of working
- Increase in efficiency and scheduling through whole of the patient pathway through service redesign
- Spoke site activity repatriation and new model of care
- Strategic alliances \ franchise chains and networks
- Increase partnership working across both Sussex and Kent and Medway with greater emphasis on pathway design
- Decision in principal to move ahead with due diligence with BSUH & WSHT
- Development of increased partnership working through the merger to include greater economies of scale and efficiencies for work load and also potential cash savings in the longer term

Controls / Assurances

- Performance Management regime in place and performance reports to the Board.
- Contract monitoring process and CIP Governance processes strengthened.
- Finance & Performance Committee in place, forecasting from month 7 onwards subject to caveats with regards to the NHS environmental changes
- Audit Committee with a strengthened Internal Audit Plan.
- Budget Setting and Business Planning Processes (including capital) approved for all areas.
- Income / Activity capture and coding processes embedded and regularly audited
- Weekly activity information per Business unit, specialty and POD reflected against plan and prior year and revised trajectories in line with the phase 3 guidance.
- Spoke site, Service line reporting and service review information widely circulated.
- Service reviews started and working with a combined lead from the DoO and DoF

Gaps in controls / assurances

- Structure, systems and process redesign and enhanced cost control
- Model Hospital Review and implementation
- Identification and Development of transformation schemes to support long term sustainability
- Non achievement of efficiencies to achieve lower cost profile
- Understanding of payment mechanisms in future periods

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**3 March 2022**		**Agenda reference:**	**44-22**	
Report title:	**Financial, operational and workforce performance assurance**				
Sponsor:	Paul Dillon-Robinson, committee chair				
Author:	Paul Dillon-Robinson, committee chair				
Appendices:	NA				
Executive summary					
Purpose of report:	Board Assurance on matters discussed at the committee's meeting on Monday 24th January. A verbal update on the latest meeting, on 28th February, will be given at the meeting.				
Summary of key issues	Operational performance : positive projections for reductions in longer waiting lists by year-end, potential impact as a cancer hub and theatre utilisation. Workforce indicators : vacancy management Financial results : forecasting break-even under current regime Business planning for 2022/3 : challenging demands and unclear on the financial impact				
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:	Committee is looking 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: 3 March 2022
Reference no: 44-22
Report from: Paul Dillon-Robinson, Committee Chair
Report date: 22 February 2022

Financial, operational and workforce performance assurance

Introduction

The finance and performance committee met on 24th January (reported below) and will have met on 28th February 2022 (a verbal update can be given at the meeting).

1. Operational performance

The committee noted the Trust's role as a cancer hub, from 14 January, that would have an impact on our access targets, but took assurance that forecasts for 104ww, 78ww and 52ww were on target for the year-end, albeit expecting a "hockey stick" effect after that.

Risks to performance continue to be late referrals (particularly for cancer) and staff absences, whilst it is still too early for the remedial plan for Sleep to have an impact.

The committee discussed the work on health inequalities, and the importance of capturing complete and accurate data. The trust's focus, given the nature of services, has been on cancer and learning difficulties.

Theatre utilisation continues to remain outside the KPIs for late starts and early finishes, although no clear trend or explanation can be seen from the analysis of data.

2. Workforce performance

The management of vacancies remains a core focus and, whilst they have come down and new starters are being processed, there still remains a gap from the desired level of staffing.

Vaccination as a condition of deployment was discussed in some detail, and the issue then discussed at the following Board meeting, albeit that the issue has been subsequently dropped.

3. Financial performance

The financial forecast remains a break-even for the year-end, under the current funding arrangements. There remains uncertainty about the treatment of ERF income, which is a system allocation.

The trust's expenditure run-rate remains broadly consistent with the historic trend

4. Business planning for 2022/3

The committee reviewed a presentation on the business planning guidance for 2022/23 noting the drive for increased activity (particularly achieved through greater productivity), focus on waiting lists and recovery.

Financial risks remain, from how the ICB will introduce the new aligned payment and incentive contracts, the impact of changes to national tariff, as well as how dental commissioning will approach the new year.

5. Other

The committee reviewed the corporate risks allocated to it and was pleased to see that clinical coding risk was downgraded following the successful programme of work. It also discussed risks around IT security and noted the new risk related to the licence conditions. Updates were also received on Information Governance, Data Quality and Cyber Security.

The business case for the iRefer diagnostics clinical support system, which is being piloted by the trust and funded centrally was noted and assurance taken on the process adopted.

The committee approved twelve policies.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**3 March 2022**		**Agenda reference:**	**45-22**	
Report title:	**Operational Performance Report**				
Sponsor:	Abigail Jago, Director of Operations				
Author:	Operations Team				
Appendices:					
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 • Cancer Work Streams – Health Inequalities Deep Dive				
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:	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:	NA				
Assurance route					
Previously considered by:	Finance & Performance Committee				
	Date:	28/02/22	Decision:	Outcome not available due to timing of F&PC meeting and board reporting deadline. A verbal update will be provided at the board meeting.	
Next steps:					

Operational Performance Report

Abigail Jago, Director of Operations

February 2022

Contents

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Headlines

Queen Victoria Hospital NHS Foundation Trust

Cancer:

- Performance **meeting national / local set standards** for 2WW, 62 day and faster diagnosis.
- Performance **behind agreed trajectory** for 62 day backlog (2 patients) and patients waiting greater than 104 days (2 patients) primarily due to late referrals. 31 day remains behind plan in month which continues to be driven by skin.

Diagnostics:

- **DMO1** – Radiology only DMO1 performance is **99.53%**. Sleep continues to remain challenged - Sleep only DMO1 performance has increased 5% in month to **37.27%** . Revised trajectory confirmed to meet compliance by August 2022.

Waiting Lists and Long Waiters:

- Patients waiting over **104** weeks have reduced by 5 in month and is within plan. Services remain on track to eliminate ahead of March 2022.
- Patients waiting over **78** weeks has reduced and is within plan; all services have seen an in month reduction.
- Patients waiting over **52** weeks has reduced and is within plan.

Activity Vs Plan:

- **Day case** activity has remained consistent with last month and is below plan, which is driven by case mix challenges.
- **Elective** activity has remained consistent with last month and is below plan, driven by corneo.
- **First outpatients** and **follow up outpatients** have fallen in month and remain below plan. Driven by vacancies and leave in corneo. Follow up was impacted by a fall in Orthodontic activity.

CANCER NATIONAL POSITION: *(Dec-21)*

2WW: **31** out of 131	**31 Day:** **78** out of 142
FDS: **14** out of 144	**62 Day:** **19** out of 143

DMO1 NATIONAL POSITION: *(look back - Dec-21)*

National: 71.0%	**QVH DMO1:** 87.6%

RTT NATIONAL POSITION: *(look back – Dec-21)*

National RTT18: 63.8%	**QVH RTT18:** 67.8%
National % >52WW: 5.1%	**QVH % >52WW:** 2.0%

FORWARD LOOK / PERFORMANCE RISKS

- 22/23 first cut trust level elective delivery plan complete / service level plans under development
- Ongoing Cancer Hub role to support the system.
- Anticipated increase in **52WW** due to cancer hub provision and waiting list distribution.
- **62D/104D backlog** – remain an ongoing performance risk due to continued challenge of late referrals and patient initiated delays.
- **31 day** – performance challenges into January, due to medical delays and theatre skin capacity.
- Sleep staffing position; continued performance risk for **DMO1** and **elective activity**. Ongoing work to address.
- Ongoing risk around patients delaying / unable to attend for treatment for Covid and Non-Covid reasons.

Performance Summary

Queen Victoria Hospital NHS Foundation Trust

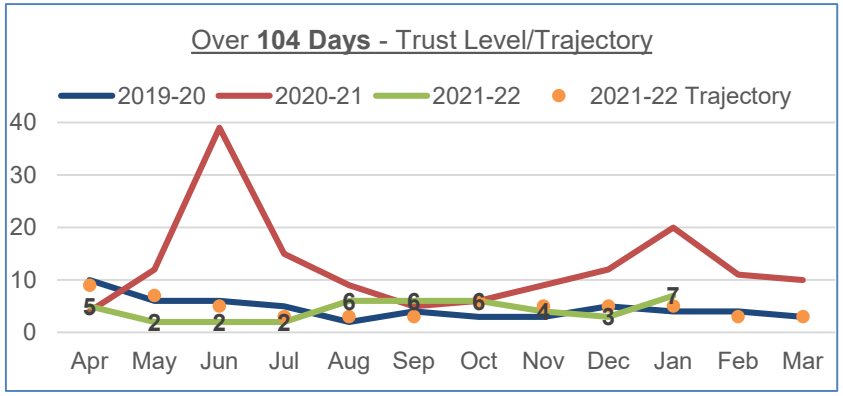
	KPI	TARGET / METRIC	SOURCE	FEB21	MAR21	APR21	MAY21	JUN21	JUL21	AUG21	SEP21	OCT21	NOV21	DEC21	JAN22
CANCER	Cancer 2WW	93%	National	98.2%	98.8%	97.8%	98.5%	97.0%	91.2%	89.2%	89.7%	90.2%	88.8%	94.8%	-
	Cancer 62 day	85%	National	87.5%	87.7%	87.5%	89.2%	89.3%	88.4%	91.7%	91.7%	85.5%	88.0%	85.5%	-
	Cancer 31 day	96%	National	94.8%	94.6%	95.5%	97.3%	98.0%	96.7%	95.6%	96.0%	96.5%	94.9%	94.0%	-
	Faster Diagnosis	75% (by March '24)	National	82.8%	83.2%	84.7%	88.9%	85.4%	86.9%	82.5%	80.5%	83.0%	82.1%	88.2%	-
	Cancer 104 day	Internal trajectory	ICS	11	10	5	2	2	2	6	6	6	4	3	7
	Cancer 62 day backlog	Internal trajectory	ICS	22	8	15	12	18	21	28	30	30	28	24	26
	Cancer 62 day backlog	<5% of PTL	Local		2.3%	4.6%	2.7%	4.8%	4.3%	5.6%	5.7%	6.0%	5.5%	6.0%	6.6%
DIAGNOSTICS	DMO1 Diagnostic waits	99% <6 weeks	National	99.15%	98.92%	98.88%	97.51%	94.07%	90.76%	86.89%	86.24%	87.88%	91.06%	87.60%	89.70%
	Histology TAT	90% <10 days	Local	94%	94%	95%	97%	91%	97%	96%	95%	93%	98%	98%	92%
	Imaging reporting	% <7 days	Local	98.4%	97.0%	96.8%	99.1%	97.2%	97.0%	97.1%	98.1%	97.2%	95.4%	95.7%	98.0%
RTT WAITS	Total Waiting List Size	N/A	N/A	10,416	11,002	10,583	10,487	11,032	11,524	11,242	11,224	11,271	11,438	11,541	12,241
	RTT104	0 by March '22	ICS	-	2	5	6	4	6	7	4	6	4	6	1
	RTT78	0 by March '22	Local	62	87	126	137	99	103	106	74	49	23	22	15
	RTT65	0 by March '23	Local	-	-	-	-	-	-	-	-	-	-	-	54
	RTT52	0 by March '23	ICS	907	903	715	534	370	310	272	225	213	206	229	192
	RTT18	92%	National	69.96%	70.22%	71.20%	74.14%	77.59%	76.08%	75.52%	73.53%	71.80%	70.31%	67.82%	68.10%
RECOVERY ACTIVITY	Day Case	Recovery plan (% of)	ICS	-	-	100.8%	89%	93%	89%	83%	92%	97%	94%	95%	92%
	Elective	Recovery plan (% of)	ICS	-	-	92.6%	104%	93%	89%	76%	107%	94%	88%	89%	96%
	First Outpatients	Recovery plan (% of)	ICS	-	-	103.4%	95%	113%	98%	82%	92%	95%	98%	88%	94%
	Follow Up Outpatients	Recovery plan (% of)	ICS	-	-	112.8%	103%	102%	97%	89%	100%	98%	99%	93%	97%
	Outpatient Therapies	Recovery plan (% of)	ICS	-	-	105.9%	108%	111%	113%	99%	113%	104%	113%	91%	105%
	Non Elective	Recovery plan (% of)	ICS	-	-	103.1%	112%	104%	105%	101%	96%	96%	92%	87%	98%
MIU	MIU	95% discharged <4hrs	National	99.8%	100%	99.9%	99.9%	99.1%	99.9%	99.6%	98.9%	99.5%	99.7%	99.1%	99.7%
RAG	Deteriorating position or plans / cause for concern			Improving position or plans / local trajectories on track						Delivery of national / local standard					

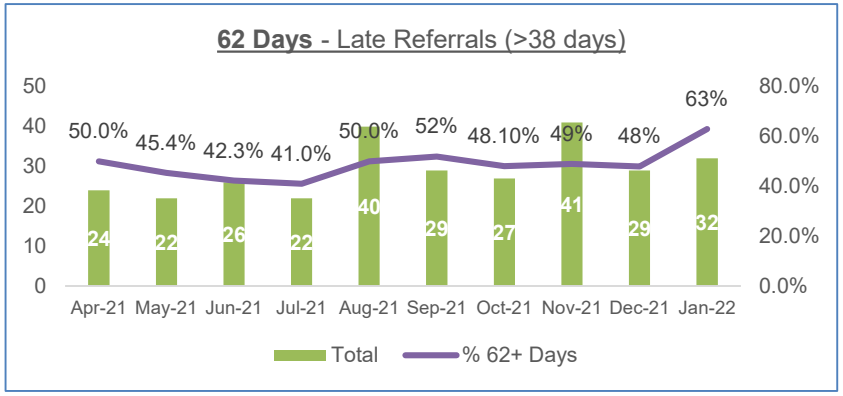
Cancer

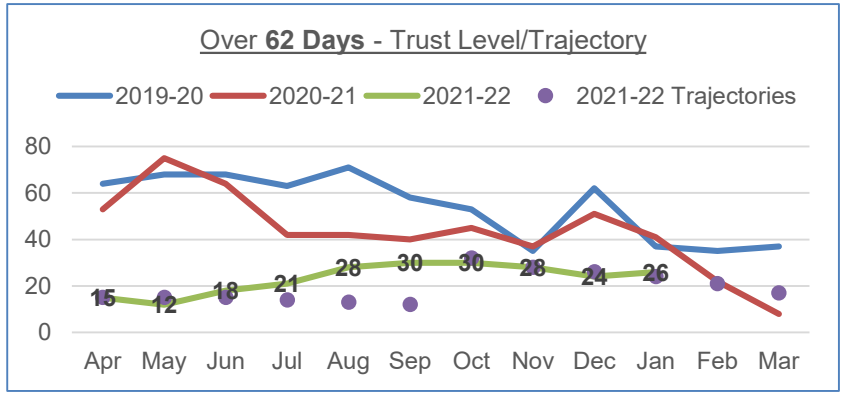
Performance Dashboard / 62 days / 104 day backlog / recovery

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%	91.2%	89.2%	89.7%	90.2%	88.8%	94.8%				↑
62 Day Referral to Treat	86.5%	87.5%	89.2%	89.3%	88.4%	91.7%	91.7%	85.5%	88.0%	85.5%				↓
Faster Diagnosis	77.5%	84.7%	88.9%	85.4%	86.9%	82.5%	80.5%	83.0%	82.1%	88.2%				↑
62 Day Con Upgrade	90.1%	90.0%	92.3%	83.9%	100%	90.9%	100%	61.5%	78.9%	85.7%				↑
31 Day Decision to Treat	93.0%	95.5%	97.3%	98.0%	96.7%	95.6%	96.0%	96.5%	94.9%	94.0%				↓
31 Day Sub Treat	94.0%	94.4%	100%	87.5%	80.0%	88.9%	93.3%	100%	87.5%	62.5%				↓







PERFORMANCE COMMENTARY

- **2WW** – met standard with 22 breaches; 11 were patient choice. There was a 27% increase in patients seen in the days 0 to 7 during the reporting period.
- **62 day referral to treat** – met standard.
- **Faster diagnosis** – met standard.
- **62 day consultant upgrade** – met standard.
- **31 day decision to treat** – standard not met by 2% – driven by medical delays and skin theatre capacity.
- **31 day subsequent** – standard not met – driven by skin due theatre capacity challenges.
- **62 day backlog** – trajectory not met (by 2 patients) and PTL % (32 late referrals in month of which 63% > 62 days).
- **Over 104 day** – trajectory not met (by 2 patients) due to an increase in late referrals received in month.

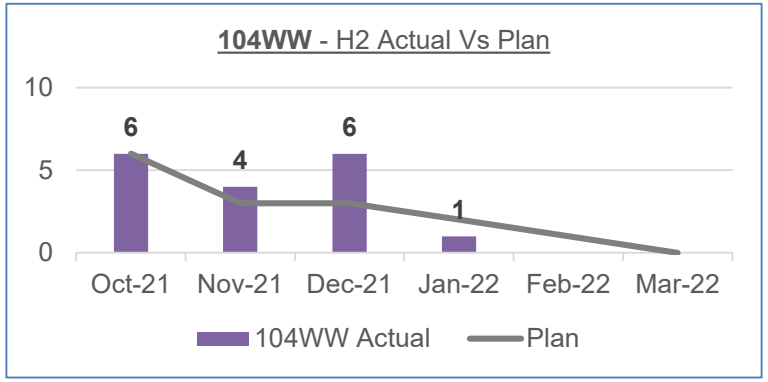
FORWARD LOOK / PERFORMANCE RISKS

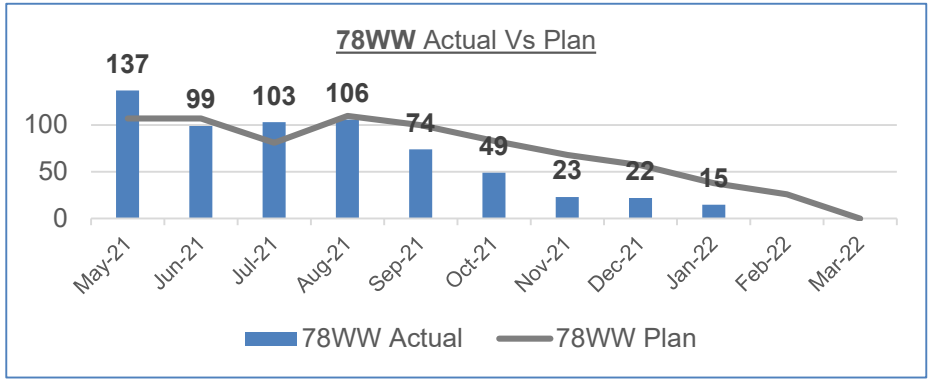
- The unvalidated January performance for **2WW, FDS** and **62 day** is above plan.
- The unvalidated January performance for **31 day** is below plan, due to ongoing medical delays and skin theatre capacity.
- **62 day backlog** – Ongoing risk around inclusion of late referrals from other trusts, with an average remaining at 29 late referrals a month. Patient initiated delays challenge ongoing.
- **Over 104 day** – Key risk is late referrals from other trusts. Over the last 4 months an average of 5 late referrals per month, received past 104 days.
- Current delays where surgery is being cancelled due to medical reasons - Covid and non-Covid.

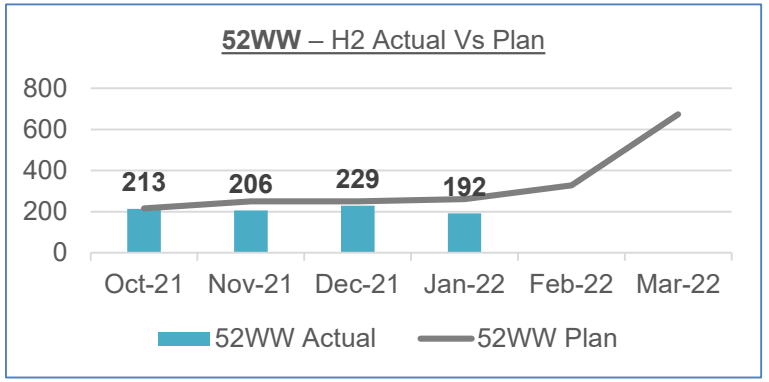
RTT Waits

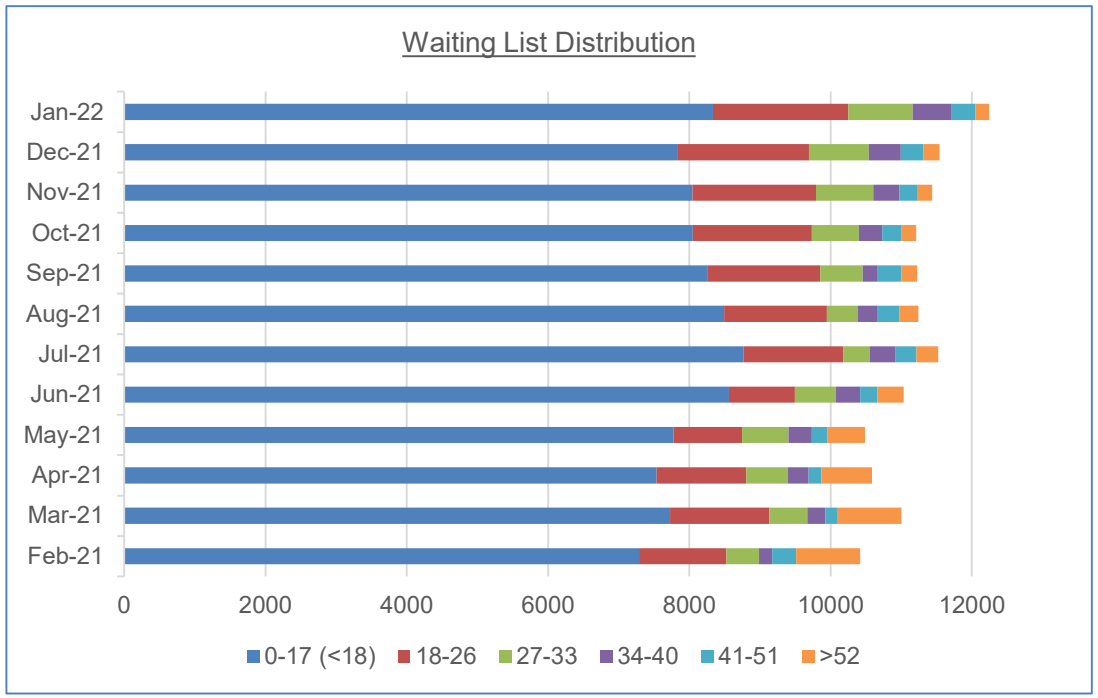
104WW / 78WW / 52WW

Queen Victoria Hospital NHS Foundation Trust









PERFORMANCE COMMENTARY

- **104WW** – Meeting H2 trajectory with 1 plastics patient waiting over 104 weeks, which is patient choice. This patient has a 'To Come In' (TCI) date.
- **78WW** – Meeting trajectory, with a reduction of 7 of patients waiting over 78 weeks to 15; Corneo - 1, MaxFacs - 3, Plastics – 11. A increase in percentage with TCI/treatment booked to 67%; 5 are patient deferred.
- **52WW** – Meeting H2 trajectory with an in month reduction of 37 of patients waiting more than 52 weeks to 192. 28.1% of patients have a TCI booked. Of the total number waiting 66.15% are Plastics, 15.63% are Max Fac, 17.19% are Corneo and 1.04% are Sleep.

FORWARD LOOK / PERFORMANCE RISKS

- **104WW** remain a primary focus with a target to eliminate 104WW by March 2022.
- **65WW** – initial review of the 65 week wait position which forms part of 22/23 operational planning targets. 54 as of January.
- **52WW** – forward look shows an increase in February and March as expected, although remaining below H2 trajectory.
- Ongoing PTL validation exercise planned within all services.
- Non-admitted pathways continue to remain stable and continue to be reviewed through the PTL process.
- Ongoing risk around patients delaying treatment for Covid and Non-Covid reasons.

Recovery Activity

QVH Site / Independent Sector

Queen Victoria Hospital NHS Foundation Trust

POD	January 21/22 Activity	Recovery Plan	21/22 Activity Variance against Recovery Plan	21/22 Percentage Variance against Recovery Plan	19/20 Activity	21/22 Activity Variance against 19/20 Activity	21/22 Percentage Variance against 19/20 Activity - Threshold 95%
Day Case	806	876	-70	92%	835	-29	96%
Elective	225	234	-9	96%	281	-56	80%
First Outpatients	2902	3093	-191	94%	3112	-210	93%
Follow Up Outpatients	9304	9594	-290	97%	9379	-75	99%
Outpatient Therapies	2341	2225	116	105%	2413	-72	97%
Non Elective	543	553	-10	98%	448	95	121%
Grand Total	**16121**	**16575**	-454	97%	**16468**	**-347**	**98%**
RAG RATING		Below 90% of recovery plan		90%-100% of recovery plan		Over 100% of recovery plan	

PERFORMANCE COMMENTARY

- **Day Case** – Corneo delivered 72% of 19/20 day cases, shortfall continues to be driven by reduced theatre capacity compared to 19/20. Max Fac/ENT delivered 87% of 19/20; shortfall driven by case mix variation compared to 19/20 and the loss of 6 sessions to accommodate cancer hub capacity. Plastics delivered 114% of 19/20 day cases driven by additional independent sector capacity.
- **Elective** – Max Fac/ENT maintained performance with 99% of 19/20. Corneo recovered performance with 96% of 19/20. Plastics delivered 92% of 19/20. Sleep maintain delivery of 52% of 19/20 driving the Trusts underperformance.
- **First Outpatients** – Corneo performance improved slightly to 85% of 19/20. Underperformance driven by staff vacancy. Max Fac/ENT delivered 99% of 19/20 whilst Orthodontics delivered 160% owing to an additional weekend new patient clinic. Plastics delivered an improved performance of 107% of 19/20. Sleep delivered 88% of 19/20.
- **Follow Up Outpatients** – Max Fac/ENT delivered 116%, Corneo 92% and Plastics 97% of 19/20 levels. Sleep at 121%. Orthodontic performance improved in month to 91%.
- **Non Elective** – Max Fac at 144%, Plastics at 120%. Trust performance improved to 121% owing to reduced levels seen in 19/20.

FORWARD LOOK / PERFORMANCE RISKS

- **Corneo** – Day Case numbers expected to see an improvement due to Saturday and Centre for Sight (CfS) lists. Tissue availability continues to be a risk for elective performance. Cancer hub impact on theatre mitigated to some degree by CfS capacity. OP performance for February expected to improve to near 19/20 levels.
- **Plastics** – Delivery of Day Case and First Outpatient activity expected to continue into February. Performance expected to remain consistent for Elective and Follow Up.
- **Max Fac** – Ongoing challenge with inpatient activity driven significantly by the loss of 15 theatre sessions due to cancer hub activity in February and a similar number expected for March. Outpatient performance expected to reflect January performance.
- **Sleep** – Performance expected to remain at recent levels driving elective underperformance. Ongoing technician shortages continue to drive challenges.
- **Independent sector** – Level of capacity will be pivotal in delivery of activity targets.
- Risk to admitted activity delivery continue to be driven by Covid-19 system challenges and cancer hub requirements as well as cancellations due to staff and patient isolation.

Recovery Work Streams

Outpatients

Virtual Consultations:

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

- Continuing to achieve the required standard – 27% for January.
- Data reconciliation ongoing with system – awaiting a further update at the next Sussex Outpatient Transformation meeting in March.

Patient Initiated Follow Up (PIFU):

Begin reporting on PIFU activity across the six national metrics from the end of Q2 with a target of 1.5% by December and 2% by March of outpatient activity as PIFU.

- Pilot of paper based clinical review for PIFU in sleep commenced in January 2022. Evaluation to be undertaken during February before continuing roll out.
- Exploring PIFU options within Max Fac, Plastics and Sleep (medicine).
- Work underway on a Patient Stratified Follow Up for a skin cancer pathway.
- 170 patients moved to a PIFU pathway in January, which is an increase from last month owing to Sleep. This is 1.26% of all outpatient activity.

Referral Optimisation:

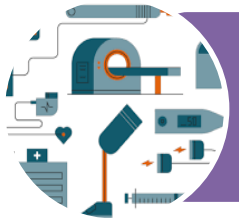
Increase the uptake of A&G to the national ambition of 12% by March 2022.

- Dental e-Referral System (DeRS) – trial of new recording method commenced in January, refining process and working through reporting requirements with the system.
- Planned to report A&G DeRS activity from April.

FORWARD LOOK / PERFORMANCE RISKS

- **KPIs –** due to ongoing workforce challenges within Business Intelligence (BI) work to further develop reporting mechanisms has been delayed. KPIs are being reviewed in line with the newly released operational planning guidance for 2022/23. To be taken forward through new Transformation Board.

Diagnostics - CDC



Diagnostics:

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

- QVH operates as an early adopter CDC to provide patients with access to diagnostic tests nearer to home.
- To connect QVH with primary and secondary care colleagues, QVH will be piloting a digital system called ‘Bleepa’, which will enable all relevant clinicians to review, discuss and plan the next step for each patient’s care.
- Implementation of breathlessness pathway with digital platform Bleepa progressing well.
- Pathway coordinator in place.
- Weekly multidisciplinary team meeting (MDT) established to discuss patient diagnostics in a timely manner, providing GP’s with outcomes in an efficient and effective pathway.
- Further discussions required with the ICS to determine longer term plan for the CDC and associated funding.

Cancer Work Streams
Health Inequalities Deep Dive

Health Inequality Work Streams

Queen Victoria Hospital NHS Foundation Trust

A priority set out in the NHSE/I 2022/23 priorities and operational planning guidance is to 'continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities'. A key clinical area for the ICS to target in health inequalities improvement, as part of the CORE20 PLUS5 is Early Cancer Diagnosis, diagnosing 75% of cases at stage 1 or 2 by 2028.

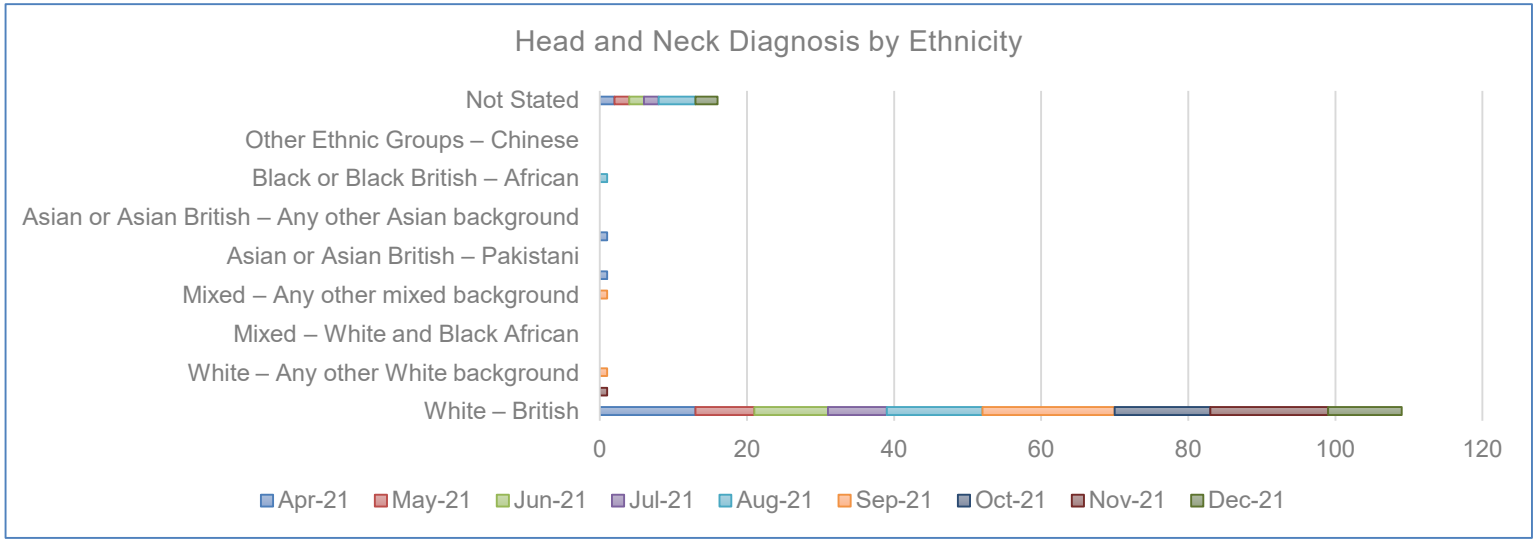
The current health inequality work streams at QVH is aimed at improving data collection, establishing regular reports with detailed analysis, focusing on any trends and working collaboratively with partners. The current work streams are:

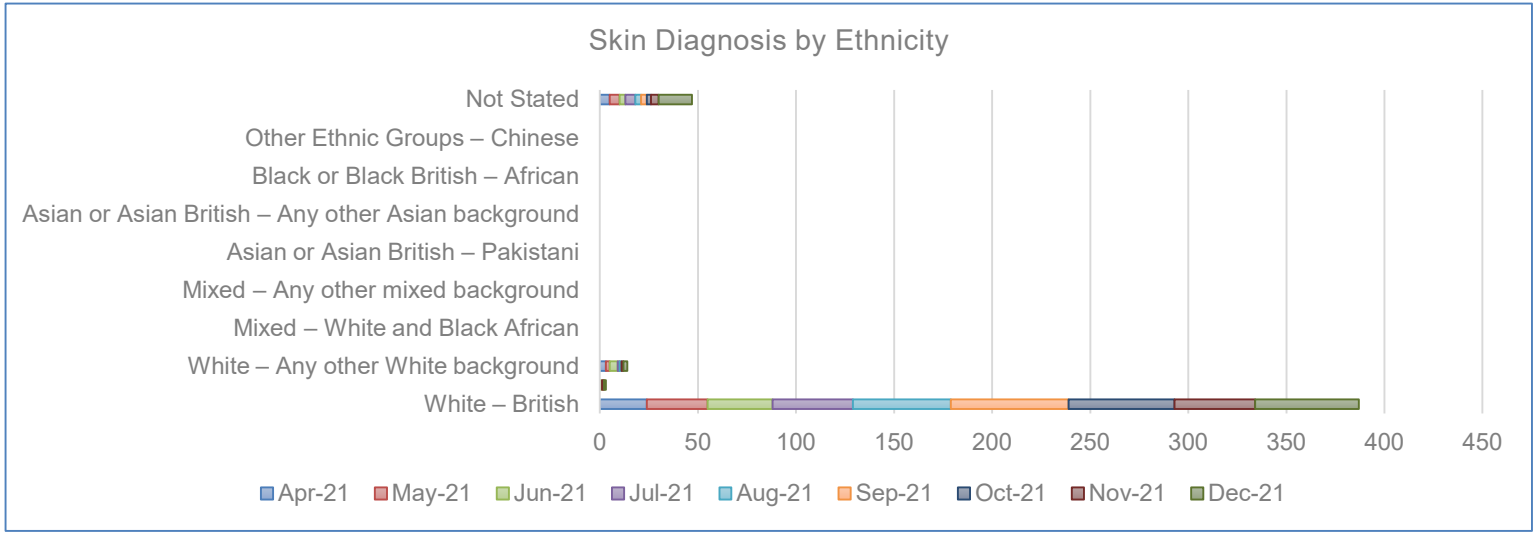
Ethnic coding: understand the needs of patients from different groups to help provide better and more appropriate services

IMD scoring: ensuring that our services are reaching all our local communities and identifying any patients that could be at risk

Gender, age and other known protected characteristics: addressing and affirming equitable access, experience and outcomes

Work stream: ethnicity collection



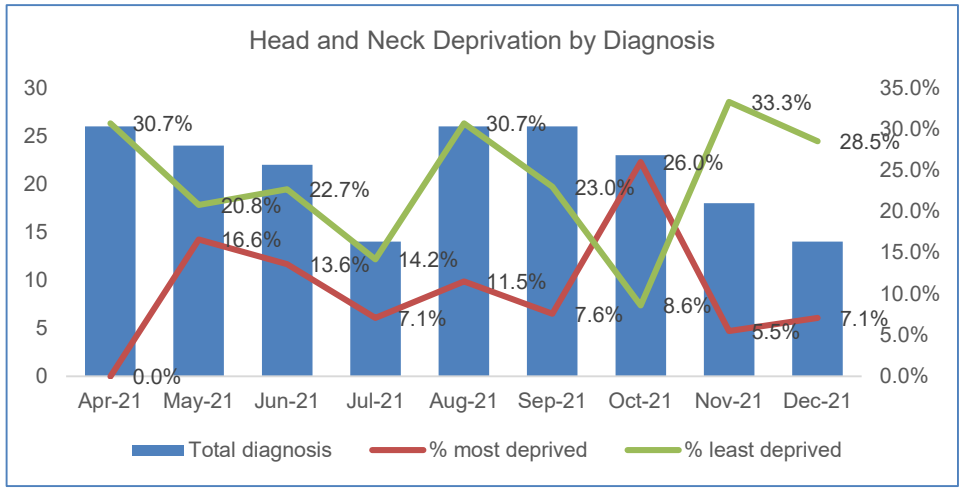


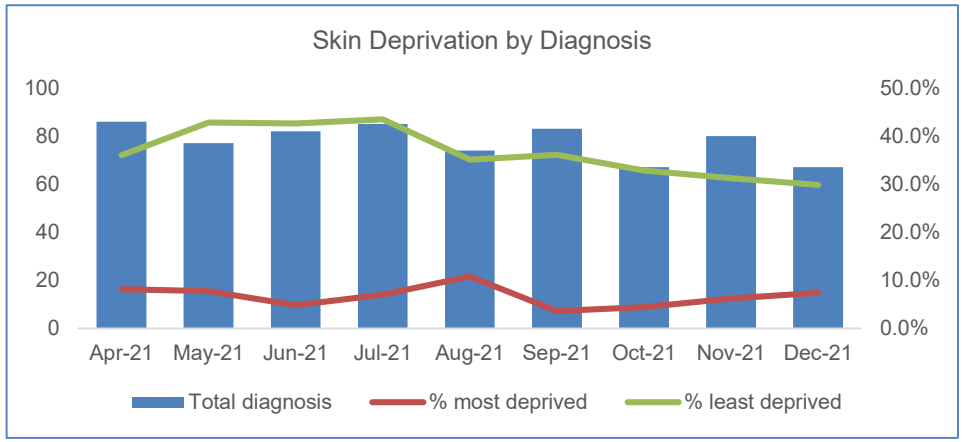
Commentary

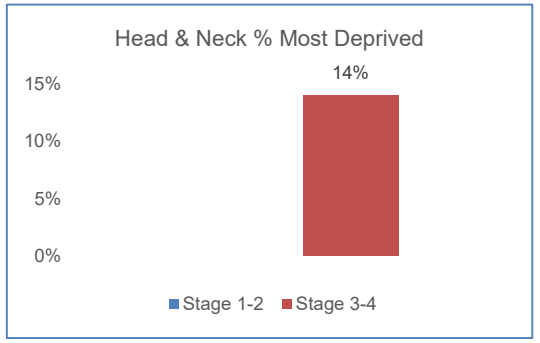
- This data is looking at the split of ethnicity by diagnosis between April 21 and December 21, for skin and head & neck cancer.
- 83% of head & neck diagnosis are White – British, with 1% in White – Any other White background, White – Irish, Mixed – Any other mixed background, Asian or Asian British – Indian, Asian or Asian British – Bangladeshi and Black or Black British – African.
- 86% of skin diagnosis are White – British, with 3% in White – Any other White background and 1% White – Irish.
- There is a requirement to improve the recording of ethnicity. In order to understand any trends or if any actions are required, at least 90% of patients would need to have an ethnic code recorded.

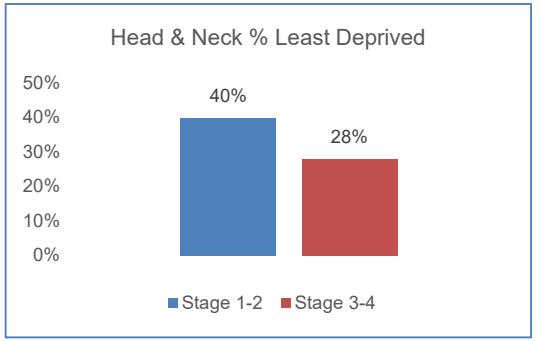
NB: these figures are taken from the number of patients diagnosed with cancer at QVH and elsewhere that underwent treatment at QVH. Not all patients will have a stage.

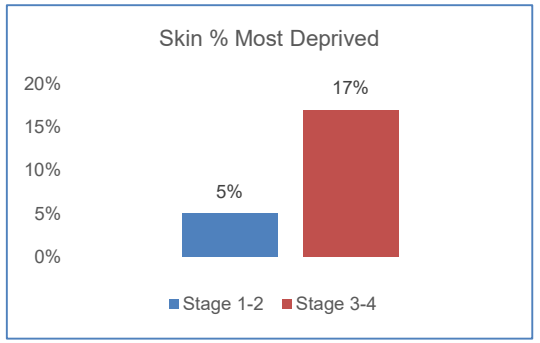
Work stream: deprivation

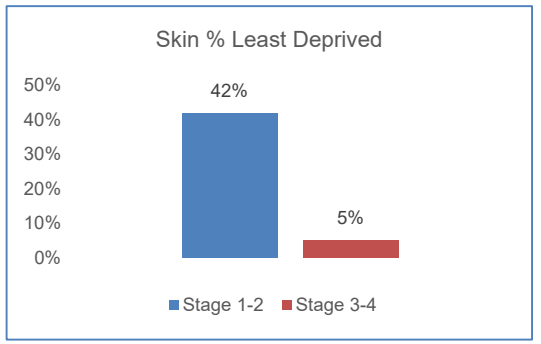










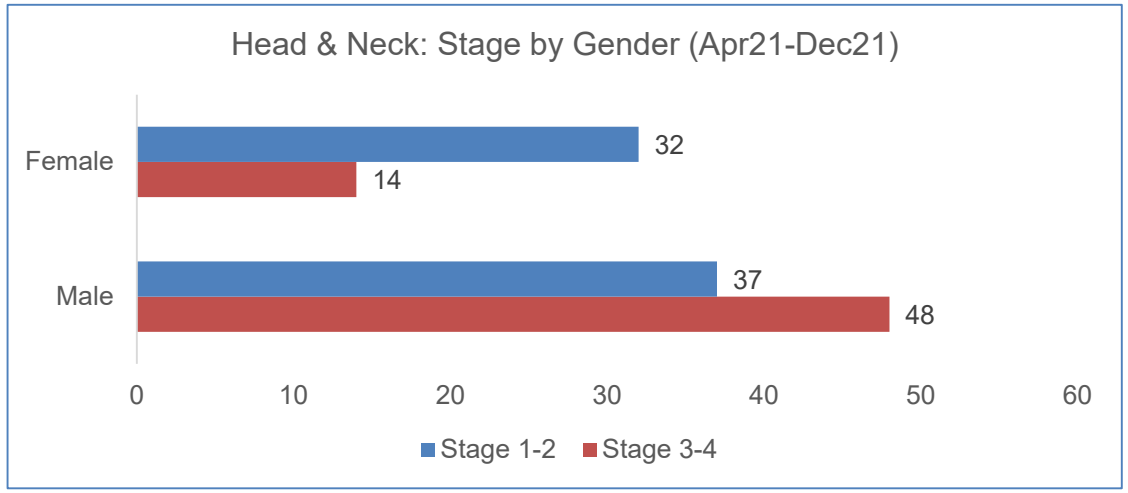


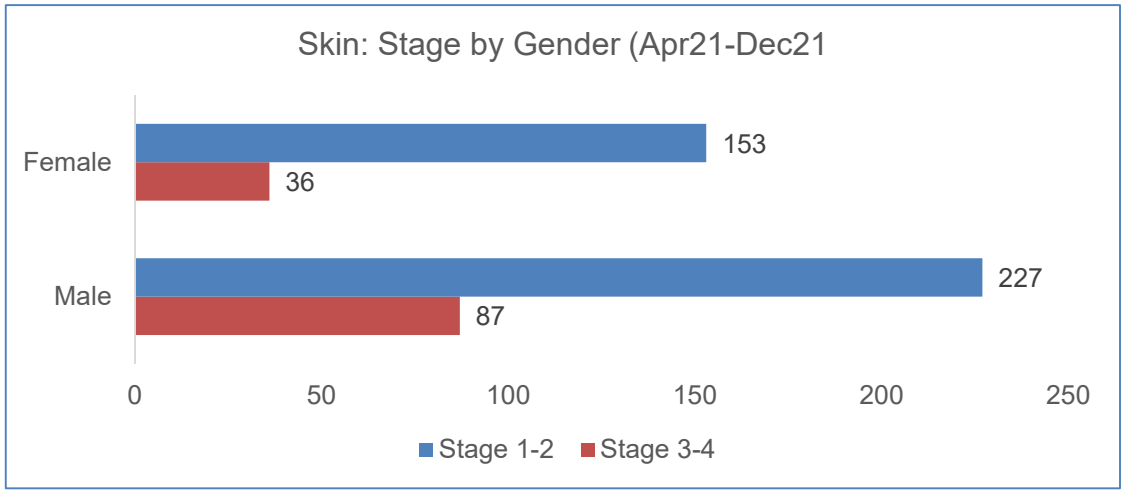
Commentary

- For head & neck diagnoses, the IMD is variable each month, with the most deprived reaching 26% in October, with the lowest of 0% recorded in April. Similar trends can be seen in the least deprived category. Whereas skin is more consistent re IMD for diagnoses each month.
- A deep dive has been taken looking at the IMD by cancer stage, for December 21. It is showing for both cancers there is a higher percentage of least deprived at stage 1-2 and a higher percentage of most deprived at stage 3-4.

NB: these figures are taken from the number of patients diagnosed with cancer at QVH and elsewhere that underwent treatment at QVH. Not all patients will have a stage.
Important to note: the data currently does not include all patients from Medway and Darent Valley, as these patients are on a separate PAS system.

Work stream: gender



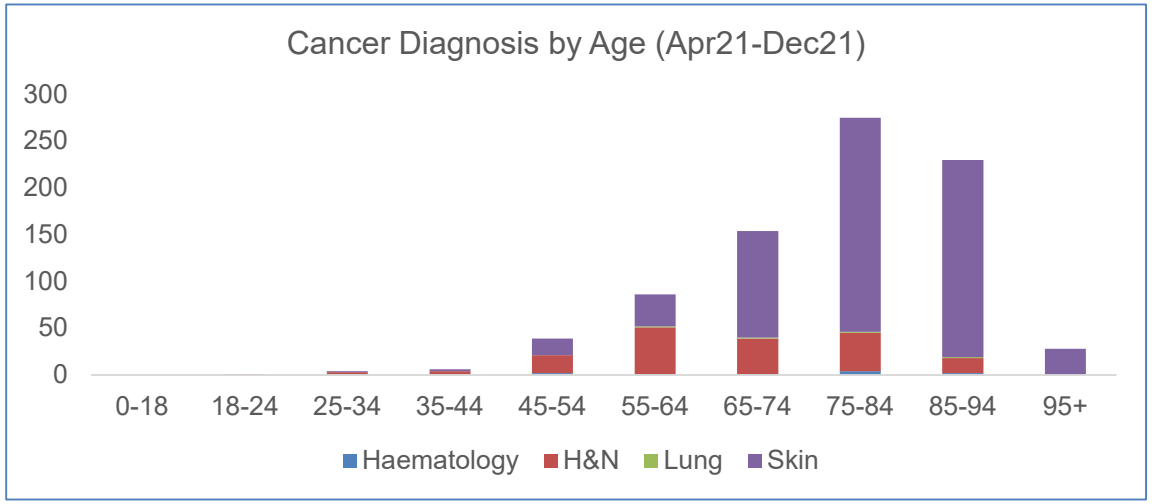


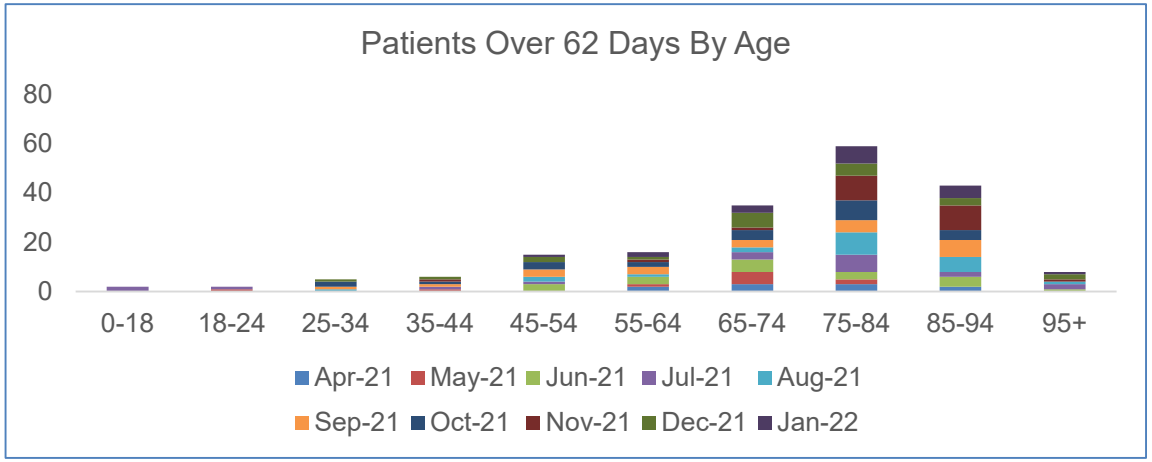
Commentary

- 66% of head & neck diagnoses are male, with 34% female (new, recurrence and progression). For skin 62% of the diagnoses are male, with 38% female.
- Continuing to see male head & neck patients being diagnosed with a later stage, YTD 56% of males are being staged between 3-4. Whereas for females, only 30% are being staged between 3-4. In total 53% of all confirmed head & neck patients are presenting between stage 1-2, whilst 47% are presenting between stage 3-4.

NB: these figures are taken from the number of patients diagnosed with cancer at QVH and elsewhere that underwent treatment at QVH. Not all patients will have a stage.

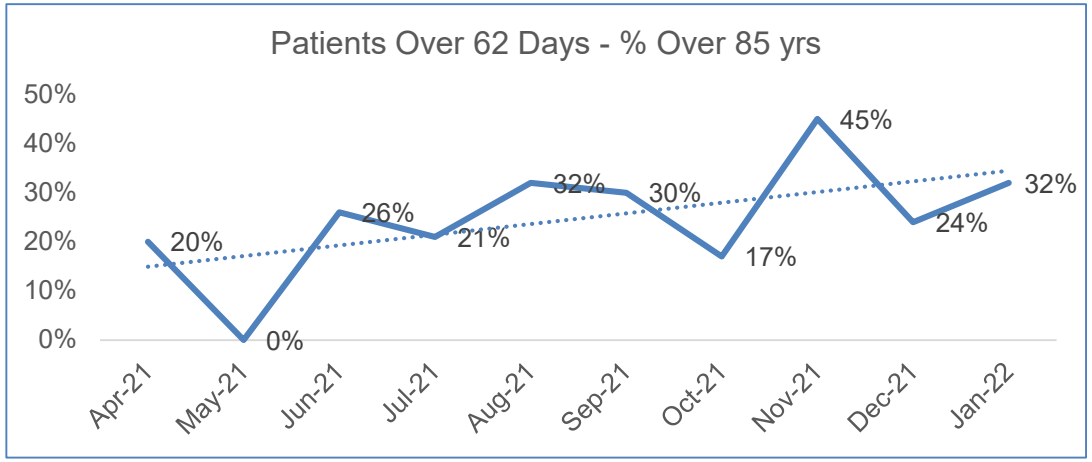
Work stream: age





Commentary

- 83% of all the confirmed cancer diagnoses are over 65yrs, with 31% over 85yrs. 1% of all confirmed cancer diagnoses are under 34yrs.
- The percentage of patients 85yrs and over that are waiting over 62 day is an increasing trend although noting the relative backlog size. November reported 45% of patients (11 in total), over 62 days, at 85yrs+. It is suspected that care home lockdown challenges and reliance on family members to attend appointments is contributing to this. Services continue to manage pathways to ensure mechanisms are in place for available support to patients (i.e. change to virtual where appropriate, regular contact with the family and safe guarding where appropriate and clinical reviews).



NB: these figures are taken from the number of patients diagnosed with cancer at QVH and elsewhere that underwent treatment at QVH. Not all patients will have a stage.

Report cover-page					
References					
Meeting title:	**Finance & Performance Committee**				
Meeting date:	**3 March 2022**		**Agenda reference:**	**46-22**	
Report title:	**Finance Report 2021/22 – Month 10**				
Sponsor:	Michelle Miles – Director of Finance and Performance				
Author:	Michelle Miles – Director of Finance and Performance				
Appendices:	Finance Performance Report Month 10 - Report				
Executive summary					
Purpose of report:	To provide the Board with an overview of the Trust's financial performance.				
Summary of key issues	• The Trust I&E position M10 YTD is a £0.7m surplus to actuals, expenditure remains in line with trend and activity performance. • The trust in line with national requirements is operating under block income regime with a plan set for H1 and H2 and this will now be reported as one financial year. • The Trust is forecasting a £1.2m surplus, this is a change from breakeven in M10. The change in forecast factors in the change in activity case mix as the Trust moves to a cancer hub. • Expenditure run rate (both Pay and Non-Pay) is broadly in line with last 12 months averages. Services across the trust are currently carrying vacancies that are not fully backfilled. • The cash position for the Trust continue to remain favourable due to the level and timing of the block payments arrangement this year. • Better payment practice code (BPPC) YTD is compliant against the standard of 95% of invoices to be paid within 30 days, but there are historic issues to be resolved. • Capital spend YTD is slightly above plan. Successful bids for significant central funding allocations for 21-22 projects has increased the capital plan from £4m by £3.6m to £7.6m. The Capital forecast is £0.5m surplus to plan.				
Recommendation:	To note the report				
Action required *[highlight **one** only]*	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):			KSO3:	KSO4:	KSO5:
			Operational excellence	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	KS04 – Financial Sustainability				
Corporate risk register:	KS04 – Financial Sustainability				
Regulation:					
Legal:					
Resources:	No current resources.				
Assurance route					
Previously considered by:					
	Date:		Decision:	N/A	
Next steps:					

Financial Performance Report

Michelle Miles, Director of Finance & Performance

January 2022

Trust Board

Income & Expenditure Month 10

Queen Victoria Hospital 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	Variance
Income											
Patient Activity Income	5,219	6,297	6,541	244	54,076	62,178	62,576	398	74,015	74,346	331
Other Operating Income	(45)	785	183	(602)	3,907	4,499	2,923	(1,576)	6,069	3,669	(2,399)
Block projected top up	52	780	757	(24)	53	7,984	9,032	1,048	9,545	9,315	(230)
Total Income	**5,226**	**7,862**	**7,480**	**(382)**	**58,035**	**74,661**	**74,532**	**(129)**	**89,629**	**87,332**	**(2,297)**
Pay											
Substantive	(3,791)	(4,948)	(4,482)	465	(37,740)	(47,236)	(43,380)	3,856	(57,131)	(50,568)	6,563
Bank	(261)	(154)	(301)	(147)	(2,722)	(1,488)	(2,732)	(1,244)	(1,797)	(3,978)	(2,181)
Agency	(153)	(13)	(66)	(53)	(1,969)	(117)	(624)	(507)	(143)	(768)	(625)
Total Pay	**(4,205)**	**(5,115)**	**(4,850)**	**265**	**(42,431)**	**(48,840)**	**(46,735)**	**2,105**	**(59,071)**	**(55,314)**	**3,756**
Non Pay											
Clinical Services & Supplies	(526)	(476)	(436)	40	(5,422)	(6,938)	(7,994)	(1,056)	(7,889)	(8,366)	(477)
Clinical Services & Supplies	(602)	(593)	(677)	(84)	(5,830)	(5,491)	(5,930)	(439)	(6,677)	(7,116)	(439)
Drugs	(124)	(123)	(103)	20	(1,238)	(1,233)	(1,154)	79	(1,479)	(1,384)	95
Establishment Expenses	(169)	(257)	(165)	91	(2,740)	(2,283)	(2,391)	(108)	(2,796)	(2,869)	(73)
Consultancy	(21)	(10)	(128)	(117)	(156)	(91)	(136)	(45)	(112)	(6)	106
Other non pay	(541)	(593)	(822)	(228)	(4,092)	(5,231)	(4,984)	246	(6,418)	(6,264)	154
Total Non Pay	**(1,982)**	**(2,052)**	**(2,330)**	**(278)**	**(19,478)**	**(21,267)**	**(22,589)**	**(1,322)**	**(25,371)**	**(26,005)**	**(634)**
Non Operational Expenditur	(137)	(150)	54	204	(1,318)	(1,322)	(1,255)	67	(1,622)	(916)	706
Non Operating Income	2	0	1	1	20	1	1	0	1	1	0
Depreciation and amortisati	(200)	(350)	(350)	(1)	(2,812)	(3,571)	(3,503)	68	(4,271)	(4,200)	71
Total Expenditure	**(6,523)**	**(7,667)**	**(7,476)**	**191**	**(66,018)**	**(75,000)**	**(74,082)**	**918**	**(90,334)**	**(86,434)**	**3,900**
Surplus / (Deficit)	**(1,297)**	**195**	**4**	**(191)**	**(7,983)**	**(339)**	**451**	**789**	**(705)**	**897**	**1,603**
Adjusted financial performance											
Technical				*0*			*253*	*253*		*303*	*303*
Adjusted Surplus / (Deficit	***(1,297)***	***195***	***4***	***(191)***	***(7,983)***	***(339)***	***703***	***1,042***	***(705)***	***1,200***	***1,906***

QVH PERFORMANCE COMMENTARY

YTD M10 the Trust is reporting £0.7m surplus to actuals.

Income
Expectation of no ERF income for M7 –M10 as income is dependent on system achievement. The YTD position assumes no ERF income from H2.

Expenditure
Pay expenditure is in line with trend and activity performance. The Trust continues to have a number of vacancies across all areas with the main area being Nursing & healthcare.

The Trust plan has been set to deliver 19/20 activity levels with the 19/20 establishment levels to deliver the required activity plans.

QVH FORWARD LOOK / PERFORMANCE RISKS

Forecast:
The Trust is forecasting £1.2m surplus on actuals The Trust forecast has changed from M9 break even by £1.2m surplus with technical adjustments. With the transfer of the Trust to be the cancer hub in Q4, the Trust expects a reduction in underlying run rate with the change in case mix.
The Trust forecast assumes

- Income: No additional income for H2 ERF, as payment is dependent on the system achieving as a whole.
- Expenditure: Runrate remains as current trend levels
- No additional funding sources in Q4

Risks

- The trust operational performance is to deliver activity to 19/20 levels.
- Staff challenges and vacancies, which will impact service delivery as the Trust works to meet the 89% clock stop threshold.

Mitigations

- The Trust continues to review staffing, pay budget costs and wte review has been undertaken and reconciled for alignment. Further pay analysis on actual pay costs and the impact of enhanced costs is ongoing in monthly reviews.

Notes As normal in forecasting, no amendment has been made for revaluation, central PPE, any additional funding received which is not at present anticipated or large stock adjustments

SOFP - Balance Sheet Month 10

Queen Victoria Hospital NHS Foundation Trust

Statement of financial position 2021-22

£000's	Prior Year End: March 2021	April	May	June	July	August	September	October	November	December	January	Change In Month	Change In Year
Non Current Assets													
Fixed Assets	54,165	53,857	53,732	53,384	53,316	53,070	53,250	53,025	52,913	52,598	52,572	(26)	(1,593)
Other Receivables	227	227	227	227	227	227	227	227	227	227	227	0	0
Total Non Current Assets	**54,392**	**54,084**	**53,959**	**53,611**	**53,543**	**53,297**	**53,477**	**53,252**	**53,140**	**52,825**	**52,799**	**(26)**	**(1,593)**
Current Assets													
Inventories	1,462	1,460	1,442	1,469	1,465	1,462	1,470	1,493	1,496	1,478	1,479	1	17
Trade and other Receivables	4,140	3,353	4,544	6,289	6,679	11,180	4,420	3,932	4,377	4,942	5,665	722	1,525
Cash and Cash Equivalents	8,582	9,072	8,933	8,358	8,851	11,142	11,971	12,946	12,501	12,147	12,869	722	4,287
Total Current Assets	**14,184**	**13,885**	**14,919**	**16,115**	**16,995**	**23,783**	**17,861**	**18,372**	**18,375**	**18,567**	**20,013**	**1,446**	**5,829**
Current Liabilities													
Trade and other Payables	(10,544)	(9,575)	(10,060)	(10,949)	(12,486)	(12,987)	(13,237)	(13,734)	(13,585)	(13,700)	(14,426)	(727)	(3,882)
Borrowings	(893)	(883)	(883)	(857)	(857)	(857)	(889)	(898)	(904)	(861)	(866)	(5)	27
Provisions	(88)	(88)	(88)	(88)	(87)	(87)	(87)	(87)	(87)	(87)	(87)	0	1
Other Liabilities	(431)	(396)	(337)	(349)	(343)	(6,838)	(322)	(328)	(340)	(456)	(887)	(431)	(456)
Total Current Liabilities	**(11,956)**	**(10,942)**	**(11,368)**	**(12,242)**	**(13,773)**	**(20,769)**	**(14,535)**	**(15,046)**	**(14,916)**	**(15,104)**	**(16,266)**	**(1,162)**	**(4,310)**
Subtotal Net Current Assets	**2,228**	**2,943**	**3,551**	**3,873**	**3,222**	**3,015**	**3,325**	**3,326**	**3,459**	**3,463**	**3,746**	**283**	**1,519**
Total Assets less Current liabilties	**56,620**	**57,027**	**57,510**	**57,484**	**56,765**	**56,312**	**56,803**	**56,578**	**56,598**	**56,288**	**56,546**	**257**	**(74)**
Non Current Liabilties													
Borrowings	(3,653)	(3,653)	(3,653)	(3,266)	(3,266)	(3,231)	(3,231)	(3,231)	(3,214)	(2,824)	(2,824)	0	829
Provisions	(908)	(908)	(908)	(908)	(909)	(909)	(909)	(909)	(909)	(909)	(909)	0	(1)
Total Non Current Liabilties	**(4,561)**	**(4,561)**	**(4,561)**	**(4,174)**	**(4,175)**	**(4,140)**	**(4,140)**	**(4,140)**	**(4,122)**	**(3,733)**	**(3,733)**	**0**	**828**
Total assets Employed	**52,059**	**52,466**	**52,949**	**53,311**	**52,590**	**52,172**	**52,663**	**52,438**	**52,476**	**52,556**	**52,813**	**257**	**754**
Tax Payers Equity													
Public Dividend Capital	21,005	21,005	21,005	21,005	21,005	21,005	21,005	21,005	21,005	21,005	21,005	0	0
Revaluation Reserve	13,943	13,943	13,993	13,993	13,993	13,993	13,993	13,993	13,993	13,993	13,993	0	50
Income and Expenditure Reserve	17,111	17,518	17,951	18,313	17,592	17,174	17,665	17,440	17,478	17,558	17,815	257	704
Total Tax Payers Equity	**52,059**	**52,466**	**52,949**	**53,311**	**52,590**	**52,172**	**52,663**	**52,438**	**52,476**	**52,556**	**52,813**	**257**	**754**

QVH PERFORMANCE COMMENTARY

- Non current assets have decreased in value up to month 10 which reflects the rate of capital programme spend compared with the depreciation/amortisation costs. The capital spend is forecast to increase towards financial year end.
- Trade receivables: Increase in month is due to the invoicing of £880k for CDC early adoption.
- The £4m increase in cash in the bank through the year continues to reflect the net benefit of income received above the current spend rate, involving: receipt of block income; ERF income; cash funding relating to last financial year; capital spend lag; and the increase in expenditure accruals for payments expected to be made later.
- Trade payables have increased in year by £4m which reflects the increase in various expenditure accruals.
- Other liabilities in month have increased by £431k reflecting deferral of income due to quarterly invoicing in advance.
- Borrowings (current and non current) consist of the theatre capital loan and outpatient pod finance lease. The reductions in June and December are the principal instalment payments made on the theatre loan.
- Provisions (current and non current) relate 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 income & expenditure.
- Income and expenditure reserve reflects the historic and current position of the statement of comprehensive income (SOCI).

Cashflow Report Month 10

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 10 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**	**11,142**	**11,971**	**12,778**	**12,501**	**12,144**	**12,866**	**7,512**
Receipts												
Block & System income	6,283	6,283	6,304	6,291	6,315	7,203	7,060	6,534	6,133	6,867	4,133	4,133
Elective Recovery Fund (tbc)	0	0	0	0	1,708	816	605	589	0	0	0	0
Other Core Income incl HEE	1,675	256	211	162	886	0	0	0	0	0	0	1,020
Receipts from other income	109	167	130	163	147	112	336	159	455	272	138	138
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	3,300
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**	**9,055**	**8,131**	**8,001**	**7,282**	**6,588**	**7,140**	**4,271**	**8,591**
Payments												
Payments to NHS Bodies	(644)	(687)	(364)	(459)	(561)	(390)	(611)	(1,207)	(275)	(166)	(665)	(732)
Payments to non-NHS bodies	(2,584)	(1,876)	(2,037)	(1,290)	(1,954)	(1,906)	(1,770)	(1,980)	(1,702)	(1,790)	(4,500)	(4,500)
Net Payroll Payment	(2,460)	(2,417)	(2,442)	(2,471)	(2,379)	(2,720)	(2,573)	(2,413)	(2,553)	(2,487)	(2,487)	(2,487)
Payroll Taxes	(1,197)	(1,167)	(1,220)	(1,200)	(1,172)	(1,147)	(1,416)	(1,204)	(1,266)	(1,245)	(1,245)	(1,245)
Pensions Payment	(691)	(697)	(703)	(703)	(698)	(704)	(823)	(756)	(704)	(729)	(729)	(729)
PDC Dividends Payment	-	-	-	-	-	(435)	-	-	-	-	-	(792)
Loan Interest & Repayment	-	-	(449)	-	-	-	-	-	(443)	-	-	-
Total Payments	**(7,577)**	**(6,845)**	**(7,215)**	**(6,123)**	**(6,764)**	**(7,302)**	**(7,193)**	**(7,560)**	**(6,945)**	**(6,417)**	**(9,626)**	**(10,485)**
Net Cash Movement	**490**	**(139)**	**(570)**	**493**	**2,291**	**829**	**808**	**(278)**	**(357)**	**722**	**(5,355)**	**(1,894)**
Closing Balance	**9,067**	**8,928**	**8,358**	**8,851**	**11,142**	**11,971**	**12,778**	**12,501**	**12,144**	**12,866**	**7,512**	**5,618**

QVH PERFORMANCE COMMENTARY

- Cash balances are expected to reduce in H2 by capital spend. At M10 the forecast closing cash assumes circa £5m cash will be spent in respect of capital items in February and March.
- Forecast 'Block and system Income' is based on H2 plan values and no H2 forecast of ERF has been included.
- There is currently a cash balance which covers a month and a half 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 H2 block and system income per the plan. No H2 forecast of ERF has been made. The M10 forecast assumes a £4m reduction in income to reflect transfer to a cancer hub but this is not confirmed.
- The M10 cashflow includes the assumption of £3.3m additional capital PDC in March in respect of approved capital bids (MOUs) and a higher level of closing capital creditors by circa £3m.

Debtors Month 10

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 10 2021/22

Debtors

	Jan 21 £'000	Feb 21 £'000	Mar 21 £'000	Apr 21 £'000	May 21 £'000	Jun 21 £'000	Jul 21 £'000	Aug 21 £'000	Sep 21 £'000	Oct 21 £'000	Nov 21 £'000	Dec 21 £'000	Jan 22 £'000	In Month Change £000
NHS Debtors														
0-30 Days Past Invoice Due Date	927	308	803	605	383	53	114	6,381	474	184	194	402	1,272	**870**
31-60 Days Past Invoice Due Date	5	743	62	132	239	353	32	29	12	177	252	116	300	**185**
61-90 Days Past Invoice Due Date	8	4	743	18	116	231	353	37	14	11	195	189	53	**(136)**
Over 90 Days Past Invoice Due Date	1,661	796	747	666	650	708	873	1,004	842	939	871	993	1,200	**207**
Total NHS Debtors	**2,601**	**1,852**	**2,355**	**1,422**	**1,388**	**1,345**	**1,371**	**7,450**	**1,341**	**1,311**	**1,511**	**1,699**	**2,825**	**1,126**
Non NHS Debtors														
0-30 Days Past Invoice Due Date	90	70	193	175	34	49	76	117	112	305	14	374	110	**(264)**
31-60 Days Past Invoice Due Date	24	30	12	12	157	14	22	45	79	48	31	26	6	**(20)**
61-90 Days Past Invoice Due Date	8	19	9	11	15	139	14	12	14	67	57	65	6	**(60)**
Over 90 Days Past Invoice Due Date	410	391	398	343	335	344	475	489	445	367	516	438	486	**48**
Total Non NHS Debtors	**533**	**510**	**611**	**541**	**540**	**545**	**587**	**663**	**650**	**787**	**618**	**903**	**608**	**(296)**
Total Invoiced Debtors	**3,134**	**2,362**	**2,966**	**1,963**	**1,928**	**1,890**	**1,958**	**8,113**	**1,991**	**2,098**	**2,129**	**2,603**	**3,433**	
NHS : Total NHS & Non NHS ratio	*0.83*	*0.78*	*0.79*	*0.72*	*0.72*	*0.71*	*0.70*	*0.92*	*0.67*	*0.63*	*0.71*	*0.65*	*0.82*	

QVH PERFORMANCE COMMENTARY

The month 10 total debtor balance of £3.4m is 56% lower than the average monthly balance of £7.7m in 2020-21.

The month 10 debtor balance is £0.8m higher than reported at M9. This is due mainly to invoices for Revenue funding for the early adopter of CDC activity at QVH for Q3 & Q4 issued to NHS East Sussex CCG in Month 10.

At M10 close, 6 external debtors owed more than £0.1m:-
NHS East Sussex CCG - £0.9m, Brighton And Sussex University Hospitals NHS Trust - £0.6m, Royal Surrey NHS Foundation Trust - £0.2m , NHS Kent and Medway CCG - £0.2m, University Hospitals Sussex NHS Foundation Trust - £0.1m, Aneurin Bevan Lhb - £0.1m

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. It should be noted that the majority of older debtors were provided for in 2020-21.

Creditors Month 10

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 10 2021/22

Trade Creditors

	Jan 21 £'000	Feb 21 £'000	Mar 21 £'000	Apr 21 £'000	May 21 £'000	Jun 21 £'000	Jul 21 £'000	Aug 21 £'000	Sep 21 £'000	Oct 21 £'000	Nov 21 £'000	Dec 21 £'000	Jan 22 £'000	In Month Change £'000
NHS Accounts Payable Creditors														
0-30 Days Past Invoice Due Date	278	247	395	131	147	103	93	116	341	87	93	95	190	95
31-60 Days Past Invoice Due Date	117	157	42	85	25	59	28	16	97	29	2	14	38	24
61-90 Days Past Invoice Due Date	90	91	102	35	56	36	25	25	40	18	17	2	27	26
Over 90 Days Past Invoice Due Date	722	774	691	608	645	663	634	490	480	497	419	424	358	(66)
Total NHS Accounts Payable Creditors	**1,207**	**1,269**	**1,230**	**860**	**872**	**862**	**781**	**646**	**958**	**631**	**530**	**535**	**612**	**78**
Non NHS Accounts Payable Creditors														
0-30 Days Past Invoice Due Date	513	325	1,323	444	423	650	363	200	682	454	465	458	772	314
31-60 Days Past Invoice Due Date	410	91	84	101	49	74	89	36	30	29	33	119	67	(53)
61-90 Days Past Invoice Due Date	12	18	44	28	47	35	92	58	34	32	6	25	23	(2)
Over 90 Days Past Invoice Due Date	16	60	38	16	69	77	150	112	166	153	43	53	46	(8)
Total Non NHS Accounts Payable Creditors	**949**	**493**	**1,489**	**588**	**589**	**836**	**694**	**406**	**912**	**668**	**547**	**657**	**907**	**251**
Total Accounts Payable Creditors	**2,156**	**1,762**	**2,719**	**1,448**	**1,461**	**1,698**	**1,474**	**1,052**	**1,870**	**1,299**	**1,077**	**1,191**	**1,520**	
NHS : Non NHS ratio	***0.56***	***0.72***	***0.45***	***0.59***	***0.60***	***0.51***	***0.53***	***0.61***	***0.51***	***0.49***	***0.49***	***0.45***	***0.40***	

QVH PERFORMANCE COMMENTARY

- The invoiced creditors balance at month 10 is £1.5m compared to a running average of £1.7m.
- NHS and Non NHS balances have both increased this month compared to last by £0.3m. This is mainly due to large value invoices outstanding at M10 which should be paid next month.
- There are 4 creditors with a balance over £0.1m - Medway NHSFT (£0.3m) disputed historic SLA, Kainos Software Ltd (£0.1m) current Month 10 invoices not yet due, East Kent Hospitals University NHS Foundation Trust (£0.1m) and Sectra Ltd (£0.1m) current Month 10 invoices not yet due. Work is ongoing with creditors to resolve the queries outstanding.

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 holders to process and gain approval for invoice payment as quickly as possible.
- As old queries are resolved and invoice payment released, this may adversely impact the Trust's BPPC performance.

Better payment practice code Month 10

Queen Victoria Hospital
NHS Foundation Trust

Better payment practice code						
Compliance target: 95% of invoices being paid within 30 days of receipt	Current YTD	Current YTD	Previous Month YTD	Previous Month YTD	Current Month	Current Month
	January	January	December	December	January	January
	Invoice Quantity	Invoice Value £000	Invoice Quantity	Invoice Value £000	Invoice Quantity	Invoice Value £000
Non NHS						
Total bills paid	14,571	31,689	13,208	28,636	1,363	3,053
Total bills paid within target	13,836	30,605	12,582	27,783	1,254	2,822
Percentage of bills paid within target	**95.0%**	**96.6%**	**95.3%**	**97.0%**	**92.0%**	**92.4%**
NHS						
Total bills paid	1,003	5,220	929	5,072	74	148
Total bills paid within target	917	5,079	865	4,974	52	105
Percentage of bills paid within target	**91.4%**	**97.3%**	**93.1%**	**98.1%**	**70.3%**	**70.9%**
Total						
Total bills paid in the year	**15,574**	**36,909**	**14,137**	**33,707**	**1,437**	**3,201**
Total bills paid within target	**14,753**	**35,684**	**13,447**	**32,756**	**1,306**	**2,927**
Percentage of bills paid within target	**94.7%**	**96.7%**	**95.1%**	**97.2%**	**90.9%**	**91.4%**
Compliance target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Above (below) target	(0.3%)	**1.7%**	**0.1%**	**2.2%**	**(4.1%)**	**(3.6%)**

QVH PERFORMANCE COMMENTARY

- NHSI/E is monitoring BPPC closely. The target is 100% of invoices to be paid within 30 days, with compliance at 95%.
- Trust total creditor performance YTD is
  - Number of invoices: 94.7 % (0.3% below compliant)
  - Value of invoice 96.7% (compliant)
- NHSI/E have indicated that the main focus for compliance would be on value and non NHS creditors.
- The key sub-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 DEVELOPMENT

- 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.
- The Trust is performing at above the 95% £value cumulative compliance level whilst also working to resolve some historic issues. The financial services team are continuing review of performance, key factors and reporting analytics 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 10

Queen Victoria Hospital NHS Foundation Trust

	Year to Date £'000			21/22 Forecast Outturn £'000		
	Plan	Actual	Variance	Plan	Forecast	Variance
Estates Projects						
Main theatres heating boilers	120	125	(5)	120	125	(5)
Eye bank air handling unit	180	212	(32)	180	212	(32)
Other	579	579	0	1,283	956	327
Total Estates Projects	**879**	**916**	(37)	**1,583**	**1,293**	**290**
Medical Equipment						
Microvascular/ENT microscope	0	0	0	170	170	0
Laser for scar service	0	0	0	150	95	55
Other	204	204	0	458	509	(51)
Total Medical Equipment	**204**	**204**	0	**778**	**774**	**4**
Information Management & Technology (IM&T)						
Windows 10 / Server 2012 Upgrade	32	32	0	250	245	5
Radiology systems (PACS/RIS) reprovision	89	89	0	200	157	43
EDM scanning solution	56	56	0	175	175	0
Patient record system for Ophthalmology	13	13	0	165	165	0
Other	140	140	0	540	520	20
Total Information Management & Technology (IM8	**330**	**330**	0	**1,330**	**1,262**	**68**
Capitalised staff costs	**247**	**247**	-	**350**	**317**	**33**
Contingency	0	0	0	**70**	-	70
Total internaly funded projects	**1,660**	**1,697**	(37)	**4,111**	**3,646**	**465**
DHSC NHSIE bid funded projects:						
Cyber security	-	-	0	144	144	0
Diagnostics Imaging - PACS	-	-	0	453	453	0
Community Diagnostics Centres (CDC)	109	109	0	364	364	0
Modular Theatres (Targeted Investment Fund TiF)	-	-	0	2,290	2,290	0
Long Term Conditions (LTC) tech platform. (TiF)	-	-	0	60	60	0
MOS (Store Conversion) - (TiF)	-	-	0	30	20	0
Imaging Academies workstations	-	-	0	29	29	0
Reequip Ultrasound	69	69	0	69	69	0
Total external PDC funded projects	**178**	**178**	-	**3,439**	**3,429**	**10**
Total Capital	**1,838**	**1,875**	(37)	**7,550**	**7,075**	**475**

QVH PERFORMANCE COMMENTARY

- Successful bids for significant central funding allocations for 21-22 projects has increased the capital plan from £4.1m to £7.6m.
- In light of the new major projects being undertaken, supply chain issues and other resource constraints all capital project plans have been, and continue to be, reviewed to manage the risks of delivery in the last quarter of the finance year, and to establish a robust forecast for 21-22 year end.

QVH FORWARD LOOK / PERFORMANCE RISKS

- The Trust total capital forecast is £7.1m at M09, £0.5m below plan. This is being monitored for acceleration, slippage and mitigation options.
- There is high risk on the delivery of microvascular microscope, laser-scar and corneal equipment due to current supplier lead times but they are currently considered to be feasible.
- To reach forecast for the internal funded plan the Trust will need to deliver nearly 50% of the spend in the last quarter, as well as the commitments required on the additional bid funding of £3.4m. However the modular theatres will be delivered in site with the next four weeks which is a significant proportion of the capital spend. Capital project managers are working to expedite projects.
- The Trust will review the allocation of funds to approved projects in line with the current feasibility of delivery before the end of the year. This will be reported into the ICS as well as NHSE/I.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**3 March 2022**		**Agenda reference:**	**46-22**	
Report title:	**2022/23 planning update**				
Sponsor:	Michelle Miles, Director of Finance and Performance				
Author:	Michelle Miles, Director of Finance and Performance Tony Reeves, Associate director of business development				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide the Board with a summary of the planning principles being applied and the local and national milestones in the planning process for 2022/23.				
Summary of key issues	As set out in paper				
Recommendation:	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:	KS04: Financial Sustainability				
Corporate risk register:	KS04: Financial Sustainability				
Regulation:					
Legal:					
Resources:	No current resources.				
Assurance route					
Previously considered by:	F&PC 24 January 2022				
	Date:		Decision:	N/A	
Next steps:	As set out in timeline in paper				

2022/23 Planning Principles

Queen Victoria Hospital NHS Foundation Trust

- 2022-23 Planning will take place between January – March 2022.
- Trust Financial plan which reflects the resources required (Pay and Non pay) to deliver activity in 2022/23.
- Triangulation of activity, Pay WTE & expenditure and Non pay
- Meetings taken place with Budget holders to review, agree and sign off plan: Activity, Pay and Non pay
- National Planning Guidance still being issued in terms of elective recovery

Area	Principles
Activity	Baseline target 104% of 19/20 value weighted to reflect growth
Income	Patient activity income (fixed payment for 104% + under/overperformance adj. of 75% of tariff) Other income Baseline M8 budget
Pay	Baseline M8 budgeted establishment
Non pay	19/20 Outturn or 21/22 budget whichever was higher in line with the agreement for the H2 Plan
Area	**Principles**
Service developments	Approval by EMT
Cost pressures	Approval by EMT
Efficiencies	Target 3-4%
Capital	Estates, Equipment and IMT Approval by HMT

2022/23 Planning Timetable

Queen Victoria Hospital NHS Foundation Trust

Local Milestones / National planning milestones	Date
Completion of Commissioner Notice Item/Service Development POAPs (plan on a page) for Review	By 17th Dec 2021
Business Planning Steering Group Planning Launch	21st Dec 2021
Issue of cost pressures/service developments, efficiencies and capital templates to Business Units	22nd Dec 2021
National publication – Draft 2022/23 tariffs, operational guidance & templates, standard contract consultation, CQUIN guidance	Expected pre-Xmas
Activity plan templates and baseline budgets issued	W/C 3rd Jan 2022
Return of completed templates by Business Units	14th Jan 2022
Budget review meetings including review of cost pressures/efficiencies	17th Jan – 7th Feb 2022
Triangulation of activity, income and budgets with commissioning plans	w/c 14th Feb 2022
1st Star Chamber – Review Capital Funding Requests	21st Feb 2022
Submission of first cut operational plans to system – activity & performance, finance, workforce	23rd February 2022
System submission of draft operational plan and provider finance plan	17th March 2022
2nd Star Chamber – Final Review of Capital Funding Requests	21st Mar 20202
Approval of Final Operational plan by the Trust Board – F&P Committee	25th April 2022
System submission of final operational plan	28th April 2022

KSO5 – Organisational Excellence

Risk Owner: Interim Director of Workforce & OD
Date 22nd February 2021

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

Risk
- Ongoing discussions about the future organisational form of QVH creates an uncertainty impacting on recruitment and retention of a workforce with the right skills and experience.
- The impact on recruitment and retention across the Trust leads to an increase in bank and agency costs and having longer term issues for the quality of patient care and staff engagement
- Significant challenges being seen with staffing levels in individual areas with both high vacancy and absence rates over the winter period.

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. Ensuring the People Promise is being delivered
- 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 previously were shielding/vulnerable, including BAME staff not being able to return to full duties. Monitoring longer terms impact of second wave & vaccination programme.
- The DHSC mandatory requirement for all front line NHS staff to be fully vaccinated as a condition of employment from 01/04/2022
- Impact on workforce confidence in a sustainable future, due to uncertainty or misinformation from outside and inside the Trust related to potential merger

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

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:	**3 March 2022**		**Agenda reference:**	**49-22**	
Report title:	**Workforce Report – February Report – January Data**				
Sponsor:	Lawrence Anderson, Interim Director of Workforce and OD				
Authors:	• Gemma Farley, Employee Relations & Wellbeing Manager • Sarah Oliphant, Employee Services and e-Systems Manager • Annette Byers, Head of Organisational Development • Helen Moore, Medical Education Manager				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide a monthly update of Workforce KPI's and OD activity				
Summary of key issues	The 2021 staff survey results were released to the Trust on 17th February and are currently being interpreted. The results are also being interpreted by an coordination centre in conjunction with other Specialist Trust's in the Country to provide a better representative picture of results. The results are currently under embargo until March 2022 and we are awaiting the date this is lifted. Key highlights of the report show vacancies rose slightly in January, with increases in both bank and agency however we are still demonstrating a stable workforce currently. Sickness absence has slightly reduced from the previous month, although still over registering over 4%. Appraisal rates have slightly approved since December 2021 and MAST rates continue to be over 90% consistently				
Recommendation:	The Board are asked to note the report				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	**KSO1:** ***Outstanding patient experience*** ✓	**KSO2:** ***World-class clinical services*** ✓	**KSO3:** ***Operational excellence*** ✓	KSO4: *Financial sustainability*	**KSO5:** ***Organisational excellence*** ✓
Implications					
Board assurance framework:	• KSO5. Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care • Engaged and motivated staff deliver better quality care (KSO1)				
Corporate risk register:	Impact of pandemic on workforce availability				
Regulation:	Well Led				
Legal:	n/a				
Resources:	Managed by HR/OD with support from finance, operations and nursing				
Assurance route					
Previously considered by:					
	Date:		Decision:	Information	
Next steps:					

Workforce and Organisational Development Report

Lawrence Anderson, Interim Director of Workforce &OD

February 2022 (January 2022 Data)

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Headlines

Engagement & Communication:

- Initial 2021 Staff Survey results have been issued and OD & L are now working on extracting data to update the board on the findings. OD&L are working on producing over 30 reports for the various departments across QVH based on the findings.
- Regular communications continue to be sent to heads of department and all QVH staff on any training, development and apprenticeships available.
- The NQPS results for each quarter will be published on Qnet for all staff to view. The outcomes for Q4 2021/22 is due to be published shortly.

Attraction & Retention:

- An increase of 3.40 days in time to recruit (Conditional offer to ready to start) with 37.25 days in January compared to 33.85 days in December.
- The number of adverts put live increased by 2 to 39 in January and the same increase in new starters to 25 in January.
- Time to authorise a post on Trac has decreased slightly and remains well within the 5 day KPI.
- With more leavers than new starters to the Trust (10.18 leavers and 9.15 starters from outside of the trust)

Health & Wellbeing:

- The Healthy Workplace Allies network met in January 2022 to agree terms of reference, and have created a Qnet page with information https://qnet.xqvh.nhs.uk/Staff/HealthyWorkplaceAllies/SitePages/Home.aspx
- Weekly emails throughout January focused on: World Religion Day (16th January 2022); Dry January; and Cervical Cancer Awareness Month. Ongoing webinars available from Care First (EAP) continued to be shared with all staff.
- The work-related stress indicator tool (WRSIT) project continues with many departments already having completed and implementing the actions. Where there are less than 10 people in the department/ team, we have created a paper-based version of the questionnaire to undertake offline.

Learning & Education:

- Overall Stat & Mand compliance is **88.97%** across QVH – decreased by 0.30% from last month 89.27% (includes non perm and perm staff)
- Appraisals compliance slightly increased and is now **80.61%** across QVH (up by 0.25% from last month 80.36%). Concern this will fall in the Red RAG rating in the next few months if action is not taken.

Talent & Leadership:

- Apprenticeship uptake continues to be positive and we have nearly reached our government target.
- Leadership opportunities continue to be promoted across QVH from the Leadership Academy, HEE, NHS Elect and the ICS.

Workforce KPI Summary

Queen Victoria Hospital
NHS Foundation Trust

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2020/21 & 2021/22			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Establishment WTE *Note 1				1035.09	1042.49	1042.49	1031.34	1031.34	1032.34	1057.51	1057.51	1061.28	1067.59	1068.59	1072.63	**1072.63**	◄►
Staff In Post WTE				927.02	932.50	934.23	931.78	930.44	930.22	922.66	910.88	919.42	924.62	935.09	939.52	**932.11**	▼
Vacancies WTE				108.07	109.99	108.26	99.58	100.90	102.12	134.85	146.63	141.86	142.97	133.50	133.11	**140.52**	▲
Vacancies %	>12%	8%<>12%	<8%	10.44%	10.55%	10.38%	9.65%	9.78%	9.89%	12.75%	13.87%	13.37%	13.39%	12.49%	12.41%	**13.10%**	▲
Agency WTE				10.83	9.78	10.55	7.46	11.06	12.11	12.89	9.97	8.28	6.83	11.79	10.91	**10.44**	▼
Bank WTE *Note 2				76.20	66.31	87.81	64.81	64.22	72.64	78.37	71.08	70.05	71.07	77.85	66.63	**77.85**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	10.63%	10.25%	10.76%	11.55%	10.94%	12.20%	13.15%	14.11%	14.60%	15.02%	15.43%	15.72%	**15.23%**	▼
Monthly Turnover				1.66%	0.20%	1.45%	1.34%	0.33%	2.03%	1.49%	2.12%	1.25%	1.28%	1.15%	1.31%	**1.20%**	▼
12 Month Rolling Stability % *Note 3	<70%	70%<>85%	>=85%	88.87%	89.06%	88.91%	88.37%	87.84%	87.11%	85.09%	85.09%	85.43%	85.03%	84.49%	84.10%	**83.83%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	3.48%	2.50%	2.75%	2.49%	3.04%	3.63%	3.17%	3.27%	4.13%	4.47%	4.54%	4.24%	*TBC*	▼
% staff appraisal compliant (Permanent & Fixed Term staff) *Note 4	<80%	80%<>95%	>=95%	82.03%	83.69%	86.32%	86.50%	85.23%	83.72%	85.17%	86.08%	83.93%	82.08%	81.24%	80.36%	**80.61%**	▲
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 5	<80%	80%<>90%	>=90%	92.30%	91.47%	91.65%	92.57%	92.34%	92.35%	91.98%	92.35%	90.92%	90.85%	91.48%	91.39%	**91.27%**	▼

		2019-20	2020-21	19-20 & 20-21
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%**	▲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

NHS Staff Survey 2021:

- This year the themes of the survey are aligned to the 7 People Promise's along with findings on Staff Engagement and Morale:
  1. We are compassionate and inclusive
  2. We are recognised and rewarded
  3. We each have a voice that counts
  4. We are safe and healthy
  5. We are always learning
  6. We work flexibly
  7. We are a team
- A total of **117** questions were asked in the 2021 survey, of these **92** can be positively scored, with **60** of these which can be historically compared. As a result, this will mean it will be difficult to compare with previous year's results.
- Preliminary work is now being done to analyze the findings and a report will be produced to go to Board in May 2022.
- Over 35 additional bespoke reports be produced on the key findings for each department (where results are available).
- <u>All results are embargoed until March 2022</u>

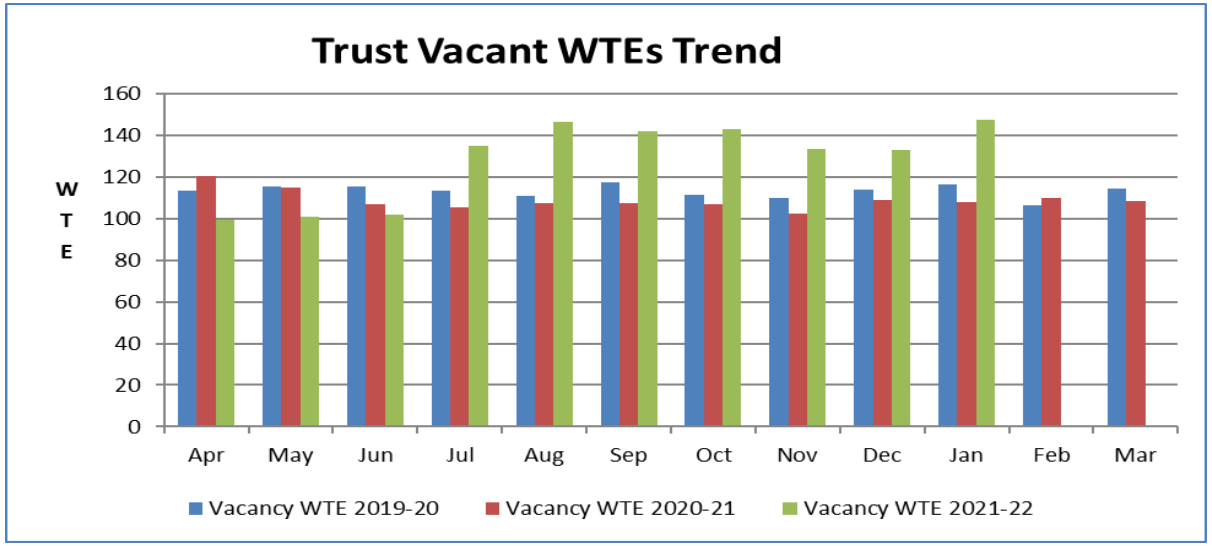
National Quarterly Pulse Survey (NQPS):

- The NQPS for Q4 2021/22 has just closed and results have been uploaded to the Model Hospital. Once this has been done we will be able to compare QVH results to the National and Local benchmarking groups in detail.
- All QVH NQPS results will be uploaded to the Staff Survey Qnet page for staff to view

COMMENTARY	FORWARD LOOK / POTENTIAL RISKS
• Final QVH Staff Survey 2021 response rates show we have an improved return rate of 64% compared to 59% in 2020.	• 2021 survey findings will be difficult to compare against 2020 finding due to significant changes to department groupings.

GOAL 2: Attraction & Retention

Queen Victoria Hospital NHS Foundation Trust



	Non Medical		Medical	
	Posts advertised this month	Recruits in Pipeline	Posts advertised this month	Recruits in Pipeline
Corporate	10.4	3.6	NA	NA
Eyes	2.8	2	2	1
Sleep	4	0	0	0
Plastics	1	0	12	12
Oral	4.6	1.2	1	0
Periop	14	10.01	1	6.4
Clinical Support	7.85	5.85	0	0
Outpatients	0	0.8	NA	NA
Director of Nursing	4.38	1	NA	NA
Operational Nursing	17.07	8.19	NA	NA
Community Services	1.2	1.2	0	0
QVH Trust Total	**67.3**	**33.85**	**16**	**19.4**

VACANCY PERCENTAGES	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Corporate	11.93%	12.81%	15.01%	▲
Eyes	11.25%	6.11%	3.27%	▼
Sleep	22.52%	22.15%	28.26%	▲
Plastics	6.40%	5.34%	6.40%	▲
Oral	9.01%	9.93%	8.42%	▼
Periop	12.21%	11.73%	13.18%	▲
Clinical Support	13.48%	12.07%	13.21%	▲
Outpatients	30.25%	30.25%	33.64%	▲
Director of Nursing	7.18%	7.14%	1.61%	▼
Operational Nursing	14.73%	15.25%	18.04%	▲
Community Services	8.14%	14.39%	14.39%	◄►
QVH Trust Total	12.49%	12.41%	13.66%	▲

COMMENTARY

- SIP as at 31.1.22 was 932.11wte a 7.41wte decrease on December. Vacancies increased in all Business units apart from Eyes, Oral, director of nursing and Community Services
- Trust overall vacancy rate has increased to 13.66% with Outpatients remaining the highest at 33.64%
- Number of adverts placed increased from 37 to 39 in January, with actual advertised WTE reducing considerably from 85.9 in December to 48.95 in January
- 46 candidates completed employment checks (taking 19.45 days for internal and 30.65 for external on average)
- Reduction in leavers in January to 10.18 WTE.

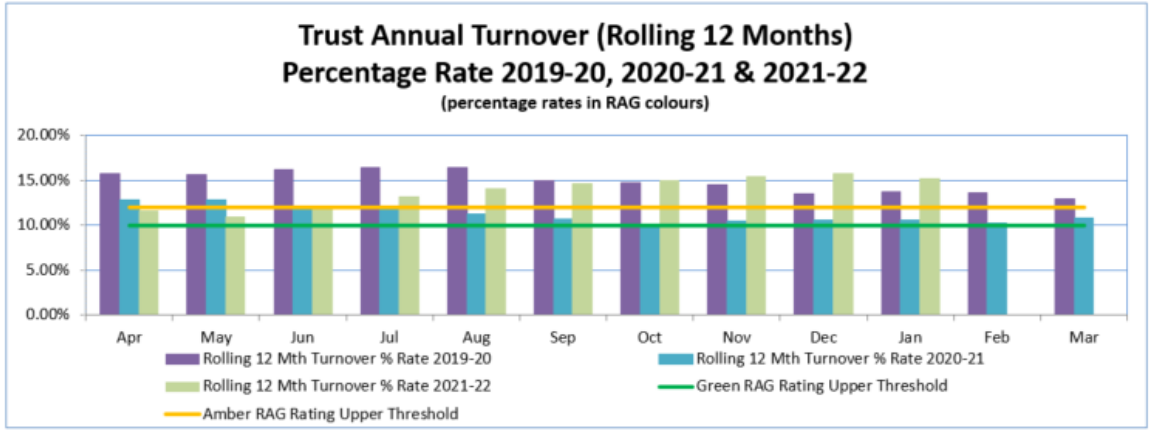
FORWARD LOOK / POTENTIAL RISKS

- Reintroduction of “New Starter Premium” to attract and retain new registered staff to specified areas
- Commencement in February of wording on all adverts informing gathering of COVID vaccine data for all starters to trust
- Recruitment and Selection Policy updated and published on Qnet with clearer processes for all stages

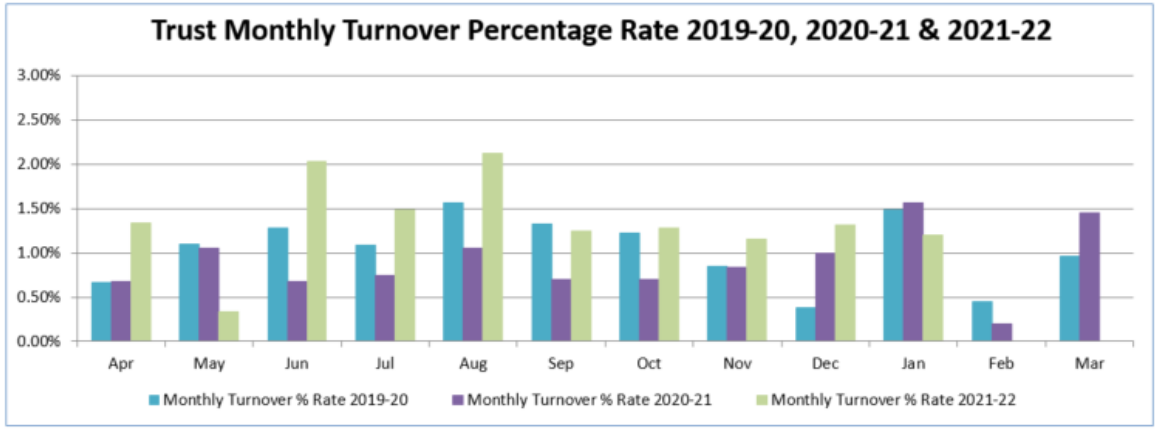
Turnover, New Hires and Leavers

Queen Victoria Hospital
NHS Foundation Trust

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Corporate %	15.49%	15.58%	14.23%	▼
Eyes %	42.70%	42.86%	45.03%	▲
Sleep %	17.55%	24.34%	25.25%	▲
Plastics %	20.77%	20.57%	22.71%	▲
Oral %	14.67%	14.67%	14.42%	▼
Peri Op %	12.18%	11.12%	10.62%	▼
Clinical Support %	14.23%	14.37%	12.21%	▼
Outpatients %	11.65%	11.65%	7.88%	▼
Director of Nursing %	9.41%	11.70%	9.95%	▼
Operational Nursing %	14.09%	15.06%	15.83%	▲
Community Services %	14.69%	15.24%	4.87%	▼
QVH Trust Total %	15.43%	15.72%	15.23%	▼



MONTHLY TURNOVER excl. Trainee Doctors	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Corporate %	1.42%	0.55%	1.44%	▲
Eyes %	0.00%	3.97%	5.81%	▲
Sleep %	0.00%	7.27%	3.71%	▼
Plastics %	2.38%	0.00%	1.86%	▲
Oral %	0.67%	0.00%	0.00%	◄►
Peri Op %	1.15%	1.02%	0.95%	▼
Clinical Support %	1.06%	1.27%	0.52%	▼
Outpatients %	0.00%	0.00%	0.00%	◄►
Director of Nursing %	1.41%	2.34%	0.00%	▼
Operational Nursing %	1.23%	2.03%	1.21%	▼
Community Services %	0.00%	0.00%	0.00%	◄►
QVH Trust Total %	1.15%	1.31%	1.20%	▼



COMMENTARY

- Of the 10.18 WTE leavers 3.48 were qualified nurses.
- 12 monthly Turnover has decreased to 15.23% and January turnover has decreased to 1.20%.
- Of the 9.15 WTE starters (new to QVH) in January 2.33 WTE where qualified nurses

FORWARD LOOK / POTENTIAL RISKS

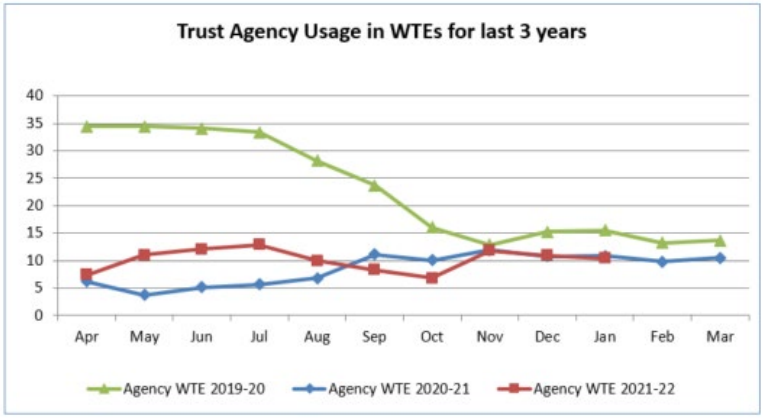
- Potential risk of decrease (national and locally) of starters due to vaccination data and uncertainty around VCOD
- Reintroduction of New Starter Premium to attract and retain more starters to QVH

Temporary Workforce

Queen Victoria Hospital
NHS Foundation Trust

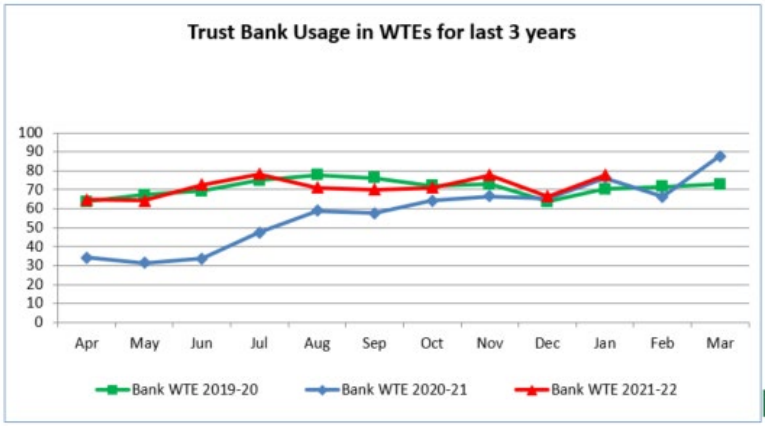
Agency				
BUSINESS UNIT (WTE)	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Corporate	4.05	3.41	2.99	▼
Eyes	0.00	0.00	0.00	◄►
Sleep	0.75	0.50	0.41	▼
Plastics	0.00	0.00	0.00	◄►
Oral	0.00	0.00	0.00	◄►
Periop	2.12	1.78	2.27	▲
Clinical Support	0.86	0.40	0.67	▲
Outpatients	0.00	0.00	0.00	◄►
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	4.01	4.82	4.10	▼
Community Services	0.00	0.00	0.00	◄►
QVH Trust Total	11.79	10.91	10.44	▼

Bank				
BUSINESS UNIT (WTE)	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Corporate	9.59	8.19	9.40	▲
Eyes	3.81	2.59	2.12	▼
Sleep	4.34	3.77	4.33	▲
Plastics	2.83	1.21	2.09	▲
Oral	3.32	3.09	4.77	▲
Periop	18.14	16.71	20.29	▲
Clinical Support	5.15	4.44	3.06	▼
Outpatients	1.28	0.89	2.06	▲
Director of Nursing	2.40	3.45	2.53	▼
Operational Nursing	25.38	21.23	25.60	▲
Community Services	1.61	1.07	1.61	▲
QVH Trust Total	77.85	66.63	77.85	▲



Agency				
STAFF GROUP (WTE)	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Qualified Nursing	4.51	5.17	5.70	▲
HCAs	0.64	1.06	0.00	▼
Medical and Dental	1.73	0.87	1.08	▲
Other AHP's & ST&T	0.86	0.40	0.67	▲
Non-Clinical	4.05	3.41	2.99	▼
QVH Trust Total	11.79	10.91	10.44	▼

Bank				
STAFF GROUP (WTE)	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Qualified Nursing	29.68	25.16	30.21	▲
HCAs	10.55	9.02	11.36	▲
Medical and Dental	5.04	3.72	4.77	▲
Other AHP's & ST&T	4.36	3.81	3.08	▼
Non-Clinical	28.21	24.92	28.43	▲
QVH Trust Total	77.85	66.63	77.85	▲



COMMENTARY

- Agency has slightly decreased on last month to 10.44wte and bank has increased by 11.22wte to 77.85wte. This increase in bank is following trend on previous January's.
- Highest Agency usage in Operational Nursing at 4.10 WTE agency and 25.60 in bank
- Qualified Nursing was the highest Bank and Agency

FORWARD LOOK / POTENTIAL RISKS

- 3 more bank admin candidates being processed following interviews
- Review to take place on process of Bank and Agency requests to streamline the process ensuring compliance continues

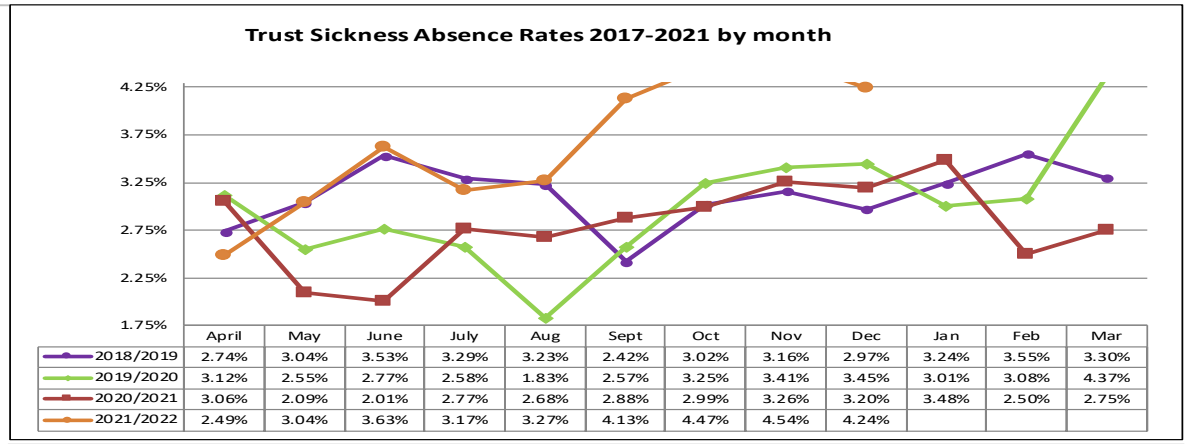
GOAL 3: Health and Well-being

Queen Victoria Hospital NHS Foundation Trust

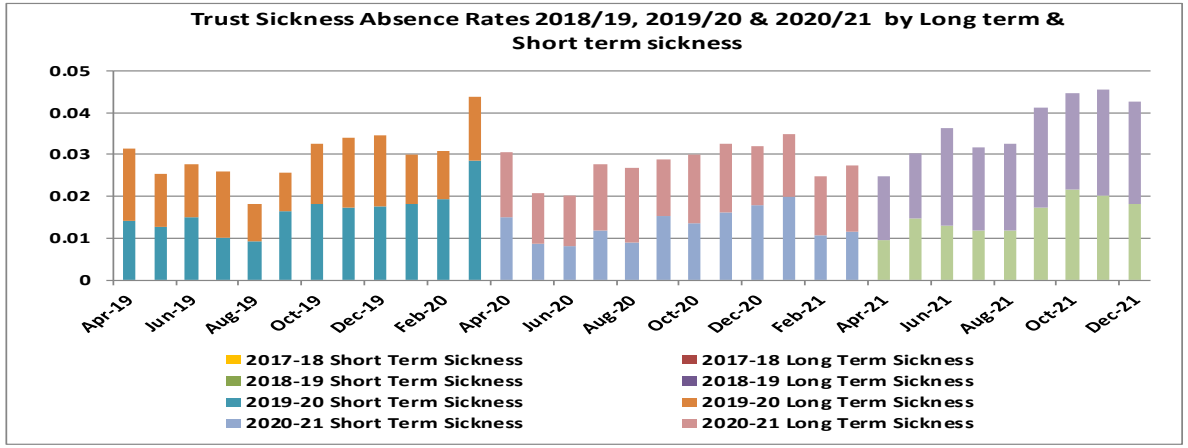
SHORT TERM SICKNESS	Oct-21	Nov-21	Dec-21	Compared to Previous Month
Corporate	2.50%	2.49%	1.18%	▼
Clinical Support	2.34%	2.58%	3.20%	▲
Plastics	2.73%	1.13%	1.08%	▼
Eyes	0.00%	1.08%	0.61%	▼
Sleep	6.41%	2.70%	2.62%	▼
Oral	0.60%	0.97%	0.92%	▼
Periop	1.62%	2.73%	1.66%	▼
Outpatients	5.03%	1.22%	0.73%	▼
Director of Nursing	1.12%	2.75%	1.37%	▼
Operational Nursing	2.42%	1.55%	2.92%	▲
Community Services	0.53%	0.96%	3.81%	▲
QVH Trust Total	2.15%	2.01%	1.83%	▼

LONG TERM SICKNESS	Oct-21	Nov-21	Dec-21	Compared to Previous Month
Corporate	2.53%	2.10%	2.58%	▲
Clinical Support	0.49%	2.54%	1.06%	▼
Plastics	0.00%	1.10%	1.67%	▲
Eyes	0.00%	0.00%	0.00%	◄►
Sleep	8.28%	7.18%	4.77%	▼
Oral	3.26%	3.27%	3.01%	▼
Periop	4.45%	3.79%	2.80%	▼
Outpatients	3.09%	4.91%	4.91%	◄►
Director of Nursing	2.31%	2.13%	1.15%	▼
Operational Nursing	1.49%	1.85%	3.10%	▲
Community Services	0.00%	0.00%	0.00%	◄►
QVH Trust Total	2.32%	2.53%	2.42%	▼

ALL SICKNESS (with RAG)	Oct-21	Nov-21	Dec-21	Compared to Previous Month
QVH Trust Total	4.47%	4.54%	4.24%	▼



	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%
2021/2022	2.49%	3.04%	3.63%	3.17%	3.27%	4.13%	4.47%	4.54%	4.24%			



COMMENTARY

- The Trust's total absence in December 2021 saw a marginal decrease to 4.24%, an increase from the same month last year which was at 3.20% (in 2019 the Trust total for November was 3.45% as a comparison). The average sickness absence total in the 3 months October to December was 4.42% which is an average increase of 0.89% from 3.52% in the 3 month period July to September.
- A marginal decrease in short term and long term sickness absence was seen between November and December 2021.
- The top 3 reasons for absence remain consistent reported as gastrointestinal problems, headache/migraine, and cold cough flu – influenza.

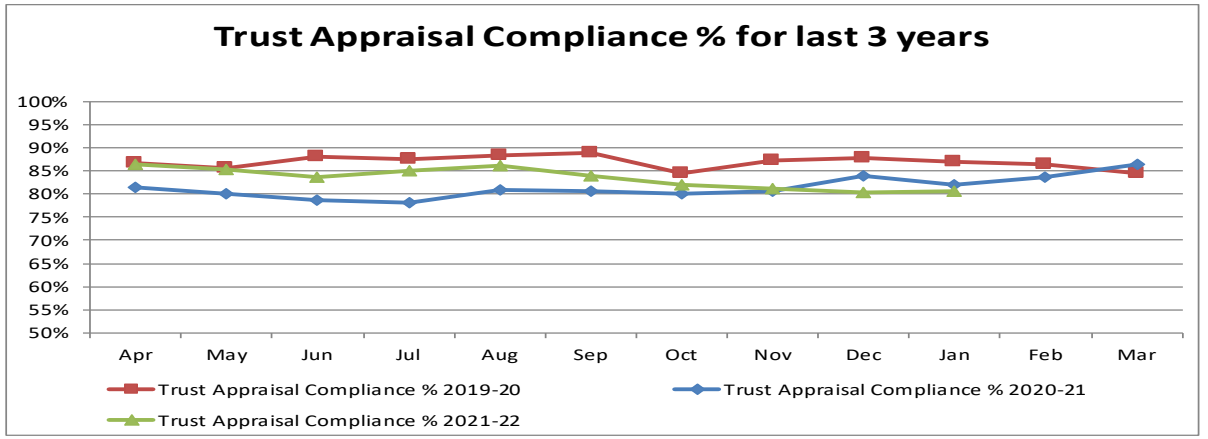
FORWARD LOOK / POTENTIAL RISKS

- Although the total sickness absence has marginally decreased in month, it remains a concern sitting above the Trust target.
- As we emerge into the spring months, it is expected that sickness absence levels will reduce.
- There will continue to be both formal and informal absence management

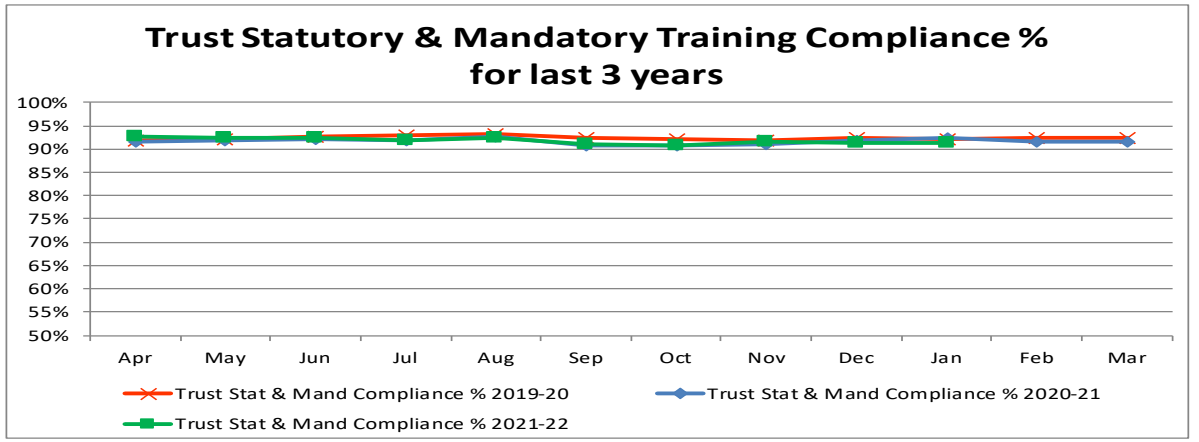
GOAL 4: Learning and Education

Queen Victoria Hospital NHS Foundation Trust

APPRAISALS	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Corporate	79.41%	81.46%	78.71%	▼
Eyes	72.73%	73.53%	75.76%	▲
Sleep	37.93%	35.71%	29.63%	▼
Plastics	77.27%	72.83%	76.67%	▲
Oral	74.73%	65.56%	66.67%	▲
Peri Op	77.60%	79.46%	75.14%	▼
Clinical Support	91.53%	88.43%	91.80%	▲
Outpatients	87.50%	91.67%	91.30%	▼
Director of Nursing	96.15%	92.59%	89.83%	▼
Operational Nursing	89.00%	88.41%	92.79%	▲
Community Services	94.29%	71.43%	69.23%	▼
QVH Trust Total	81.24%	80.36%	80.61%	▲



MANDATORY AND STATUTORY TRAINING	Nov-21	Dec-21	Jan-22	Compared to Previous Month
Corporate	92.48%	93.00%	93.51%	▲
Eyes	85.09%	80.65%	85.47%	▲
Sleep	91.61%	91.26%	91.33%	▲
Plastics	83.39%	81.52%	80.15%	▼
Oral	86.95%	88.43%	91.31%	▲
Peri Op	91.08%	91.58%	91.31%	▼
Clinical Support	96.85%	96.64%	96.08%	▼
Outpatients	96.52%	97.01%	95.31%	▼
Director of Nursing	94.37%	95.67%	95.89%	▲
Operational Nursing	93.58%	93.27%	91.21%	▼
Community Services	88.89%	83.55%	89.29%	▲
QVH Trust Total	91.48%	91.39%	91.27%	▼



COMMENTARY

- 322 course bookings for January 2022
- 187 attendees (58% of all bookings)
- 55 did not attend (17% of all bookings)
- 27 withdrew within 2 weeks of the course (17% of all bookings)
- 18 withdrew more than 2 weeks before the course (8% of all bookings)
- 35 on cancelled courses (11% of all bookings)

FORWARD LOOK / POTENTIAL RISKS

- Appraisals slightly increased this month but are still a risk and may potentially drop to below 80% and turn red in the RAG rating category unless action is taken in departments to ensure staff receive their appraisals. This may also resulting staff and managers not meeting the Pay Progression requirements.
- Risk continues as a result of Covid-19 and self-isolation impact on training delivery, compliance levels and trainer availability.

GOAL 5: Talent & Leadership

Including OD&L and Medical Education activity

Queen Victoria Hospital NHS Foundation Trust

SHCP – Leadership, OD and Talent Group activity:

- The group met in February 2022 to discuss a new approach to talent across the SHCP. A consultant was brought in to facilitate a discussion on the current status and what we are trying to achieve. The idea to create effective system working across the SCHP which will allow us to attract and retain talent. There is a need to create career pathways to support mobilisation of talent around the system and to provide more opportunities/placements. The need to involve all system partners including primary care, social care, voluntary/third sector and local authorities will be crucial and to develop a talent management competency.
- The group is meeting again in March 2022 and will look at potential next steps.
- All previous QVH staff that attended the Coaching Programme (8 in total) have been invited to join a community of practice group.
- Developing Excellence, Together has been advertised for new cohorts 11 - 23 and at QVH we have had 4 staff members apply
- A new 'Reaching New Heights' offer which is for BAME colleagues who are interested in coaching and gaining the national ILM Level 3 accreditation with the opportunity to become part of the Sussex Coaching Network will launch in April and comms for this will be circulated in the next 2 weeks.

Apprenticeships:

- To date we have 17 new starts in apprenticeship for this financial year however, and 1 new start in January 2022.
- Functional skills continues with our new provider (Functional Skills UK) and will be evaluated.

Other activities:

- OD&L have received several requests for support for teams and we expect this trend to continue once the NHS Staff Survey results are published.
- There has been no interest from across the Trust for managers/team leaders to participate in an Action Learning Set (ALS) workshop.
- QVH is in the process for recruiting 7 KickStart placement. Kickstart provides real life work experience for long term unemployed local young people.
- February corporate induction programme was held in the LDC Training room for 11 new starters only 8 arrived as Covid impacted on numbers)
- Funding Panel was held in January 2022, OD & L processed 19 Applications and several ad-hoc applications have come in for February. Next meeting is due to take place in March 2022.

Medical Education activity

The first junior doctors' induction of the year took place at the beginning of February, with 19 new doctors in Plastic Surgery, Anaesthetics and Corneo Plastics welcomed to QVH. Planning is underway for the next induction in April.

Additional funding has been approved by HEE to support the trainees in Plastic Surgery with recovery following the impact of Covid on their training. The funding will be used for locum shifts to allow trainees access to lists that provide additional teaching opportunities.

Following the GMC survey results, further feedback on the actions taken to date has been received from the Head of School of Surgery for London for the Higher Plastics trainees. An additional update is due to the HoS in February but the progress so far is positive.

The plastics monthly teaching timetable is in place for the first nine months of 2022, with excellent sessions planned and the opportunity to use two separate rooms being taken on some occasions to allow dedicated sessions for core and higher trainees.

The latest round of Local Faculty Group meetings are underway, to ensure continued educational governance in all specialties.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03 March 2022**		**Agenda reference:**	**50-22**	
Report title:	Board effectiveness review				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Authors:	Clare Pirie, Director of communications and corporate affairs Hilary Saunders, Deputy Company Secretary				
Appendices:	A: Board seminars and presentations 2021/22 B: Development of individual Board members C: Details of NED champions at QVH D: Board committee terms of reference				
Executive summary					
Purpose of report:	The purpose of this report is to consider the performance of the Board of Directors at QVH and identify any actions needed to ensure that the Board has the skills, experience and approach needed to ensure the Trust remains an innovative and high performing organisation.				
Summary of key issues	This paper is structured around the eight key lines of enquiry of the Care Quality Commission's well led domain.				
Recommendation:	The Board is asked to: • **AGREE** the contents of this review, noting that detail will be included in the 2021/22 annual report and accounts. • **APPROVE** the Board sub-committee terms of reference.				
Action required *[highlight **one** only]*	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:** *Outstanding patient experience*	**KSO2:** *World-class clinical services*	**KSO3:** *Operational excellence*	**KSO4:** *Financial sustainability*	**KSO5:** *Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	This paper enables the Trust to comply with the FT Code of Governance				
Legal:	None				
Resources:	This paper seeks best use of existing resources.				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:	• This evaluation will be noted in the Annual Report and Accounts • Assuming approval, terms of reference will take immediate effect.				

Report to:	Board of Directors
Meeting date:	3 March 2022
Agenda item reference no:	50-22
Sponsor:	Clare Pirie, Director of communications and corporate affairs
Authors:	Clare Pirie, Director of communications and corporate affairs Hilary Saunders, Deputy Company Secretary
Date of report:	23 February 2022
Appendix:	A: Board seminars and presentations 2021/22 B: Development of individual Board members C: Details of NED champions at QVH D: Board committee terms of reference

QVH Board of Directors Effectiveness review

Introduction

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

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

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

Recommendation

The board of directors is asked to:

- **AGREE** the contents of this evaluation, noting that it will be referenced in the 2021/22 annual report and accounts.
- **APPROVE** the attached committee terms of reference for the next twelve months.

CQC theme		Developments at Board level in 2021/22
1. Leadership	The most effective Boards are those that drive organisational performance especially at times of great stress and change. Sound leadership creates an organisational culture of continuous improvement, motivated staff, and enhancing its long-term sustainability.	The development activities undertaken by individual directors are summarised in Appendix B, and while opportunities and the capacity of directors to undertake personal development over the past year were significantly impacted, all Board members have ensured they are well equipped to deliver in their roles. The Trust has a well-developed appraisal process, which is used to identify individual development needs. The Chief Executive has agreed with each executive director a personal development plan as part of their individual appraisal. The Chair conducts annual non-executive director appraisals and is herself appraised by the senior independent director; the Chair and NEDs also have individual development needs documented and reviewed through this process. A facilitated Board development day took place in June 2021.
2. Vision and strategy	The strategic focus in 2021/22 continues to be around securing the long-term future of QVH.	QVH is an outward looking organisation with a strong track record of engaging with system working. Through 2021/22 of members of the Board have continued to engage with partners throughout the region. The operational focus on becoming a regional cancer hub in the context of the pandemic has contributed to QVH visibility and attracted praise for the swift response and high quality of services. Staff have been kept well informed through virtual meetings and written briefings. The recommendations of the independent review published in February 2022 will be implemented while taking this work forward.
3. Culture	As an effective board, we need to shape a culture for the organisation, which reflects QVH's values and is ambitious, self-directed, responsive, and encourages innovation. We have a commitment to openness and transparency and to put patients and communities at the centre of everything we do. Board members are also expected to exemplify the seven Nolan Principles of public life: selflessness, integrity, objectivity, accountability, openness, honesty, leadership.	QVH has a strong culture of celebrating success. The staff awards process was last carried out in February 2021; plans are being developed for a face to face staff awards event in summer 2022, pandemic allowing. The process of recognising educational achievements continued throughout the year with one to one visits from members of the Board and celebration in internal communications, and more than 100 long service awards were given out direct to individual staff in their place of work. Throughout the year the Board received regular updates on the five goals of the people and organisational development strategy (engagement and communication, attraction and retention, health and well-being, learning and education, talent and leadership), work which plays an important role in supporting the QVH values and culture. The 2021 staff survey results are currently embargoed and will be considered in detail by the Board when available.

CQC theme		Developments at Board level in 2021/22
		All Board members have been subject to the Fit and Proper Persons Test since it was introduced in 2014/15. This declaration is included with all Board papers as a reminder and signed off on appointment and annually by the Chair.
4. Governance	Good governance involves clarity about structures, processes and systems of accountability; at QVH, these are regularly reviewed and improved.	In August 2021, the Board revised and approved its Standing Financial Instructions, Standing Orders and Schedule of Matters Reserved for the Board. New NHSEI guidance published in December 2021 set out an updated approach to NED champion roles which is in line with the Trust's preferred approach as a unitary board. The guidance describes four roles for which trusts should have designated NED champions; any other current champion roles should be ceased and embedded in the governance arrangements through alignment with the committee structure. Implementation of this is set out in Appendix C. In line with the recommendations of the independent review of QVH's handling of challenges encountered in progressing a merger proposal with University Hospitals Sussex NHS Foundation Trust, the practice of governors attending sub-committees has been ended and the lead governor no longer attends private Board. These changes were recommended to support role clarity. The Deputy Co Sec and the Executive Assistant Team Lead deliver a minute writing course, raising the standard of minutes across the organisation to ensure that we have a good record of assurance and decision-making.
5. Risks and performance	The Board continues to ensure that the organisation has a robust and effective risk management system. The corporate risk register is reviewed by the Board at each meeting. Public board agendas are structured around the Trust's five key strategic objectives (KSOs). Each KSO is prefaced by the relevant part of the BAF, (with overall BAF summary included in the Chief executive's report). Detailed explanations of changes to risk scores are provided within each relevant section.	Active engagement with a meaningful Board assurance framework is evidenced throughout the year in Board and sub-committee minutes. The December Board seminar also included a focus on the strategic approach to risk management.
6. Information	QVH Board papers include a good level of detail on quality, operations and finance	On a quarterly basis, the Audit committee continues to undertake a deep dive into an individual key strategic objective, seeking assurance in respect of gaps and controls.

CQC theme		Developments at Board level in 2021/22
	and the Board works to ensure these are considered in a holistic way. A programme of sub-committee assessments identifies ways in which papers and processes can be further improved.	The Audit committee reviewed its effectiveness in December 2021. The overall scores were positive and there were no key themes identified. The main areas of discussion were regarding the measurability of objectives and outcomes, and communication from the Committee to managers and other staff. The committee considered that this was best addressed at board level rather than by individual committees The finance and performance committee review carried out in December 2021 identified a small number of areas for improvement including introducing a more structured induction for new committee members, and a six-monthly discussion on the wider assurances brought from things such as performance review meetings and NED visits to services or attendance at other meetings. Going forwards the reporting on the year-end financial forecasts (especially M6 and M9) will include the principal estimates and judgements included in the figures, with the associated risks / implications, to guide discussion and challenge. Quality and governance committee carried out a self-evaluation in January 2022. In the context of a committee which looks at detailed reports across a wide range of areas, it was noted that papers can be lengthy and numerous, and would benefit from executive summaries of key issues, clear recommendations and explanations of the data. Assurance from the committee to Board is good, further work could be done to improve communication of key information from the committee to staff. N&RC has not carried out an effectiveness self-assessment in 2021/22.
7. Engagement	The Board ensures it continues to meet its responsibility to engage with stakeholders through various means including attendance of a QVH patient, where possible, at each public session to describe their experience of care at the Trust. Where difficult to arrange the Board receives an update from the director of nursing on a recent patient experience. The Friends and Family Test was suspended at a national level in response to the pandemic, however there is regular and continued scrutiny of feedback on patient experience.	Changed ways of working in the pandemic mean face to face meetings with staff have been limitted, but Board members have continued to engage with staff. The chief executive has held frequent online staff briefings with other executive and non-executive directors joining these. NEDs have also joined various virtual team meetings. There is significant and ongoing work related to the possible merger with University Hospitals Sussex; key stakeholders including NHS partners, QVH members and MPs across Kent Surrey Sussex have received updates. QVH staff have been engaged through chief executive briefings, attendance at departmental and team meetings, attendance at consultants' fora. The staff Q&A has been updated when new issues arise and shared through internal communications channels. The findings of the independent review related to this will be implemented. Full Friends and Family Test (FFT) data submissions and reporting has been available throughout the 2021/2022 financial year. It is acknowledged that the continuing impact of the pandemic has, however, reduced the opportunity for patients to provide FFT feedback face to face or as a written submission.

CQC theme		Developments at Board level in 2021/22
	All members of the Board attend the quarterly meetings of the Council of Governors. In 2021/22 there were a significant number of additional meetings with governors (17 meetings in total).	Where patients wanted to share their experience or raise concerns, they were encouraged to contact the Patient Experience Manager, by email or telephone, and were also directed to the Care Opinion website. Patient feedback throughout the year has been very positive, especially our inpatients with 100% of respondents likely or very likely to recommend us to their friends and family each month since June 2021.
8. Improvement	Continuous improvement is one of the core values of QVH. To support this we have identified a need to adopt a service improvement methodology. Board committees continue to undertake their annual effectiveness reviews, These self-assessments support the Board's evaluation of performance. Actions taken as a result are described above. Board members' personal development supports ongoing improvement.	Work is underway to commence use of Patient First at QVH; this is the successful improvement methodology used by University Hospitals Sussex. All individual members of the Board, both executive and non-executive, have participated in development opportunities during 2021/22 as shown in Appendix B and have agreed personal development plans. In addition to some formal training, Board member development is supported through networks, shadowing, opportunities provided at no cost by national bodies such as NHS Providers, Federation of Specialist Hospitals, Healthcare Financial Management Association, NHSEI as well as more specialist professional bodies. Board members at QVH have a strong presence in national and regional professional bodies, both contributing and benefiting from these relationships and opportunities. Appendix B should not be considered a comprehensive list as executive directors spend a considerable proportion of their time on meetings outside of the Trust, but each director has identified what they consider their key personal development opportunities over the year. In addition to the Board seminars shown in Appendix A, Board members regularly attend the joint hospital governance committee which meets every six weeks and has a clinical focus including the findings of clinical audit, learning from national and local issues of clinical safety, clinical innovation. All Board members remain up to date with core training in areas like information governance and fire safety.

Appendix A
Board seminars and presentations in 2021/22

Date	Event
01 April 2021	**Board seminar** Strategic case discussion, including revised timeline and approach and review re staff with sole responsibility for a function
03 June 2021	**Facilitated Board development session** Facilitated organisational development session combining reconnection as a team after a long time without face-to-face contact with work on the strategic approach to the future.
25 June 2021	**Board seminar** Strategic case options appraisal
01 July 2021	**Board seminar** Review of full draft strategic case
22 July 2021	**Board seminar** Review of final strategic case
07 October 2021	**Board seminar** CEO update including • System challenges (and QVH role) • H2 finances and financial settlement • Provider collaboratives update • ICS development BAME Allyship session led by Dr Roberta Babb, Registered Clinical Psychologist
02 December 2021	**Board seminar** • Full business case update • Draft risk management strategy
03 February 2021	**Board seminar** • Digital transformation session led by NHS Providers and Public Digital • QVH corporate strategy

Appendix B
Development of individual board members

	EVENT
Anita Donley - joined the board as interim Chair in November 2021	• Attendance at regular ICS meetings, SE NHSEI meetings, Kent and Medway Chairs meetings
Paul Dillon-Robinson	• Involved with the HFMA in a variety of roles; tutoring at Masters level on managing healthcare business; delivering webinars on a range of management areas; coaching individuals in the NHS; developing guidance for ICS (governance and financial management); research and investigation related to the above. • Non-executive member and more recently Chair of the Rural Payments Agency's Audit & Risk Assurance Committee (ARAC), as Chair also on the DEFRA ARAC. Recently appointed as ARAC chair of a part of the MoD. Both roles support comparison with central government practice, and induction has required review of central government governance guidance. • Undertook governance reviews of independent schools, to a best practice checklist, making recommendations for improvement. Involved in development of EDI guidance for sector. • Self-certified maintained CPD for the ICAEW, through reading publications and exploring areas of relevant interest.
Kevin Gould	• Various audit committee technical update seminars (mostly four largest professional services networks) • Developed and presented several sessions on climate change and sustainability • Led governance review of a large public body • Webinars on board responses to climate change, belonging, diversity and inclusion, safeguarding and health & safety • Accounting for sustainability (A4S) summit • ICAEW climate summit
Gary Needle	• HSJ Conference online - April • NHS Providers NED network seminars - June and September • NHSI leadership framework for health inequalities seminar - December • NED on Board network membership • Regular attendance at Sussex NHS Trust Chairs group • International learning from role as Consultant Advisor to Minister of Public Health, Qatar
Karen Norman	• Revalidated professional registration with Nursing and Midwifery Council (NMC) • Visiting Professor, Doctorate in Management Programme, Business School, University of Hertfordshire. Supervising 6 Doctoral research students and teaching on international programme requiring keeping abreast of contemporaneous management and leadership literature.

	• Visiting Professor, School of Nursing, Kingston University and St George's, University of London. Teach at Masters level on Leadership and Management of Change module requiring keeping abreast of contemporaneous NHS, nursing and clinical issues • University of Hertfordshire Annual Complexity and Management Conference 2021: 'The Complexity of Practice.' • Leadership framework: Health inequalities improvement program • Seminar on allyship; Third Eye Psychology
Steve Jenkin	• Member of Sussex Health & Care Partnership (SHCP) Executive Group including two half-days development sessions • Attendee of Gold system call on weekly (or more frequently) calls during pandemic • Role in SHCP - acute representative on MH Steering Group and member of Sussex Acute Collaborative Network • Staff and Governor briefings on partnership working • Regular staff briefings including consultants bi-monthly meetings • Weekly meetings with clinical directors; monthly Hospital Management meetings • NHS Providers CEO & Chairs briefings • Fortnightly attendance at NHSE/I SE Regional Director's meeting • Attendance at NHSEI Digital Diagnostics Showcase (May 2021) • Board Away Day on BAME Allyship facilitated by Dr Roberta Babb of Third Eye Psychology (October 2021) • Attended NHSEI/NHS Providers workshop on future direction for specialised services and the development of the commissioning model (October 2021) • NHS Providers annual conference – participant in some sessions (November 2021)
Abigail Jago	• Sussex women's director network • STP chief operating officers group • Managing Successful Programmes (MSP) • System silver calls • System planning & recovery calls • Sussex Acute Collaborative Network • Sussex Planned Care Board • Sussex Cancer Board • Ongoing professional coaching
Michelle Miles	• Member of the ICS CFO Finance leadership group • SIRO annual training day • Member of ACMA • Attend national and regional CFO/DoF forums • South East Women in Leadership
Clare Pirie	• National event on shifts in public attitudes to care related to the pandemic • Employment law tribunal training • Charity legacies training session • Leadership – giving feedback • Attends national and regional communications and engagement sessions

	• Attend national and local company secretary network sessions • Attends national NHS Charities Together forums
Nicky Reeves	• NHS Providers Executive Director Induction Feb 2021 • Mini MBA – May 2021 • Trust representative on Silver system calls during Covid incident response • Member of Sussex and Regional CNO Groups • Member of Sussex Clinical Harm Review Group • Member of Clinical Leadership Group Board
Lawrence Anderson	• NHS Employers Monthly HR Directors forums for SE England • ICS Workforce Directors forum, meeting weekly through pandemic • Sussex HCP People Committee • National webinars from NHS Chief People's office • SRO for Vaccination as a Condition of Deployment • SRO of the Sussex Healthcare Providers Violence Prevention and Reduction Group • Member of CIPD • Member of the Pan London Medical HR Network • Member of the National Association of Medical Personnel Specialists (NAMPS) • NHS Providers Annual Conference 2021

Appendix C: Non-Executive Director Champion Roles

The approach set out below is aligned to national guidance *Enhancing board oversight: A new approach to non-executive director champion roles* (December 2021). Board oversight and assurance for other issues is embedded in governance arrangements and an audit trail of discussions and actions is provided in the minutes of relevant committees.

Role	Requirement	QVH implementation
Wellbeing guardian	This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision. The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials.	GN is designated NED
FTSU NED champion	The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation. The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report). All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why. A full description of NED responsibilities can be found in the FTSU supplementary information.	KG is designated NED
Doctors disciplinary NED champion/independent member	Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as "the designated member" to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only.	Shared role allocated to NED on a case-by-case basis

Role	Requirement	QVH implementation
Security management NED champion	Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement. While promotion of security management in its broadest sense should be discharged through the designated NED, relevant committees may wish to oversee specific functions related to counter fraud and violence/aggression. Boards should make their own local arrangements for the strategic oversight of security of assets and estates.	TBC PDR or KN

Terms of reference

Name of governance body

Audit Committee

Constitution

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

Accountability

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

Authority

The Committee is authorised by the Board of Directors to:

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

Purpose

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

Duties and responsibilities

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

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

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

Reviewed by Audit in December 2021
Approved by the Board of Directors at its meeting on XX

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

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

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

2. Financial reporting

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

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

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

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

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

Internal audit

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards ~~2013~~ 2017 and provides

appropriate independent assurance to the Committee, Chief Executive (as accounting officer) and Board of Directors. This will be achieved by:

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

External audit

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

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

Whistle blowing

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

Counter fraud

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

Management

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

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

Other assurance functions

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

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

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

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

Meetings

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

The Committee will meet ~~quarterly~~at least four (4) times a year.

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

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

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

Chairing

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

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

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

Secretariat

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

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

Membership

Members with voting rights

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

Ex-officio attendees without voting rights

- Chief Executive (as Accounting Officer) who shall discuss with the Committee at ~~8/**/9~~least annually the process for assurance that supports the annual governance statement. The Chief Executive should also be in attendance when the Committee considers the draft annual governance statement along with the annual report and accounts.
- Representatives of the Trust's internal auditors.
- Representatives of the Trust's external auditors.
- The Trust's counter fraud specialist who shall attend at least two meetings of the Committee in each financial year.

In attendance without voting rights

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

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

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

Quorum

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

Attendance

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

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

Papers

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

Reporting

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

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

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

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

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

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

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

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

Review

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

The next scheduled review of these terms of reference will be undertaken by the Committee in December 2022 in anticipation of approval by the Board of Directors at its meeting in March 2023.

* Definitions

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

Terms of reference

NAME OF GOVERNANCE BODY

Finance and Performance Committee (F&PC)

CONSTITUTION

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

ACCOUNTABILITY

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

AUTHORITY

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

PURPOSE

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

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

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

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

To fulfil its purpose, the Committee will also:

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

DUTIES AND RESPONSIBILITIES

Duties

Financial and operational performance

- Review and challenge construction of operational and financial plans for the planning period as defined by the regulators.
- Review, interpret and challenge in-year financial and operational performance.
- Review, interpret and challenge workforce profile metrics including sickness absence, people management, bank and agency usage, statutory and mandatory training compliance and recruitment.

- Oversee the development and delivery of any corrective action plans and advise the Board of Directors accordingly.
- Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the Board of Directors.
- Refer issues of quality or specific aspects of the Quality and Gg~~o~~overnance C~~c~~ommittee's remit, and maintain communication between the two committees to provide joint assurance to the Board of Directors.

Corporate risks

- Review corporate risks, allocated to the committee for oversight, and the implementation of remedial actions.

Estates and F~~f~~acilities strategy and maintenance programmes

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

Information management and technology strategy, performance and development

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

Capital and other investment programmes and decisions

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

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

Cost improvement plans

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

Business development opportunities and business cases

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

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

Responsibilities

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

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

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

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

CHAIRINGMANSHIP

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

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

MEETINGS

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

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

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

SECRETARIAT

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

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

MEMBERSHIP

Members with voting rights

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

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

Ex-officio members without voting rights

- The Director of Nursing

In attendance without voting rights

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

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

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

Reviewed by F&PC in
For approval by Board of Directors on 3 March 2022

QUORUM
For any meeting of the Committee to proceed, two non-executive directors and one executive director of the Trust must be present.
ATTENDANCE
Members and attendees are expected to attend all meetings or to send apologies to the chair and Committee secretary at least one clear day* prior to each meeting. Attendees may, by exception and with the consent of the chair, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act and vote on behalf of the Committee member.
PAPERS
Papers to be distributed to members and those in attendance at least three clear days in advance of the meeting.
REPORTING
Minutes of the Committee's meetings shall be recorded formally and ratified by the Committee at its next meeting. The chair shall prepare a report of the latest~~each~~ Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues which require disclosure to the Board of Directors including where executive action is continually failing to address significant weaknesses. Issues of concern and/or urgency will be reported to the Board of Directors in between its formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the Trust chair. Instances of this nature will be reported to the Board of Directors at its next formal business meeting. The Committee chair ~~and governor representative~~ shall report verbally at quarterly meetings of the Council of Governors.
REVIEW
These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency. The next scheduled review of these terms of reference will be undertaken by the Committee in February 2023~~1~~ in anticipation of approval by the Board of Directors at its meeting in March 2023~~1~~.
***DEFINITIONS**
In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Reviewed by F&PC in
For approval by Board of Directors on 3 March 2022

Terms of Reference

Name of governance body

Quality & Governance (Q&G) Committee

Constitution

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

Accountability

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

Authority

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

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

Purpose

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

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

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

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

To fulfil its purpose, the committee will also:

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

Duties and Responsibilities

Duties

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

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

Responsibilities

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

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

Meetings

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

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

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

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

Chairing

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

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

Secretariat

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

- Preparation of the draft agenda for agreement with the chairperson
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the committee's work programme.
- Prepare and collate the question template and circulate prior to meeting

Membership

Members with voting rights

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

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

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

In attendance without voting rights

The following posts shall be invited to attend routinely meetings of the Committee in full or in part but shall not be a member or have voting rights:

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

- Clinical Commissioning Group (CCG) – principle commissioner of the Trust's services.

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

Quorum

For any meeting of the Committee to proceed, the following combination of members must be present:

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

Attendance

Members are expected to attend all meetings or to send apologies to the chair and Committee secretary at least one clear day* prior to each meeting. A suitable deputy should be sent to cover any absence. Furthermore, members need to advise the chair in advance if they have to leave the meeting early or are planning to arrive late.

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

Papers

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

Reporting

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

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

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

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

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

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

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

Review

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

The next scheduled review of these terms of reference will be undertaken by the Committee in February ~~2022~~ 2023 in anticipation of approval by the Board of Directors at its meeting in March ~~2022~~2023.

Definitions

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

Terms of reference

Name of governance body

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

Constitution

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

Accountability

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

Authority

The Committee is authorised by the Board of Directors to:

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

Purpose

The purpose of the Committee is to:

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

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

Duties and responsibilities

Duties (nominations)

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

Duties (remuneration)

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

Responsibilities

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

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

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

Meetings

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

The Committee will usually meet three times a year.

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

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

Chairing

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

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

Secretariat

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

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

Membership

Members with voting rights

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

Ex-officio attendees without voting rights

- Chief Executive
- Director of Workforce and Organisational Development

In attendance without voting rights

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

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

Quorum

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

Attendance

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

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

Papers

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

Reporting

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

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

Review

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

The next scheduled review of these terms of reference will be undertaken by the Committee before approval by the Board of Directors at its meeting in March ~~2021~~2023.

*** Definitions**

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	3 March 2022		**Agenda reference:**	**51-22**	
Report title:	**Changes to Trust constitution**				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Authors:	Clare Pirie, Director of communications and corporate affairs Hilary Saunders, Deputy company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of this report is to seek Board approval for proposed changes to the current Trust Constitution.				
Summary of key issues	Details of changes are included in the accompanying report				
Recommendation:	The Board of Directors is asked to **approve** proposed changes to the Constitution				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	This document is an integral part of the Trust's primary governing documents				
Legal:	Changes are in line with legal advice.				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	If the Board approves recommendations i – v, these will take immediate effect. If the Board approves recommendations vi – vii, they will be returned to Council of governors for approval.				

Report to:	Board Directors
Agenda item:	51-22
Date of meeting:	3 March 2022
Report from:	Clare Pirie, Director of communications and corporate affairs
Report authors:	Clare Pirie, Director of communications and corporate affairs Hilary Saunders, Deputy company secretary
Date of report:	21 February 2022
Appendices:	NA

Proposed amendments to the Trust Constitution

BACKGROUND
In the context of the recommendations of the Independent Review, a number of updates to the Constitution are needed.

Section 53 of the Trust's Constitution states that the Trust may make amendments of its Constitution only if:

a) More than half of the members of the Board of Directors present and voting at a meeting of the Board of Directors approve the amendments
b) More than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve the amendments.

The current version of the Constitution can be found on the QVH website.

The following amendments were approved by the Council of Governors at its meeting on 21 February 2022.

1. **Proposed amendment concerning the lead governor role**
   a) Interpretation and definitions
   Interpretation and definitions will read:
   'Lead Governor means the governor nominated by the Trust to fulfill the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code' and as set out in the role description and personal specification.

   b) Section 26 – Lead governor
   Section 26.1 will read:
   In accordance with a process approved by the Chair after consulting the Council of Governors, the Secretary will administer the nomination procedure for a Lead Governor.

   c) Section 26.2 and 26.3
   Text will be deleted from the Constitution. To maintain the integrity of clause numbering throughout the document the clause numbers may be marked 'Not used'.

   d) Section - 39 Board of Directors meetings
   Section 39.6 text will be deleted from the Constitution. To maintain the integrity of clause numbering throughout the document the clause number may be marked 'Not used'.

2. **Proposed amendment concerning chairing of Council of governor meetings**
    a. Section 21 – Council meetings
    Section 21.14 will read:
    If the Meeting Chair has a conflict of interest in relation to the business being discussed, then the Deputy Chair shall chair that part of the meeting. Should the Deputy Chair not be present then one of the other non-executive directors shall chair that part of the meeting.

If the Board approves these amendments they will come into immediate effect.

The following amendments were not approved by Council at its meeting on 21 February. The majority of governors at that meeting expressed a desire to await the plan for an alternative mechanism with which to promote effective understanding of Trust business and assurance regarding the work of the NEDs. This work is currently underway.

In the meantime, the Board is asked to approve the following amendments in anticipation of a solution being identified by the time of the next Council of Governor meeting in April, at which time these amendments will be returned for approval. At this point they would take immediate effect.

3. **Proposed amendment concerning the governor representative role**
    a. Interpretation and definitions
    Interpretation and definitions:
    The definition of Governors' Steering Group will be deleted.
    b. Section 25 – Governors Steering Group (GSG)
    This paragraph will be deleted and to maintain the integrity of clause numbering throughout the document the clause numbers may be marked 'Not used'.

RECOMMENDATION
The Board is asked to **APPROVE** the following amendments to the Constitution, **NOTING** they will take immediate effect.

i. Lead governor: amendment to interpretation and definitions as described in paragraph 1a
ii. Lead governor: amendment to section 26.1 as described under 1b.
iii. Lead governor: amendment to sections 26.2 and 26.3 as described under 1c.
iv. Board of Directors meetings: Amendment to section 39.6 as described under 1d.
v. Chairing of Council of governor meetings: Amendment to section 21.14 as described under paragraph 2a.

The Board is asked to **APPROVE** the following amendments to the Constitution **NOTING** that they will require approval by the Council of Governors before taking effect.

vi. Interpretation and definitions: Deletion of reference to the Governor Steering Group as described under paragraph 3a.
vii. Governor Steering Group: Deletion of section 25 as described under paragraph 3b.

NEXT STEPS

If the Board approves recommendations i – v, these will take immediate effect.

If the Board approves recommendations vi – vii, they will be returned to Council of governors for approval.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**3 March 2022**		**Agenda reference:**	**52-22**	
Report title:	**Annual seal report 2022**				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Author:	Hilary Saunders, Deputy company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	For the Board to comply with S10 of the Trust's standing orders by noting any sealings made in the last 12 months				
Summary of key issues	There have been no sealings since the last annual report				
Recommendation:	The Board is asked to **NOTE** the contents of this 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:	Ensures compliance with S10 of the Trust' standing orders, approved by the Board in August 2021				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board of Directors
Meeting date:	03 March 2022
Agenda item reference no:	52-22
Report from::	Clare Pirie, Director of communications and corporate affairs
Author:	Hilary Saunders, Deputy Company Secretary
Date of report:	23 February 2022

Annual seal report

Purpose

1. The purpose of this paper is to comply with section 10 of the Trust's Standing Orders by providing an annual report of all sealings made in the last 12 months.

Background

2. S.10 of the Trust's Standing Orders, approved by the Board of Directors in August 2022 state:

> ***Sealing of Documents***
> *Documents can only be sealed once they have been authorised by a resolution of the Board of Directors or of a committee thereof, or where the Board of Directors has delegated its powers.*
>
> *Building, engineering, property or capital documents do not require authorisation by Board of Directors or a committee thereof, but before presenting for seal these documents do require the approval and signature of the Finance Director (or an officer nominated by him/her) and the authorisation and countersignature of the Chief Executive (or an officer nominated by him/her who shall not be within the originating directorate).*
>
> *The fixing of the seal shall be authenticated by the signature of the Chair (or the Deputy Chair in the absence of the Chair) and one Executive Director.*
>
> ***Register of sealing***
> *An entry of every sealing shall be made in a record provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least annually. The report shall contain details of the description of the document and date of sealing.*

Annual report

3. Since 31 March 2021 there have been no resolutions to fix the seal of the Trust to a document.

Issues and risks

4. There are no issues or risks specifically relating to document sealed since the last report.

Recommendation

The board of directors is asked to **NOTE** this annual report of sealings.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03 March 2022**		**Agenda reference:**	**53-22**	
Report title:	**Nomination and remuneration committee assurance update**				
Sponsor:	Anita Donley, Trust Chair				
Author:	Clare Pirie, Director of communications and corporate affairs				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide assurance to the board in relation to matters discussed at the nomination and remuneration committee meeting on 6 January 2022				
Summary of key issues	The committee met to consider issues related to changes in the executive director team as described in this report.				
Recommendation:	The Board is asked to **NOTE** the contents of this report.				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience* √	KSO2: *World-class clinical services* √	KSO3: *Operational excellence* √	KSO4: *Financial sustainability* √	KSO5: *Organisational excellence* √
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	None				

Report to:	Board of Directors
Meeting date:	03 March 2022
Report from:	Anita Donley, Trust Chair
Author:	Clare Pirie, Director of communications and corporate affairs
Appendices:	N/A
Report date:	17 February 2022

Nomination and remuneration committee assurance report
Meeting held on 6 January 2022

The Nomination and remuneration committee met on 6 January 2022 to consider issues related to changes in the executive director team.

The committee:

- Agreed the process, tenure and remuneration for appointment of a new medical director. The post continues to be remunerated through 6 PAs plus £15,000 responsibility allowance. Since the meeting Tania Cubison, previously deputy medical director, has been appointed to this role on a three year term.

- Received an update on progress in the appointment of a new director of operations. This is a permanent appointment on national VSM (very senior manager) terms and conditions. Since the meeting an appointment has been made with a planned date to take up post on 21 March 2022.

- Agreed the process for appointment of a Chief Nurse, recognising that a substantive appointment would now be best for the Trust in place of the previous one year interim arrangement.

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