NHS
Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 1 September 2022

Session in public
13:00 – 15:00

MEMBERSHIP
BOARD OF DIRECTORS
September 2022

Members (voting):

Trust Chair	-	Jackie Smith
Senior Independent Director	-	Gary Needle
Non-Executive Directors	-	Paul Dillon-Robinson
	-	Kevin Gould
	-	Karen Norman
Chief Executive	-	Steve Jenkin
Medical Director	-	Tania Cubison
Chief Nurse	-	Nicky Reeves
Director of Finance and performance	-	Michelle Miles

In full attendance (non-voting):

Director of Operations	-	Shane Morrison-McCabe
Director of Communications and Corporate Affairs	-	Clare Pirie
Director of Workforce (interim)	-	Lawrence Anderson
Governance Officer	-	Ellie Simpkin

Annual declarations by directors 2022/23

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)								
Jackie Smith Trust Chair	Chair, Barnet, Enfield & Haringey Mental Health NHS Foundation Trust Chair, Camden & Islington NHS Foundation Trust Former CEO Nursing and Midwifery Council	Director, Wenurses social media platform	Nil	Nil	Nil	Nil	Nil	Nil
Paul Dillon-Robinson Non-Executive Director	Trustee/ Director, Hurst Educational Trust Trustee/ Director, Association of Governing Bodies of Independent Schools	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

							Churchwarden for Parish of Buxted & Hadlow Down, trustee of Friends of St Margaret, and St Marks House School trust.	of the Association of Governing Bodies of Independent Schools. Churchwarden for Parish of Buxted & Hadlow Down, trustee of Friends of St Margaret, and St Marks House School trust
Kevin Gould Non-Executive Director	Director, Sharpthorne Services Ltd	Nil	Nil	Independent Member of the Board of Governors, Staffordshire University. 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 Senior independent director	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	Nil	National Chair of the Emergency Management of severe	Nil	Nil	Spouse (Ian Harper) is the director of welfare for BLESMA (the	Nil

		Medio legal expert. This is as a sole trader, not a limited company.		burns senate (part of the British Burn Association)			military charity for 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)								
Shane Morrison-McCabe 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)							
Jackie Smith 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 Senior Independent Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Karen Norman Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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 Chief Nurse	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other members of the board (non-voting)							
Shane Morrison- McCabe 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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Business meeting of the Board of Directors
Thursday 01 September 2022
13.00-15.00

Agenda: session held in public				
WELCOME				**Time**
126-22	**Welcome, apologies and declarations of interest** *Jackie Smith, Trust Chair*			13.00
STANDING ITEMS		**Purpose**	**Page**	
127-22	**Patient story**	*Assurance*	-	13.02
128-22	**Draft minutes of the public meeting held on 07 July 2022** *Jackie Smith, Trust Chair*	*Approval*	1	13.10
129-22	**Matters arising and actions pending from the public meeting held on 07 July 2022** *Jackie Smith, Trust Chair*	*Review*	9	13.12
130-22	**Chair's report** *Jackie Smith, Trust Chair*	*Assurance*	10	13.15
131-22	**Chief executive's report** *Steve Jenkin, Chief Executive*	*Assurance*	12	13.18
TRUST STRATEGY				
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services				
132-22	**Board Assurance Framework KSO1 & KSO2** *Nicky Reeves, Chief Nurse* *Tania Cubison, Medical Director*	*Assurance*	27	13.30
133-22	**Corporate Risk register (CRR)** *Nicky Reeves, Chief Nurse*	*Review*	29	13.32
134-22	**Quality and Safety report** *Nicky Reeves, Chief Nurse* *Tania Cubison, Medical Director*	*Assurance*	48	13.40
135-22	**Annual reports** a) Safeguarding (adults and children) annual report 2021/22 b) Infection prevention and control annual report 2021/22 c) Patient experience annual report 2021/22 d) Emergency preparedness, resilience and response annual report 2021/22 e) Research and innovation annual report 2021/22 f) Appraisal and revalidation annual report 2021/22 *Nicky Reeves, Chief Nurse* *Tania Cubison, Medical Director*	*To note*	62	13.50
136-22	**Quality and Governance assurance** *Karen Norman, Non-executive Director and Committee Chair*	*Assurance*	189	13.52

Key strategic objectives 3 and 4: operational excellence and financial sustainability				
137-22	**Board Assurance Framework KSO3 & KSO4** *Shane Morrison-McCabe, Director of Operations* *Michelle Miles, Director of Finance and Performance*	*Assurance*	195	13.55
138-22	**Operational performance** *Shane Morrison-McCabe, Director of Operations*	*Assurance*	197	13.57
139-22	**Community diagnostics centre (CDC) business case** *Shane Morrison-McCabe, Director of Operations*	*Approval*	206	14.10
140-22	**Financial performance** *Michelle Miles, Director of Finance and Performance*	*Assurance*	209	14.20
Key strategic objective 5: organisational excellence				
141-22	**Board assurance framework KSO5** *Lawrence Anderson, Interim Director of Workforce and OD*	*Assurance*	220	14.35
142-22	**Workforce monthly report** *Lawrence Anderson, Interim director of Workforce and OD*	*Assurance*	229	14.37
143-22	**Workforce Race Equality (WRES) and Workforce Disability Equality (WDES) standards** *Lawrence Anderson, Interim Director of Workforce and OD*	*Assurance*	236	14.45
144-22	**Financial, operational and workforce performance assurance** *Paul Dillon-Robinson, Non- executive Director and Committee Chair*	*Assurance*	247	14.52
GOVERNANCE				
145-22	**Audit committee assurance** *Kevin Gould, Non- executive Director and Committee Chair*	*Assurance*	250	14.55
146-22	**Nomination and remuneration assurance** *Gary Needle, Senior Independent Director*	*Assurance*	252	14.58
MEETING CLOSURE				
147-22	**Any other business (by application to the Chair)** *Jackie Smith, Trust Chair*	*Discussion*	-	14.59
MEMBERS OF THE PUBLIC				
148-22	*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 Leonora.may1@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.* *Jackie Smith, Trust Chair*			
149-22	*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.* *Jackie Smith, Trust Chair*			

Document:	Minutes (Draft & Unconfirmed)	
Meeting:	**Board of Directors (session in public)** **10am-1pm 07 July 2022** **Via Microsoft Teams**	
Present:	Gary Needle (GN)	Senior independent director (voting) (Chair)
	Lawrence Anderson (LA)	Interim Director of workforce (non-voting)
	Tania Cubison (TC)	Medical director (voting)
	Paul Dillon-Robinson (PDR)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Shane Morrison- McCabe (SMM)	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)	Chief nurse (voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
In attendance:	Leonora May (LM)	Deputy company secretary (minutes)
	Joy Curran (JC)	Consultant anaesthetist and guardian of safe working
	Liz Blackburn (LB)	Deputy chief nurse
Apologies:	Anita Donley (AD)	Trust Chair
Members of the public:	Two (and additional two for item 96-22)	

Welcome

95-22 **Welcome, apologies and declarations of interest**

The Chair opened the meeting, welcoming members of the Board, attendees and members of public in attendance. Two members of public were in attendance including one public governor.

The Chair reminded members of the public that they were invited to observe the meeting in public but not to participate in discussions.

Apologies were received from the Trust Chair.

There were no declarations of interest other than those already recorded on the register.

Standing items

96-22 **Patient story**

The Board welcomed a patient who had joined the meeting to give an account of his recent experience at the QVH minor injuries unit (MIU).

In March 2022, the patient attended the QVH MIU with serious back pain which had extended to his arms, legs and shoulders. He was assessed by the MIU clinical services manager who quickly understood the seriousness of his condition and signposted him to a choice of local accident and emergency (A&E) departments.

The patient left QVH MIU with his notes and a letter and was met at the Princess Royal Hospital A&E by a triage nurse. It was evident to the patient that the QVH MIU clinical services manager had already spoken to the triage nurse about his condition to ensure that he received appropriate treatment.

Five days later the patient was discharged from the hospital to recover at home. To his surprise he received a follow up phone call from the QVH MIU clinical services manager

	who wanted to know how he was. The patient expressed that he was very pleased to receive a follow up phone call from the clinical services manager who had gone above and beyond for him as a patient. The Board noted the positive impact that the MIU clinical services manager was having on the service and that the patient feedback would be passed on. The QVH MIU continues to be well used by East Grinstead residents. The Board expressed thanks for the patient for joining the meeting and for sharing his positive experience at QVH MIU.
97-22	**Guardian of Safe Working update** JC presented the guardian of safe working annual report to the Board who noted that no unsafe junior doctor rotas were reported during the period. Rota gaps have continued to occur at a low and steady rate with most of the gaps filled by internal locum doctors. The Board noted that exception reporting has increased to above pre pandemic levels, especially in plastic surgery where steps had been taken to improve the rota design. This is a much improved position from 2020/21. In response to a question from a Board member, JC confirmed that it was rare for consultants to 'act down' to cover shifts and that this only happens when a registrar on a night shift calls in sick last minute. The first consultant on call would stay on to cover the shift and another would cover the on call. The Board sought assurance that there no major concerns regarding disruption to junior doctors training or education. JC confirmed that there is currently no disruption to junior doctor training or education, although some junior doctors are having to catch up on modules which were postponed due to Covid and this may prolong their time as a trainee. There is some flexibility to pay others to cover locum in order to free up junior doctors to catch up on training and education. The Board noted that the Trust is moving forward with the idea of using physician associates to improve work flow and cut down on the locum cover required for the uncovered daytime workload. The number of physician associates is growing as more are qualifying from the three year course and funding for the additional staff will be considered. Maxillofacial consultants are keen to have a junior doctor in post who is able to cover both maxillofacial and plastics who is employed by the Trust. This is being considered and will also help to negate the need for locums. The Board thanked JC for her work as guardian of safe working and with the junior doctors. The Board **noted** the contents of the report. [JC left the meeting]
98-22	**Draft minutes of the public meeting held on 05 May 2022** The Board **agreed** that the draft minutes of the public meeting held on 05 May 2022 were a true and accurate record of that meeting and **approved** them on that basis.
99-22	**Matters arising and actions pending from the public meeting held on 05 May 2022** SMM gave a verbal update on action 77-22, 'collect and analyse patient feedback related to the patient initiated follow up scheme…' SMM reported that she had met with the general managers to discuss patient feedback regarding the scheme. To date, there have not been any incidents, complaints or reported issues with the pathways. TC confirmed that she had

	been using patient initiated follow ups for twelve months and stated that in her experience the pathway is working as it should be. PDR confirmed that the finance and performance committee had received further data regarding staff appraisals at QVH. The committee were assured that the appraisal process is good but there is further work to do in assuring the committee that the appraisals are effective. The Board **noted** the verbal update on the action related to patient feedback from the patient initiated follow up scheme. The Board **noted** the written updates provided for the three completed actions.
100-22	**Chair's report** GN presented the report to the Board. The Board thanked AD for her service in post as Chair of the Trust and welcomed Jackie Smith who would start in post as QVH Chair on Monday 11 July 2022. The Board **noted** the contents of the report.
101-22	**Chief Executive's report** SJ presented his report to the Board, highlighting key issues which are as follows: - Jackie Smith to take up role of QVH Chair from 11 July 2022 - Getting it right first time (GIRFT)- Prof Tim Briggs attended the JHCGM to give a presentation about GIRFT methodology - 2022/23 key risks- keeping our staff engaged, motivated and supported during a time of great change, maintaining patient and staff safety throughout the pandemic and securing a sustainable future for QVH - Independent review recommendations - NHS Sussex and the Health and Care Act 2022 - The Messenger review and Fuller Stocktake report Board members who had joined the GIRFT presentation by Professor Tim Briggs fed back that it was well received by staff and was described as being inspiring, especially for junior doctors. GIRFT would be a focus for the quality and governance committee over coming months. The Board noted that Covid numbers are increasing and that this was having an impact on the Trust's capacity and staffing. The Board received an update on the community diagnostics centre (CDC). The Trust is working closely with c. ten GP surgeries regarding pathways for patients experiencing breathlessness and non-surgical abdominal issues. The Board **noted** the contents of the report.
102-22	**Transaction programme update** SJ presented the update on the transaction programme for the potential merger with University Hospitals Sussex (UHSx) to the Board. The Board noted the timeline which indicated a possible merger date of 1 April 2023. SJ acknowledged that this was ambitious, given the amount of work to be completed before Board decision making is possible. In response to concern raised by Board members regarding the indicative timeline and readiness of clinical services strategy, SJ confirmed that the timeline would be reviewed by the Board at its September meeting and will be updated if necessary.

	The Board acknowledged that there is further work to be done to understand any implications of the possible merger date being postponed past 1 April 2023 and therefore going into a new financial year. It was noted that there will be an opportunity for Board members to input on expectations regarding due diligence ahead of any full business case being finalised. The Board **noted** the contents of the report.
Trust strategy	
Key strategic objectives (KSO) 1 and 2: outstanding patient experience and world-class clinical services	
103-22	**Board Assurance Framework** NR and TC presented the board assurance frameworks related to KSO1 and KSO2. There had been no material updates to the board assurance frameworks for KSO1 or KSO2 since the last Board meeting. For KSO2, TC highlighted that repeat prescriptions in sleep are no longer an issue and this will be removed from the framework. A pharmacist is in post and the team are moving forward with antimicrobial prescribing. The Board **noted** the board assurance frameworks related to KSO1 and KSO2.
104-22	**Corporate Risk register (CRR)** NR presented the CRR to the Board who noted the highest scoring risks which were highlighted on the front cover of the report. One of the risks added to the register since the previous meeting was related to the national shortage of Remifentanil. NR reported that she is working with the chief pharmacist on a standard operating procedure to mitigate this risk which will be reasonably long term. MM provided the Board with an update related to the new risk around the operational delivery of pathology services which was IT systems related. Work within the ICS on the IT systems is ongoing. A business case would be presented to the finance and performance committee and it was noted that the Trust's spend would be minimal. A written update on progress for risk 1255- sterile services provision failures would be included within the CRR report for the next meeting The Board **noted** the contents of the report.
105-22	**Quality and Safety report** NR presented the quality and safety report and Covid update to the Board. The national cancer patient experience survey results were received yesterday and it was reported that QVH had received good results. There is only one measure where QVH had received a below average result and the Trust was on par with or above others with the rest of the scores. There have been considerable staffing challenges for the sleep service and an external review of the service had been conducted which had informed an action plan that staff are working to implement. In response to a question from a Board member, NR confirmed that there had not been any significant complaints regarding the sleep service, although the staffing challenges are causing delays in treatment. The Board **noted** the contents of the report.

106-22	**6 monthly Nursing Workforce review** NR presented the 6 monthly nursing workforce review report to the Board, noting that it had been well received by the quality and governance committee at its meeting on 4 July 2022. It was confirmed that 'vaccination as a condition of deployment' has been withdrawn nationally. The quality and governance committee had taken assurance regarding the fact that the nursing hours could be matched to patient needs and that there is a safe provision of care evidenced in the report. Additional work had been completed to review the Peanut ward staff rota as there had previously been some gaps. The team were confident that from September 2022 rota gaps would be significantly reduced and this will continue to be an improving picture. The Board noted that the high number of staff retiring is a risk and were pleased to see retire and return initiatives in place to mitigate this and retain staff. The Board **noted** the contents of the report.
107-22	**Quality and Governance assurance** KN presented the quality and governance assurance report to the Board, noting that there had been an additional meeting since the report was published. The committee approved the annual quality report 2021/22 at its extraordinary meeting on 27 June 2022 as per delegated authority from the Board. The annual quality report is available on the Trust's website. KN provided the Board with a verbal update on the most recent quality and governance committee meeting on Monday 4 July 2022. The committee agreed that the following four CQUIN indicators are the most relevant for QVH- staff flu vaccinations, recording of NEWS2 score, escalation time and response time for unplanned critical care admissions, cirrhosis and fibrosis tests for alcohol dependent patients and achieving high quality decision making conversations in specific specialised pathways to support recovery. The committee received a report on compliance in practice visits which had restarted. The services internally assessed in this way received a compliance score of 92% which amounts to a CQC rating of outstanding or good. The committee also received a learning from deaths summary which will be included in the next quality and safety report to Board. The Board **noted** the contents of the report.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
108-22	**Board assurance framework** SMM and MM presented the board assurance frameworks related to KSO3 and KSO4. The Board noted the main opportunities for KSO3, including the new modular theatres which are now complete and confirmation of McIndoe's theatre capacity for quarter two. In response to a question, MM confirmed that there would be a new national finance scheme for revenue allocation. It is not expected that the scheme will make a fundamental changes to the Trust's baseline. The Board **noted** the board assurance frameworks related to KSO3 and KSO4.
109-22	**Operational performance**

	SMM presented the operational performance report to the Board who noted the headlines as set out within the report. In response to a question, SMM agreed to provide more detail around 104 day cancer waits outside of the meeting. **Action SMM.** The Board noted that there is an increase in demand for the plastics service. The team are looking to put on additional theatre sessions to ensure that they are being used as efficiently as possible. There is also an increase in referrals for the sleep service and it was noted that some other NHS sleep services had reduced or stopped service provision. There has been an increase in CPAP patients due to Covid. The team are working to recruit more staff into the service in order to increase capacity and activity The Board **noted** the contents of the report.
110-22	**Financial performance** MM presented the financial performance report to the Board and highlighted that the deficit position will improve for month three because of additional income for inflationary cost pressures. No elective recovery fund moneys had been accrued other than for specialised commissioning. The Board noted the risk associated with the non-delivery of elective activity as set out within the report. MM confirmed that there are no contingencies because the plan is based on high levels of efficiencies, with £3m at risk if the activity level is not delivered. MM reported that the Trust has a break even plan for 2022/23 with additional funding to support increased inflationary costs. The additional funding is available based on conditions that must be reviewed at a system and organisational level. The Trust plan includes 3.9% efficiencies, made up of cash releasing and productivity. Board members stated that this was a big ask for a Trust with a small annual turnover. The efficiencies would continue to be reviewed through monthly performance review meetings and the finance and performance committee would continue to monitor this financial risk closely. The Board **noted** the contents of the report.
Key strategic objective 5: organisational excellence	
111-22	**Board Assurance Framework** LA presented the board assurance framework related to KSO5 and reported that there had been no significant changes since the last Board meeting. The Board **noted** the board assurance framework related to KSO5.
112-22	**Workforce Monthly report** LA presented the workforce monthly report to the Board. He reported that vacancy levels have reduced although there has been challenges in time to hire over in recent weeks due to a new occupational health IT system which has led to delays in occupational health clearance. In general, there has been a reduction in sickness absence. In response to a question, LA confirmed that apprenticeship applicants were a mixture of both internal and external candidates and that it continues to be a good development tool for internal members of staff.

	The Board noted that career events and work experience are useful tools in attracting staff to the Trust. The Board **noted** the contents of the report.
113-22	**Financial, operational and workforce performance assurance** PDR presented the report to the Board. The Board noted that the committee had completed deep dives on theatre utilisation and sleep services. The committee will continue to focus on theatre utilisation given its link to the delivery of increased productivity PDR reported that the committee will continue to monitor the risks associated with the business plan, namely lack of agreement of contracts, lack of clarity around elective recovery funding and the increased requirement to deliver efficiencies. The Board **noted** the contents of the report.
Governance	
114-22	**Approval of changes to standing orders and standing financial instructions including reservation of powers and scheme of delegation** MM presented the report to the Board. The audit committee had reviewed the proposed changes to the standing orders and standing financial instructions at its meeting on 15 June 2022 and agreed to recommend to the Board that it approves them. The Board **approved** the proposed changes to the standing orders, standing financial instructions and reservation of powers and scheme of delegation for publication internally and on the Trust website.
115-22	**Audit Committee assurance** KG presented the report to the Board who **noted** the contents.
Meeting closure	
116-22	**Any other business (by application to the Chair)** There was none.
Members of the public	
117-22	**Questions from members of the public** The Board received two questions in advance of the meeting. CP read out the questions and the Trust's responses to the questions which were as follows. Question: Given the again climbing rates of COVID (including myself testing positive this week) why are board meetings not being held in a virtual or hybrid format, which would promote greater attendance, but instead being held in person? If the justification is cost please can the board provide the cost benefit analysis that has been done to support his decision. Response: The July Board meeting is being held in a virtual format due to a number of Board members self-isolating. An online meeting allows for member of the public, such as the governor who has raised this question, to observe the meeting remotely. Meetings in person allow for a different quality of discussion between the meeting participants. The Trust is working to balance these issues, and to ensure that whether a public meeting is held remotely or in person the public and press are able to attend. We do not currently have the technology to support a hybrid meeting format, and are looking into that further.

	Question: The term 'Fragility of clinical services' has been repeatedly used to justify QVH's absorption into UHSx without specific detail. Please can the board provide a list of the fragile services areas and the specific reason for the *fragility* for each service or sub-service? Response: As a small specialist hospital, QVH has high quality, safe services but does not have the full range of clinical services that would be found in a large teaching or general hospital. Staff work very hard to mitigate some of the risks that arise from that, for example through protocols for the level of patient co-morbidities we can accept in patients requiring surgery. In small clinical and non-clinical services, where a team may consist of very few people, staff work above and beyond their usual hours when colleagues are absent and when vacancies arise. These factors combine to make services fragile; there is no list of fragile services.
118-22	**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.

Matters arising and actions pending from previous meetings of the Board of Directors - PUBLIC									
ITEM	MEETING Month	REF.	TOPIC	CATEGORY	AGREED ACTION	OWNER	DUE	UPDATE	STATUS
1	May	77-22	Operational performance	KSO3&4	Collect and analyse patient feedback related to the patient initiated follow up scheme and report back to the Board.	SMM	July	To date, there has not been any incidents, complaints or reported issues with the pathways.	Closed
2	July	109-22	Operational performance	KSO3&4	Confirm current position on seven 104 day waits for cancer patients.	SMM	July	Four were late referrals, one was admitted to another hospital so could not be treated at QVH simultaneously, one patient is undergoing cardiology investigations and is unfit for the procedure and one patient has cancelled four excisions due to ill health.	Closed

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	01/09/2022		**Agenda reference:**	**130-22**	
Report title:	Chair's report				
Sponsor:	Jackie Smith, Trust Chair				
Author:	Jackie Smith, Trust Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on Chair, non-executive director and governor activities since the last meeting				
Summary of key issues	- AGM 18 July 2022 - Council of governors meeting 18 July 2022 - Re-appointment of Paul Dillon-Robinson - Governor seminar on the Trust's historical financial position - NHS Sussex				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:	N/A				

Report to:	Board Directors
Agenda item:	130-22
Date of meeting:	1 September 2022
Report from:	Jackie Smith, Trust Chair
Report author:	Jackie Smith, Trust Chair
Date of report:	24 August 2022
Appendices:	None

Chair's report

This is my first report as Chair since I joined the Trust on 11 July 2022.

I have met with all executive director colleagues and all my fellow non-executive directors. One to one meetings are also being arranged with all governors; to date I have met with a small number of governors including the new lead governor, Chris Barham. Unsurprisingly, conversations have largely focused on the Transaction Programme and the work being done on the Options Appraisal. Everyone has been open about the challenges and opportunities for the Trust with a strong commitment and emphasis on finding a long term solution for the Trust, addressing the issues set out in the strategic case for change.

I have met with the chairs of the Integrated Care Board and University Hospitals Sussex, and look forward to further building relationships across the wider south east system in the coming weeks.

Our AGM was held on 18 July with over 70 attendees joining online. Attendees heard from the chief executive who presented a summary of the annual report and accounts 2021/22 and the forward plan. The Trust's auditors presented a summary of audit findings and the auditor's annual report 2021/22. On the same day, the council of governors met and received an update on the Transaction Programme and from the Board sub-committee chairs. Council received the Trust's membership strategy and approved the re-appointment of Paul Dillon-Robinson as a non-executive director for a further three years.

On 2 September, the third of three governor seminars planned in response to the recommendations of the Independent Review will be held, and will be focussed on the Trust's historical financial position.

The CEO's report will reference important achievements. QVH senior leaders also continue to play an important role in all aspects of the Sussex Health and Care Partnership at both system level, and in the evolution of place and neighbourhood plans.

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,22/08/2022. KSO 3, 4 and 5 were reviewed at the Finance and Performance Committee on 25/07/2022. 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 BAF'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:	**01/09/2022**		**Agenda reference:**	**131-22**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	1) Independent review – recommendations 2) Integrated Dashboard 3) 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	• Pay award 2022/23 • Options • Health & Social Care Select Committee report on Workforce				
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:					
Corporate risk register:	None				
Regulation:	N/A				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	BAF reviewed at EMT				
	Date:	23/08/22	Decision:		
Next steps:					

CHIEF EXECUTIVE'S REPORT
SEPTEMBER 2022

TRUST ISSUES

Chief of Finance

Michelle Miles (left) starts a new role at East Kent Hospitals NHS Foundation Trust next month having joined QVH in February 2018.

Her place at QVH will be taken by James Drury (right), an experienced interim finance director, who joined us on 30 August.

Developing the full business case for possible merger

Work has been underway since June 2022 to develop a delivery plan for the programme. This includes a Programme Management Office (PMO) to co-ordinate and support delivery, and eight workstreams (clinical, legal & governance, finance & performance, communications & engagement, HR, organisational development, IM&T, estates).

There was discussion at the most recent programme meeting of the importance of the clinical workstream in laying the foundations for work in other areas, such as patient engagement, and that some workstreams have been able to progress faster than others due to the availability of staff.

August has been a relatively quiet month for the programme due to annual leave, and we expect to provide further updates during September and October.

Staff Awards

We were delighted to be able to hold our Staff Awards event on 30 June, after a pandemic pause, so congratulations to everyone who was shortlisted as well as those who won. We received more than 350 nominations for all of the categories combined so competition was incredibly tough this year. A couple of awards for a special mention are the Patient Experience Award and the Chair's Cup.

<u>Patient Experience Award</u>

There is never a dry eye in the house by the time the winner of this category is announced. This award, nominated by our patients and their relatives, recognises some of those who are extra

special. Well done to our two very worthy winners Kim Foster (right), staff nurse, Peanut ward; and Sarah Bailey (left), consultant anaesthetist. Here they are pictured receiving their awards from Liz Blackburn, deputy chief nurse.

The Chair's Cup

The winner of this award Ben Davis, IT Support Assistant, pictured right, received nominations from right across the organisation for living the Trust's values every day in their work. Although they are not at the forefront of clinical care they are most certainly part of the golden thread that runs through our organisation, and very much appreciated for their unfailing helpfulness and can do attitude, regardless of how busy they are.

Annual General Meeting

Although originally planned to be in person, increasing Covid rates saw our Annual General Meeting revert to a virtual meeting once again on 18 July. Particularly pleasing was to see over 70 people join the call to hear from the chief executive and Dean Gibbs from our external auditors KPMG.

National Cancer Patient Experience Survey

The latest National Cancer Patient Experience Survey, published in July, shows that patients referred to QVH felt informed, supported and trusted all of the team involved in their cancer care. The survey is designed to monitor national progress on cancer care and provide information to drive quality improvements to support cancer patients. Patients who received inpatient care from April-June 2021 were asked to provide feedback; this period coincided with our role as a specialist surgical cancer centre during the pandemic. The results showed QVH scored above the national average in many areas with:

- 83% of patients saying they were definitely involved as much as they wanted to be in decisions about their care and treatment
- 96% saying they were always treated with dignity and respect while they were in hospital
- 85% of patients saying they definitely got the right level of support for their overall health and wellbeing from hospital staff
- 96% of patients commenting they have confidence and trust in all of the team looking after them during their stay in hospital
- 96% saying they were always able to get help from ward staff when needed.

Modular theatres

Our two new modular theatres saw their first patients on 11 July and we anticipate seeing around 140 patients a month which will improve our waiting list. These theatres replace the two in Rowntree

Thank you to everyone who has worked on the project, especially to those who came in over the weekend to make sure we were ready for our first patients.

Hardship Fund

In June we set up a hardship fund for individual members of staff in sudden financial distress. It was something that staff had suggested and has been kindly funded by QVH Charity. What does the fund do? The fund can provide an emergency payment to help a member of staff where they are struggling because of either a sudden, significant drop in income or a need for unexpected, significant expenditure. The scheme is open to all staff including bank staff. The maximum payment that will be made from the fund is £500, although often the amount needed by somebody in sudden financial hardship is much less than this.

Psychological services for people with cancer

Through QVH Charity, the hospital has obtained grant funding for a new role in the psychological therapies team. Dr Ruth MacQueen, clinical psychologist, has been appointed specifically to support cancer patients and staff in relation to the impact Covid-19 has had on cancer services. Ruth is now working with the wider cancer team as well as directly with patients to increase the provision of psychological support for people with cancer. Patients can self-refer, or staff can contact the team to refer with the consent of the patient.

Our healthy eating working group

We have set up a healthy eating working group to review the Autumn/Winter menu to introduce more healthy and budget friendly options. The group consists of Liz Moore, senior clinical dietitian; Paul Addison, head of facilities; Tooba Arif, plastic surgery registrar, Kim Brinkworth, Canadian Wing matron, and the chief executive.

2022/23 Key risks

The Board regularly reviews the three overarching risks to delivering the Trust's corporate objectives and the ongoing safe delivery of clinical services. Since our last Board meeting:

1. Keeping our staff engaged, motivated and supported during a time of great change – continuing briefings by the CEO in both open staff meetings and individual team meetings. Since the last Board meeting we have celebrated in person our Staff Awards (details contained within this report).
2. Maintaining patient and staff safety through the pandemic – we continue to respond to updated national guidance, carefully considering the implications for our work. In July we opened our two new modular theatres which will allow up to 140 procedures to take place.
3. Securing a sustainable future for QVH –business case now submitted for expansion of our community diagnostic offer to our local community which includes supporting a spoke site at Crawley Hospital.

These overarching risks are reflected in all the KSO BAFs and reviewed when preparing board papers for each KSO. The CEO is accountable for leading on the management these risks.

Independent review

As reported in CEO report in May, the independent review of QVH's handling of challenges encountered in progressing a merger proposal with University Hospitals Sussex NHS Foundation Trust given the range of views about the future of QVH was received by the Board and was published in full. The Board is committed to ensuring the recommendations are acted on effectively, with good ongoing engagement with staff and external stakeholders.

Appendix 1 shows an update on progress delivering against the 12 recommendations in the independent review.

Integrated Performance Dashboard Summary
Our Integrated Performance Dashboard (Appendix 2) reflects the M4 position and an abbreviated highlight from the National Quarterly Pulse Survey which has replaced the Staff Friends and Family Test.

Board Assurance Framework (BAF)
The entire BAF was reviewed at executive management meeting (23/08/2022) alongside the corporate risk register. KSO 1 and 2 were reviewed at the Quality and Governance Committee, 22/08/2022. KSO 3, 4 and 5 were reviewed 30/08/22 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 3) during June and July 2022.

NATIONAL SCENE
George Cross for the NHS

On 12 July the Queen awarded the NHS the George Cross. Health leaders from the four UK nations were awarded the medal at a small ceremony at Windsor Castle. It is only the third time ever that a George Cross has been awarded to an organisation rather than an individual.

Joining the event was May Parsons, the nurse who delivered the world's first vaccine outside of clinical trials on 8 December 2020. The Queen said the vaccine effort which began on that day was "amazing" as she celebrated the achievements of the NHS.

The Queen presenting NHSE CEO Amanda Pritchard and May Parsons, nurse the George Cross at Windsor Castle

Appointments
Two key recent appointments:

- Rt Hon Steve Barclay MP appointed as the new Secretary of State for Health & Social Care
- Dr Henrietta Hughes as the new patient safety commissioner for England.

Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter

NHSE published a letter on 12 August outlining the next steps to increase capacity and operational resilience in urgent and emergency care (UEC) ahead of winter, setting out the objectives and key actions underpinning its winter plan. Headlines include:

- Increase of 7,000 general and acute beds (through a combination of physical beds and virtual wards)
- Integrate COVID booster jabs with the flu vaccination programme to minimise hospital admissions from these viruses.
- Staff sharing and bank sharing arrangements must be established and recruitment should be targeted abroad where necessary. Trusts should develop roles for volunteers to reduce pressure on services, including community first responders and support in discharge.

<u>Core objectives and key actions for operational resilience</u>

1) Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.
2) Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
3) Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
4) Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
5) Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
6) Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
7) Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.
8) Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

Steve Jenkin
Chief Executive

Implementing the recommendations of the independent review

In December 2021, NHS England and NHS Improvement South East Region and the then newly appointed interim Chair of Queen Victoria Hospital NHS Foundation Trust (QVH), Anita Donley, commissioned an independent review of QVH's handling of challenges encountered in progressing a merger proposal with University Hospitals Sussex NHS Foundation Trust given the range of views about the future of QVH. In February 2022, the report was received and welcomed by the Trust Board, and published in full.

The Board is committed to ensuring the recommendations are acted on effectively, with good ongoing engagement with staff and external stakeholders. This appendix is an update on progress delivering these recommendations.

	Recommendation	Action
1	A work programme for the merger process should be developed, which allows for a holistic set of stakeholders to be engaged as the work is undertaken. At the heart of this should be clinical engagement, but wider engagement with staff, patients and stakeholders will also be important.	The work programme has been established, with appropriate programme governance. The programme is being delivered through eight workstreams: Legal and corporate governance; Clinical; Finance and performance; Communications and engagement; HR; Organisational development; Information management and technology; Estates.
2	The work programme should reflect that the FBC needs to rehearse the strategic case in a level of depth including the case for change, the long-list of options, the hurdle criteria, the short-list of options, the evaluation criteria, and the appraisal leading to the preferred option.	The process to review the case for change, the long-list of options, the hurdle criteria, the shortlist of options, the evaluation criteria, and the appraisal leading to the preferred option with input from the QVH clinical directors will be reported to public board when concluded.
3	The work should report to a steering group that includes multi-professional clinical and financial leadership, prior to the Board. The current steering arrangements should be reconstituted to include the Sussex Integrated Care Board (ICB), the NHSEI South East Region, UHSussex and QVH.	Programme governance includes the workstreams reporting to a programme board with multi-professional clinical and financial leadership, prior to Board. The Joint Oversight Group includes the Sussex Integrated Care Board (ICB), the NHSEI South East Region, UHSussex and QVH.
4	The steering group should oversee the development of a proportionate communications and engagement plan to accompany the work programme and should monitor an engagement log which is maintained as the work is undertaken. a. The plan should carefully consider each aspect of the process and the necessary stakeholder group(s) to contribute to it.	The communications and engagement workstream is overseen by the programme board. The communications and engagement plan has been refined with stakeholders and representative staff groups to ensure that it will support an inclusive process for producing the business case. It will be a live document and will be updated as the programme progresses, so that

	b. Discussions with stakeholders should take place to understand the most effective way to engage with them, ensuring the FBC is the product of an inclusive process. c. Once produced, the plan should be tested with representative staff groups within QVH, QVH Clinical Directors and relevant clinical leaders from UHSussex before being finalised. d. The plan should be under review so that themes from the engagement are responded to and reflected in the programme of work as required.	themes from the engagement are responded to and reflected in the programme of work as required.
5	Once the work programme and engagement plan have been developed in draft, a seminar session with the Council of Governors should take place, ideally in person, to review the plans prior to finalising so Governors' feedback can be incorporated.	A seminar with governors was held on 27 June to support governor feedback on the work programme and engagement plan.
6	A resourcing plan should be developed to support the delivery of the work programme with resource commensurate to the task. The resourcing of the team should be supported by the ICS. The team itself should be embedded in QVH, working in partnership with a lead director from the ICB and the team at UHSussex.	The programme is supported by a programme management office (PMO) team managing and reporting progress against the programme plan, monitoring progress of workstreams, monitoring programme risks and issues. The team work closely with both QVH and UHSussex and resourcing is supported by the ICS (NHS Sussx).
7	The clinical body should be engaged in this work at the earliest opportunity and should do so in partnership with clinical teams from UHSussex before pressing ahead with the development of the preferred option. The development of the preferred option should engage clinical teams of the two Trusts, with staff members from all professions.	This work is led through the Clinical workstream. Work is underway on a 'stock take' of QVH clinical and clinical support services to ensure the challenges and opportunities identified by staff working in those services are taken into account. The clinical service review and strategy process will require a multi-disciplinary approach, engaging clinical and non-clinical staff in a robust process focussed on patient benefit. An independent clinical lead, Dr Edward Rowland who was until recently medical director at Barts Healthcare, has been appointed to work closely with the medical and nursing directors of QVH and UHSussex and their teams, providing oversight and facilitation in the process of clinical review and engagement.
8	The staff Governors should meet with other representative staff groups and be supported to ensure that all staff are engaged in the merger process and that the holistic views of staff are appropriately represented, including the difference of opinion that exists. If staff	The staff governors and staff ambassadors met and discussed their different roles on 4 April. The staff governors met with the Chair and senior independent director on 6 April.

	Governors are unable to represent the views of all staff a change in the constitution should be made to ensure the staff Governors are more representative of the whole staff.	Staff briefings through Connect on existing multiple contact points for staff including staff governors, staff side/unions, staff ambassadors, FTSU guardian, QVH ethnically diverse staff network. Support for staff governors in fulfilling their role including provision of staff governor email address and promotion of staff drop-in sessions.
9	The additional NHSEI licence conditions should be developed into a Trust policy reflecting the requirements for the Governors of the Trust to adhere to the seven principles of public life. The policy needs to outline the approach taken where these principles are breached, which must ultimately lead to dismissal if conduct is unacceptable. This policy should be shared with staff in the Trust who engage with Governors so that they understand what to do if they believe they are being bullied or harassed by someone.	An external governance expert was commissioned to develop a procedure for the Trust to follow when responding to any concern raised about a governor's conduct, behaviour or actions. This procedure was discussed with governors at 11 April Council of Governors meeting, and agreement was not reached in the meeting. It is planned that this issue will be considered again at the October Council of Governors meeting in the context of the expected new national *Code of governance for NHS provider trusts.*
10	To support Governors to discharge all their statutory responsibilities effectively, and ensure that roles of Governors are clear: a. There should be dedicated meetings with all Governors on matters relating to the merger process b. The merger process should not be included on other agendas such that Governors are able to engage effectively on other matters c. Governor representation in other meetings of the Board should be brought into line with recognised best practice, and the following arrangements should cease: i. Lead Governor attendance at private meetings of the Board ii. Governor representatives on subcommittees of the Board	The quarterly Council of Governors meetings are now divided into Part A and Part B, to achieve effective separation and dedicated time for the merger and for other matters without increasing the burden on Board members, governors and company secretarial support. Lead governor no longer attends private Board. Governor representative attendance at subcommittees has been ended. New lead governor role description agreed which includes responsibility for liaising with all governors for agenda suggestions and then meeting with Company Secretary and Chair. Work ongoing with governors on promoting effective understanding of Trust business and assurance regarding the work of the NEDs.
11	The regional and ICB finance teams should take a role in supporting the Trust to discuss the financial position of the organisation with stakeholders, including deterioration of performance, the feasible actions that can be taken to improve the position, and the potential benefits that may be derived from a merger. The outcome of this session should be alignment on what more, if anything, is needed in the work plan going forward.	The executive team is working with regional and ICB colleagues to deliver a workshop for governors to develop a fuller understanding of QVH finances; this is scheduled for 2 September.
12	Detailed communications should flow from the regional NHSEI leadership via its Specialist Commissioning function and the Sussex	This will be discussed and implemented with NHSE and ICS (NHS Sussex) colleagues.

	ICS, setting out how they plan to work with QVH to ensure the continued delivery of the specialist services that QVH provides, safeguards their quality and meets the relevant national clinical standards. This will need to be aligned with the work that QVH and UHSussex will undertake to develop a shared clinical strategy.	
1.28	The scope of work that needs to be undertaken to develop a positive and constructive relationship between all Governors and the Board is significant, but necessary if all parties are to discharge their duties effectively, including with respect to the proposed merger. To allow this work to be undertaken in a timely manner and with a consistent group, we advise that as far as is permissible within the Foundation Trust code of governance, no change is made to the Council of Governors until NHSEI are sufficiently assured that they are prepared to lift the additional licence conditions	The Council of Governors took the decision on 21 Feb 2022 not to hold public governor elections in 2022. The next public and staff governor elections will be in 2023.

Integrated Dashboard Summary
Key indictators at a glance -September 2022 (reporting M4)

NHS
Queen Victoria Hospital
NHS Foundation Trust

KSO1 Outstanding Patient Experience & KSO2 World Class Clinical Services

C-Diff	0	↑
MRSA	0	→
E-coli	0	→
Gram-negative BSIs	0	→
Serious Incidents	0	→
Never Events	1	↓
No of QVH deaths	0	↑
No of off-site deaths	1	↑
(within 30 days)		
Complaints	7	→
Closed <30 days	5	→
FFT		
In patients	99%	→
Outpatients	95%	→
MIU	90%	→
Day surgery	97%	→
Hand trauma	92%	→

KSO3 Operational Excellence

MIU <4hrs	99.60%	→
RTT 18 weeks	63.50%	→
Cancer 2ww	89.50%	→
Cancer 62 day	85.10%	→
Diagnsotics <6weeks	72.06%	↓
52ww	301	↓
Recovery activity		
Day case	83.00%	↓
Elective inpatient	92.00%	↓
First outpatients	85.00%	↑
Follow-up outpatients	-12.00%	↓
Outpatient therapies	116.00%	↓
Non-elective	115.00%	↑

Key	Improved Performance	Deteriorating Performance	Remains the same
	↑	↓	→

KSO4 Financial Sustainability (YTD)

Income	30,362k	→
Pay expenditure	18,821k	→
Non-pay expenditure	11,541k	→
Surplus/Deficit	0	→

Income includes ERF paid YTD as at M4.

KSO5 Organisational Excellence

Vacancy rate	3.30%	↑
Turnover rate	15.25%	↓
Sickness rate	2.94%	↑
Appraisal rate	85.17%	↑
MAST	91.98%	↑

National Quarterly Pulse Survey (NQPS)

Employee Engagement Score	7.5	4 - Highest 25%
Advocacy Score	8.2	4 - Highest 25%
Involvement Score	7.2	4 - Highest 25%
Motivation Score	7.1	4 - Highest 25%

QVH media update – June 2022

Justin Bieber's facial palsy diagnosis

When singer Justin Bieber revealed he was living with facial paralysis caused by Ramsay Hunt Syndrome, news agencies were keen to learn more about the condition. This included experts from our facial palsy team, who are also involved in the charity Facial Palsy UK, being called upon for their knowledge.

Catriona Neville, our extended scope practitioner facial therapist, was interviewed for BBC News 24 and Sky News, and Charles Nduka, consultant plastic surgeon, was filmed talking about the syndrome for news agency Reuters. Charles was also interviewed by The Guardian, admitting that he developed sudden onset facial palsy himself during lockdown. He explained that knowing the symptoms he was able to receive treatment but calls upon doctors to be more aware of the condition as early treatment with antivirals and steroids "increases recovery rates in cases of Ramsay Hunt syndrome from about 50% to about 70%".

Scammers target car parks

Queen Victoria Hospital was named in a number of regional news stories about scammers targeting car parks across Sussex. Unfortunately one episode involved our patient car park. Our facilities and security teams have been working with Sussex Police and supporting those affected who have been refunded by their bank.

The news items, instigated by Sussex Police, explain that scammers approach their victim telling them they need to buy a new parking ticket because an enforcement officer has taken a photo of their vehicle. The scammer then pockets the card, claiming the machine has eaten it, before making fraudulent transactions. Outlets to run the information, which called for witnesses, were ITV News Meridian; Sussex Express; Brighton and Hove News; Sussex Live; and the UKNIP website.

Charity support all the way from Hollywood

QVH Charity is one of three beneficiaries of the Ava Gardner Trust, a fund supporting causes that were close to the heart of Hollywood star Ava Gardner. Trustees Ava Thompson and Ava Malissa Silver, visited Queen Victoria Hospital for the first time in March to see where Sir Archibald McIndoe carried out his pioneering surgery. Ava became friends with McIndoe and through him got to know some of the burned and wounded young airmen who formed the Guinea Pig Club. The trustees charted their visit in a blog.

Press releases

In June we did not issue any press releases but did publish the following updates on our website:

- Coronavirus information and advice for our patients and visitors – update of standing story
- Our latest visiting guidance – update of standing story
- Mask wearing at our hospital – update of standing story
- Issues with our phone system

QVH media update – July 2022

Cancer patients rate hospital in national survey

The latest National Cancer Patient Experience Survey shows that patients referred to Queen Victoria Hospital felt informed, supported and trusted all of the team involved in their cancer care. The period covered by the survey, April-June 2021, was also when the hospital made a significant contribution to supporting people with cancer from across Sussex, Surrey and Kent, in its pandemic role as a specialist surgical cancer centre.

The results of the national survey showed that we scored above the national average in many areas, including 96% of patients commenting they have confidence and trust in all of the team looking after them during their stay in hospital. This achievement was featured on the InYourArea website and also on the Sussex ICS website.

Facial reanimation

Sammy Taylor Spoke to the Daily Mail about how she became the “first person in the UK” to have facial reanimation surgery to help restore movement to her face. The surgery, carried out at Queen Victoria Hospital, took place in 2020 when she was aged 25. The surgery was to help restore movement to her face following a stroke during surgery to remove a brain tumour which left her with “half of her face frozen”.

The purpose of surgery can be to achieve symmetry when the face is resting, or to create movement but cannot completely restore the face to what it looked like before experiencing facial palsy. In the article Sammy explains "I've just entered my first 10k run (which would have been a challenge for me before) but even more so after needing to learn to walk again… I continue to live with facial paralysis and it has definitely come with a set of battles I wouldn't have imagined."

ENT services in Sussex

The National Health Executive website explained how a new single point of access system was being launched in Sussex for NHS ear, nose, and throat (ENT) services. The intention is to streamline the referral process for GPs and other health professionals. The project brings together all the NHS organisations providing ENT services in the region, including University Hospitals Sussex NHS Foundation Trust, East Sussex Healthcare NHS Trust, and Queen Victoria Hospitals NHS Foundation Trust.

NHS performance in the “busiest ever summer”

Using monthly national performance data, the MailOnline ran an article about the performance and waiting times of each trust in the UK for routine procedures, x-rays and A&E waits. Queen Victoria Hospital is mentioned in a section talking about "the nation's quietest hospitals" where we alongside Moorfields Eye Hospital, and Liverpool University Hospital have "as few as 46 per cent of beds taken." It does not reference theatre capacity or the number of patients who receive a procedure without needing a bed.

We were also mentioned in a focus on A&E where "Just five trusts — Moorfields Eye Hospital, Queen Victoria Hospital, North East London, Southern Health and Northumbria Healthcare — saw at least nine in 10 patients within this timeframe [4 hours]" despite us not having an A&E. Our minor

injuries unit does measure discharges against the 4 hour standard but is not the same as an A&E.

Face coverings return amid rising Covid rates

The BBC News website ran a story about the reintroduction of mandatory face mask wearing across Sussex in response to rising Covid-19 rates. Queen Victoria Hospital is listed as one of the trusts participating, although we had not fully removed mask wearing in all of our clinical areas.

Help during the heatwave

Due to the additional pressures health services in Sussex experienced due to the heatwave in the middle of July, Sussex Health and Care Partnership asked for the public to stay safe during the extreme heat and to use the right services for their needs if they do become ill. Sussex Express ran this public service information which included mentioning Queen Victoria Hospital's minor injuries unit and its opening hours.

When life imitates art

In an article on the website The Conversation, author Liam Bell talks about how one of the protagonists in his latest novel 'Man at Sea' was brought to life thanks to the wealth of information he gained researching the Guinea Pig Club and visiting Queen Victoria Hospital back in 2017. "For me, the initial wartime [WWII] narrative clicked with the discovery of the Guinea Pig Club." The article was repeated on the Scroll.in website and news9live.com.

Ad hoc mentions

Patient Steve Rowe spoke to Kent Online about a dog attack whilst he was our cycling. He came to Queen Victoria Hospital for plastic surgery procedures to his face and hands.

The Gizmo Writeups website ran a story about actress Amanda Redman, including her net worth and achievements. Queen Victoria Hospital is mentioned in the 'top 8 facts you didn't know about Amanda' in relation to the burns she sustained as a toddler after an accident with scalding hot soup.

Press releases

In July we issued the following press releases:

- Cancer patients rate hospital in national survey

We also published the following updates on our website:

- Stay safe in the sun
- Our latest visiting guidance – update of standing story
- Mask wearing at our hospital – update of standing story
- Your invite to the Queen Victoria Hospital AGM 2022

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed 2nd August 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 infection outbreak impacting on clinical care Risk 1220
4) Quality and supply issues with current sterile services provider Risk 1255

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
- Increasing challenge with recruitment, particularly Head and Neck unit, critical care and paediatrics. Risk register has been updated to reflect these challenges
- **Ongoing issues with sterile services provider. Weekly contract review meetings.**

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 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
- Implementation of Patient First improvement methodology during next 3 to 6 months

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.
- Clinical Harm Review process
- 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
- **Asymptomatic staff screening, comprehensive IPC board assurance document, patient screening pathways revised in line with national guidance. Risk 1210**

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, 1238, 1239

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Date last reviewed: 10 August 2022

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

Risk

1. Potential for harm to patients due to long waits for surgery
2. Maintaining safe & effective clinical services evidenced by excellent outcomes & clinical governance
3. Restricted facilities to manage some more complex patients

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

Rationale for current score

- Adult burns ITU and paediatric burn derogation
- Paediatric inpatient standards and co-location
- Compliance with 7 day services standards
- Spoke site clinical governance.
- Consultant medical staffing of Sleep Disorder Centre & Histopathology
- 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
- Limited access to some secondary services such as paediatrics and ITU

Initial Risk Rating 5(C)x3(L) =15, moderate
Current Risk Rating 4(C)x4(L)=15, moderate (CR1221)
Target Risk Rating 4(C)x2 L) = 8, low

Future Risks

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

Future Opportunities

- Sussex Acute Care Network Collaboration
- ICS networks and collaboration
- Efficient team job planning
- Research collaboration with BSMS
- New services – glaucoma, virtual clinics & sentinel node expansion, transgender facial surgery
- Multi-disciplinary education, human factors training and simulation
- QVH-led specialised commissioning
- E-Obs and easier access to systems data
- Possible merger with University Hospitals Sussex
- Better team working with the burns network

Controls and assurances:

- Clinical governance leads and reporting structure, Clinical indicators, NICE reviews and implementation
- Relevant staff engaged in risks OOH and management
- Service Level Agreements for secondary services such as Paediatrics and ITU with surrounding trusts
- Networks for QVH cover-e.g. burns, surgery, imaging, lower limb and trauma
- Regional discussion of complex patients esp burns before acceptance and to confirming ongoing plan
- Diversion of inpatient paediatric burns patients to alternative network providers
- 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 and 104 day cancer breeches
- Antibiotic Stewardship meetings and presentations at Joint Hospital Governance Meeting

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 staffing model & network
- Antimicrobial prescribing (CRR 1221)

Report cover-page					
References					
Meeting title:	**Board of directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**133-22**	
Report title:	**Corporate Risk Register: on August 24th 2022**				
Sponsor:	Nicky Reeves, Interim Director of Nursing				
Author:	Karen Carter-Woods, Head of Risk & 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 (July to August 24th): ➢ Three new corporate risks added: ID1267, ID1268 & ID1272 ➢ No corporate risks closed ➢ No corporate risks rescored **<u>Most notable risks on CRR</u>**: ID877: Financial sustainability ID1250: Additional licence conditions ID1264: Risk to operational delivery of Pathology Services: IT systems related				
Recommendation:	The board is asked to **note** the Corporate Risk Register information				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	The entire BAF has been reviewed by EMT alongside the CRR, The corresponding KSOs have been linked to the corporate risks.				
Corporate risk register:	This document				
Regulation:	All NHS trust are required to have a corporate risk register and systems in HMT place to identify & manage risk effectively.				
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.				
Resources:	Actions required are currently being delivered within existing trust resources				
Assurance route					
Previously considered by: 30 August 2022 22 August 2022	**<u>F&P:</u>** all risks except patient safety risks – as at 1st August 2022 **<u>Q&GC</u>**: all patient safety risks – as at 1st August 2022				

Corporate Risk Register Report
July and August 2022 Data

Key updates

Corporate Risks added between 01/7/2022 and 24/8/2022: three

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x5=15	1267	Recruitment Challenges for Sleep Physiology and Technical team	GM Sleep Exec Sign off - DoO
4x4=16	1268	Significantly Increased Referral Numbers to Sleep Service	GM Sleep Exec Sign off - DoO
3x4=12	1272	Plastics Administration Team Resources	Service Manager & Exec Director Ops

Corporate Risks closed this period: nil

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

Corporate Risks rescored this period: nil

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

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

Risk Register management

There are 88 risks on the Trust Risk Register as at 24th August 2022, of which 33 are corporate, with the following modifications occurring during this reporting period (1st July to 24th August incl):

- Three new corporate risks added: ID1267, ID1268 & ID1272
- No corporate risks closed
- No corporate risks rescored

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

Risk Register Heat Map: The heat map below shows the 33 corporate risks open on the trust risk register as at the 24th August 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**	**6**	**2**
Possible 3		**5**	**34**	**5** ID: 834, 968, 1210, 1226, 1265	**2** ID:1242, 1259
Likely 4		**2**	**11** ID: 1040, 1077, 1217, 1240, 1245, 1247, 1249, 1253, 1254, 1255, 1272	**3** ID1250, 1264, 1268	**0**
Certain 5		**2**	**11** ID1140, 1189, 1198, 1199, 1221, 1225, 1231, 1238, 1239, 1266, 1267,	**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	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1272	12/08/2022	Plastics Administration Team Resources	Challenges in delivering timely/adequate cover of our services such as rota management, theatre scheduling, Clinic typing and oncology scheduling and general patient pathway administration.□ □	Interim plans with the appointment of Bank staff; band 2, band 3 to support where needed. □ Substantive staff undertaking bank hours to help cover the backlog of work.□ Rota Manager and Rota Coordinator positions advertised Trac□ Daily huddle to coordinate priority of workload through team□ Band 6 Service Coordinator overseeing Rota□ Service Manager assisting at Band 4 level with oncology administrative processes□	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	9		KSO1 KSO2 KSO3
1268	19/07/2022	Significantly Increased Referral Numbers to Sleep Service	Referral numbers to Sleep Services have doubled in comparison to previous rates and currently over 600 per month for a sustained period.	Recruiting to new posts, although that in itself is a risk. Outsourcing of some overnight diagnostic tests where clinically appropriate. Consultant triages referrals to prioritise most urgent.	Shane Morrison-McCabe	Philip Kennedy	Compliance (Targets / Assessments / Standards)	16	8		KSO1 KSO2 KSO3 KSO4
1267	19/07/2022	Recruitment Challenges for Sleep Physiology and Technical team	Physiology/Technical team has had significant difficulties in recruiting to vacant posts. Trust has agreed to increase establishment following external review of service and benchmarking tools. Service may have long-standing vacant posts if cannot fill them all.	Seeking to apply Financial recruitment incentive for new starters. have sourced agency staff to support service. Consultant triages new referrals to ensure most urgent cases are prioritised.	Shane Morrison-McCabe	Philip Kennedy	Compliance (Targets / Assessments / Standards)	15	9		KSO1 KSO2 KSO3 KSO4
1266	24/06/2022	Ophthalmic electronic patient record (EPR) - absence	The absence of a functioning Ophthalmic EPR prevents us from participating in the RCOphth National Ophthalmology Database (NOD) Audit which allows for quality assurance of NHS cataract surgery.□ □ QVH participated in the NOD for the first 3 years, but withdrew from year 4 onwards as free use/licensing of Medisoft (one of the principle Ophthamic EPR systems) was withdrawn.	At present, we perform an annual partial retrospective audit, the most recent covering a 5 month period with an aim to audit PCR rate in line with RCOphth requirement in order to assess quality of care. To identify complications, multiple sources need to be utilized - cataract complications book: checking when vitrectomy used, theatre log books were used to check description of surgeries and the Ophthalmic implants book which is used across all theatres at QVH.	Shane Morrison-McCabe	Andre Litwin	Compliance (Targets / Assessments / Standards)	15	9	**August 22** - Further to discussions at EMT meeting, the requirement for an electronic solution was discussed at the HMT meeting on 18/07/22. It is agreed in principle, however, further work has been requested and ensuring IM&T are fully engaged. In addition, a series of meetings have been set up to work up the Option with UHSx into a full business case (including clinical pathways and implementation plan).	KSO2 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1265	14/06/2022	National remifentanil shortage	Reduced theatre productive due to longer recovery time for patients requiring additional staff input and space.□ Increased risk of post-operative side effects with older agents.□ Risk of increased complication rate and mortality rate.□	1. All anaesthetic staff made aware of shortage.□ 2. To plan which patients are priority for remifentanil.□ 3. Ensure that full allocation is ordered each week.□ 4. Risk assessing feasibility of vial sharing during this period□ 5. Remifentanil is still available but in smaller quantities. Anesthetists have made changes in practice to ensure there is no total stock outage at QVH□ 6. Weekly monitoring of total stock in hospital. Information sent to lead anaesthetists.□ 7. Audit of airway issues to be undertaken by Anaesthetic registrar in recovery to compare to previous results□ □	Nicola Reeves	Judy Busby	Patient Safety	12	8	**23/08/2022** - Reviewed. Current usage is higher than central allocation. Anaesthetic leads are aware of challenges□ 9/8/22 Controls in place updated in line with discussion at CGG□ 5/8/22 Continuous monitoring of the situation. Anaesthetists updated weekly of stock level. Currently still have stock and receiving allocation.□ 27/07/2022 - ongoing review. □ 7/7/22 - Situation being closely monitored. QVH still has stock. Changes in anesthetic practice has reduced use. Pharmacy only supplying one box per order. Did not receive allocation of 1mg or 2mg vials last week as out of stock. SOP for multidosing of vials written but not yet approved.	KSO1 KSO2 KSO3
1264	20/06/2022	Risk to operational delivery of Pathology Services: IT systems related	Risk to operational delivery of Pathology Services and progression of Programme. □ □	Progression of LIMS and MES workstreams: Potential for risk to increase if workstreams are delayed □ Limited mitigation until new LIMS in place □	Michelle Miles	Fiona Lawson	Compliance (Targets / Assessments / Standards)	16	8	**22nd August 22**: Project manager now in post to ensure that QVH has the additional capacity for the pathology network workstream.□ 1st August 22: Progression of LIMS workstream within NS7 Pathology Network. There is still potential for risk to increase if workstream is delayed as current LIMS is at end of support 1st Jan 2023. There is limited mitigation until new LIMS is in place.	KSO2 KSO3 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1259	16/03/2022	Increased Cyber Security Threats due to Russia	There is a cyber security risk of Russia targeting the UK with ransomware and denial-of-service attacks.	All security updates are deployed and installed within 14 day of being released □ Microsoft Defender for Endpoint (MDE)on all Desktops and servers has been enabled □ Microsoft Defender Antivirus (MDAV)on all desktops and servers has been enabled□ Reregister on NHS Digital provided Vulnerability Management Services including Early warning and Web Checker.□ Ongoing vulnerability scanning of Trust IT Infrastructure	Michelle Miles	Nasir Rafiq	Information Management and Technology	15	4	**01/08/2022**: new firewall have been installed. cyber security Screen savers implemented to all desktops.□ 24/06/22: Active Directory Assessment migration work has started however due to the complexity and risk of managing service impact the changes are taking longer than expected. The firewalls upgrade work is scheduled to start on 11 July and completed by 28th July.□ new cyber security screen savers will be deployed in July providing guidance to staff. A report will be presented to the IMT group in 12 July with recommendation to minimise the risk score.□ □ 16/05/2022: Active Directory Assessment has been completed and work to mitigate security vulnerabilities has starts, work expected to be completed by 30 June 2022. □ Secure Boundary will be part of the firewall upgrade works which has already started and expected to be completed by 31 July 2022.□ □ 28/04/22:IT continue to review the IT security and the security posture of the IT Infrastructure. new user password policy scheduled to be implemented w/c 2/05/22.□ □	KSO1 KSO2 KSO3 KSO4 KSO5
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	Shane Morrison-McCabe	Claire Ziegler	Compliance (Targets / Assessments / Standards)	12	9	05.07.2022 - paper presented outlying the current challenges was presented by Director of Operations at F&P. Outcome was to provide a further details regarding the options available. A paper will be presented to EMT in the week commencing 11th July 2022.	KSO2 KSO3 KSO4 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1254	16/02/2022	Speech and Language Therapists Staffing (Inpatients and Outpatient/Community Services)	Current workforce for Head and Neck SLT team is at 52% and Community SLT team is at 28% of budgeted establishment due to vacancies.□ Risks:□ 1.Will breach local targets for waiting times for non-urgent outpatients □ 2.Inability to provide indirect clinical services-(training/reviews of policy's/audit) □ 3.Reliant on Bank and agency staffing □ 4. High pressure on current SLT staff affecting wellbeing/moral	1. Remote Agency cover to supply ENT outpatient SLT caseload-0.2WTE□ 2. Bank use of Band 6 Community SLT - 0.2WTE□ 3. Patients with Urgent triage are prioritised□ 4. Regular team meetings, triage and debrief sessions for staff□ 5.Targeted recruitment continues, both posts have been through 1 cycle of advertisement and interviews- unsuccessful.□ 6. Resourcing team in collaboration with Therapy manager and Principal SLT looking at boosting advertising of post□ 7. Clinical staff have delegated roles to admin who is progressing well although new into post□ 8.Clinial Lead has reduced input in roles internally, AFC panel, mediation etc.□ 9. Monitoring activity and demand, bi-monthly	Shane Morrison-McCabe	Sarah Holdsworth	Compliance (Targets / Assessments / Standards)	12	9	21/07/2022□ 0.6 B7 vacancy recruited to. Unable to backfill or cover with agency the B7 Community SLT maternity leave vacancy despite trying. The B6 Community SLT covering some of the gap with additional hours where possible. Delay in urgent cases being seen within 2 weeks. The team review the caseload weekly and prioritise patients. □ 16/02/2022- Re-advertising B7 H&N SLT job as is and as a development role band 6-7 under Annex 21 - Live currently on TRAC. Agency request submitted to EMT last week for B7 Community SLT to cover maternity leave- awaiting decision.	KSO1 KSO2 KSO5
1253	15/02/2022	Waiting List managment: Plastics	Patients not added to the Waiting List on Patient Centre.□ Patients can have a 'wait list form' on Evolve completed, however this does not transpose onto the waiting list on patient centre: they are therefore not tracked on the PTL. □ □	1. New process: med secs to ensure that when typing clinic letters, they automatically cross reference within patient centre system to ensure that an "addition" to wait list has been completed and the patient has been added.□ 2. Evolve have developed a waiting list report that will be distributed weekly to cross check the PTL to ensure no patients are missed: audit to be progressed	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	6	29/06/2022 - risk discussed at Plastic Business Unit Meeting. Service Manager reported that 'V Look-Up' is working well for catching patients who have not been added to the waiting list and the report continues to be distributed twice-a-month. Service Manager is going to present risk status with a view to downgrading/closing. □ 13/04/2022 - Report now available from Evolve on all completed Waiting List Forms with V "look up" facility for cross checking on Patient Centre. Initial findings have uncovered patients not added onto the waiting list for both Plastics & H&N. Further investigation underway within services.□ 31 March 2022 - have requested update on progress against this piece of work from Service Manager, who has been working hard to address. Have also queried whether mitigations are working, as incident volumes associated with this problem appear to be non-existent for February since the incident was opened.	KSO1 KSO3 KSO5

ID	Opened	Risk Title	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	28/7/22: Substantive Chair now in post - Action taken on recommendations of independent review. Communication of the change in licence conditions to all relevant stakeholders and discussion about the implications□ 22/06 New chair appointed by CoG starts on 11 July. Action plan from independent review being implemented and discussed monthly with regulator.□ March 2022 - independent review and recommendations welcomed and accepted by Board on 3 Feb and shared with Council of Governors on 21 Feb. Action plan being developed on all 12 recommendations.□ Recruitment process underway for chair – interviews scheduled for 22 April□ □ 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	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	6	29/06/2022 - additional lists offered to consultant body for Saturdays and in-week. Some degree of uptake. Additional weekly list for Sentinel node created to support ongoing address of demand. Updated spreadsheet of Sentinel node position created in order to support oversight of position. Conversations underway with other suppliers of nuclear medicine, as there is a degree of unreliability associated with KIMs scanners. □ 13/4/22 - Capacity challenges continue. Option of Saturday lists/3 session days being explored. SLNB Task and Finish Group set up.□ 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.□ 04/03/2022 - emailed review of sentinel node waiting list and proposed short-term plan to address the volumes. □ 31/03/2022 - weekly task and finish meeting set-up to address. Governance was not in place formerly with adequacy and as a consequence the service has not been quite as responsive as it needs to be. We are also	KSO1

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1247	10/01/2022	First appointment delays from tertiary referrals: Plastics (skin)	First appointments not generated upon receipt of referral to QVH.□ Triage delays: paper copies	Review and improvement of processes □ Validation of PTL□ □ □	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	9	25/7/22 Delay to roll out of Evolve Triage Worklist due to workload pressures. Updated user guide created and roll out by mid/end August. Incidents still being reported on no first appointments booked for some patients.□ 29/06/2022 - triage worklist trialed and proved to be a success. The ambition now is to roll it out more widely. At present we are still seeing instances of delayed address of first appointments and the intention is to raise these as incidents so that the problem can continue to be represented. □ □ 04/05/2022 - meeting with Clinical Leads took place to introduce the concept of the triage worklist and trial is due to shortly begin.□ March 2022: (Service Manager Review)□ Evolve Triage Worklist form ready for trial by Plastics Clinical Leads. User Guide and demo planned and trial to commence at the end of April 2022.□ 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.□	KSO3
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□	Shane Morrison-McCabe	Phillip Connor	Compliance (Targets / Assessments / Standards)	12	12	25/7/22 - (BR) Risk likelihood increased from 9 to 12. Not been able to appoint in first round of adverts to Rota Coordinator. Current Rota Manager has now resigned and leaves on 26/8 which will leave no substantive rota team in place. Bank cover for 21 hrs p/w to commence by end of July and requires training. Existing Rota Manager had Covid and this has put rota back and as a consequence of this, and not the 2 x WTE required, we are only 4 weeks out with the rota. Service Co-Ordinator now spending all her time on rota. On top of admin pressures, we have sickness in Registrars which is impacting on staffing the rota. Some activity has had to be suspended.□ 29/06/2022 - POAP written. Just need a few tweaks before being submitted to EMT. Have now gone out to recruit for band 4 Rota Co-ordinator, as per plan. Trust have agreed to two further SpR WTEs starting in October to support with general consolidation of rota. Work underway to calculate what will now be required with expanded portfolio of theatre capacity. □ 04/05/2022 - EMT approval for up-banding of band 3 Rota Co-ordinator to a 4, in order to improve the calibre and coverage in the rota service. Furthermore, a meeting is being	KSO3

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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 **01/08/2022**: last IMT meeting was cancelled therefore report will be provided to the IMT group on 09/08/22 with recommendations as to reduce the risk score.□ Update 24/06/2022: new updated vulnerability scanning software from Qualys has been deployed to provide further reassurance of mitigation. Ongoing work with third party suppliers to mitigate the risk without service impact. A report will be provided to the IMT group on 12/07/22 with recommendations as to reduce the risk score.□ Update 04/05/2022: External third party cyber security support are still reviewing the remediation put in place. once confirmed update will be provided to the SIRO.□ Update 11/04/2022: all remediation work has been completed however there are still two system showing up on our vulnerability scanners even though the suppliers have provided remediation / fixes which has been implemented. Further detailed work to ensure all remediation work has been completed as specified is underway by Trust third party cyber security support. once confirmed a report will be provide to the SIRO and CEO, update NHS Digital CareCERT Alert and updated Trust Risk Register.□	KSO1 KSO2 KSO3 KSO4 KSO5
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	24/06/22: The Mobile Device Management policy and the forthcoming Digital Communications policy may provide some control. Scope is just Trust owned devices, so more required regarding staff using their own devices to install and use apps for PID even if the app is authorised centrally, (NHSEngland). □ □ We will consider interpolating a section statement regarding the Trust standpoint on use of apps for PID that are unauthorised at local level on own devices, (already prevented on Trust devices) plus another round of formal communications to all staff focused on clinical. We also have a professional speaker on the topic invited to Trust wide clinical audit in September.□ □ 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	KSO3

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1239	02/11/2021	Canadian Wing Staffing	Unable to fulfil the rota requirement	management of activity	Nicola Reeves	Liz Blackburn	Patient Safety	15	6	**23/08/2022** - reviewed, remains a moderate risk□ 27/07/2022 - reviewed□ 22/6/22 - Good uptake of bank shifts, recruitment remains a challenge.□ 6/4/22 - Remains an ongoing issue□ 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	**August 2022** - Twilights not cover for next off duty period remain minimal. Rostering now prioritizing twilights. Staffing situation expected to improve with addition of new nurse and nurse returning from absence. □ 27/07/2022 - From 8th August,twilight shifts covered with minimal numbers of shifts vacant. New nurse starting once recruitment checks are complete and a nurse potentially returning from long term sickness. This will help bolster the twilight cover further.□ 22/6/22 - Interviews in progress for two band 5 posts.□ 6/4/22 - Ongoing, new Matron now in post□ 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

ID	Opened	Risk Title	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.	Shane Morrison-McCabe	Victoria Worrell	Compliance (Targets / Assessments / Standards)	15	9	01/06 update: trust continuing to receive late referrals across Kent, Surrey and Sussex. Detailed reporting is continuing at Cancer Board level. Started to include percentage of late referrals within the backlog, on a weekly basis, communicating this with the Sussex ICS. Continuing to maintain a grip on the 24 day target, compared to 2020/21 the trust has improved its 24 day performance by 7%, reporting a decrease each year of patients breaching the 24 day target.□ 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	June 2022: Specialised commissioners continue to review prior to creation of options appraisal□ 6/4/22 - no update on options appraisal available□ 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□ 31/03/2022 - we are at risk of being short 1.5 Burns Consultants given lead times for recruiting to these posts. Furthermore, we have had no eligible consultants in the last round of advertising. We are working up a plan to cover uncovered DCCs and to potentially recruit a fellow to the Burns consultant post, which may be a more attractive prospect. PC	KSO1 KSO2 KSO3 KSO5

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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	**23/08/2022** - Risk reviewed□ 27/07/2022 - ongoing□ 22/6/22 - Vacancy remains, continue to advertise vacant posts.□ 6/4/22 - Vacancy continues to be a challenge. Ward has been closed on a number of days to maintain safety by redeploying staff as appropriate□ 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. □	KSO1 KSO2
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	**5/8/22** New audit regarding indication and duration documentation underway.□ 7/7/22 Audit completed by antimicrobial pharmacist. Reviewing SLA with Brighton regarding microbiologist cover□ 8/6/22 Date for next stewardship meeting arranged□ 20/5/22 Audit being undertaken to identify individuals not complying.□ 28/4/2022 Meeting chaired by MD to discuss action plan and review microbiology SLA□ 24/3/22 Handler has been changed to Chief Pharmacist, although MD leading on risk. Looking at a different ways to engage clinicians in the process. □ February 2022: Incoming MD working collaboratively with Clinical Leads□ July 2021: anti-microbial stewardship group formed, to meet fortnightly - MD to chair	KSO1 KSO2

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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	28/7 - process to refresh Case for Change and Options Assessment will be reported to QVH Board when complete.□ 22/06 - Over the course of three workshops, a group including executive directors, non-executive directors and clinical directors has refreshed the Case for Change and Options Assessment; including considering changes in both the national and local context. Paper for the QVH Board on 7 July will document the process undertaken and the conclusion of the process, including the reasoning. Briefings to East Grinstead Town Council (21/06) and Mims Davies MP (22/06).□ March 2022: Joint appointment by QVH/UHSx of a clinical oversight lead for the clinical strategy review, to commence end of April. Timeframe being developed on full business case.□ 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	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	**23/08/2022** - national guidance continues to be adhered to. □ 27/07/2022 - Further reductions in mask wearing and testing paused due to increase in prevalence during July. Under constant review.□ 22/6/22 - Patient covid testing pathways reviewed and rolled out. Mask wearing guidance reviewed in all areas.□ 6/4/22 - Guidance reviewed and QVH SOPs being amended to bring up to date□ 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	KSO1 KSO2

ID	Opened	Risk Title	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	**23/08/2022** - capacity paper currently with Chief Nurse for review. □ 27/7/2022 - reviewed - ongoing, still awaiting outcome of capacity review□ 22/6/22 - Continued vacancy with CCU, review of staffing and bed capacity being undertaken.□ 22/4/22: B5 vacancy = 5.81 WTE with 1.0 WTE recruited to. □ Out of the 3.53 WTE Band 5s, 2.53 WTE are new to ITU (started within 6 months). □ B6 vacancy = -0.09 WTE vacancy with 0.61 WTE to be available from the 8th May 2022□ Rolling advert out for band 5s and are soon to advertise for PT/FT Band 6 □ 6/4/22 - ongoing staffing challenges being managed on a day to day basis□ 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	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	**23/8/22**□ 10 PA post, shared with Epsom and St Helier offered and accepted, with proposed start date of 5th October.□ On going development of Consultant Job Plans with aim of advertising in September□ All locum Drs asked to confirm their availability for remainder of 2022 in order to provide greater stability of service provision and capacity. □ 29/6/22: Funding for an additional 19PA Consultant time approved by EMT. Development of Job Plans underway with medical staffing team. One candidate has withdrawn from FT post but will provide remote clinics on Bank. Joint Registrar with EStH has resigned from post. Plans still progressing for one FT post shared with EStH, due to start Oct 22. Currently doing small number of Bank sessions. Majority of Consultant clinics are provided off-site by locums. Option to do further joint recruitment with EStH.□ May need to revise risk scoring upwards□ 20/4/22: Two Additional Consultants recruited to Bank with plans in progress for 2 x Fixed Term posts in conjunction with EStH to begin in September. Additional hours agreed with Middle Grade Dr from August □	KSO3

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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 □ □	Shane Morrison-McCabe	Sarah Solanki	Compliance (Targets / Assessments / Standards)	15	9	**22-08-2022** Apprentice has start date of 26th Sept. Trainee sonographer post - interviews starting this week. CDC BC funding not yet approved by government. 1 Bank sonographer started last week. I have had 3 people talking about retirement (2 radiographers/ 1 sonographer). 1 radiographer will be leaving ASAP due to retirement. 05-08-2022 Apprenticeship funding from HEE approved. Candidate successfully accepted by Sussex uni. trainee sonographer post shortlisted and interview date offered. Awaiting funding approval for CDC. Bank sonographers - 1 has a start date, 1 is still being onboarded. RTP person starting this month. Several people are talking about retirement. 15-07-2022 Trainee US post out to advert. Apprenticeship successfully appointed to - Uni interview next week. Both Bank sonographers being on-boarded. PACS admin role - JD needs tweaking. 23-06-2022 - EMT approved trainee sonographer post, apprenticeship post and PACS support. JD's evaluated - need tweaking. Apprenticeship JD - approved. interviewing next week for post. Uni EOI and contract completed. lots of interest from local sonographers to work here and expand their knowledge. interviewed 1 bank sonographer 2	KSO1 KSO2 KSO3 KSO5
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	ESHT have said they will lead on a re-procurement process for the consortium. □ Philips have said they will extend the current contract - costs will need to be agreed as hardware will need replacing.	Michelle Miles	Sarah Solanki	Information Management and Technology	15	4	**22-08-2022** - Work still ongoing. Phillips extension Req going to be raised to cover until end of Dec 2022. We can cancel with 30 days notice and get monies back. Data migration ongoing. Go live still projected as 17th Sept. Initial home reporting of workstations went ok on site. Need to test in the home. □ 05-08-2022 data migration has started. Some delay in migration which had to be stopped twice. This could delay other PACS go live dates but not QVH. Go live still currently 17th Sept. Radiologist champion training completed. Home workstation been built and needs testing in home environment - this working is a show stopper. Setting up things like report templates etc in the live environment. □ 15-07-2022 - new go live is the Sept 17th currently. Migration may start next week if all testing goes well. Due diligence testing completed on the system yesterday showed network slowness. Other sites are now moving forward with their lease lines work. We will likely need to extend Phillips support for another month but no costs provided as yet. □ 23-06-2022 - Project delayed due to a number of factors. Proposed new go live is the 17th Sept but S&S consortium need more dates within a 6 week period to go live. Migration	KSO1 KSO2 KSO3 KSO4

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1077	22/08/2017	Recruitment and retention in theatres	* Theatres vacancy rate is increasing□ * Pre-assessment vacancy rate is increasing□ * Age demographic of QVH nursing workforce: 20% of staff are at retirement age□ * Impact on waiting lists as staff are covering gaps in normal week & therefore not available to cover additional activity at weekends□ June 2018:□ * loss of theatre lists due to staff vacancies	1. HR Team review difficult to fill vacancies with operational managers□ 2. Targeted recruitment continues: Business Case progressing via EMT to utilise recruitment & retention via social media□ 3. Specialist Agency used to supply cover: approval over cap to sustain safe provision of service / capacity□ 4. Trust is signed up to the NHSI nursing retention initiative□ 5. Trust incorporated best practice examples from other providers into QVH initiatives□ 6. Assessment of agency nurse skills to improve safe transition for working in QVH theatres□ 7. Management of activity in the event that staffing falls below safe levels.□ 8. SA: Action to improve recruitment time frame to reduce avoidable delays	Shane Morrison-McCabe	Claire Ziegler	Patient Safety	12	4	**22.08.2022** Update July/August. Still a shortfall in HCA's out to advert. B5 resignation and still awaiting on boarding completion B7 Day Surgery and B6 Theatres. ODP shortage, in house apprenticeship training underway and review of nurse anesthetic course availability locally.□ 20.07.2022 Update June/July Shortfall in HCA out to advert but recent unsuccessful recruitment. Awaiting on boarding B7 Admissions. □ 22.06.2022 Update May/June 2022. Recruited into B6 X 3 ODP apprenticeship X 3 B5 AP's X 2 . Lead for recruitment working with long-term workforce plan to retain existing staff and demonstrate career opportunities and development to ensure the continued delivery of activity and planned increase□ 11.05.2022 Update for April 2022: Recruited into B6 anaesthetics and B5 scrub with 3 new starters B2. Continue to be challenged by high cost area and staff looking for career development. Working to wider the opportunities for different workforce groups to incentivise retention.□ □ 11.03.2022 Update for February 2022: Recruitment continues to be a challenge. Unable to book agency, it has been rumoured	KSO1 KSO2
1040	13/02/2017	Age of X-ray equipment in radiology	Significant numbers of Radiology equipment are reaching end of life with multiple breakdowns throughout the last 2 year period.□ □ No Capital Replacement Plan in place at QVH for radiology equipment	All equipment is under a maintenance contract, and is subject to QA checks by the maintenance company and by Medical Physics.□ □ Plain Film-Radiology has now 1 CR x-ray room and 1 Fluoroscopy /CR room therefore patients capacity can be flexed should 1 room breakdown, but there will be an operational impact to the end user as not all patients are suitable to be imaged in the CR/Flouro room. These patients would have to be out-sourced to another imaging provider.□ □ Mobile - QVH has 2 machines on site. Plan to replace 1 mobile machine for 2019-2020□ □ □ Fluoroscopy- was leased by the trust in 2006 and is included in 1 of these general rooms. Control would be to outsource all Fluoroscopy work to suitable hospitals during periods of	Shane Morrison-McCabe	Sarah Solanki	Patient Safety	12	2	**22-08-2022** - Moving to phase 2 of MES. Some risk around relevant estates input now head of estates and deputy director are now leaving. □ □ 05-08-2022 - moving to phase 2. worked through T&C. Financials have been updated for OBC. Finalised documents with commercial solutions. Really need estates input and assistance for moving forward. □ □ 15-07-2022 - T&Cs have been discussed and moving forward with phase 2. New estates lead has now had a meeting with commercial solutions and is in the picture regarding the project. Meeting on Monday with finance/procurement/Radiology to feedback any key points to Commercial solutions. □ □ 23-06-2022 - Phase 2 documentation for commercial solutions being finalised. Meetings booked with finance and estates in early July to discuss further. Financials were due to be revised on the BC. Not sure if this yet completed. □ □ 24-05-2022 - MES board met. DoF wants to see updated BC and complete phase 2 of the project. NHS framework meeting with	KSO1 KSO2 KSO3

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
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.□	Tania Cubison	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	4	June 2022: nil update□ February 2022 - nil 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	KSO2 KSO3 KSO5
877	21/10/2015	Financial sustainability	1) Failure to achieve key financial targets would adversely impact the NHSI "Financial Sustainability Risk rating and breach the Trust's continuity of service licence. □ 2)Failure to generate surpluses to fund future operational and strategic investment	1) Annual financial and activity plan□ 2) Standing financial Instructions □ 3) Contract Management framework □ 4) Monthly monitoring of financial performance to Board and Finance and Performance committee 5) Performance Management framework including monthly service Performance review meetings 6) Audit Committee reports on internal controls□ 7) Internal audit plan	Michelle Miles	JMCI	Finance	20	16	**August 2022**: YTD breakeven position for month 3. Further work is ongoing with regards to forecasting for the year and also review of the planning for 23/25 in line with national guidelines. In addition the Trust has started work on the HFMA checklist which is a national requirement to ensure the Trusts process and governance are reviewed.□ June 2022:Third submission of the business plan has been submitted with increased levels of efficiencies required to deliver a break even plan. Additional income of £1.3m granted to the Trust to mitigate the increased inflation.□ was February 2022: Planning for 22/23 is underway, first draft submission on the 17th of March. Plans will be discussed at Finance & Performance and subsequently the board. □ 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.□	KSO4

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
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	Tania Cubison	Dr Edward Pickles	Patient Safety	12	4	April 2022 - SLA still being reviewed□ 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:	**Quality and safety report**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**134-22**	
Report title:	Quality & Safety Board Report – September 2022				
Sponsor:	Nicky Reeves, Director of Nursing and Quality				
Author:	Amy Brownlie, Clinical Audit and Outcomes Specialist				
Appendices:	None				
Executive summary					
Purpose of report:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Summary of key issues	The Committee's attention should be drawn to the following key areas detailed in the reports: • QVH has received pleasing results in the 2021 Cancer Patient Experience Survey • New clinical harm review process implemented • Learning from deaths process reviewed • One Never Event declared				
Recommendation:	The Committee is asked to be assured that the contents of the report reflect the quality and safety of care provided by QVH during this time				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: *Financial sustainability*	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	The 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 report contributes and provides evidence of compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's fundamental standards.				
Legal:	As above. The report upholds the principles and values of The NHS Constitution for England and the communities and people it serves – patients and public – and staff.				
Resources:	The report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	22/08/22	Decision:	Approved subject to additions regarding inquest outcome, out of hours returns to theatre update and quality priority update	
Next steps:					

Executive Summary - Quality and Safety Report, September 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. QVH has received pleasing results in the 2021 Cancer Patient Experience Survey: • The Trust's results were much better than most trusts for 7 questions • The Trust's results were better than most trusts for 28 questions • There was one question where the Trust scored below the expected range QVH staff have managed patient safety well during the recent hot weather. Q1 - Quality priorities met. Q&GC noted 0 falls in July. **Patient experience** Discussion at Q&GC regarding increased numbers of patient complaints. This can be seen as multi-factoral and there has been a change in counting methodology. **Infection control** The Covid infection control board assurance framework was reviewed in Q&GC - no actions required at this time.

Executive Summary - Quality and Safety Report, September 2022

Domain	Highlights
Medical Director	**Sleep Services** Following the external review of the sleep service the subsequent action plan is being implemented. New staff are in post having filled previous vacancies and recruitment is progressing with the new posts. **Antimicrobial stewardship** The antimicrobial stewardship programme continues. We have reviewed our current practice against the Start Sharp Then Focus national stewardship programme and confirmed that we are aligned to these standards. Our new antimicrobial pharmacist is working with medical and nursing colleagues to audit the implementation of our new drug charts, and we are considering new approaches to accountability. We are looking at a hybrid solution to microbiology support with the plan for fixed Teams virtual meetings to improve accessibility and continuity for micro advice. **Clinical harm reviews** The Harm Review forms are now active on evolve and the clinicians can record the sub-types of harm that are being standardised across the ICS. There is now a group email for the clinical review team so that there is immediate visibility of any patient graded as having sustained severe or moderate harm. A stepped process allows the recording of reviewed but not definite outcomes so that clinicians can undertake the reviews without all results available and therefore flag potential issues in a timely manner. 104 day cancer breach reviews have been prioritised and are now up to date although pathology is not available in all cases so that the final outcome may have been deferred. Contd...

Executive Summary - Quality and Safety Report, September 2022

Domain	Highlights
Medical Director	**Learning from deaths** In the 12 months between 1st October 2020 - 30th September 2021 there were 26 adult deaths. 4 occurred during inpatient episodes at QVH, 14 within 30 days of an inpatient episode and 8 within 30 days of an outpatient procedure. The 4 inpatient deaths were reviewed and although the general standard of care was very high there have been learning points raised. A Medical Director's summary has now been included for all these cases. The process of learning from deaths has been reviewed. Unexpected deaths from referred condition and complications of treatment will be reported separately from deaths from unrelated condition and those on palliative care pathways where there may still be learning for the organisation. The investigation process will be streamlined to ensure that opportunities for learning are fed back to the teams and then embedded into practice. **Inquest outcome** QVH attended a recent inquest and are now taking steps to address actions from this and feed back to the coroner by end of September 2022. These actions include commencing the creation of national guidance for the management of a specific medical device.

Report by Exception - Key Messages

Domain	Issue raised	Action taken
Safe: Learning When Things Go Wrong	Never Event	One Never Event was declared this period: wrong site block.

Safe - Performance Indicators

Metric Description	Target	Q2 2021/22		Q3 2021/22			Q4 2021/22			Q1 2022/23			Q2 22/23	12 month total/ rolling average
		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-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	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram negative bloodstream infections (including E.coli)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA screening - elective	95%	84%	96%	95%	96%	98%	95%	98%	93%	98%	97%	98%	99%	96%
MRSA screening - trauma	95%	97%	97%	98%	99%	99%	99%	98%	97%	99%	100%	99%	99%	98%
Incidents														
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Serious Incidents	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Theatre metrics														
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	5	2	3	2	3	3	3	3	0	3	6*	6*	27
Paediatrics under 3 years: Induction of anaesthetic was between 18:00 and 08:00	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WHO quantitative compliance		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Non-clinical cancellations on the day		9	10	8	23	7	4	29	19	5	8	10	10	165
Needlestick injuries	0	2	1	2	3	2	1	0	2	0	2	2	1	18
Pressure ulcers (all grades)(Theatre metric)		1	0	2	0	0	0	0	1	0	0	0	0	4
Paediatric transfers out (<18 years)		0	0	0	2	0	0	0	2	0	1	0	0	5
Medication errors														
Total number of incidents involving drug / prescribing errors		9	3	11	5	6	4	17	10	6	13	17	19	120
No & Low harm incidents involving drug / prescribing errors		8	2	6	4	5	4	14	8	5	11	13	15	95
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		0.6	0.6	3.0	0.6	0.6	0.0	1.9	1.2	0.6	1.1	2.3	2.2	1.2
Pressure Ulcers Hospital acquired - category 2 or above		2	0	2	1	0	0	1	0	0	0	3	0	9
VTE initial assessment (Safety Thermometer)	95%	100%	100%	100%	100%	96%	100%	100%	93%	100%	100%	100%	96%	99%
Patient Falls														
Patient Falls assessment completed within 24 hrs of admission	95%	95%	100%	100%	96%	100%	95%	100%	100%	95%	100%	100%	100%	98%
Patient Falls resulting in no or low harm (inpatients)		5	2	1	7	1	1	6	1	5	2	3	0	34
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	0	0	0	0	0	0	0	0	0	0	0	0
Patient falls per 1000 bed days		4.6	3.6	2.8	1.9	1.8	3.6	4.7	0.0	5.3	8.4	4.0	3.7	3.7

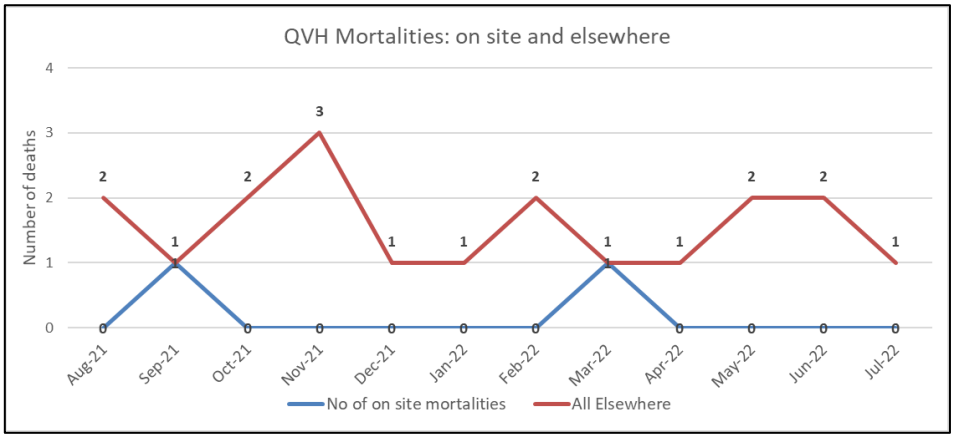
nc = not collected or not reported
*All cases reviewed - no inappropriate patients operated on out of hours

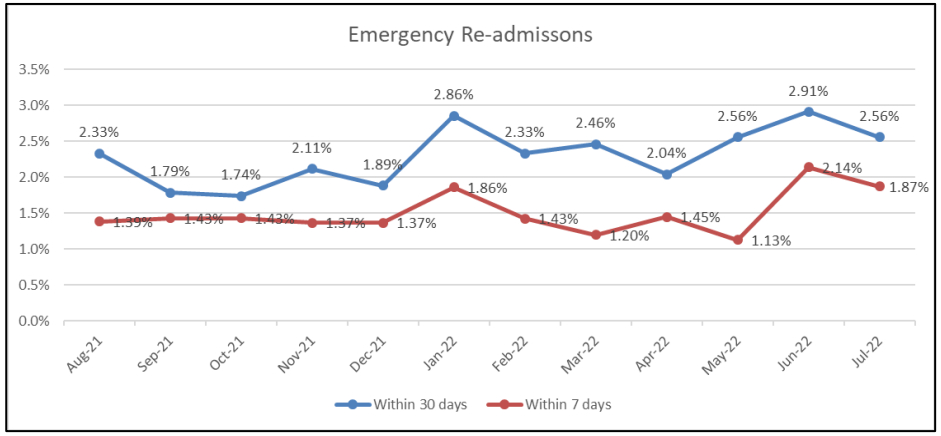
Safe - Performance Indicators

KPI	Target	Average	Latest Month	Variation Jul-22	Assurance Jul -22	Comments for the latest period shown for each metric
MRSA - Elective	95%	98%	99%			Ongoing review of data quality and ensuring robust methodology for data collection.
MRSA - Trauma	95%	96%	99%	H		Ongoing review of data quality and ensuring robust methodology for data collection.
Serious Incidents	0	0.1	0			0 reported in June and July. 1 Never Event reported in July.
Total no of incidents involving drug/prescribing errors	0	11.2	15			All incidents reviewed in Pharmacy review of Datix.
Falls per 1000 bed days	0	3.1	0.0			Falls incidents continue to fluctuate. No key patterns to mechanism have been identified. Work around falls prevention continues and this has now been selected for a Quality Priority. The latest progress is that the new falls documentation has been approved by CGG and should be rolled out shortly. Additional training is being planned to introduce these forms to staff. The Policy is currently being rewritten.
Pressure ulcers per 1000 bed days	0	0.4	0.0			All Datix incidents reviewed by Tissue Viability Nurse. 0 reported in July.
Complaints	0	4.5	7			Whilst fluctuating month by month complaints have fallen within the expected range throughout the period. Patient sentiment and expectations have changed as a result of the pandemic and its impact on services. Thematic analysis of the complaints raised, alongside other patient experience information, is shared with service areas to keep up to date with the potential changes and identify opportunities. We also continue to celebrate what we are doing well to ultimately ensure our services continuously improve.
Mortalities	0	1.1	1			No cause for concern. Figures are within the expected boundaries.

Variation			Assurance		
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

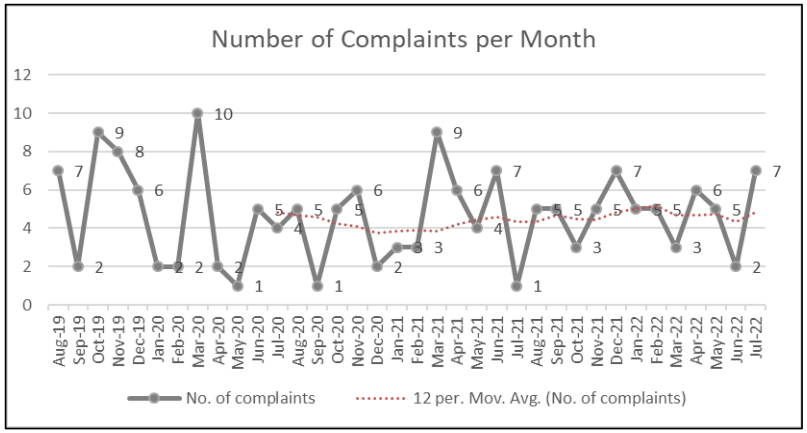
Effective - Performance Indicators

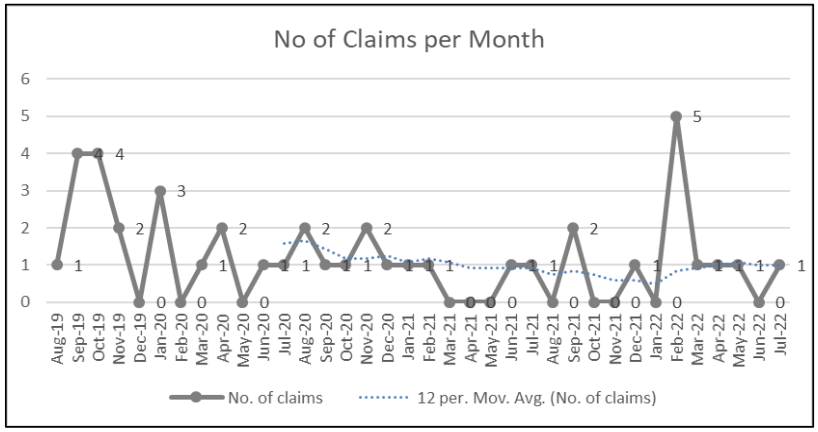




Mortalities Report			Q2 2021/22		Q3 2021/22			Q4 2021/22			Q1 2022/23			Q2 22/23
			Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Mortalities within 30 days of an inpatient episode or outpatient procedure	Inpatient	No of on site mortalities	0	1	0	0	0	0	0	1	0	0	0	0
		No of mortalities elsewhere	1	1	0	3	1	1	2	0	1	1	3	1
	Outpatient		1	0	2	0	0	0	0	1	0	1	0	0
	All Elsewhere		2	1	2	3	1	1	2	1	1	2	3	1
Reviews		Completed Preliminary Reviews	2	0	0	2	1	1	2	1	1	2	2	nc
		No of deaths subject to SJR	0	1	0	0	0	0	0	1	0	0	0	nc
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





	Q2 2021/22		Q3 2021/22			Q4 2021/22			Q1 2022/23			Q2 22/23
	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Number of complaints	5	5	3	5	7	5	5	3	6	5	2	7
Complaints per 1000 spells	0.28	0.25	0.16	0.25	0.40	0.27	0.29	0.15	0.35	0.24	0.11	0.40
Number of claims	0	2	0	0	1	0	5	1	1	1	0	1
Claims per 1000 spells	0.00	0.10	0.00	0.00	0.06	0.00	0.29	0.05	0.06	0.05	0.00	0.06
Number of cases referred to PHSO	0	0	0	0	0	0	0	0	0	0	0	0

Nursing Workforce - Performance Indicators, Safe Staffing Data

Staffing continues to be challenge on Peanut ward, during the month of June there were two nights when there were overnight inpatients. The unit was staffed on the twilight shift on 10 occasions with no inpatients, there were 17 instances where we could not accept an overnight patient. In July there were unusually high levels of sickness absence in the team. There was one overnight inpatient, which we were unable to staff the night shift for, this patient was 16 years old and cared for on Canadian Wing. The unit was staffed on the twilight shift on four occasions with no inpatients. There were 26 instances where we could not accept an overnight patient. Following the successful recruitment of a Band 5 staff nurse, and staff returning form long term sickness absence, cover for the twilight shifts in August and September are much improved.

Safe staffing data from both June and July demonstrates compliance with staff numbers above the 95% threshold. Staffing levels continue to be reviewed throughout the day and appropriate redeployment of staff to support areas with any staffing challenges.

Combined Staffing exc. Site — *Target 95%*

Jun-22

	Planned staff			Actual staff				Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA		RN	NA	HCA	RN	NA	HCA
DAY	3853	149.5	1875	3841	161	1852	*Total Hrs Planned and Actual*	3738	149.5	954.5	3726	149.5	954.5
				99.7%	107.7%	99%	*% Planned Hrs Met*				99.7%	100.0%	100.0%
			5877			5854	*Total Hrs Planned & Actual - Combined reg & support*			4842			4830
						99.6%	*% Planned Hrs Met - Combined reg & support*						99.8%

NIGHT

Nursing Workforce - Performance Indicators, Safe Staffing Data

Combined Staffing exc. Site — *Target 95%*

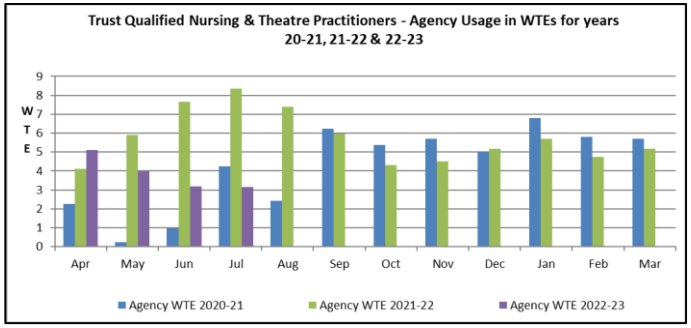
	Planned staff			Actual staff			Jul-22	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA		RN	NA	HCA	RN	NA	HCA
DAY	4738	299	2772	4669	299	2726	*Total Hrs Planned and Actual*	NIGHT 3554	149.5	1093	3496	149.5	1058
				98.5%	100.0%	98%	*% Planned Hrs Met*				98.4%	100.0%	96.8%
			7809			7694	*Total Hrs Planned & Actual - Combined reg & support*			4796			4704
						98.5%	*% Planned Hrs Met - Combined reg & support*						98.1%

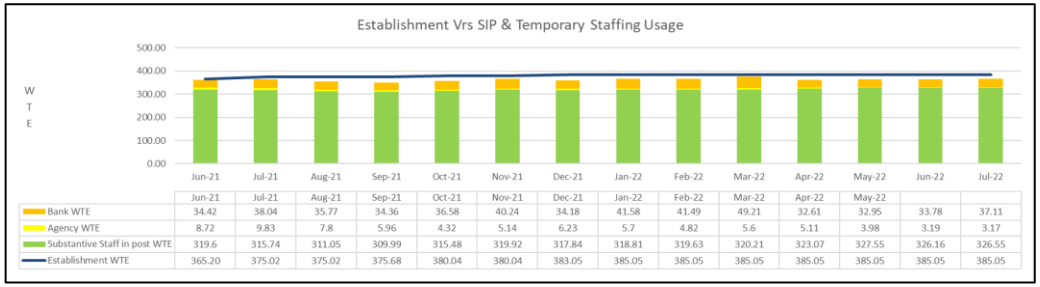
Nursing Workforce - Performance Indicators

ALL QUALIFIED & UQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2020-21 & 2021-22			Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)				375.02	375.02	375.68	380.04	380.04	383.05	385.05	383.05	385.05	383.05	**385.05**	383.05	**385.05**	◄►
Staff In Post WTE				315.74	311.05	309.99	315.48	319.92	317.84	318.81	319.63	320.21	323.07	**327.55**	326.16	**326.55**	▲
Vacancies WTE				59.28	63.97	65.69	64.56	60.12	65.21	66.24	63.42	64.84	59.98	**57.50**	56.89	**58.50**	▼
Vacancies %	>18%	12%<>18%	<12%	15.81%	17.06%	17.49%	16.99%	15.82%	17.02%	17.20%	16.56%	16.84%	15.66%	**14.93%**	14.85%	**15.19%**	▼
STARTERS WTE (Excluding rotational doctors)				0.00	1.41	3.93	4.68	9.97	6.56	2.95	4.32	2.61	6.76	**3.00**	2.00	**1.80**	▼
LEAVERS WTE (Excluding rotational doctors)				3.21	6.76	1.12	1.60	3.61	4.41	3.48	2.80	2.53	3.99	**1.01**	1.51	**2.52**	▲
Starters & Leavers balance				-3.21	-5.35	2.81	3.08	6.36	2.15	-0.53	1.52	0.08	2.77	**1.99**	0.49	**-0.72**	
Agency WTE (Data From Healthroster)				9.83	7.80	5.96	4.32	5.14	6.23	5.70	4.82	5.60	5.11	**3.98**	3.19	**3.17**	▼
Bank WTE (Data From Healthroster)				38.04	35.77	34.36	36.58	40.24	34.18	41.58	41.49	49.21	32.61	**32.95**	33.78	**37.11**	▲
Trust rolling Annual Turnover %	>=12%	10%<>12%	<10%	11.36%	12.52%	12.62%	13.32%	12.89%	12.81%	12.82%	13.76%	13.78%	14.29%	**14.30%**	12.35%	**12.24%**	▼
Monthly Turnover				1.09%	2.14%	0.38%	0.53%	1.13%	1.46%	1.15%	0.93%	0.84%	1.36%	**0.35%**	0.53%	**0.88%**	▲
Sickness Absence %	>=4%	4%<>3%	<3%	3.21%	3.61%	3.98%	4.69%	5.12%	5.29%	6.47%	6.37%	6.39%	**5.05%**	**3.75%**	**4.02%**	***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





Medical Workforce - Performance Indicators

Metrics	Q2 2021/22		Q3 2021/22			Q4 2021/22			Q1 2022/23			Q2 22/23	12 month rolling
Medical Workforce	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	
Turnover rate in month, excluding trainees	1%	1%	4%	0%	1%	1%	1%	0%	3%	1%	1%	1%	21%
Turnover in month including trainees 9%	18%	18%	5%	1%	1%	1%	9%	1%	5%	1%	0%	1%	48%
Management cases monthly	0	0	0	0	0	0	0	0	0	0	0	0	0.01
Sickness rate monthly on total medical/dental headcount	1%	3%	3%	2%	2%	3%	3%	4%	2%	1%	3%	nc	nc
Appraisal rate monthly (including deanery trainees)	70%	65%	52%	61%	57%	61%	68%	74%	70%	69%	69%	67%	67%
Mandatory training monthly	82%	80%	79%	81%	82%	82%	80%	84%	84%	85%	87%	87%	83%
Exception Reporting – Education and Training	10	5	1	1	1	0	0	0	1	0	0	0	12
Exception Reporting – Hours	10	2	3	3	0	1	1	1	3	5	7	6	42

Medical & Dental Staffing

The August induction successfully welcomed new trainees in Anaesthetics, Plastic Surgery, Corneo Plastics and Radiology. Planning is now underway for the September induction, predominantly Dental Core Trainees, and the October induction, mostly Plastic Surgery. The Dental Core Trainees are often new to working in a hospital environment so will be given additional induction time, including simulation training in how to recognise an unwell patient, to support them as they adjust to their new working environment.

Education

The GMC survey of doctors in training was released in July and was discussed at the Local Academic Board (LAB) meeting that month. At the LAB meeting, the Deputy Dean for Sussex commended QVH for an excellent set of results. This year's results are the strongest that the Trust has received in a long time: with 20 green flags, 3 light green flags, two light pink flags and no red flags in any speciality. See the image below for more detail.

Medical Workforce - Performance Indicators

GMC NATIONAL TRAINING SURVEY 2022
QVH ANALYSIS

Summary of results

Programme Group	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting systems	Work Load	Teamwork	Handover	Supportive environment	Induction	Adequate Experience	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design	Facilities
Anaesthetics	98.33	100.00	97.92	85.00	77.08	91.67	81.25	94.44	91.11	94.44	93.52	95.14	77.98	96.48	65.74	77.78	84.72	90.63
CST	88.75	96.25	96.88	72.50	62.50	87.50	75.00	85.00	80.00	84.38	81.25	85.94	80.21	69.17	52.09	76.56	64.06	77.50
OMFS	88.75	98.75	95.83	82.50	56.25	77.08	93.23	80.00	83.75	84.38	81.25	93.75	83.33	77.50	77.09	70.14	60.94	88.33
Plastic surgery	83.33	93.33	93.75	79.17	52.78	83.33	73.27	71.67	75.83	83.33	77.78	86.46	68.33	84.45	58.33	72.92	61.46	81.67

Red	Strong negative outlier	Pink	Negative in comparison to the average but not quite a negative outlier.
Green	Strong positive outlier	Light Green	Positive in comparison to the average but not quite a positive outlier.
White	Within the range of the average	Grey	Less than three trainees
Yellow	No trainees responded to questions relating to this indicator		

The 2022 results overall show positive outcomes across all specialties, with 20 green flags and three light green flags. There has been a particular improvement in Higher Plastic Surgery, and continued strong results in Core Surgery as well, which is testament to the efforts made by the Plastic Surgery team.

An action plan will be developed to address the two pink flags in Higher Plastic Surgery, but it is fantastic to have a set of survey results with no red flags in any specialty.

The aim now will be to ensure that these results continue into next year's survey.

As ever, it is important to remember that the results are based on small numbers of HEE appointed trainees. The significance of the results is therefore not always easy to interpret, with the responses of one trainee potentially accounting for large swings. This does not detract from the importance given to the results.

NB: in 2022 insufficient trainees responded to the survey from radiology and therefore their responses were not counted for QVH's survey results.

Report cover-page					
References					
Meeting title:	**Board of directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**135a-22**	
Report title:	**Safeguarding Adults & Children's Annual Report 2021/22**				
Sponsor:	Nicky Reeves, Chief Nurse				
Author:	David Johnson, Safeguarding Adults Named Nurse and MCA lead Katy Fowler, Named Nurse for Safeguarding Children and LAC.				
Appendices:	None				
Executive summary					
Purpose of report:	Each year a safeguarding report is produced to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.				
Summary of key issues	**Current Challenges:** • Replacement of Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS); significant planning and investment required. • Recent change in the way training compliance is reported has caused significant difference between compliance rates of permanent staff vs. bank staff, particularly level 3. Despite this, the safeguarding training figures still demonstrate good compliance **Current Achievements:** • We have been able to return to face-to-face training sessions • All members of the safeguarding team have worked to maintain and develop their knowledge and experience in the role, attending level 4 virtual training • Continuing engagement of staff and recognition of safeguarding responsibilities. • Compliance with the Mental Capacity Act (MCA) has continued to be a trust priority. An MCA workshop was held in October 2021 and is due to be repeated annually. • Improved connections with West Sussex Safeguarding Adults Board and Safeguarding Children Partnership and the establishment of Child Safeguarding Liaison Group within West Sussex. • Strengthened Looked After Children (LAC) safeguarding systems across the trust. QVH Named Nurse for Safeguarding and LAC continued engagement with the network of LAC professionals across Sussex; this led to engagement with CCG's participation assistant who is a care experienced young person to capture patient voice within our staff training. • Safeguarding Children's Named Nurse has been working with UHSx Paediatrician and two Brighton Medical School students to review MDT database: evaluated patterns and types of injuries in children where there had been safeguarding or child protection concerns. • Bespoke training offered to secretarial staff across the trust				
Recommendation:	The Board is asked to **note** the annual report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives:	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: *Financial sustainability*	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	Applicable to KSO1,2, 4 and 5				
Corporate risk register:	No current open corporate risks.				
Regulation:	All Boards must publish an annual safeguarding report and demonstrate to regulators that appropriate safeguards are in place to protect vulnerable adults and all children.				
Legal:	All health care providers are required to meet safeguarding criteria for adults- Care Act 2014. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to safeguard and promote the welfare of children.				
Resources:	No new resources required				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	25.7.22	Decision:		
Next steps:					

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

Safeguarding

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2021 to March 2022

Document Control: committees and groups who have approved this report
Executive sponsor: Nicky Reeves, Chief Nurse

Authors: **David Johnson, Safeguarding Adults and MCA Named Nurse**
Katy Fowler, Safeguarding Children and LAC Named Nurse

Date: June 2021

Type: Annual Report
Version: V2
Pages: Number
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1.	Executive Summary

Each year a Safeguarding Report is produced for QVH Board to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.

QVH safeguarding systems and arrangements continue to be improved and strengthened. Safeguarding support for staff is well established. Safeguarding Audits continue to provide assurance for the organisation and also identify any key development areas.

Current Challenges:

- The replacement of Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS) is looming and significant planning and investment is required to ensure the Trust is ready to be replace the Local Authorities as a Responsible Body in discharging its appropriate accountabilities under LPS.
- Following a recent change in the way training compliance is reported it has been noted that there is significant difference between the compliance rates of permanent staff versus bank staff, particularly at level 3. The team have met with the Workforce Services and Learning and Development Centre teams to address this disparity. Despite this, the safeguarding training figures still demonstrate good compliance (see Appendix E for details.

Current Achievements:

- The Trust continues to recover from the effects of the Pandemic and have been able to return to face-to-face training sessions which provides an enhanced learning environment and greater interaction with staff than the virtual sessions which were mandated during the height of the pandemic.
- All members of the safeguarding team have worked to maintain and develop their knowledge and experience in the role, attending level 4 virtual training, with the support of the Trust.
- Continuing engagement of staff and recognition of safeguarding responsibilities.
- Compliance with the Mental Capacity Act (MCA) has continued to be a trust priority for the last year. An MCA workshop, led by a prominent barrister, was held in October 2021 and is due to be repeated annually.
- Improved connections with West Sussex Safeguarding Adults Board and Safeguarding Children Partnership and the establishment of Child Safeguarding Liaison Group within West Sussex.
- Strengthened Looked After Children safeguarding systems across the trust. QVH Named Nurse for Safeguarding and Looked After Children continued engagement with the network of Looked After Children professionals across Sussex. This has led to engagement with the CCG's participation assistant who is a care experienced young person to capture patient voice within our staff training.

- During this year, the Safeguarding Children's Named Nurse has been working with UHS Paediatrician, Dr Kamal Patel, and two Brighton Medical School students to review the

	MDT database. The retrospective review evaluated the patterns and types of injuries in the population of children where there had been identified safeguarding or child protection concerns. This review will be fed back to the Joint hospital governance group to share learning and identify key themes. • Bespoke training offered to secretarial staff across the trust

2.	Introduction
2.1	Each year a Safeguarding Report is produced for QVH Board to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.
2.2	QVH is registered with the Care Quality Commission (CQC). To be registered, QVH must be assured that those who use the services are safeguarded and that staff are suitably skilled and supported to provide effective safeguarding as part of health care delivery. As a Foundation Trust, QVH is licensed via NHS Improvement, which is conditional upon registration with the CQC. In the last CQC inspection report (2019) the CQC report said: 'There were arrangements to keep service users safe from abuse which were in line with relevant legislation. The majority of staff had received training, were able to identify who might be at risk of potential harm and knew how to seek support or advice', 'Staff understood and complied with the relevant consent and decision-making requirements of legislation, including the Mental Capacity Act, 2005'. QVH must demonstrate that there is safeguarding leadership and commitment at all levels of the organisation and that staff are fully engaged. To support local accountability and assurance structures QVH safeguarding leaders need to engage with West Sussex Safeguarding Children Partnership (WSSCP), West Sussex Safeguarding Adults Board (WSSAB) and relevant commissioners. QVH must ensure a culture exists where safeguarding is everybody's business and poor practice is identified and addressed. Effective safeguarding arrangements must be in place to safeguard children and adults who are at risk of abuse or neglect. These arrangements include: • safe recruitment • effective training for staff • effective supervision arrangements • working in partnership with other agencies • Identification of a Named Doctor and Named Nurse for safeguarding children, plus a Named Nurse for adult safeguarding and Mental Capacity Act lead. The named professionals have a key role in promoting good professional practice within QVH, supporting local safeguarding systems and processes, providing advice and expertise, and ensuring safeguarding training is in place, is delivered and of a suitable quality. They are

	expected to work closely with QVH Chief Nurse, Sussex Designated Professionals, WSSCP and WSSAB.
2.3	The effectiveness of safeguarding systems is assured and regulated by a number of mechanisms. They include: • Internal assurance processes and Board accountability • Partnership working with WSSCP and WSSAB • External regulation and inspection by Care Quality Commission (CQC) and NHS England. • Local safeguarding peer review and assurance processes • Effective contract monitoring
2.4	QVH Board members review monthly safeguarding metrics at the Quality and Governance Committee and receive an annual safeguarding report, which is provided so that the Board can be assured that the Trust is undertaking its safeguarding duties and responsibilities, as well as delivering its statutory safeguarding responsibilities safely and effectively. The Board should critically appraise the QVH safeguarding report by making sure patient safety, staff activity, governance arrangements and safeguarding data are transparent and clear so that they can confirm they are assured.

3.	**Legislative Frameworks and National Safeguarding Agenda.**
3.1	**Safeguarding Adults:** Safeguarding means *"protecting an adult's right to live in safety, free from abuse and neglect" (Care Act 2014).* To implement this Act a three-step test is applied to patient circumstances: 1. does the patient have care and support needs, 2. are they at risk of or experiencing abuse or neglect, 3. as a result are they unable to protect themselves. The arena for safeguarding adults continues to evolve since the implementation of the Care Act (2014). Organisations such as QVH, must comply with the act to stop abuse or neglect wherever possible, prevent harm and reduce the risk of abuse or neglect to adults with care and support needs. They should safeguard adults in a way that supports them in making choices about how they want to live their lives and provide information in accessible ways to help adults understand how to stay safe and what to do to raise a concern. In order for staff at QVH to achieve these aims, it is necessary to ensure that all staff are clear about roles and responsibilities, create strong multi-agency partnerships and support the development of a positive learning environment. As an organisation, QVH adhere to the Sussex Safeguarding Adults Policy & Procedures as this provides an overarching framework to coordinate all activity undertaken where a concern relates to an adult experiencing or at risk of abuse or neglect. These procedures represent

	standards for best practice in Sussex and have been endorsed by Brighton & Hove, East Sussex and West Sussex Safeguarding Adults Boards. They are available online, with links to the website via the internal intranet (QNET). This document is reviewed and updated by the West Sussex Safeguarding Adults Board.
3.2	**Safeguarding Children:** *'The welfare of the child is paramount'* principle was enshrined in the Children Act 1989 and has driven the development of systems and arrangements used to safeguard and/or protect children since that time. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to ensure that services are designed to safeguard and promote the welfare of children. The Section 11 self-audit is required to be completed bi-annually and is due for completion this year. In 2020, all actions were assessed as green, with evidence provided to support the assessment, with the exception of one amber section, which required the creation of a safeguarding supervision policy which is now in place. National guidance also stipulates that each NHS trust must identify a lead nurse for Child Sexual Exploitation (CSE) and Looked After Children (sometimes referred to as 'children in care'). These responsibilities are part of the Safeguarding Children Named Nurse Job Description. The Local authority have requested that we make them aware of any children who are not in education or privately fostered to enable them to undertake their statutory duties; we have ensured that this is completed for all children throughout the geographical area that QVH cover. These are reported in the monthly metrics that go to the board for information.
3.3	**Mental Capacity Act (MCA) 2005 & Deprivation of Liberty Safeguards (DoLS):** The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) have placed an emphasis on ensuring that the rights of vulnerable people (aged 16 and over) to make decisions are protected. Decisions made on behalf of people who lack capacity to do so themselves should only be made using the MCA legal framework. Capacity is described as a person's ability to make a specific decision at a specific time, for example - for specific serious medical treatment or surgery. The DOLS were added into the MCA and is an additional Safeguard providing guidance on procedures that ensures care and treatment for those who lack capacity to consent to their accommodation is only delivered in their best interest and using the least restrictive options to ensure their safety. To be lawful, it needs to be authorized by the local authority, but in the hospital urgent self-authorisation can be used when necessary. QVH staff are required to understand and comply with the requirements set out in the MCA 2005. The QVH Mental Capacity and Deprivation of Liberties Policy was reviewed and updated during 2021. The new QVH orange mental capacity assessment and best interest form has now been used within the Trust for over a year and we are currently testing out whether this works for medical colleagues.

	At year-end compliance rates for Mental Capacity Act training are currently at **92%** across the organisation. A departmental risk assessment for MCA is in place until a clear organisational overview of implementation in practice is embedded. Currently the organisation is aware of cases reported to the MCA lead, but this does not give a full picture of how well the Trust adheres to the MCA. A patient file audit is in the process of being completed in order to gain a fuller understanding of how well the MCA is embedding within the organisation and to see if any changes are needed in the orange form. During the last year the Safeguarding team worked with Psychological Therapies to develop patient information leaflets for 16 & 17 year olds and their families to explain how the MCA applies to this cohort. Implementation of Liberty Protection Safeguards (LPS) legislation to replace DoLS continues to face delays and is not expected to be implemented until Spring 2024. QVH are represented at the Sussex LPS steering group by QVH named nurses. The new legislation will apply to patients who lack capacity from 16 years onwards. There is a departmental risk in place regarding LPS as legal implementation will be required once it starts. The draft legislation is currently out to publication, but it is expected that investment from the Trust will be required to facilitate implementation and manage day-to-day requirements of LPS. Once more is known about the outcome of the consultation a Board Seminar is planned to be held to give board level oversight of this significant change in practice. In order to prepare for the implementation of LPS organisations are encouraged to strengthen MCA knowledge and application. This is being achieved through updating the MCA training slides as well as providing additional bespoke training on DOLS for Matrons, Heads of Nurses and Site Practitioners. This will ensure that we are applying a DOLS to every patient who meets the requirements, meaning we will have accurate DOLS figures to guide us with planning for the implementation of LPS.
3.4	**PREVENT** The United Kingdom's long-term strategy for countering international terrorism is called 'CONTEST'. Published in 2006 and reviewed in 2009, 2011, 2018, its aim is 'to reduce the risk to the UK and its interests overseas from terrorism, so that people can go about their daily lives freely and with confidence'. CONTEST comprises of four key elements: • Pursue: to stop terrorist attacks ~ detecting and disrupting threats of terrorism. It is targeted at those who have committed a crime or are planning to commit a crime. • Protect: to strengthen our protection against a terrorist attack ~ strengthening our infrastructure from an attack including buildings, public spaces and our borders. • Prepare: to mitigate the impact of a terrorist attack. Focuses on where an attack cannot be stopped and aims to reduce its impact by ensuring we can respond effectively. • Prevent: to stop people becoming terrorists or supporting terrorism. 'Prevent' is different from the other three in that it focuses on early intervention before any illegal activity takes place and hence operates in the non-criminal sphere. Involving a broad range of

	partners, it is about minimising the risk, at an early stage, of people adopting extremist views which support violence or terrorism. NHS providers are expected to contribute to the Prevent agenda. The delivery of the '*Prevent*' agenda in the trust, is led by the Safeguarding Named Nurses who are both 'Prevent Leads' for the trust. Level 3 PREVENT training is now delivered via a National eLearning package, compliance for this year sits at 92% (a figure of 85% compliance is required nationally). Prevent basic awareness training is provided to all QVH staff as part of safeguarding training sessions at levels 1 and 2 and is currently uptake is at 90%. The PREVENT approach is explained in the QVH Safeguarding Policy. The Prevent delivery plan which is a tool kit for the Prevent leads is available via the QNET. QVH report Prevent data to NHS England quarterly, no Prevent referrals were made during 2021-22. The Named Nurses represent QVH at the Prevent Leads Meeting run by the Clinical Commissioning Group Designated Nurse for Safeguarding Adults.

4.0	**Sussex Clinical Commissioning Groups (CCGs) Safeguarding Standards**
	During 2016-2017 the CCGs used the *Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework* (March 2013, updated 2019) to produce a set of Sussex Safeguarding Standards to make explicit their expectations of NHS providers in relation to safeguarding. The CCGs across Sussex have in place quality and safety systems, and processes in order to enable continuous improvements and the 'safeguarding standards guidance' now forms part of these arrangements. The nine standards were developed to enable assurance to be provided to demonstrate patients of all ages are safeguarded effectively. The standards enable all parties to identify key benchmarks to ensure an effective, systematic, auditable approach to enable the safeguarding of all patients, whatever their age. The Sussex standards were reviewed and updated by the CCGs during 2019.These standards were shared with QVH Board at a safeguarding seminar during November 2019, this is due to be repeated in 2022. The standards enable the safeguarding team at QVH, as well as commissioners to audit against benchmarks to ensure effective measures are in place. This section of the report is organised based on these standards. Additional standards for Looked After Children have been added which the safeguarding team reports on via the CCG exception reporting system.
4.1	**STANDARD 1: Strategic Leadership**
	The Executive Board Lead for safeguarding vulnerable people, MCA & DOLS is the Chief Nurse who oversees compliance with safeguarding legislation and trust responsibilities. The purpose of this role is to monitor protection of people who use services at QVH and to ensure these are understood by staff and implemented throughout the organisation**.**

The QVH Safeguarding Strategy (updated 2021) supports a progressive response to the changing landscape framing the delivery of healthcare services at QVH. An action plan sits under this strategy and this can be reviewed in Appendix A.

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

The Safeguarding team currently links with the Designated nurses and the wider Sussex safeguarding network via regular meetings to ensure that QVH is kept updated on the fast-changing local safeguarding picture. The safeguarding team disseminate relevant information to staff in a timely way.

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

- Nicky Reeves, Chief Nurse , Executive Board Lead for Safeguarding
- David Johnson, Named Nurse for Safeguarding Adults (covers: Adults, MCA & DoLS Lead and Prevent Lead)
- Katy Fowler, Named Nurse for safeguarding Children (covers: Children, Child Sexual Exploitation (CSE) lead and Looked After Children (LAC) lead and Prevent Lead)
- Ms Tania Cubison, Named Doctor Safeguarding.
- Debra Yeoh, Nurse Specialist Safeguarding Children.

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

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

Across QVH there is a network of link champions for safeguarding from service areas. They attend a safeguarding steering group to discuss clinical issues, access information, review learning and to share practice improvement across the organisation. An example of the link champions work within the steering group is new domestic abuse posters, providing patients with information and sources of support; they are designed to signpost people to relevant help regardless of how they identify. These posters are awaiting approval and will be rolled out shortly across patient facing areas within the trust.

The Joint Hospital Governance Group provides a far-reaching internal audience where safeguarding discussions can be undertaken, such as sharing learning from Safeguarding Reviews and Audit, and how improvements in practice might be applied in QVH. It is a useful conduit for learning from case examples and experiences. The results of the Child not brought for appointment audit was reported back to this group to ensure maximum exposure and awareness of this important issue across the trust.

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

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

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

Sussex Looked After Children NHS Professionals Network:
This newly formed pan-Sussex group is chaired by a Sussex Designated Nurse for Looked After Children. The group includes named nurses for looked after children from across Sussex, like the safeguarding health forum, it provides an arena for sharing learning and discussing challenges as well as working together to drive improvements for this cohort of children and young people. The looked after nurses designate team have, through the CCG recently employed two care experienced young people through the 'kick start' programme. Through this forum the QVH Named Nurse for Looked After Children has linked in with these staff members to enhance QVH training about this cohort.

Child Safeguarding Liaison Group (CSLG)
This is a subgroup of the WSSCP. It is a multi-agency group which considers joint working practice in respect of child safeguarding arrangement, improving joint working and enhancing good communication and relationships. It is co-chaired by the Sussex Designated Doctor and a senior children's social care manager. Complex, non-urgent cases from West Sussex can be reviewed and identify changes that are required specific to that case and wider learning for the safeguarding system.

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

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

Safeguarding supervision is offered to all QVH staff as required on a case-by-case basis, supported by QVH safeguarding supervision policy. The safeguarding team also offer bespoke training sessions for teams or individuals via discussions in team meetings, most recently the secretarial teams from the trust specialities have attended bespoke safeguarding and MCA training. The purpose of these activities is to strengthen communication, networking and dissemination of safeguarding information and practice across the organisation.

	Safeguarding supervision is provided to the Safeguarding team on a regular basis by the Sussex Designated Nurses team for Safeguarding Children and Adult Safeguarding Named Nurses. Staff are provided with support to manage any concerns they raise. Human Rights: Protecting the vulnerable and those at risk, is a key component of our trust objectives. Focussing on quality and patient experience we work alongside partner agencies to promote the safety, health and well-being of people who use our services. QVH has effective systems in place to highlight and respond to shortfalls in capacity which have an impact on the ability to meet safeguarding responsibilities. These are highlighted to the board through the internal DATIX reporting system, and regularly discussed at the strategic safeguarding group meetings and reviewed by the Safeguarding Named Nurses. There is currently no safeguarding corporate risks. There are three safeguarding departmental risks: • Not able to demonstrate full compliance with implementation of the MCA, currently data captured on the Datix system covers cases brought to the attention of the safeguarding team (risk rating 9 - LOW) Nursing and Quality department. MCA quality priority was in place this year, details are outlined later within this report. • MIU risk (Risk rating 6- LOW) relating to access to previous information held in the trust about patients re-attending. Staff in MIU do not access the full records of patients when they attend, this poses a risk in terms of safeguarding. Work is underway to mitigate the risks including health records now amalgamating individuals MIU records from January 2021. The trust has implemented EMIS, an integrated community facing system where primary care information is available for MIU staff to access. However, this system has not provided the information from the GP system that had been hoped for. The longer term aim is for the MIU team to have access to EVOLVE. This risk is monitored at the Strategic Safeguarding Group. MIU now uses Electronic Discharge Notification (EDN), which ensures that robust discharge information is shared with the GP and Health Visitor (as appropriate) about the episode of care and any concerns raised. • The introduction of Liberty Protection Safeguards (LPS) to replace DOLs during 2022. Corporate risk (Risk rating 9): legislation due to be implemented in 2022. Records will be subject to legal scrutiny for this aspect of care delivery. QVH safeguarding team are involved in the Sussex-wide LPS steering group.
4.2	**STANDARD 2: Lead effectively to reduce the potential of abuse**
	QVH has policies, processes and procedures in place to enable staff to manage and when required to report any concerns they have for patients or members of the public attending QVH sites. If their concerns are not heard there are escalation processes which can be used. Training and procedures help to highlight how people's diversity, beliefs and values may influence the identification, prevention and response to safeguarding concerns. The QVH safeguarding 'documents and information overview' is provided for the organisation in APPENDIX D to

demonstrate interaction between a range of policies and procedures when safeguarding is might be under consideration.

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

The Datix data collection system captures safeguarding (adults and children) practice and learning across the organisation. Safeguarding Datix reports are shared across the organisation to aid case discussion and to share learning via the Steering group.

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

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

- QVH safeguarding children and young people leaflet for families.
- Information leaflet regarding attendance at the trust with dog bite injuries for all patients.
- Next of Kin: understanding decision making authorities
- Mental Capacity Act Guide for patients and their families
- Young People in Work experience from Health and Safety Executive. This can be provided for those YP who are injured at work
- Deprivation of Liberty Safeguards and you.
- Parental Responsibility
- Children missing in education
- MCA for 16 and 17 year olds; a parent's guide.
- MCA for 16 and 17 year olds; a young person's guide.

In response to three disclosures of historical abuse the Safeguarding Team are producing additional leaflets to support patients who disclose historical abuse allegations. The remit of the safeguarding team in this matter is to encourage the individual to report the allegation to the police as well as safeguard any other vulnerable adults, young people or children who may still be at risk from the perpetrator.

QVH posters and leaflets encouraging patients to talk to staff, clinical managers, PALs and the safeguarding team if they have any concerns about a patient are available across the hospital site. We have designed a domestic abuse support poster which, once approved, will be available in all patient facing areas. .

During 2020 the CCG launched ICON throughout Sussex, this programme addresses infant crying. Its aim is to prevent abusive head trauma and is evidence based. We have supported the key messages of ICON by having posters available in key areas within the trust for parents to see, we also include this in training.

4.3	STANDARD 3: Responding effectively to allegations of abuse
	QVH have arrangements in place to ensure that patients are safeguarded by responding appropriately to any allegation of abuse or neglect. Safeguarding Adults Activity The Safeguarding Named Nurse receives notification of any safeguarding concerns relating to adults via email or the DATIX reporting system. Each concern raised is reviewed and investigated. Process issues and learning from each event is now shared using monthly and quarterly safeguarding Datix Reports. This approach provides oversight of all safeguarding adult referrals made to social care services across the region. The table in Appendix E provides details of the monthly safeguarding adult activity reported on DATIX for the past year. Safeguarding Children Activity The Children's Safeguarding Team receive reports of any safeguarding children concerns, which occur within QVH via email and through DATIX. These are followed up by the Children's Safeguarding Team; providing support for staff managing these situations as well as a means to review case management, following up outcomes with statutory partners and to enable learning to be shared. The QVH Electronic Document Management system (Evolve) is currently being used within the trust. There is a safeguarding section available, should it be required, for all patients, which can be used to file safeguarding information to make sure it is available for staff seeing the patient. There is an access audit system in place so that all access is monitored. During training staff are encouraged to check the safeguarding tab if it is relevant to do so. The safeguarding children named nurse worked to redesign the safeguarding concerns record sheet to ensure that this section is automatically uploaded to the safeguarding section on EVOLVE, this seems to have embedded well. An adult safeguarding documentation form has been developed over the past year and has been approved to be used. There are now plans for this to be rolled out across the Trust and training provided to embed the use of this form alongside EVOLVE. The safeguarding section in QVH Electronic Discharge Summary was to be audited this year but this has been delayed because of the pandemic. The purpose of this section is to enable handover of care to GP and other community health services; this has been delayed. The National Child Protection Information systems (CP-IS) is used by Minor Injuries Unit and Peanut Ward to check whether children or young people have a child protection plan or are looked after by a local authority. This national database provides the means for robust communication regarding vulnerable children across and between NHS and local authority systems nationwide, although there are limits to the system. There has been some work this year to integrate the CP-IS check into patient centre, rather than staff having to access this separately, as is currently the case. The information governance lead safeguarding children named nurse have been in contact with NHS EI to discuss how this can be done, ensuring that only the correct children (unscheduled children as per the current information sharing agreement) are being checked. This is being monitored by the Strategic Safeguarding Group.

	When Looked After Children attend the hospital for treatment, staff check who can provide consent, contact details for their Social Worker and which Looked After Children nursing team to liaise with. QVH safeguarding training includes Looked After Children and is backed up by QVH prompt cards. These cards also provide guidance on managing information regarding privately fostered children as well as for those in the care of a local authority. The QVH safeguarding team have taken advice from the Looked After Children Designated Nurse system regarding special guardianship orders and record keeping requirements. All QVH safeguarding concerns are captured on the DATIX system for recording purposes only. Enabling monthly Board metric reports to be provided to the Director of Nursing and Clinical Governance group. See Appendix B for overview of paediatric safeguarding activity during the past year <u>Allegations Against Staff</u> The Director/Deputy Director of Human Resources would be involved in the management of the Trust response to any allegations against trust staff. *'Allegations against staff'* procedures are followed. During the last year, there have been two queries that have been discussed with the Local Authority Designated Officers; no further action was required. . We do not currently have any National *Allegations against staff* data with which to compare against other trusts.
4.4	**Standard 4: Safeguarding practice and procedures**
	The Safeguarding Team develop a wide range of documents for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. For a list of what is in place for QVH please refer to Appendix B. Documents are placed on the Website or QNET intranet. All documents are systematically reviewed and updated in collaboration with relevant services and governance groups. Information is monitored and reviewed regularly and updated on the QNET, including information on who to contact for advice and support. QVH prompt cards have been updated in 2020 and are available on the Intranet for staff. The safeguarding team plan to review the QNet safeguarding and MCA pages to make them more user friendly. <u>Safeguarding referral:</u> All safeguarding referral forms are now provided on line by local authorities, staff are supported to complete these when help is requested. QVH has seen an increase in safeguarding and child protection referrals to children's social care departments across the region. This may be due to an increase in incidents where parent's behaviour whilst in hospital has raised concerns in relation to the impact this may have on their children. Specifically this has been in relation to QVH's "one parent policy" which was implemented due to the Covid pandemic.

Restrictive interventions:

When a patient is identified as needing any form of control, restraint or therapeutic holding staff need to follow hospital policy. In the last year existing policy has been reviewed but not yet launched. This is a complex aspect of practice and it is important to get the right advice and guidance in place.

The children's restrictive interventions and therapeutic holding policy is ready to launch, but has been delayed until the launch of the adult safer holding policy. Advice has been taken from the Designated Team on how best to approach the problems being faced by staff. It comes down to interpretation of MCA or Mental Health legislation.

MCA:

All QVH staff are required to understand their legal responsibilities under the Mental Capacity Act including undertaking mental capacity assessment, best interest decision making processes and when to complete a DoLs process. MCA data is no longer captured on the Datix system as this fails to give an accurate reflection of the total number of best interest's decisions across the Trust. A quarterly audit cycle, will instead, be used to provide assurance of the Trusts compliance with the MCA by focussing on the quality of the completed orange MCA forms. This audit will also provide the first opportunity to critique the orange forms since their implementation and identify any amendments required to aide usability for the clinicians.

Domestic violence and abuse (DVA)

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

The QVH psychological therapies team and some of the QVH safeguarding team can undertake Domestic Abuse Stalking Honour (DASH) risk assessments to help inform next steps to protect patients. Worth DVA specialist services and the police can provide advice and support to staff at QVH. Staff have recently sought advice and support from Worth services in relation to a patient and were able to signpost them to local specialist services.

Patient DVA procedures are in place. Staff experiencing DVA policy is in place. One member of staff who experienced DVA has been supported this year.

The safeguarding team are working with a specialist DVA charity to deliver some bespoke domestic abuse training for QVH staff. The subject of DVA is highly sensitive and staff need to feel empowered and confident to approach this issue with their patients, the charity will provide specialist training which focuses on identifying and talking about DVA as well as risk assessing and safety planning for victims of DVA.

Safeguarding Audit

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

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

During 2019-20 Max-fax adult safeguarding and Safeguarding referrals audits were undertaken as part of a rolling programme of safeguarding team audits. This audit has now been repeated in 2022 but across all medical staff, the results of this audit are yet to be reported. This is to provide opportunity for shared learning and peer scrutiny with a wider audience.

Child Sexual Exploitation and Criminal Exploitation.

Recognition of Child Sexual Exploitation (CSE) or child sexual abuse requires careful assessment and consideration when concerns arise. The Safeguarding Children Named Nurse is the CSE lead for QVH and supports staff to access specialist support if required.

Staff within MIU have a 4 question-screening tool available to them when they have a concern about sexual exploitation.

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

Looked After Children.

Looked after children or Children in Care are a group of children and young people who are cared for by the local authority. This cohort of children often have increased health risks and may have significant emotional and physical health needs. Part of our role is to promote recovery, resilience and well-being in these children.

Looked After Children may be accommodated under various court orders or voluntary agreements. There can be consent implications for these children, clinicians need to understand what agreement is in place for each child.

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

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

Modern Slavery

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

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

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

The Trust has not been informed of any incidents of slavery or human trafficking during the year.

	The Trust supply chain entails the purchasing of goods and services that support the operation of our core business of healthcare. Consumables purchased include medical supplies and equipment, office supplies, marketing materials, ICT equipment and estate and facilities services such as cleaning, waste management, office fixtures and fittings, security services and uniforms. Operating with integrity governs our approach and therefore our aspiration to be recognised by our stakeholders as an organisation which is a responsible corporate citizen in all our relationships. The NHS Standard Terms and Conditions 2018 are referenced on all Trust purchase orders which include clauses around anti-slavery and human trafficking. The Trust also, where possible, will use the NHS Standard Terms and Conditions 2018 for its contracts or use NHS Framework Terms and Conditions. The Trust is committed to better understanding its supply chains and collaborating with stakeholders to improve transparency of its arrangements to ensure adequate safeguards in place to prevent incidents of slavery or human trafficking. The Trust's recruitment and selection procedures include appropriate pre-employment screening of all staff to determine right to work in the UK, and all salaries are above the National Living Wage. All employment agencies that are engaged also meet these standards as a minimum entitlement. In the event of a patient possibly experiencing slavery or human trafficking staff need to carefully assess the situation using translation services and seeing the patient alone. Data relating to these aspects of safeguarding are collected by the safeguarding team. The Modern Slavery Protocol (2020) is available on Qnet and explained in more detail during mandatory safeguarding training. <u>Working with QVH communications team:</u> The safeguarding team have close links with the communications team at QVH where there are strict guidelines for dissemination of information internally for all staff across the organisation, including updates and reviews.
4.5	**STANDARD 5: Staff competence**
	Driving improvement in all aspects of safeguarding practice is a continuous process and as such has to be reviewed, evaluated, developed and adapted over time. There is a safeguarding learning and development strategy for the organisation to steer and facilitate staff competency development in all aspects of safeguarding. Level 1 and 2 safeguarding training incorporates both adult safeguarding, child safeguarding and MCA into a single 'think family' approach to allow staff to be updated on all safeguarding issues as it is important to recognise the complexities and interconnected nature of safeguarding . We continue to offer level 3 Adult and Child Safeguarding sessions separately for consultants and those members of staff who require this additional level of training. These sessions are undertaken twice yearly. Staff needing to meet the training requirements outlined in the intercollegiate document also have the opportunity to access other level 3 training off site, as part of their personal development, including those run by the local safeguarding Boards, external conferences and workshops.

	This year, the CCG has provided some level 4 training opportunities in looked after children and safeguarding children, the most recent topic has been the role of the Local Authority Designated Officer (LADO). Level 4 training for Adult Safeguarding has also been provided and completed by the Adult Safeguarding Named Nurse. This level of training is required by the safeguarding team to ensure they are kept up-to-date in such a dynamic environment. Due to the Covid pandemic all training, levels 1, 2 and 3, were provided virtually via MS Teams, the safeguarding team has reintroduced face-to-face training across levels 1 and 2 to encourage participation and maximise learning. Level 3 training continues to be online via MS Teams. Evaluations are gained during standalone or refresher sessions, but are evaluated as part of induction when they are delivered as part of this. Responses evaluate the training well, although some staff feel there is a lot of information covered during the three hour level two session. Overall staff have expressed a preference for one joint session rather than two separate adult and child sessions. **Safeguarding Learning and development Strategy.** QVH Safeguarding learning and development strategy was reviewed and updated in 2021. This document is aligned with the core skills framework document and with national guidance from the NHS England regarding roles and competences for health care staff – from 4 intercollegiate documents (Prevent, LAC, Adults and Children). It makes transparent QVH expectations for staff including the Board with regard to safeguarding training and development. **Safeguarding Training:** **See Appendix E for training compliance data, moving forward data will be captured and reported on overall staff compliance and compliance for non-permanent staff.** **Safeguarding Responsibilities** All staff job descriptions include a safeguarding section which identifies responsibilities for safeguarding and these are reviewed through an annual appraisal and personal development planning process.
4.6	**STANDARD 6: Safer recruitment**
	QVH work to ensure that those working or who are in contact with children, young people and adults are safely recruited and Human Resource processes take account of the need to safeguard and promote the welfare of all. Making sure that QVH do everything we can to prevent appointing people who pose a risk to vulnerable people is an essential part of safeguarding practice and QVH recruit staff and volunteers following safer recruitment procedures. All staff at the Trust are employed in accordance with the NHS Employers safe recruitment pre-employment check standards. As part of their induction, new employees, including volunteers are expected to undertake mandatory training in safeguarding at either level 1, 2 or 3 or be able to provide evidence that this has been completed at another trust within the last 3 years. During the year a decision has been made between the Chief Nurse, Safeguarding Team and HR to change the Disclosure and Barring Service (DBS) requirements for all clinical staff to have enhanced checks for both adults and children. The rationale for this change is that children are

	treated in other areas of the hospital outside of Peanut ward and occasionally staff are asked to move between adult and children areas.
4.7	**STANDARD 7: Learning from incidents**
	Statutory Safeguarding Reviews: Safeguarding Adult Reviews (SAR) Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. QVH were not directly involved in any SAR during 2021-22. Learning from SARS outside of QVH is shared at safeguarding groups if relevant for care delivery. Child Safeguarding Practice Reviews. When a child dies or is seriously harmed, including death by suspected suicide, and abuse or neglect is known or suspected to be a factor in the death, West Sussex safeguarding Children Partnership (WSSCP) is required to conduct a Safeguarding Practice Review into the involvement of organisations and professionals in the lives of the child and the family. The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and, as a consequence, improve multi-agency working to better safeguard and promote the welfare of children. QVH were not directly involved in any Child Safeguarding Practice Reviews during 2020-22. Child Death Reviews. The WSSCB is also required to conduct a review of every child death to identify whether there are any lessons to be learned to prevent child deaths in the future. QVH has not contributed to any child death reviews this year. Other types of reviews. The WSSCP carry out a range of learning activities in order to understand how to improve safeguarding. This includes reviews into individual cases and reviews of practice across areas of safeguarding. QVH has not contributed to other case reviews during the year. **Learning from Internal Safeguarding Incidents** All safeguarding interactions are reported via Datix by either the staff member or the safeguarding team. This ensures incidents are captured and reported to relevant governance forums for scrutiny and learning. Incident themes & patterns are identified by the safeguarding team which enables policy and procedures to be updated and learning disseminated through training and the Safeguarding Steering Group.

4.8	STANDARD 8: Commissioning

Contract Monitoring -Sussex Clinical Commissioning Groups (CCG's) / ICB Safeguarding Standards

CCG's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective safeguarding arrangements in place.

A self-assessment tool is completed bi-annually for adult safeguarding and also a section 11 self-assessment audit for safeguarding children. These contribute to providing evidence of assurance in conjunction with assurance site visits and submission of quarterly exception reports.

In 2020, QVH completed the bi-annual safeguarding children's self-assessment audit. This is due to be repeated during 2022, but has been delayed due to the changes within the CGG.

The WSSAB conducted a Safeguarding Adults Self-Assessment Audit and a subsequent Multi-Agency Peer Challenge Meeting in January 2022 with the aim of sourcing the assurance needed for safeguarding activity across the partnership. QVH engaged in this process and were asked to RAG rate the organisations safeguarding practice across a number of domains including;

- Making Safeguarding Personnel
- Learning & Organisational Development and Leadership
- Governance & Accountability

QVH self-assessed all areas as green and faced no significant challenge from peers or the WSSAB during the meeting.

CCG exception reports are provided by QVH Safeguarding Team in April, July, October and January of each year.

No issues of concern were raised during the last year.

External regulation and inspection by CQC and NHSE

QVH CQC re-inspection during February 2019 overall the Trust sustained 'good' rating and also an 'outstanding' for care. There was no concerns raised regarding safeguarding.

The CQC reported: 'Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. They were knowledgeable about the issues and priorities for the quality and sustainability of the service, understood the challenges and how to address them. All staff we met spoke positively about the leadership, both at local and executive level. They described leaders as being visible and approachable and supporting them to deliver the best possible patient experience.'

Any safeguarding issues or concerns raised against QVH are captured and reported to the Board alongside the Board's monthly safeguarding metrics.

• No specific paediatric safeguarding concerns were raised against QVH during the last year.
• Two adult safeguarding alerts were raised regarding QVH patient care during 2021-22.

Details are captured on Datix and reported in the monthly Board metrics, as well as the outcomes from these enquiries being scrutinised in Strategic Safeguarding Group

4.9	**STANDARD 9: Safeguarding data requested by Department of Health**
	Female Genital Mutilation (FGM) Understanding of FGM and mandatory reporting duty is incorporated into QVH mandatory safeguarding training for staff. DH/NHS approved and recommended FGM e-Learning packages are also available to staff to enhance their knowledge and understanding of this subject and required practice. FGM guidance and information, with particular regard to risk assessment, mandatory reporting and recording, can be accessed by staff via the Trust QNET Safeguarding page. QVH has completed one FGM risk assessment during the last year, resulting in a referral to children's social care. There have been no patients identified as having undergone FGM. Prevent Returns QVH submit quarterly reports to Regional Coordinator at NHS England with prevent information which reflects the number of prevent referrals and details of staff compliance with training. This information is also copied to the CCG / ICB for assurance. At QVH no PREVENT referrals were made during the last year.

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

6.	**Safeguarding Learning from Experience**
	Safeguarding learning and development is a continuous process; there are a number of key regular routes for this to occur. Experience without reflection does not always result in learning. It is through the reflective process that meaning is created and new insights gained. During the year: Patient case studies are regularly reviewed at Safeguarding Steering group. Learning is then shared more widely by Safeguarding Link Staff. This approach has been

	supported by minutes and also the use of the Datix reports for Adult Safeguarding, Safeguarding Children and MCA. QVH specific case studies form the basis of the safeguarding training at all levels within QVH. Complex cases are also taken to the Joint Hospital Governance group and other governance groups for review and reflective learning. Feedback back from other agencies, peers, patients and their families either written or verbal is used as part of safeguarding discussions to enable staff to understand the impact of care provided whilst at QVH. QVH safeguarding team have worked with UHSx paediatrician and Brighton Medical School student to review our MDT database to retrospectively review the cohort of paediatric burns patients where there were safeguarding concerns raised.

8.	**Recommendations**
	Below are recommendations identified by the Safeguarding Team for the Trust Board to consider, enabling QVH to continue to discharge its appropriate accountability for Safeguarding children, young people and adults at risk of harm or abuse. • Working with the safeguarding medical lead to improve engagement with medical colleagues around training compliance. • Robust planning and investment for the implementation of LPS. • Evolve – standardisation of patient information systems and documentation methods across the trust, in order to reduce the risk of duplication and risk of information not being shared between departments. • Investment in external specialist training and release of staff from clinical duties to facilitate attendance.

9.	DELIVERING THE QVH SAFEGUARDING STRATEGY

QVH Safeguarding strategy was updated during 2021. The Trust is now at the point where safeguarding systems and arrangements are well embedded and delivery of the safeguarding agenda focused on the following priorities in 2021/22:

Priority 1: Collaborative Working focussing on:

- Engagement with WSSCP
- Information sharing and Monitoring of safeguarding concerns
- Looked After Children pathways
- MCA pathways

Priority 2: Learning and Embedding into Practice focussing on:

- Risk assessment and record keeping
- Understanding of MCA and Introduction of LPS to replace DOLS
- Recognition and management of exploitation concerns
- Continuing to embed prevention and recognition of neglect

Priority 3 Assurance and Engagement focussing on:

- Compliance with safeguarding policy and procedure
- Person centred approaches

Annual priorities are updated each year and will align where appropriate with WSSAB and WSSCP objectives, they will also take into account PREVENT and Looked after Children priorities.

10.	Conclusions and assurance

Incorporating safeguarding legal frameworks into every day clinical practice is a continuous process. Safeguarding patients and their families is everybody's responsibility.

All health care at QVH is patient centred and the safeguarding agenda aims to raise awareness of staffs roles & responsibilities to ensure effective safeguarding is provided to protect vulnerable patients whether they are children, young people, adults or other family members. Concerns identified are dealt with promptly and comprehensively and proportionately with learning from incidents shared throughout the organisation via Steering Group, training and supervision. The safeguarding team work closely with the Chief Nurse to provide strategic oversight for the organisation as well as working in partnership with other agencies to provide external assurance, peer review and information sharing. Processes are continually reviewed in order to prevent abuse or neglect taking place within the organisation such as safe recruitment and whistleblowing policy.

11.	Report approval and governance

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

APPENDIX A
TITLE: Safeguarding Strategic Group Action Plan

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

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

Strategic Objective	Actions required to meet objective	Rating (RAG)	Evidence
1. Collaborative Working	1. Engagement with WSSCP 2. Information sharing and Monitoring of safeguarding concerns 3. Looked After Children pathways 4. MCA pathways	Green	1. Attendance by Safeguarding Named Nurse and chief Nurse at WSSCP 2. Now established as part of regular practiced. Evidenced in referrals audits, use of CP-IS and patient documentation. 3. Strengthened knowledge and understanding of Looked After Children pathways by attendance at meetings and engagement with participation assistant to support training for staff. 4. MCA Orange booklet now well embedded. Specialist training provided by Barrister and MCA expert Alex Ruck-Keen. Advice regularly provided to Consultants by MCA Lead.
2. Learning and Embedding into Practice	1. Risk assessment and record keeping 2. Understanding of MCA and Introduction of LPS to replace DOLS 3. Recognition and management of exploitation concerns	Green	1. MDT approach to risk assessment for Burns injuries. Paediatric & Adult safeguarding paperwork ensure that information is captured in the correct sections, is easily accessible to staff and provides prompts. EDN section provides opportunities for information sharing with other professionals. 2. LPS implementation delayed. MCA and DoLS training increased to prepare for implementation of LPS.

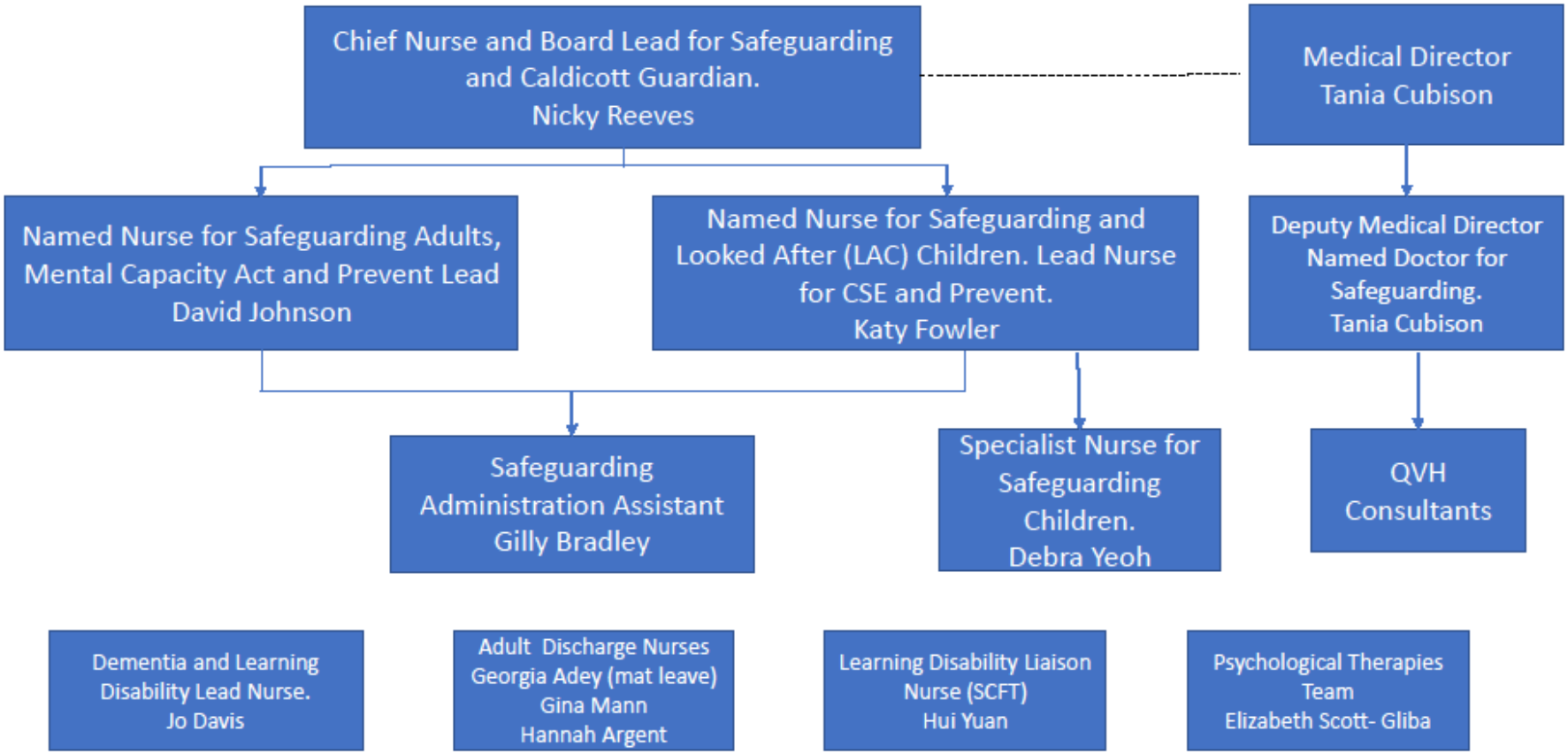
	4. Continuing to embed prevention and recognition of neglect		3. Discussed case examples through training and group meetings. Modern Slavery protocol in place. 'Four questions' Child Sexual Exploitation questions embedded within MIU paperwork. 4. Neglect case studies are covered during all levels of training. Neglect assessment tool available for staff. *How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales* by Alcohol Change UK shared with staff.
5. Assurance and Engagement	1. Compliance with safeguarding policy and procedure 2. Person centered approaches	Green	1. Referrals audit demonstrates good compliance with referral criteria. Children not brought for appointment has also been audited and results presented to JHGM with recommendations. Good compliance for safeguarding training at all levels. 2. Making safeguarding personal is now a key component of Adult safeguarding training. Consent is comprehensively covered in both safeguarding and MCA training. Referrals audit demonstrates good compliance with MSP principles in line with West Sussex Safeguarding Adults Referrals Standards.

DELIVERING THE STRATEGY

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

APPENDIX B

QVH safeguarding team structure chart.



APPENDIX C SAFEGUARDING AUDIT PROGRAMME 2021-2022, 3 year cycle

QVH rolling safeguarding audit programme

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

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

2020 topic/s	**Progress**	**Next steps**
NICE CG89 when to suspect child maltreatment audit	Underway survey monkey	Completed
NICE DVA (PH50 and QS116)	Underway survey monkey	Completed
Referrals audit Adult children	Due September 2020	
LAC (CIC) ready for records audit	Identify children on DATIX recording system – this is being done	Designated professionals have not progressed this audit

2021 topics		
Survey monkey topics		
Restrictive interventions awareness to inform training	Prepare September 2020	Delayed until policy is finalised- Liz Blackburn (HoN) leading. Heads of nursing to complete.
MCA audit	February 2020	Report pending
NICE CG89 when to suspect child maltreatment audit	Repeat March 2021	Repeat delayed due to Covid

NICE DVA (PH50 and QS116)		
West Sussex Safeguarding Children Partnership multi-agency exploitation audit.	Summer 2021	QVH has completed and submitted audit tool, no further action required as QVH data falls outside of scope of audit.
File audits		
Evolve and records safeguarding sections audit Children Adults	Prepare December 2020	This issue was identified as a concern when safeguarding section was not being populated with the safeguarding paperwork. The safeguarding team have worked with Evolve to design new paperwork with a barcode on the top to ensure that safeguarding documentation is filed correctly. No audit currently required.
Referrals audit Adult children	December 2021	Completed.
Child not brought to appointment audit	July 2021	Completed.

2022 topic/s	**Progress**	**Next steps**
Referrals audit Adult children	Due Dec 2022	
NICE CG89 when to suspect child maltreatment audit NICE DVA (PH50 and QS116)	Repeat March 2021	Repeat delayed due to Covid. Underway April 2022
MCA file audit	June 2022	
Discharge EDN audit (safeguarding section)	Dec 2022	
Child not brought to appointment audit	July 2022	

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

QVH SAFEGUARDING DOCUMENTS AND INFORMATION 2022

1.	Item	Date	Location	Next Review
1.1	QVH assurance statement	2022	Website	2025
1.2	QVH safeguarding strategy	2022	Website	2023
1.3	QVH Website and QNET	ongoing	Intranet	Ongoing review and update as required by QVH safeguarding leads
1.4	Sussex Child Protection and Safeguarding Procedures	Updated on line	Link via QNET	Ongoing review and update as required by WSSCB
1.5	Sussex adult safeguarding procedures	Updated on line	Link via QNET	Ongoing review and update as required by WSSCB
1.6	QVH safeguarding annual report	2021-22		April 2023
1.7	QVH and BSUH Paediatric SLA			Copy with Chief Nurse
1.8	QVH Safeguarding Strategic Group terms of reference	April 2022		Due April 2023
1.9	QVH Safeguarding Steering Group terms of reference	January 2022		Due January 2023
1.10	QVH safeguarding prompt cards for staff	June 2020		Review 2023 or sooner if required.
1.11	QVH Safeguarding Learning and Development strategy	2022	QNET	Jan 2025
1.12	QVH safeguarding risk assessments	ongoing	Overseen by strategic safeguarding Group	Dashboard updated quarterly
1.13	CCG exception reports- ASG	Ongoing	Overseen by strategic safeguarding Group	Jan, Apr, Jul, Oct
1.14	CCG exception reports- SGC	Ongoing	Overseen by strategic safeguarding Group	Jan, Apr, Jul, Oct
1.15	National Prevent reports	Ongoing	Overseen by strategic safeguarding Group	Jan, Apr, Jul, Oct
1.17	Combined safeguarding policy	Spring 2022	QNET	Review 2025

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

APPENDIX E

QVH Metrics for The Board – Safeguarding, MCA & Prevent (April 2022)

Item	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	August 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	April 2022
Adult SG Activity	9	13	8	5	10	11	8	6	11	5	4	6	6	3	3
*MCA assessments *See notes*	6	16	10	5	20	23	15	20	21	30	34	24	11	5	N/A
Adult SG s42 regarding QVH		1	0	1	0	0	0	0	0	0	0	0	1	0	0
Paediatric safeguarding activity	17	36	34	33	29	21	27	34	19	43	37	33	27	25	31
Allegations against staff	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Support for staff possible DVA	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
DVA cases	1	4	0	0	1	2	0	0	1	0	0	0	0	1	1
Modern slavery/exploitation cases	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0
DASH Risk assessments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MARAC referrals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FGM Risk Assessments undertaken	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Children S/G practice reviews	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Safeguarding Adult Reviews	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Prevent Referrals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Pressure Damage grade 3/4	1	0	0	0	1	0	0	0	2	1	0	0	0	0	0
MCA BI decisions	2	11	6	5	10	10	10	19	16	20	15	14	5	3	N/A
MCA DOLS	0	0	0	0	0	0	2	0	0	1	0	0	1	0	0
IMCA	1	2	0	0	2	4	1	0	1	0	4	0	0	0	0
LPA in place							2	6	4	6	11	9	2	2	N/A
Adult SG Training level 1	94	94	96	96	94	95	95	94	94	94	94	95	94	94	92
Adult SG Training and MCA Level 2 **Permanent Staff*	96	96	96	96	94	94	94	94	94	94	94	94	94	94	93
Adult SG L3	94	94	95	95	93	93	92	93	96	95	94	91	81	82	78
WRAP Training L3 Prevent ELearning option added April 2018	93	92	93	92	92	92	94	94	94	93	93	93	94	94	91
Paediatric SG and LAC L1	94	94	96	96	95	94	94	94	93	93	93	93	94	94	93
Paediatric SG and LAC L2	96	96	96	96	94	93	94	93	93	92	91	91	93	94	92
Paediatric SG and LAC L3	90	91	92	92	91	94	90	88	88	88	90	88	91	91	87

TRAINING Data:

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

Adults Safeguarding Commentary:

3 Adult safeguarding case details taken from DATIX ,

- Apr 2022- 0 cases referred to local authority.
- 0 Modern Slavery cases referred to police,
- 0 Asylum Unit patients
- 0 Adult DVA cases reported to police
- 0 Missing records
- 0 reported to Police - Adult dog bite cases

S42 referrals raised regarding QVH

- February 2023 – Patient attended MF Trauma Clinic as outpatient, ESHT A&E assumed patient was being transferred as inpatient. S42 raised as unsafe discharge as patient has dementia and was sent with instruction for soft diet for 6 weeks. Currently investigating.

Paediatric Safeguarding Commentary:

- 31 Paediatric safeguarding case details taken from Datix
- 1 Case referred to social care by QVH
- 10 Cases referred/known to social care prior to transfer to QVH.
- 1 Dog bite cases referred to police,
- 6 Home schooled child.
- 3 Looked After Children identified.
- 0 Privately fostered children identified.
- 0 Input into strategy discussions / professionals meeting.
- 2 Requests for release of records.

MCA data taken from DATIX

Currently reviewing how MCA data is captured. Planned to move away from DATIX reporting to a quarterly audit programme. Therefore numbers recorded for April 2022 reflect MCA Lead involvement only.

Report cover-page					
References					
Meeting title:	**Board of directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**135b-22**	
Report title:	**Infection Prevention & Control Annual Report 2021/2022**				
Sponsor:	Nicky Reeves, Director of Nursing				
Author:	Sarah Prevett, Infection Control Lead Nurse				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance that there is a systematic leadership in place in the organisation for the effective management of infection prevention and control for patients, staff and visitors.				
Summary of key issues	The Trust has continued to achieve low rates of reportable infections despite the continuing challenges from the ongoing pandemic of Covid-19. Nationally cases of reportable infections have been rising in hospitals and the community due to health restrictions which are a direct result of the ongoing pandemic so being able to maintain low numbers of cases has been a challenging task Assurance process has been maintained through an audit programme and comprehensive policy folder, however some audits have had to be delayed due to increased pressure on the infection control teams' time, and those that have been delayed will be prioritised for the next financial year. Time has been spent to improve decontamination support within the Trust and ensure close working ties with support services such as Facilities, Estates and Pharmacy in order to ensure infection control has been integral with all aspects of clinical and non-clinical services.				
Recommendation:	The Board is asked to **note** the annual 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:	Infection Prevention & Control contributes directly to the delivery of KSO 1 and KSO 2				
Corporate risk register:	Infection, Prevention and Control contributes to compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's Essential Standards of Quality and Safety.				
Regulation:					
Legal:					
Resources:	This annual report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	25.7.22	Decision:		
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Holtye Rd,
East Grinstead
RH19 3DZ

Infection Prevention and Control

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2021 to March 2022

Document Control: committees and groups who have approved this report
Executive sponsor: Chief Nurse and DIPC

Authors: Lead Infection Control Nurse

Date: 12 July 2022

Type: Annual Report
Version: 1
Pages: 29
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1.	Executive Summary
	The purpose of this report is to inform and provide assurance to the trust Board, patients, public and staff of the processes in place at The Queen Victoria NHS Foundation Trust (QVH) to prevent and control healthcare associated infections (HCAI). The trust has a statutory responsibility to comply with the Health and Social Care Act: Code of Practice for the prevention and control of Healthcare-Associated Infection 2008 (DH 2015). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. This report provides an overview of infection prevention and control activity at QVH for the reporting period from 1st April 2021 to 31st March 2022 and demonstrates compliance with the Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare related guidance. The key findings of the report are: • The Trust has maintained compliance with Care Quality Commission regulations relating to Infection Prevention and Control despite resources being stretched to the additional pressures put on the team from the Covid-19 pandemic • Overall incidence of Healthcare Associated Infection remains low with three cases of methicillin Sensitive Staphylococcus (MSSA) bacteraemia, zero cases of Escherichia coli (E.coli) bacteraemia and one Clostridium Difficile (CDI) infections. With each of the positive results a Root cause analysis was undertaken (RCA) with actions implemented at the time. • Actions taken by the Infection Prevention and Control team (IPACT) in response to the Global Pandemic of Covid-19 to minimise the risk to staff and patient safety and to assess and adjust hospital policies and procedures in line with national guidance

2.	Introduction
	The Trust recognises that the effective prevention and control of HCAIs is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained. This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. The purpose of this report is to provide the Board with information on trust performance and provide assurance that suitable processes are being employed to prevent and control infections. This paper provides the board with an overview of work completed during the previous year and goals for the continuing programme of infection prevention and control for the upcoming financial year. The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008, at the heart of this law there are two principles: • to deliver continuous improvements of care • it meets the need of the patient With this in mind, patient safety remains the number one priority for the Trust. Infection prevention strategy and a consistent approach are key elements to ensuring the QVH has a safe environment and practices. Infection prevention and control is the responsibility of everyone in the healthcare and is only truly successful when everyone works together. 2.1 The Infection Prevention and Control Team (Appendix A) The infection control service is delivered and facilitated by an infection control team which

consists of:

- Director of Infection Prevention and Control
- Infection Lead Nurse and Decontamination Lead. (full time, 37.5 hours/week)
- Infection Control Nurse. (part time 22.5 hours/week)
- Administration assistant.
- Antimicrobial pharmacist. Due to staff changes there have been gaps during this year in the provision of this service
- The microbiology and virology laboratory services are provided by University Hospitals Sussex (UHS). As part of this service UHS provide QVH with a Consultant Microbiologist, due to the restrictions and precautions in place due to the Covid-19 pandemic the Trust has had no onsite presence from the Consultant Microbiologist since February 2020 they have however continued to support remotely running 24 hour advice via telephone or email to support safe provision of infection control services.

2.2 The Director of Infection Prevention and Control (DIPC)

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

3. Service aim, objectives and expected outcomes

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

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

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.

8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

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

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

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

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

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

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

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

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

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

Infection prevention & control link persons (ICLP)
Infection prevention and control remains central to the maintenance and promotion of high standards throughout QVH. The ICLP Group aims to meet every quarter. Its purpose is to provide a link between the IPACT and ward/departmental staff in all clinical and non-clinical areas in order to facilitate the dissemination of information and to promote compliance with infection control policies and the Health & Social Care Act (2015). Every meeting aims to include an educational element. The ICLP members are reviewed on an annual basis or more frequently if there has been staff changes. The link staff conduct monthly infection control audits and champion good infection control practices within their teams/departments. Due to restrictions in place, changes in the way meetings are conducted and increased pressures on the infection control team due to the Covid-19 pandemic for this year the link group has not been held quarterly and continuing pressures on staff resources have meant some link workers have found it difficult to leave their areas to attend the meetings resulting in low attendance. Information has been disseminated through alternative methods including regular all site updates, emails, weekly meetings for department leads and increased ICN presence on the wards and attendance at ward meetings/daily huddles. Moving forward into the new financial year, efforts will be focussing on re-engagement of the Link Group and innovative ways to deliver these meetings for the benefit of all and ensuring the information and training delivered in these meetings is addressing the needs of the staff.

External Meetings
Infection control remains high on the national agenda although the focus for the year 2021-2022 has been on how to safely manage the risks and precautions required due to the Covid-19 pandemic all aspects of infection prevention and control has remained a priority. The ICN participates in local and national webinars and virtual meetings to ensure robust links with other infection control teams across the South East area, utilising the opportunity to share learning and resources and ensure all practices in the Trust are in line with current national guidance and best practice. The implementation of these networking meetings has ensured the Queen Victoria Hospital has become integral in local policy making and participating in forming recommendations for the South East Coast as a group to be sent to the national system in relation to both the implementation of Covid guidance and ways to tackle HCAI's.

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

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

- *Pseudamonas aeruginosa bacteraemia*

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

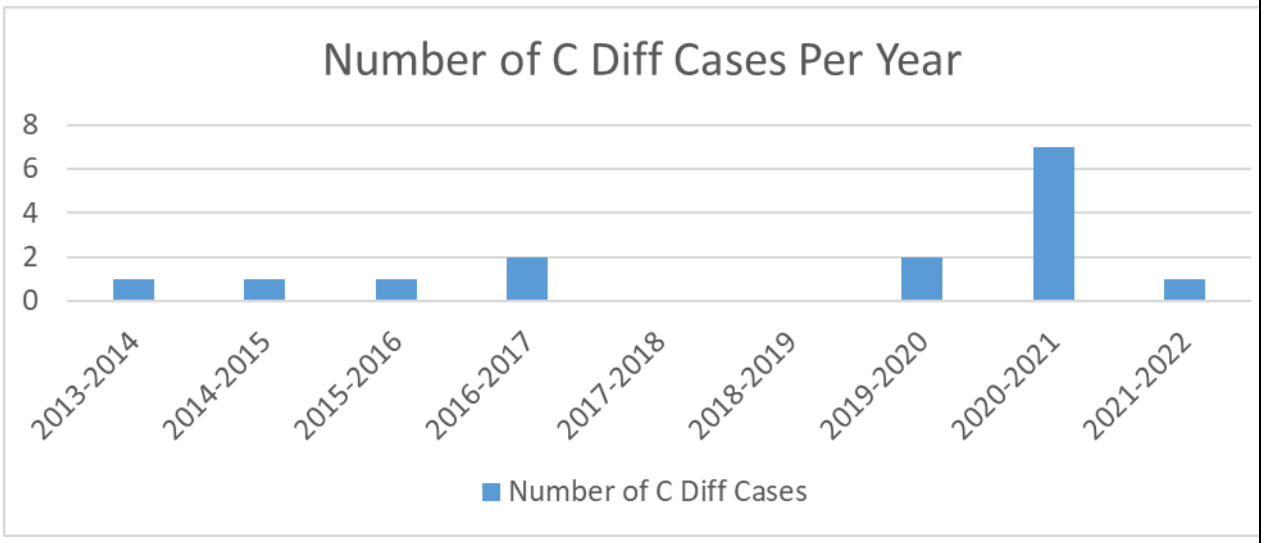
IPACT also monitor Urinary Tract Infection (UTI), *Acinetobacter, Pseudomonas, Klebsiella spp* and any other Multi Drug Resistant (MDR) organisms.

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

MRSA Bacteraemia
QVH have a target of zero cases of avoidable MRSA bacteraemia every year – the trust achieved this during the 2021/2022. There has not been a revision of this target for 2022/23.

***Clostridium difficile* infection (CDI)**
The CDI lapse in care objective target for QVH for 2021/2022 was set at zero. The Trust had two cases of CDI in 2021/2022. All cases were investigated using the Root Cause Analysis framework to look at triggering factors and identify learning needs to prevent further cases. The first cases, whilst identified at the QVH was not attributable to the Trust as the sample was sent on admission following transfer to the Burns unit from a neighbouring Trust. The second case was identified as being caused due to antibiotic therapy with multiple courses of multiple antibiotics being given to the patient in the transferring hospital before admission to the QVH. This CDI was reportable however the RCA identified it as being unavoidable due to the nature of the patient's injury dictating that aggressive antibiotic therapy was necessary. Two further cases of C.Diff colonisation were identified but these were not reportable as not active infections strict guidance on antibiotic prescribing was issued for these cases to prevent the colonisation becoming active infections. These were not reportable.

Figure 1



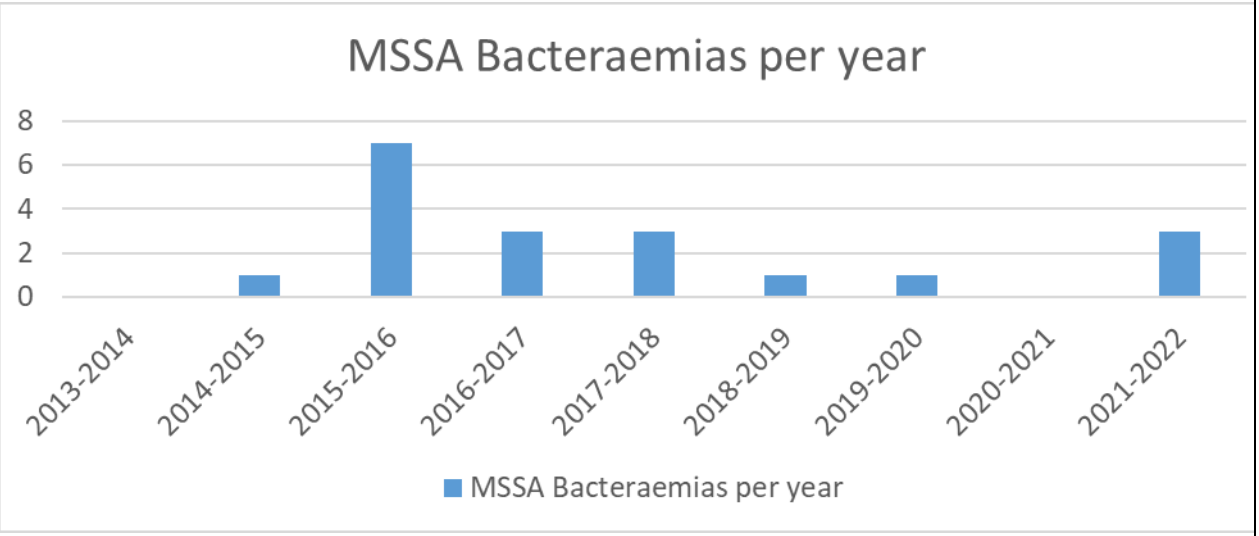
Trusts are required under the NHS Standard Contract 2022/23 to minimise rates of both C. difficile and of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England and Improvement. CDI threshold for the QVH for 2022/2023 has been set at 8

MSSA bacteraemia

No target has been set for MSSA bacteraemia to date although every effort should be taken to prevent all healthcare associated infections. QVH had three MSSA bacteraemia cases in 2021/2022. An RCA was completed for each case to look at likely causes, any possible crossovers and any learning needs. None of the RCA's showed any lapses in care, transmission of cases or areas of concerns. One of the cases had no identifiable areas of cause except that the patient had had surgery however it was unlikely to be an SSI that caused the bacteraemia due to strict procedures in place in Theatres to prevent SSI's. The second case showed the patient had multiple invasive devices and procedures including multiple theatre episodes and insertions of CVC's all of which coupled with their cancer diagnosis makes them at higher risk of a HCAI, despite this the RCA did not identify any lapses in care or inappropriate or unnecessary procedures being undertaken. The only needs identified were relating to documentation and completion of audit paperwork rather than patient care. The third case was in a patient presenting with a two week history of wound infection. Patient had experienced several bouts of infection in hands since sustaining burns two years prior. The patient had a positive blood culture within another local trust immediately prior to transfer to the QVH. Wound swabs of the area showed a methicillin sensitive staph aureus with the same resistance pattern of the MSSA identified in the patients' blood cultures. The patient has had previous swabs from other areas of skin which isolated MSSA. The RCA did not identify any lapses in care. In this case, it is likely that the MSSA bacteraemia was caused by the untreated extensive soft tissue infection.

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

Figure 2

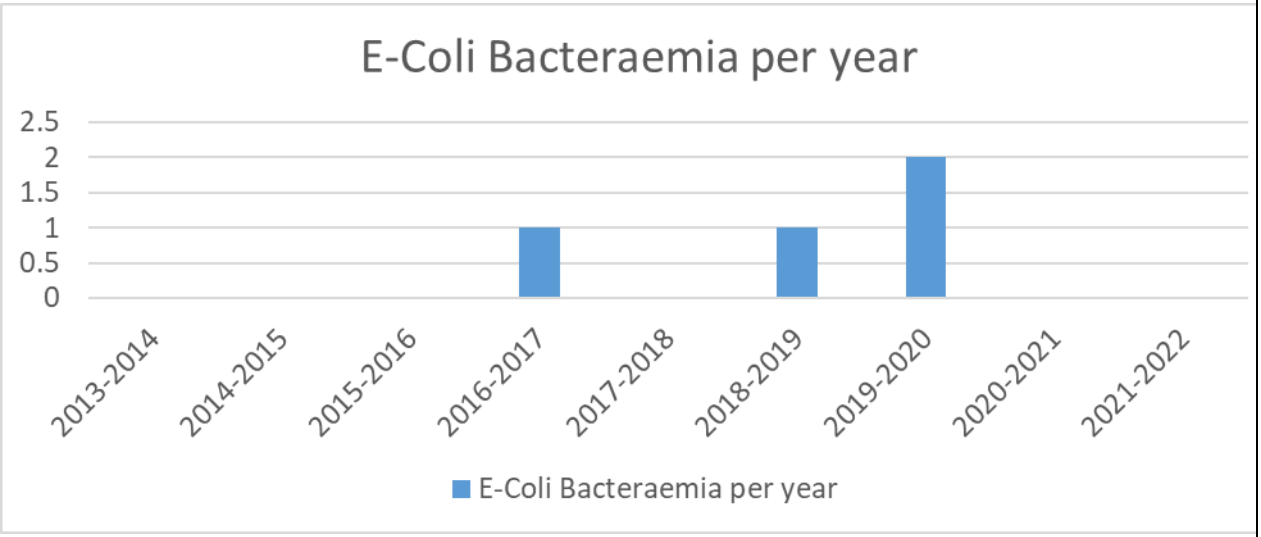


E. Coli bacteraemia

QVH had zero reportable *E.coli* bacteraemia in 2021/22,

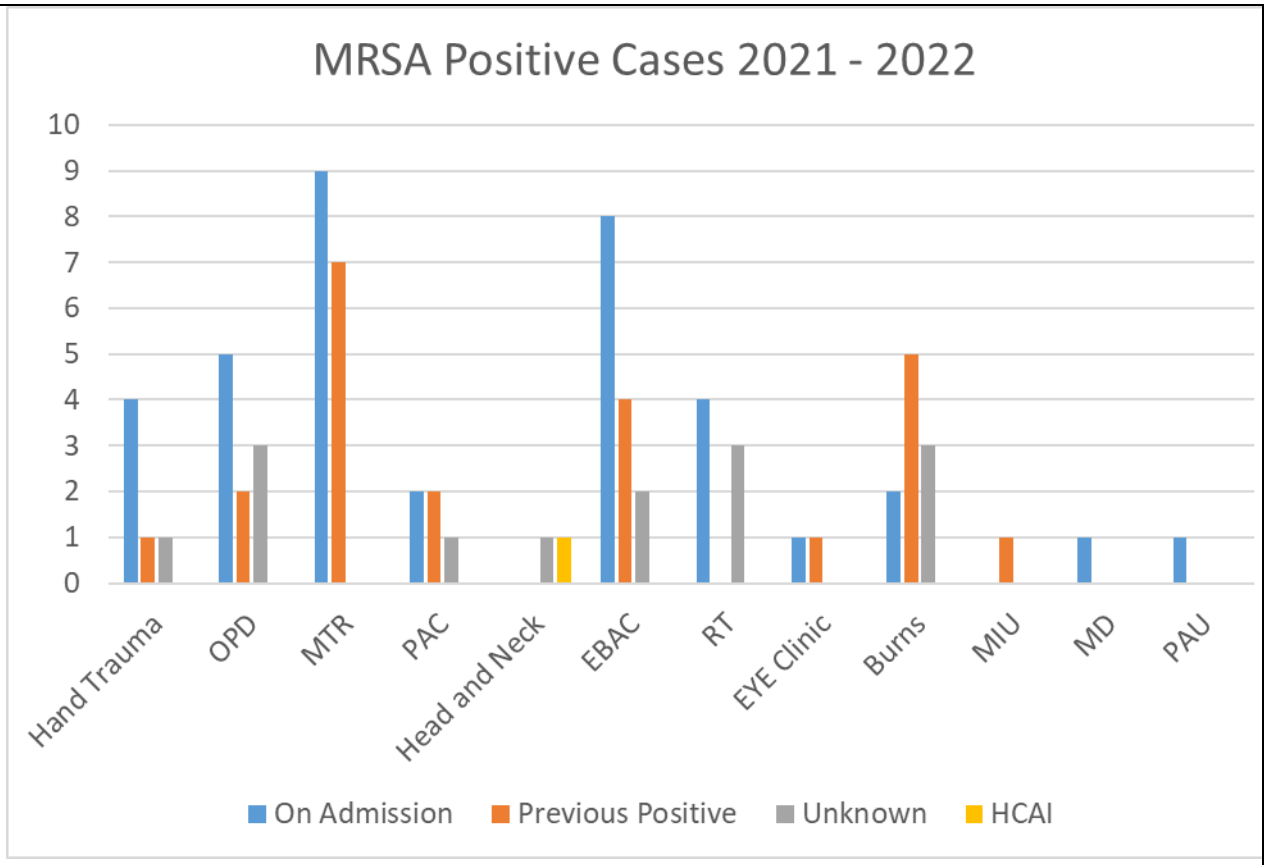
Figure 3 shows the year on year numbers of reportable *E.coli* bacteraemia

Figure 3



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

MRSA positive patients April 2020 to March 2021 (Infected and colonised)
During the period of 2021/2022 there were 84 confirmed cases of MRSA either colonisation or infection. None of the positive results were acquired from blood cultures (bacteraemia) but from either surface swabs (such as nose and groin) or from wound swabs. Of these 1 was classed as healthcare associated or hospital acquired (HCAI), 36 were identified from admission or pre-admission swabs (O/A), 32 were from patients known to be previously positive (PP) and 15 patients it was difficult to determine the source of acquisition. In July 2020, the Trust's MRSA policy changed to bring it in line with National MRSA screening guidance, focusing on screening only high risk patients, therefore, we may not always have a baseline admission swab for MRSA if the patient was deemed to be low risk on admission. Without an admission swab to provide this baseline data, we are unable to ascertain if the MRSA was acquired in the hospital setting or in the community either before or after admission. All cases of MRSA both colonisation and infection are recorded and monitor to look for any emerging patterns such as an increase in cases of a particular surgical group or a rise in MRSA cases with the same resistance pattern as this could indicate an outbreak or hospital transmission. None were identified during this time period. RCA's are completed for all HCAI cases to look at any lapses in care or areas of improvement.



4.	Activity analysis/ achievement

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

The CQC did not conduct any inspections in between April 2021 to March 2022. The Trust continues to monitor compliance set out in the Health and social care act (2010) through a robust audit plan and assurance process with reports submitted to the Quality and Governance Committee, Clinical Governance Group and other Quality groups.

The Trust Board

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

Key Performance Indicators (KPIs)

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

The remaining KPI's are ensuring all members of the IPACT are attending mandatory training and are undertaking an annual appraisal. All members of the IPACT achieved this during the year April 2021 to March 2022

Complaints

When necessary the IPACT will liaise with the Patient Experience Manager to assist with the investigation of complaints associated with infection prevention and control. The outcomes of these are fed back at the monthly IPACT and quarterly committee meetings. During this year there has been a significant decrease in formal complaints or claims relating to infection prevention and control with the Infection Control team being required to provide input in one complaint and one legal claim. The complaint related to a patients wife being concerned that her husband had been given a diagnosis in clinic by himself, reassurance given that despite restrictions being in place to minimise people in waiting areas all patients that require support can and should have someone accompany them. The legal complaint was relating to a hand trauma patient who felt they were given inappropriate antibiotic therapy which resulted in a surgical site infection. Infection Control reviewed the case, the patient's notes and available Microbiology data and submitted the findings that treatment appeared appropriate for the organisms and wound. In each case the ICNs worked with the patient experience manager to answer the patients concerns or questions citing Trust and national guidance. Whilst there were only the 2 formal concerns Infection Control continues to be available for patients, visitors and staff to contact with any concerns or questions they may have, taking the time to discuss their worries on the phone or in person with lots of calls received from people requiring reassurance over changing Covid guidance and required precautions.

Infection Prevention and Control Learning and Development

Infection Prevention and Control is part of the Trust's mandatory training programme. Due to current social distancing measure and the threat of Covid-19 face to face training sessions for the year 2021-2022 were only held for induction training and small bespoke departmental or 1:1 training sessions. All other clinical and non-clinical mandatory training sessions have been completed using E-learning. Induction training days have been held monthly for all categories of staff, with separate sessions for new Doctors' Induction and Volunteers Training. Training is carried out by the ICN's.

	Required	Achieved	Compliance %
Quarter 1	1245	1112	90.75%
Quarter 2	1232	1078	90.16%
Quarter 3	1196	1061	89.94
Quarter 4	1235	1128	89.48%

Where compliance in specific staff groups is low the leads for these areas have been contacted and asked to remind their teams to attend the mandatory training as per their role, and if they have any concerns or issues accessing the training to contact the infection prevention and control team to arrange an alternative training method.

The theme for 2021-2022 remained as 'Infection Prevention and Control, At the heart of everything we do'. Having to conduct training in a different method altered the way the message was delivered, however the IPACT ensured the training method covered the following key subjects:

- How does infection spread?
- How staff can help prevent the spread of infection
- Hand hygiene and bare below the elbows
- Correct wearing of PPE
- Dress code
- Spillage management
- Sharp safety
- Safe disposal of waste
- Compliance with DH *Pseudomonas* guidance
- Deep cleaning

- What is an HCAI
- CPE
- The rise of anti-microbial resistance
- The Health and Social Care Act (2015)
- Food hygiene
- Flu preparations including FIT testing

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

Infection Prevention and Control audit
Clinical audit is a fundamental component of clinical governance and underpins the assurance process for a high-quality service (CQC, 2010). The IPACT maintained an audit timetable that is monitored to ensure compliance with national recommendations for assurance. The following audits have been undertaken in the period April 2021 to March 2022. All Ward/Department Matrons are informed of audit results pertinent to their area as they are completed. They are asked to complete any recommendations made within the audit reports. The audit timetable was risk assessed and some audits have had to be delayed due to the need to minimise non-essential staff being on site and in the clinical departments and due to the increase pressures on the infection control team. Regular walkabouts of the Trust have been completed and key audits have all been maintained to ensure compliance with all aspects of national infection control guidance not just Covid precautions. The audits that have been postponed and will be prioritised for the next financial year are:

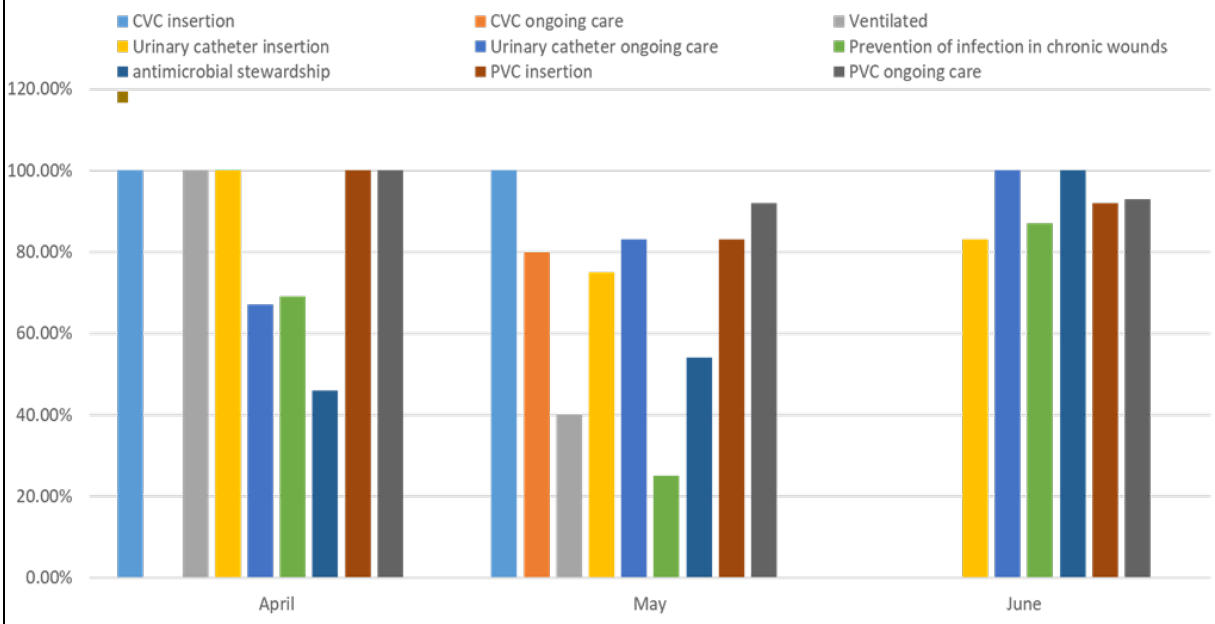
- MRSA decontamination Audit
- Aseptic technique audit

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

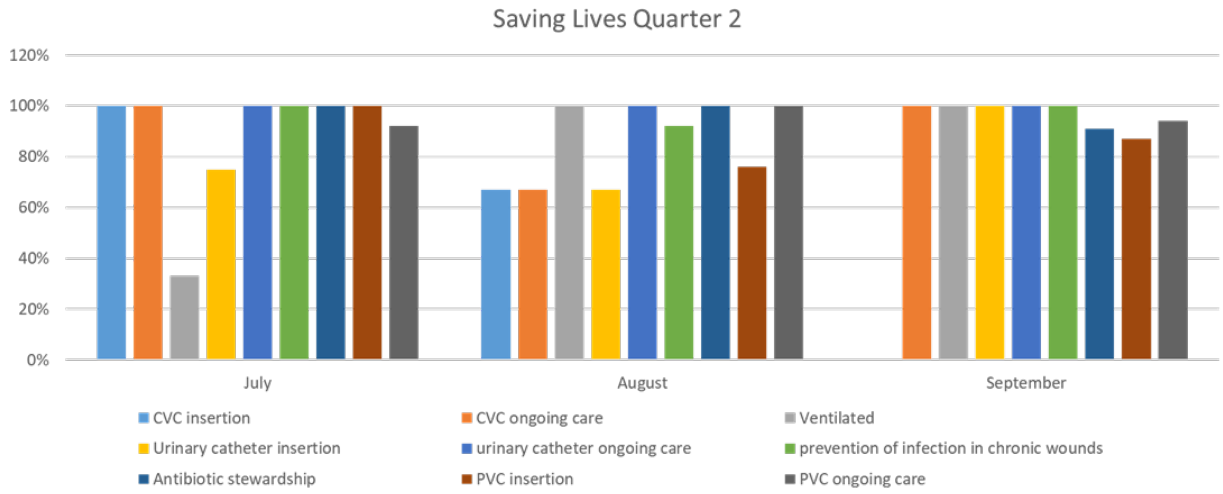
- Prevention of ventilator associated pneumonia
- Prevention of infections associated with peripheral vascular access devices
- Prevention of infections associated with central venous access devices
- Prevention of surgical site infection
- Prevention of infections in chronic wounds
- Prevention of urinary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

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

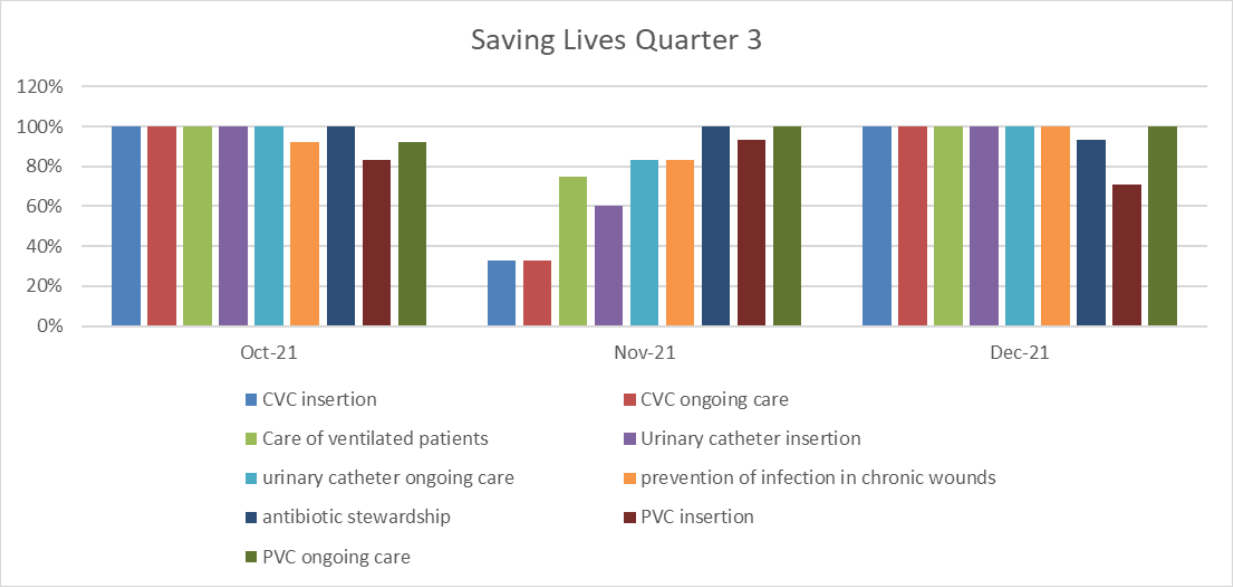
Quarter 1



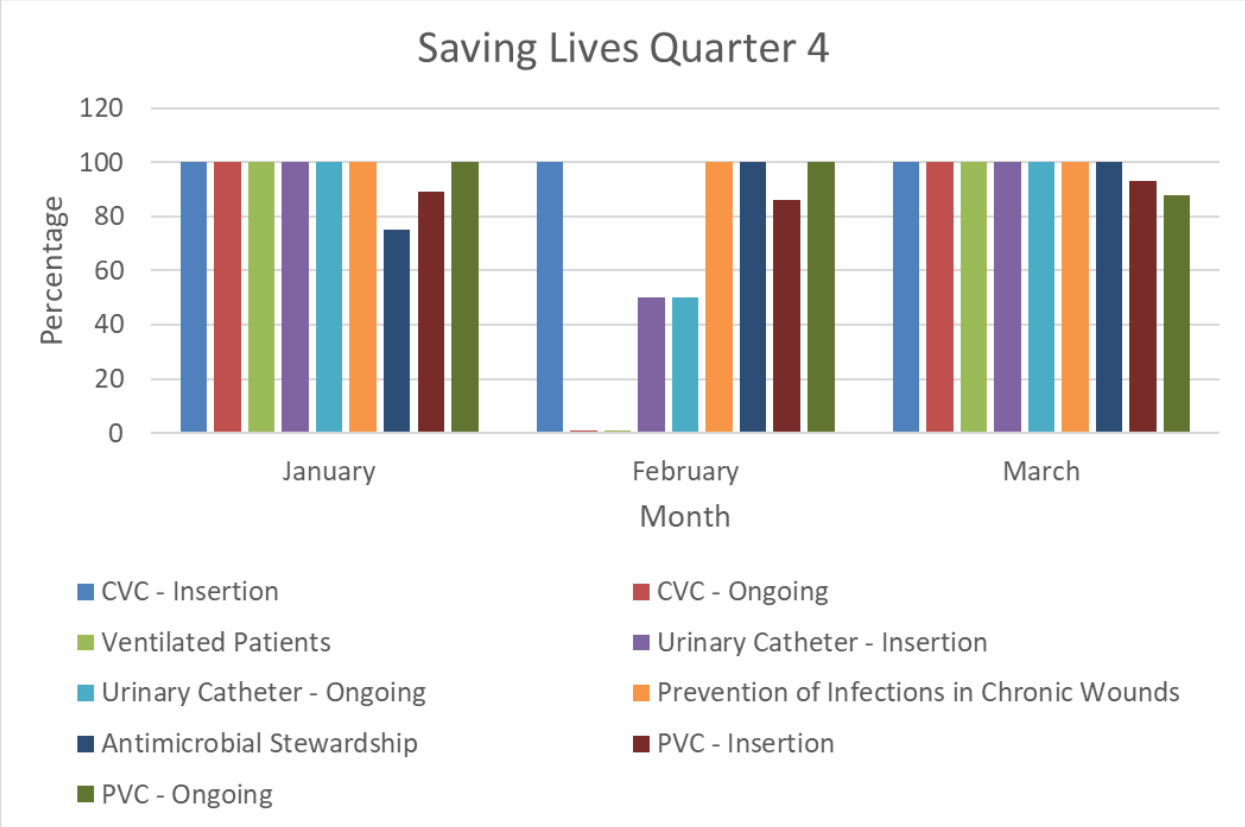
Quarter 2



Quarter 3



Quarter 4



Sharps Box audit

The annual sharps box audit was conducted by the representative from Daniels (the Trusts supplier of sharps boxes) and the infection control nurse. Every clinical area was visited and all available sharps boxes reviewed to confirm they are assembled correctly, labelled appropriately, only sharps waste was in them, being disposed of in the correct time frame and sited appropriately. Training was given at the time where areas of non-compliance was identified and additional ward specific training was arranged with the rep from Daniels and department leads.

No.	AREA	Number of sharps / speciality containers inspected	POSSIBLE SCORE	ACTUAL SCORE	PERCENT COMPLIANT
1	Ross Tilley & Margaret Duncombe	20	160	149	93.13%
2	Pre assessment	5	40	38	95.00%
3	Peanut Ward	3	24	24	100.00%
4	Burns Unit	5	40	35	87.50%
5	Critical Care Unit	8	64	58	90.63%
6	Theatres	26	208	191	91.83%
7	Outpatients	19	152	143	94.08%
8	MIU	7	56	55	98.21%
9	Sleep	3	24	23	95.83%
10	Pharmacy	1	8	7	87.50%
11	Maxillofacial & Orthotics	10	80	76	95.00%
12	Corneo OPD	13	104	100	96.15%
13	Round Tree	8	64	59	92.19%
14	X-Ray	3	24	23	95.83%

This audit was repeated by the Daniels representative and infection control team 6 months after the initial audit in order to embed the teaching that had been delivered and look for signs of improvement

Improvement was seen in most areas but for those areas that did not show improvement additional ward based training was delivered by the Daniels rep. A certificate of compliance was awarded to Maxillo facial Outpatients for their scores, this was assessed by the external auditor who felt that the greatest level of compliance was in this department.

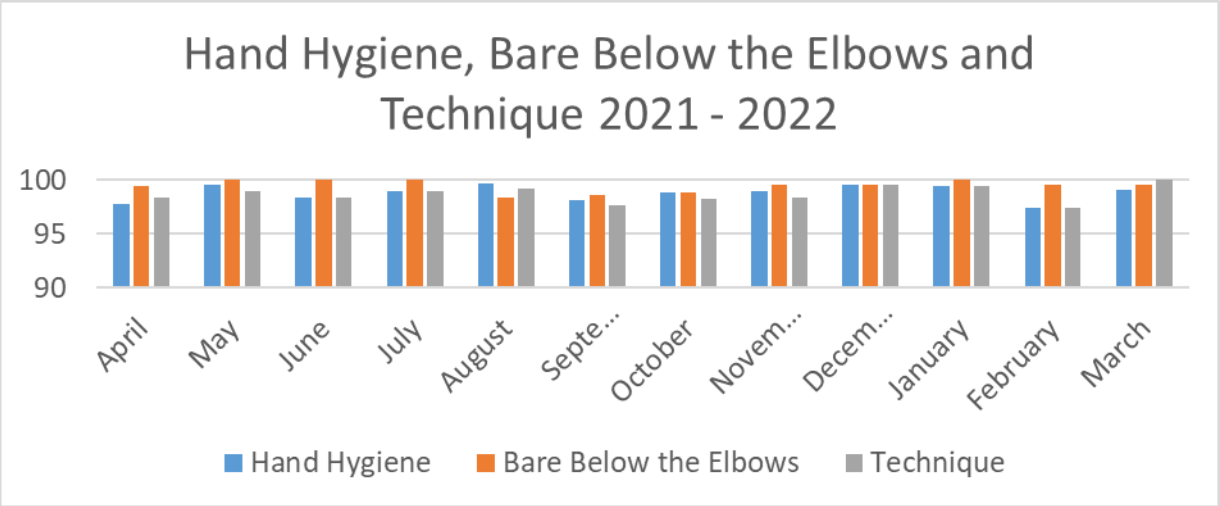
AREA	Number of sharps / speciality containers inspected	POSSIBLE SCORE	NUMBER OF NON COMPLIANCES	ACTUAL SCORE	PERCENT COMPLIANT
Physio	1	8	0	8	100.00%
Minor Injuries	5	40	3	37	92.50%
Ross Tilley	8	64	6	58	90.63%
Pre assessment	2	16	0	16	100.00%
Peanut Ward	4	32	4	28	87.50%
Burns Unit	6	48	6	42	87.50%
Critical Care Unit	3	24	1	23	95.83%
Theatres	12	96	6	90	93.75%
Outpatients	16	128	8	120	93.75%
EBAC	2	16	0	16	100.00%

Sleep	2	16	1	15	93.75%
Pharmacy	1	8	1	7	87.50%
Maxillofacial & Orthotics	12	96	0	96	100.00%
Corneo OPD	16	128	5	123	96.09%
Theatres Recovery	12	96	3	93	96.88%
X-Ray	4	32	0	32	100.00%
Margaret Duncombe	4	32	3	29	90.63%

Isolation Room Audit

This audit was conducted as a retrospective one day snap shot audit looking at patient placement within the wards to ascertain if the side rooms were being used appropriately, side room are not necessarily just for patients with known or suspected infections but can also be utilised for patients with other needs such as mental health or learning difficulty needs, patients who require a room to ensure no mixed sex wards or patients who require isolation for other reasons such as safety. The audit data suggests that isolation rooms are being used appropriately in various areas across the Trust. However, there was limited data available at the time of audit and therefore there were two areas which could not be audited. As a result of this, the decision has been made to re-audit in three months' time to ensure all relevant areas are audited and isolation room usage is judicious in each clinical area. Efforts will be made to harvest data in alternative ways to ensure an accurate and thorough auditing process.

Hand Hygiene Audits



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

Surgical Site Infection (SSI) audit

The infection control team audited Hand surgery for this SSI audit, 218 patients who underwent hand surgery in the time period were included and letters sent to them with a questionnaire. The number of questionnaires returned was 79 out of 218 sent, giving a 36% return rate. Readmission to QVH with confirmed infection is 3.8% of patients from surveys returned.
If those who reported having been prescribed antibiotics were included as a confirmed infection this would result in a 10% infection rate however, at least one patient was prescribed antibiotics for a condition unrelated to their surgery or were prescribed them pre operatively for a trauma injury.
There was no specific consultant associated with all the patients with reported problems and no obvious link between post-operative problems and not receiving prophylaxis antibiotic cover during or immediately after surgery. There doesn't appear to be any correlation between the type of procedure performed and the problems with wound healing. It is noted that approximately half of patients surveyed were trauma patients, which are more likely to be wounds contaminated by bacteria during the course of injury.

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

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

Duty of Care visit to Steris the sterile service provider

A new decontamination lead took on the role in July 2021, the role was taken over by a senior member of theatre staff.
Steris was visited by the Decontamination lead and Sterile service procurement lead in September 2021 during this visit they reviewed the current site in Guildford and then the new site in Chessington with the service move scheduled for early November 2021, following the move Chessington was again reviewed in late November 2021.Decontamination service will be monitored closely to ensure that the relocation of the sterile service provider does not affect the supply and quality of the Trusts instruments. Since the change in site there have been multiple issues and contract failures on the side of the Sterile service where there have been delays in collection and delivery of instruments resulting in this being put on the corporate risk register

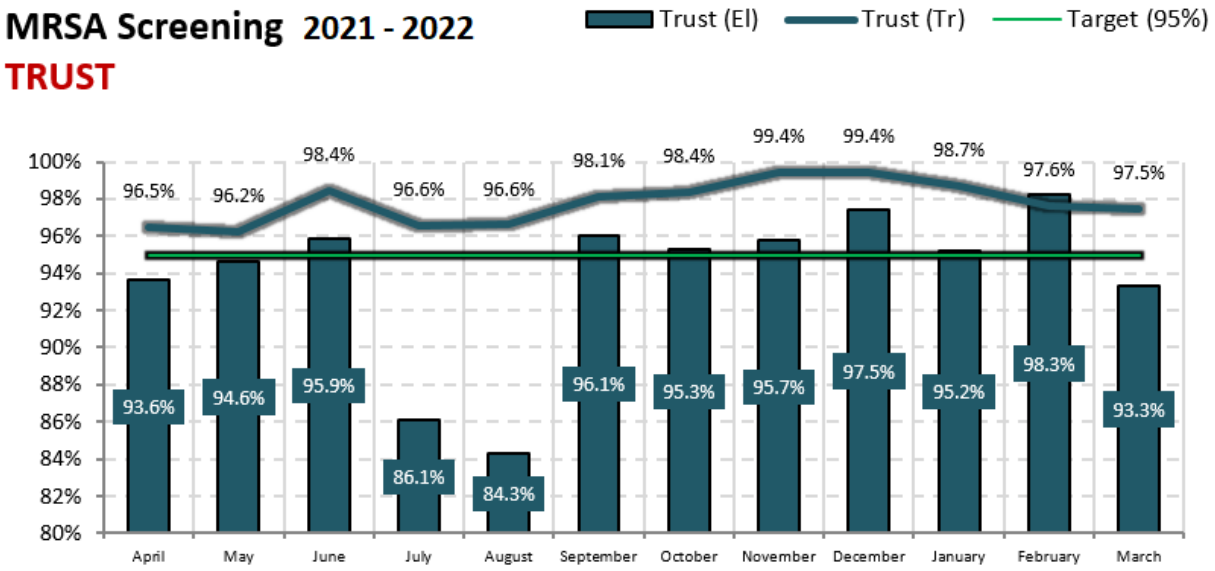
Duty of Care visit to Eastbourne Laundry

- Due to Covid-19 pandemic precautions this visit was not conducted on order to limit movement of staff between different areas/sites and minimise the risk of spread of infection. The laundry provider contract has been awarded through a tender process to a new provider ELIS who are based in South London, a thorough review and inspection of the new service provider has been conducted by the Facilities manager and annual inspections will be established at the appropriate time.

MRSA screening

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

or within 48 hours of admission day. This is to include all patients including in-patients, day cases and paediatric admissions.



Environmental Audits
Due to restrictions being in place to reduce the amount of non-essential staff in patient areas to minimise the chances of spread Covid-19minimal environmental audits were undertaken Assurance was still maintained by regular department inspections by the infection control and estates team to assess compliance with Covid restrictions including social distancing, ventilation, clear pathways, separation of ‘red’, ‘green’ and ‘amber’ pathways.

Maintenance and refurbishments continued in areas of concern.. Where work has been undertaken infection control has had oversight to ensure compliance with national infection control guidance. Any concerns noted were escalated through the site transformation team and estates and facilities.

The PLACE inspections are conducted as a multidisciplinary approach with representatives from IPACT, Estates, Facilities, Risk and Nursing with the aim of highlighting any concerns as a group to ensure a safe clean environment for patients to be cared for in. All areas are audited once a year unless significant concerns raised which require re-auditing to monitor progress of repairs.
The following areas were audited for environmental concerns.

Quarter 1

- MIU
- Peanut
- Canadian Wing
- Corneo outpatients
- OT and Physio
- Medical Education Centre
- Staff rest areas

Quarter 2

- Sleep studies unit
- X-ray
- Public toilets

Quarter 3

- Portacabin offices
- Critical Care Unit

Quarter 4

- Minor Injuries Unit – Recommended to be prioritised for refurbishment and re-audit in six months
- Sleep Unit – Minor actions noted, re-audit annually

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

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

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

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

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

Local peer review and assurance processes

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

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

The Infection Control Nurse Specialist has continued to attend local and regional Infection Control Network meetings. These have proved to provide a supportive environment to share learning, knowledge, tools and resources with our neighbouring Trusts.

Influenza arrangements

During 2021/22 support has again been given to the management of influenza (flu), with the ICN's encouraging vaccination of staff within the annual flu vaccination programme. Flu vaccination update is reported through the emergency planning reporting system.

The Infection Control Team co-ordinate the FIT testing programme for clinical staff to ensure safe practice is delivered, update the emergency plan and submit the Trust vaccination data as this is a mandatory requirement. An external training course was run to train additional FIT testers from across the Trust, the monitoring of FIT tests has now been incorporated into the staff formal education records as clinical staff are required to be FIT tested annually.

Untoward Incidents including Outbreaks

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

There has been an ongoing global pandemic of Coronavirus (Covid-19) this has had a significant impact on the working of the hospital and patient/visitor flow all actions relating to the tasks performed by the infection control team are documented in the Infection Control board assurance framework.

- Robust processes and SOP's have been produced and implemented over the last 12 months which are detailed and cover most eventualities therefore practice is becoming routine for staff.
- The Infection Control team has continue to prioritise the following actions due to Pandemic
- Working with business unit managers and department leads to produce SOP's and guidance on restarting services within the Trust to ensure they are done safely with the right level of PPE
- Assisting with the management of positive cases both in patients and staff, participating in contact tracing, testing of symptomatic staff and managing growing anxiety levels
- Co-ordinating actions for localised outbreaks of Covid-19
- Policies and SOP's reviewed and amended as guidance changes specifically in relation to pre-operative isolation and then re-admission following a Covid positive result.
- Daily checks of BSUH Covid-19 reporting spreadsheet and actions taken as required.
- Infection control continue to provide out of hours and weekend support and advice for staff

<u>April 2020 to June 2021</u>

- One patient was identified as being C.diff positive within the Burns unit in June. RCA completed which indicated that the patient was likely to have acquired the CDI in the transferring hospital due to large courses of antibiotics being given for their condition. Strict infection control precautions implemented with no current further cases.
- One MSSA bacteraemia identified in a surgical patient on Ross Tilley. No definitive cause identified for this however it is a probable SSI as the only invasive interaction/procedure he had before presenting with signs of infection was a theatre episode on the 5/5/21. No actions required as no lapses in care identified,
- Poor compliance with antibiotic prescribing in CCU identified through antimicrobial audit. Learning and actions identified and to be taken to JHGM in July, task and finish group initiate with the medical director and key clinical staff to identify the best ways to increase engagement and compliance. Entry put on the risk register relating to antibiotic compliance.

<u>July 2020 to September 2021</u>

- Three Covid positive cases on Ross Tilley in July which were treated as an outbreak, timeline is as follows:
  Index case. RL admitted 27/7 and discharged on the 28/7 Admission PCR screen returned positive. Optigene screen on the 27/7 was negative but screen on the 28/7 was positive. Patient was in room 3 under Corneo for his admission.
  FM admitted 24/7 and discharged 01/08. PCR screen sent 24/7 – negative. PCR screen sent 27/7 – negative. PCR screen sent 30/7 – positive. Optigene screens sent on the 24/7, 25/7, 27/7, 28/7, 29/7, 30/7 and 31/7 all returned negative. Patient was in room 3 under plastics for his admission
  JH admitted 29/7 and discharged 2/8. PCR screen sent 29/7 – negative. PCR screen 01/08 – positive. Optigene sent 30/7 and 2/8 both negative. Patient was in room 4 under max fac for her admission.

The following actions were undertaken: All rooms deep cleaned. All staff to have twice a week optigene screening (not lateral flow) for the next 10 days.

- Covid positive patient identified in Margaret Duncombe ward following surgery. Investigation completed to look at 'green' admission pathway. Patient transferred out to an alternative medical facility. Patients who were in the bay were isolated and put on enhanced screening – 1 returned Covid positive
- 1 MSSA positive patient identified from CCU. Patient was a major Head and Neck surgery. Likely to have been acquired due to MSSA in the wounds. All actions taken as required with no further cases.

October 2020 to December 2021

- Individual Covid positive results managed by the infection control team on an individual basis. Whilst there was a significant increase in the amount of positive cases, in both staff and patients, during December there was no link identified between cases and no hospital transmission identified but rather this reflected the national picture with a rise in cases due to a surge in Omicron cases and an increase in socialising due to the Christmas period.

January 2021 to March 2021

- Individual Covid positive results managed by the infection control team on an individual basis. There has been increased case numbers across staff within the Trust in line with the rise in community transmission. There have been small clusters identified within some staff groups, however, these have been managed with increased vigilance for symptoms, increased staff screening and enhanced social restrictive measures.
- Outbreak of Covid-19 declared in Ross Tilley ward. Index patient non-compliant with the restrictions in place at the time, 2 subsequent patients identified as contacts and infection control precautions implemented including isolating the contact patients and increased screening for all patients and staff, these 2 patients tested positive but no further cases identified, CCG aware.

5. Involvement and Engagement

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

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

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

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

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

Facilities report
Cleaning audits are undertaken by the Domestic Supervisors weekly, each clinical area is audited every week and non-clinical areas 3 monthly. Where issues or concerns related to cleaning are noted these addressed and resolved within 48 hours with a repeated audit conducted within 7 days.

	Deep cleaning programme has continued with all areas deep cleaned in line with the National Standards of Cleanliness with clinical areas done every 6 months and non-clinical areas annually. The annual Trust PLACE inspection was cancelled by health watch this year due to Covid restrictions. **Estates report – Associate Director of Estates** IPACT continues to work closely with the Estates department and are consulted on infection control issues as well as project works. **Water Safety** The Trust continues to take monthly water sample (Approximately 25 tests per month) for the monitoring of legionella Pneumophila bacteria within the domestic water supplies. This work is undertaken by TSS and their attendance and performance continues to meet expectations. All outlets are inspected for the presence of flexi pipes / dead legs / blind ends. Any defects identified are rectified e.g. flexi pipes removed & replaced with copper hard piping. Dead Legs / blind ends to be removed as far as practically feasible. All Legionella sampling is monitored by the Trusts RP of water safety, with actions taken when required. Pseudomonas samples are taken every six months within augmented areas (CCU, Head & Neck and Burns unit) **Infection Control Risks and incidents.** The ICN's receive notification of any suspected Infection Prevention and Control incidents via the Datix reporting system. The ICN's respond to each Datix report. The response may be in the form of advice or it may trigger further investigation. This activity allows the lead ICN to maintain oversight of all Infection Prevention and Control incidences Each incident identified on the Datix system is investigated by the ICN. Some incidents require no input as they are dealt with at the time and entered onto the Datix system as a formal record, for example a case of a hospital acquired infection. A list of all incidents relating to infection control is taking to the quarterly infection control group meeting for review and to look for any similarities or patterns that may require further investigation, training or service review. There are no Infection Control Risks on the corporate risk register. This is discussed at the quarterly infection prevention and control group each quarter to provide assurance there are no areas that require a risk entry. **Contract monitoring -Sussex CCG Infection Prevention and Control Standards** CCG's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective Infection Prevention and Control arrangements in place. A self-assessment tool titled a Board Assurance Framework (BAF) has been completed and reviewed and updated if required as a minimum quarterly. This has included guidance changes in relation to Covid-19 including PPE guidance, screening and isolation requirements and patient placement. When guidance has changed this BAF is reviewed and updated then submitted through the Infection Control Group and Quality and Governance committee for information and assurance.

6.	Learning from Experience
	2021/2022 continued to be an incredibly challenging year for the Trust as a whole and the Infection Prevention and Control team specifically with the global pandemic of Covid-19. The Infection Control team has maintained its close working relationships with the estates team, facilities team, clinical leads, emergency plan lead and Covid-19 groups set up to review national guidance, PPE requirements, patient pathways and flow through the Trust, estates and infrastructure, ventilation requirement, screening requirements for both patients and staff. The

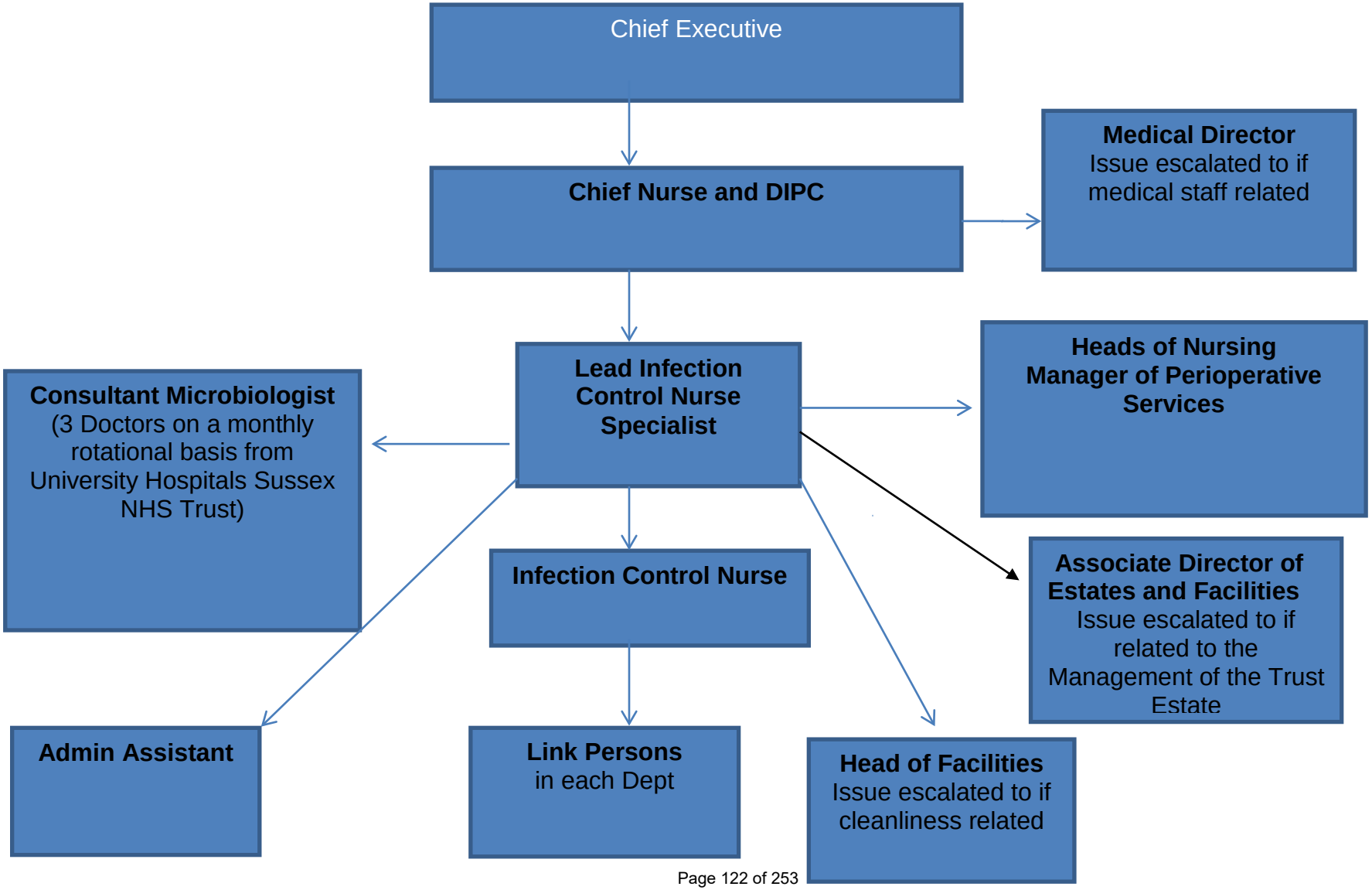
	infection control team has maintained the way they work to be more accessible for all staff throughout the last year by increasing their presence in the wards, at departmental meetings, providing an out of hour on-call service and maintaining close links with the Microbiology service at UHS to ensure timeliness of results being reported. Much of the infection control team's time and resources has been spent managing the Covid-19 outbreak, actions for this include mass FIT testing staff, working with procurement to ensure adequate supplies and much more as detailed in the sections above. As a result of the additional pressures on the infection control team, the movement of clinical services and the limitations put in place around visiting other sites some of the audits have not been conducted including the annual PLACE and aseptic technique, therefore these audits will prioritised for the coming audit period. Despite the pressure on the infection control team caused by the Covid-19 pandemic we have continued to ensure high standards of infection control have been maintained for all patients to prevent a rise in health care associated infections, this is evident through our continuing low numbers of reportable health care associated infections and low numbers of Covid positive cases, MRSA numbers and outbreaks.. Patients and staff can be put at risk by failure to adhere to good infection control practice. The Trust continues to strive to improve compliance with all aspects of Infection Control in order to safeguard the patients, service users and staff through a robust programme of education, audit and reporting. The rates of both reportable and non-reportable infections remained low however there is still improvement to be made. The areas that have been shown through the auditing process for this year as requiring improvement are: compliance with MRSA screening, compliance with hand hygiene and bare below the elbows and compliance with antibiotic prescribing. The infection control team will continue to champion and promote the implementation of infection control to all staff in all departments with the emphasis on 2022/2023 programme being reinforcing compliance with infection control and ensuring the basics are done consistently to a high standard. The infection control team aims to increase departmental based inspections, review and improve the audit programme to ensure that audits are being used to improve services, learn from incidents and target areas of concern, re-establish and refresh close working links and engagement with the estates and facilities team with the aim of making sure the structure of the building is fit for purpose with all necessary checks and assurance processes being completed. and re-inforce the basic standards of infection control by engaging with staff to understand their perception of the importance of infection control
7.	**Recommendations**
	This report has evidenced the challenges faced by the trust's Infection Control team through this financial year. The evidence in the form of audit results, low numbers of infections, meeting minutes and patient feedback has shown that overall, compliance with National guidance, Trust policy and National targets is good although there is still some improvement required. There will be ongoing challenges to be faced from the continued pandemic of Covid-19 with guidance still being updated and modified in response to the changing national and global situation, the infection control team will strive to maintain low levels of Covid cases in both the staff and patient population whilst ensuring patients and visitors have access to the services provided by the Trust, by reviewing and implementing national guidance to minimise the risk to all patients, staff and visitors. Looking forward, using the experiences and knowledge gained throughout the last financial year, further targeted work could be undertaken to improve the internal structure of key clinical areas. Priorities for this year have been identified as getting a better and more honest understanding of staff knowledge of infection control, what they think of as important, what are the barriers to compliance, what do they see as of benefit and what do they consider a hindrance to completing their jobs. With this information the Infection control team will be better able to focus training and engagement with the aim of increasing compliance with 'the basics' because without a solid foundation we cannot hope to build a service that is strong and fit for purpose.

8.	Future Plans and Targets
	There are going to be many challenges to be overcome in the foreseeable future due to the ongoing Pandemic from Covid-19. The Infection Prevention and Control team will continue to be at the forefront of the trusts strategic approach to safely providing the cancer hub, urgent procedures and trauma services. The team will continue to work flexibly and responsively to this pandemic contributing to the integrated governance and providing assurance about the fundamental management of infection prevention and control as well as bespoke solutions to evolving issues as the global situation dictates. The infection control team will work alongside the staff to ensure infection control standards are implemented by all staff in all situations, that auditing is robust and targeted, and that the basic standards of infection control are implemented and understood with the aim of achieving zero preventable infections.

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

11. Appendices

APPENDIX A **Infection Prevention and Control Structure Chart 2022/2023**



Appendix B

Infection Control Annual Programme Objectives for 2022/23

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

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

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

IC	Audit	Continue hand hygiene audit and compliance	Monthly
IC	Audit	Continue to review external contracts e.g. laundry	As required
IC	Audit	Continue to implement the DH Saving Lives audit programme	On-going
IC	Audit	Continue environmental inspections	Monthly
IC	Audit	Audit compliance with MRSA policy Audit compliance with MRSA screening	Monthly
IC	Education	Updates for Clinical Practice Educators / Department Managers / departments	As required
IC	Education	Mandatory training: Clinical Non-clinical Induction Junior doctors Consultants	X2 month X1 month X1 month X6 year X2 year Available through e-learning
IC	Education	Link person training	quarterly
IC	Education	Deliver training to staff on current issues and attend department meetings on request	As required
Estates	Management	Involvement in the Capital Programme	As required
Estates	Management	Review of estates policy and new guidance	As required
Estates	Management	Involvement in reviewing water sampling and ventilation results	As required
Estates	Management	Involvement in the prioritising of general refurbishment works within the Trust	As required
Estates	Audit	Waste facility	Annual
Decontamination	Management	Review of decontamination and disinfection policy	As required
Decontamination	Management	Update for ICC	Quarterly

Appendix C

IC Policies Ratified April 2021 – March 2022

- **Guidelines for the Control of Varicella Zoster Virus Infection (Chickenpox and Shingles)**
- **Hand Hygiene Policy**
- **Management of Staff with MRSA Colonisation**
- **Management of Patients with Clostridium Difficile (C.Diff)**
- **Policy for Isolation**

The following policy was approved in May, however it was felt that a large portion of this policy is not infection control but rather corporate and relating to professional image therefor should sit under HR

- **Uniform & Dress Code Policy**
- **Decontamination and Disinfection Policy**
- **Personal Protective Equipment Policy**
- **Procedure for the Management of Blood and Body Fluid**
- **Procedure for the Collection of Microbiological Specimens**
- **Guidelines for Management of Headlice**
- **Guidelines for Management of Scabies**

  The following policy was approved subject to minor alterations to the prophylaxis section to be made by the lead Pharmacist

- **Guidelines for Prevention of Surgical Site Infections**
- **Management of Outbreaks Policy**
- **Management of Patients with TB 2022**
- **Policy for Insertion and Care of Central Venous Catheters – to go to CGG in April for ratification**
- **PVC Policy – to go to CGG in April for ratification**
- **SSI Policy**
- **Uniform and Dress Code Policy Approved at CCG 2022**

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Report cover-page					
References					
Meeting title:	**Board of directors**				
Meeting date:	01/09/2022		**Agenda reference:**	135c-22	
Report title:	Patient Experience Annual Report 2021/22				
Sponsor:	Nicky Reeves, Chief Nurse				
Author:	Chris Parrish, Patient Experience Manager				
Appendices:	None				
Executive summary					
Purpose of report:	The Patient Experience Annual Report aims to provide a rounded picture of patient experience and, as such, provides information on all aspects of experience, good and less positive. Data collected from complaints and patient experience is analysed so that we can help identify themes and emerging trends to sustain and improve patient experience.				
Summary of key issues	This report covers the period of 1 April 2021 to 31 March 2022. It documents how all aspects of the Patient Experience service are used to identify changes that will improve the service offer of the Trust. Overall, the Trust received fifty six (56) formal complaints during this period. The main themes are medical treatment, communication and staff behaviour. There was one case referred to the PHSO. The Trust has an overall inpatient FFT recommendation rate of 99%.				
Recommendation:	The Board is asked to **note** the annual 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:	Data in the report reviewed when writing the BAF				
Corporate risk register:	No impacts				
Regulation:	No impacts				
Legal:	Claims managed appropriately within legal frameworks				
Resources:	Nil at this time				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	25.7.22	**Decision:**		
Next steps:	N/A				

Patient Experience Annual Report

Queen Victoria Hospital NHS Foundation Trust

1 April 2021 to 31 March 2022

Document Control: Quality and Governance Committee
Executive sponsor: Nicky Reeves, Chief Nurse
Author: Chris Parrish, Patient Experience Manager
Date: 14 July 2022
Data Collection: 8 April 2022
Type: Patient Experience
Version: 2
Pages: 18

Contents List

1. **Executive Summary**

We are pleased to publish the combined patient experience complaints and Patient Advice and Liaison Service (PALS) annual report for Queen Victoria Hospital NHS Foundation Trust. This report covers the period from 1 April 2021 to 31 March 2022.

With COVID-19 continuing to be prevalent part of the lives of our patients, Queen Victoria Hospital (QVH) continued to take on the special role of a surgical cancer centre. Providing appropriate and timely treatment for patients with high-risk cancers (breast, head and neck, and skin) throughout the period. Working with hospitals from across Sussex, Surrey and Kent, our staff have built on the regional and national expertise to agree the best approach for each patient and provide them with the timely treatment they needed.

Our dedicated Patient Experience Manager who is a lone worker has been on-site and continued to promote patient experience and provide assistance and help to patients/carers and service users. During this period the Trust has continued to fully respond to complaints within prescribed timelines and did not impose any restrictions to the ongoing service

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

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

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

2. Introduction

This annual report demonstrates how the Trust measures progress towards the ambitions set out in the Trust Key Strategic Objectives (KSO), focusing on KSO1 Outstanding Patient Experience. The report includes a summary of patient and carer feedback and actions and initiatives to improve patient experience between 1 April 2021 and 31 March 2022.

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

Learning from complaints is another key strand to the Trust on where and how we need to improve our services. The themes and trends identified from complaints in this period highlight the need to improve communication and information provided to patients, carers and families, improve communication on clinical treatment, improving waiting times and improving the care provided. This should be taken in the context of our strive towards an ever improving service as we already recognise that as a high performing team we can always improve when we listen to our patients feedback.

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

This assurance comes through robust investigation with meaningful actions put in place. Posters are displayed around the Trust and there is information on the Trust website to ensure that patients are made more aware about their options and the process for raising a complaint. There is also specific training provided to all staff at their induction with the Trust to ensure they can accurately and efficiently signpost patients what to do, or who to go to, if they want to complain.

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

The purpose of this report is to provide a review of the Patient Experience data collected through the Friends and Family Test (FFT), the real time survey system, national surveys as well as themes from PALS enquiries and formal complaints received within Queen Victoria Hospital NHS Foundation Trust between 1 April 2021 and 31 March 2022.

At Board level, the Trust's Chief Nurse has responsibility for patient experience which includes:

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

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

The Chief Nurse is the Executive Lead for patient experience, who chairs the Patient Experience Group (PEG) within the Trust. Their role is to be assured that action on improving and responding to patient experience concerns are addressed. Membership of PEG includes representation from; Trust staff, Trust Governors Healthwatch and patient representatives. This group routinely reviews patient experience actions and progress, to ensure areas of poor patient experience are addressed. We know from existing feedback there are many examples of excellent care and experience being delivered by our staff and the overwhelming majority of patient's comments are very positive. Staff are frequently described as being kind towards patients and towards each other, going beyond the expected level of care.

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

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

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

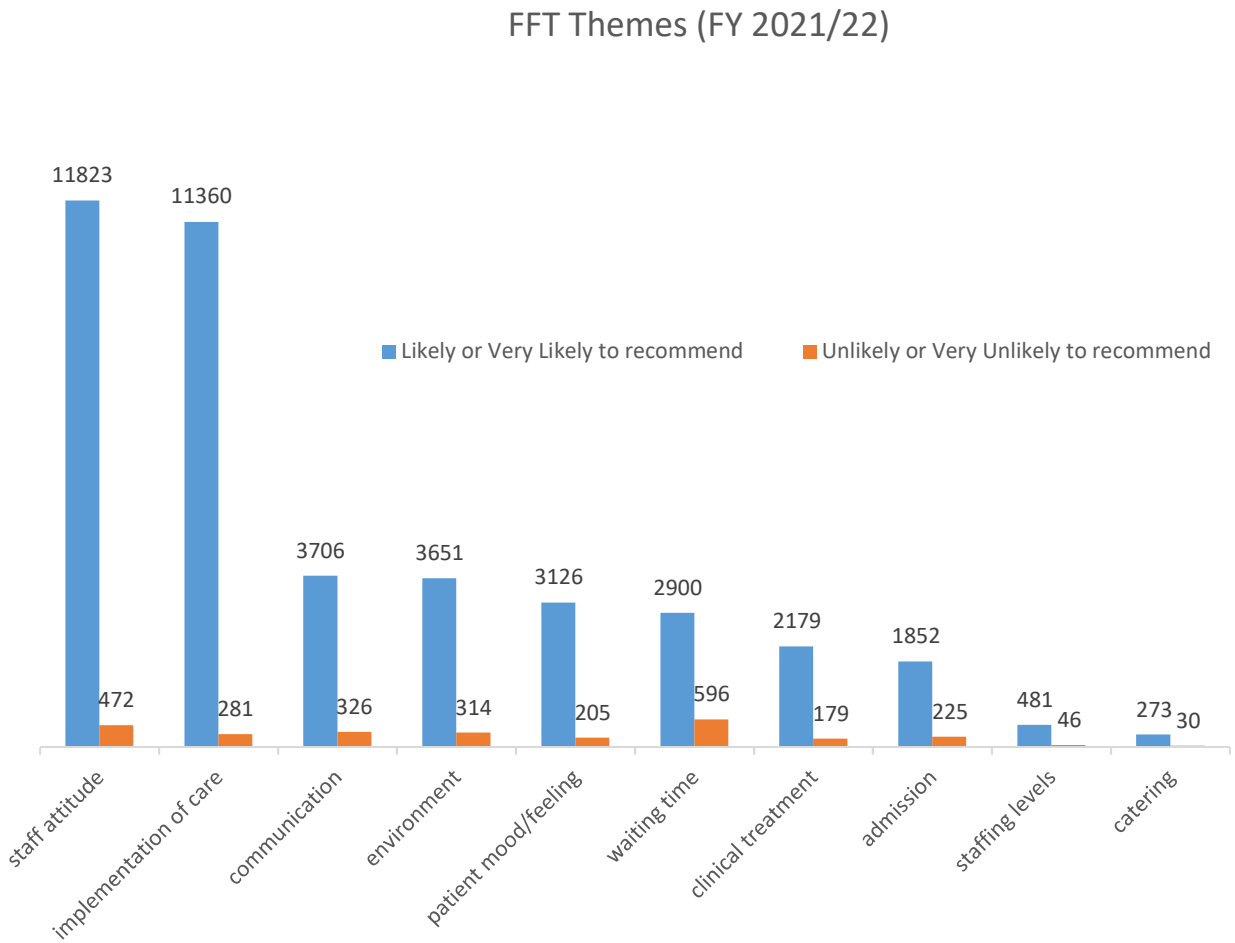
[1] NHS England & Social Care England. The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009)

3. Friends and Family Test – Capturing Patient Experience
The Friends and Family Test (FFT) gives patients who have received care through the Trust the opportunity to provide immediate feedback about their experience.

3.1 How likely are you to recommend our services to family and friends?
The FFT feedback allows us to hear from all of our patients, their carers and relatives to better understand their positive, neutral and negative experiences. In listening to this breath of opinion we can consider what we are doing well, and how we can extrapolate that information into other services, as well as hear direct suggestions for improvement.

Between April 2021 and March 2022, we received 26,510 responses to the FFT, with over 22,000 comments given. The overall percentage of inpatients recommending (very likely or likely) was 99% and all of our results bettered the national average for the period.

Through data analysis of the feedback we have a rich source of information provided to us directly by our patients. This presents the most commonly raised themes brought up by patients as improvement opportunities and areas of positivity. The table below provides these themes as a visual for the period.



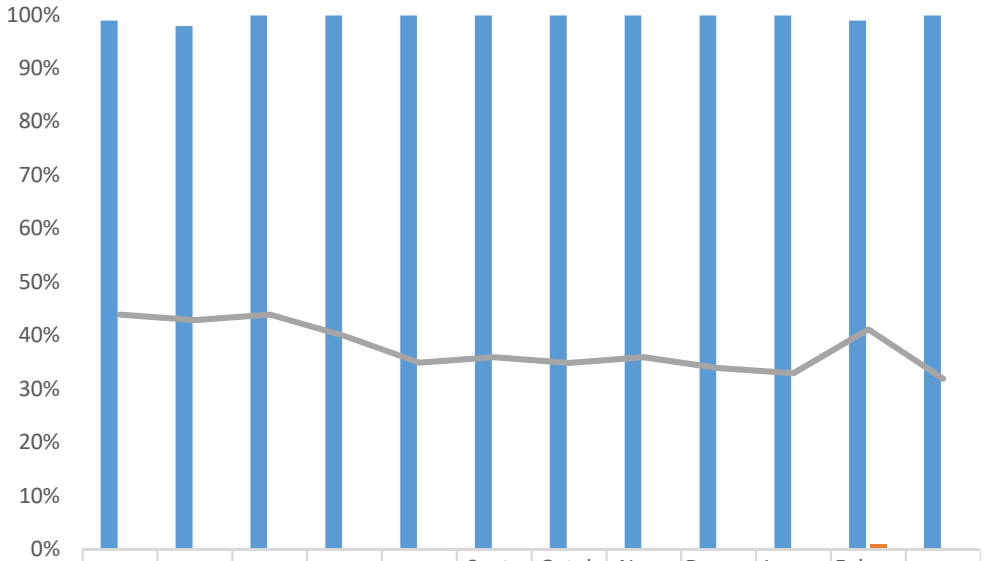
As with previous years, the vast majority of our patients are more than satisfied with the high standards of care they receive, citing the friendliness, helpfulness, excellence, clinical outcomes, professionalism and overall very positive patient experience.

Where patients felt their visit could have been improved were staff behaviour,

communication and waiting times. Of the other suggested improvements, the majority concerned issues relating to the lack of communication and information on display, specifically regarding COVID-19 measures and difficulties in parking.

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

The following chart shows the monthly inpatient Friends and Family Test results:



	April	May	June	July	August	September	October	November	December	January	February	March
Likely or Very Like to Recommend	99%	98%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%
Unlikely or Very Unlikely to Recommend	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%
Response Rate	44%	43%	44%	40%	35%	36%	35%	36%	34%	33%	41%	32%

3.2 How do we report it?

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

4. Analysing the patient experience feedback

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

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

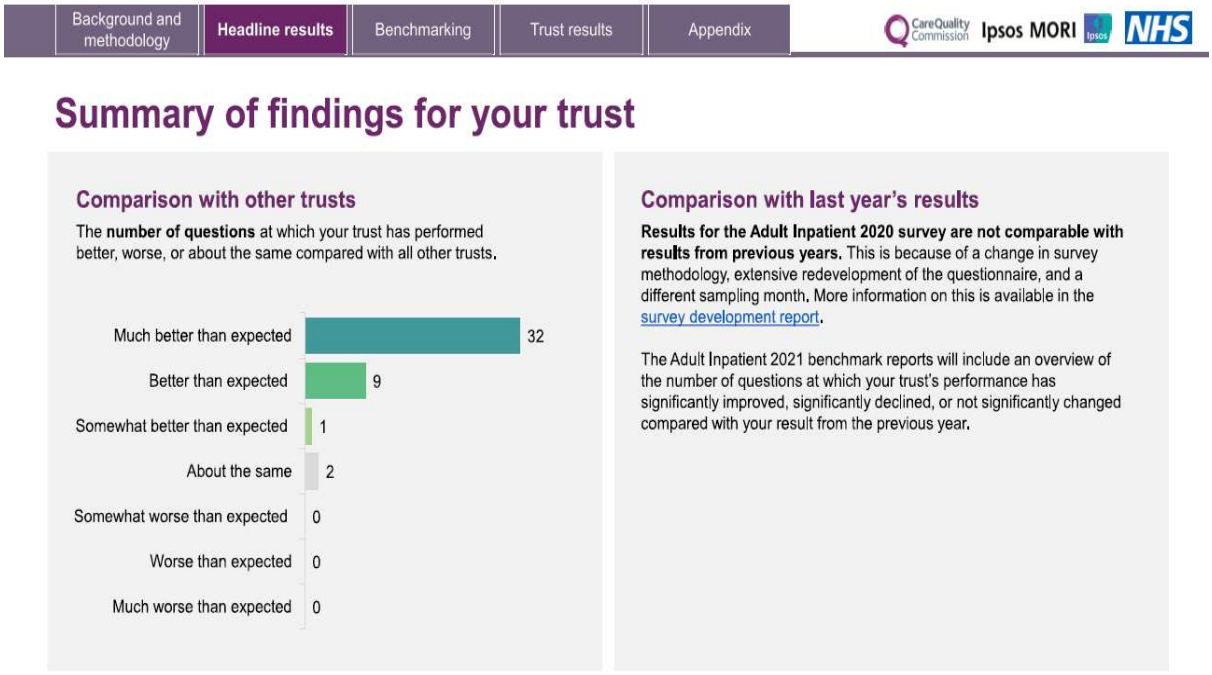
The effective analysis, accessibility and use of the large volume of data collected is facilitated by the use of our FFT database. The thematic and systemic analysis this allows, as well as the standard reports it generates, gives efficiency to the process of sharing FFT data with NHS England and learning within the Trust.

Key metrics are included in the Quality Scorecard provided to the Trust Board. Each ward

displays the FFT score for that ward for patients and staff to see.

5. National inpatient Survey 2021
This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2020. Between January 2021 and May 2021, a questionnaire was sent to 1250 inpatients at Queen Victoria Hospital NHS Foundation Trust who had attended in late 2020. Responses were received from 636 patients at this trust.

The findings of the survey have been published with the Queen Victoria Hospital being recognised as one of the top performing NHS Trusts within NHS England. Results were incredibly positive, recognising the hard work that each and every member of staff puts in to improving services and the key role our patients take in sharing how they want our services to be provided so that they are best for them. The headline results page is given below, and further information from the full report can be accessed via the recent survey results section of the QVH website.



6. Patient Story at Board

Stories can help build a picture of what it is like to be in receipt of our services and how care can be improved or best practice shared. Every bi-monthly a patient, service user or carer attends a Trust Board supported by the Patient Experience Manager to share their story directly with the Board.

The Board are keen to hear the lived experience of those sharing their story and by listening to those in receipt of our services, or caring for a loved one in receipt of our services, they gain a real insight into the direct thoughts and feelings of our patients.

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

From April 2021 and March 2022, we unfortunately had two patients who were scheduled to attend the Board but could not make it. We also had two stories presented to the Board by the patients themselves via MS Teams. These were:

- Improvement opportunity shared by the relative of a patient who attended surgery during the pandemic and was recognised to have additional support needs (September 2021).
- Positive and very personal experience of attending the corneo department during the pandemic (November 2021).

7. Patient Experience Group

The group meet on a quarterly basis, chaired by the Chief Nurse, are the key vehicle for patient representation / participation, and the group is a formal, business/assurance group comprised mainly of Trust staff, patient representatives, dementia and learning disabilities leads and Healthwatch representatives. PEG is a sub-Committee of the Board's Quality & Governance Committee. The group is a taskforce that collaboratively work together to deliver on key patient centred based on the Trust Key Strategic Objectives (KSO), focusing on KSO1 Outstanding Patient Experience and Patient Environment and Action Team (PLACE) inspection.

The group supports decision making and co-ordinates organisational change relating to patient experience and audit inspections results to support improving the delivery of patient centred care within an appropriate caring environment.

Hotel Services are an active member of the group to highlight, reviewing service criteria in light of cleaning standards and any audits, which require action that impact upon the level of current service and to share best practice.

The role of PEG is to:

- Advise the Trust on issues of concern to patients
- Form patient/representative led working groups to help develop priorities for action and ensure regular feedback on outcomes of actions
- Help develop Trust strategies, appraise information for the public developed by the Trust and help determine priorities for patient engagement
- Consider service changes and participate in a range of schemes to gather patient/ carer intelligence on Trust services including surveys, walkabouts and ward visits
- Monitor trends in complaints and feedback

- Ensure the effective implementation of action plans arising from individual local and national surveys
- Share and promote good practice in connection with patient experience

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

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

8. Complaints

This section provides a summary of formal complaints received between 1 April 2021 and 31 March 2022 in accordance with the NHS Complaints Regulations (2009). This includes:

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

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

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

The Trust uses the following definitions:

- Complaints are expressions of displeasure or dissatisfaction where the complainant wishes a formal investigation to be undertaken;
- Concerns are issues that are of interest or importance affecting the person raising them, including displeasure or dissatisfaction and where the complainant is content for the issue to be dealt with via the PALS route;
- Feedback is information/suggestions about care or services that we provide, which may be complimentary or critical;
- Compliments are expressions of thanks and praise.

The distinction between a ‘concern’ and a ‘complaint’ is challenging. Both indicate a level of dissatisfaction and require a response. It is important that concerns and complaints are handled in accordance with the needs of the individual, and investigated with an appropriate level of scrutiny. For further information please refer to our Complaints policy which gives more information on our approach to handling these cases.

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

case they wish to take their complaint further.

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

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

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

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

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

8.2 Complaints Received
From April 2021 to 31 March 2022 we received 56 formal complaints, which is an increase of 9 from the previous year (47 complaints) and can possibly be attributed to a reduction in complaints last year due to COVID-19.

Throughout this period the Trust was focused on picking up services to pre COVID-19 pandemic activity levels. It is likely that this increase in activity led to more complaints being received during this time. It is also important to recognise the impact of the COVID-19 pandemic on patient backlogs and the impact of these additional numbers on the service provided.

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

All complaints are managed individually with the complainant and in a manner best suited to resolve the particular concern raised. Methods of response can include a written response from the Chief Executive, a face to face resolution meeting with relevant staff (however during much of the year face to face meetings were not being offered due to COVID-19), and later, potentially if unresolved, an independent review of the care provided.

The Trust is committed to improving the experience of our patients from their first contact

with the Trust. Complaints and concerns provide valuable information to monitor the experience of patients, carers and relatives. Users of the service are encouraged to discuss their concerns with staff at the time the problem arises. However, it may be the case that patients feel unable to do this, or perhaps staff have tried to resolve the issue but have not achieved this. The Patient Advice and Liaison Service (PALS) provide 'on the spot advice and support' with the aim of timely resolution. In the event that this has not been achieved, PALS will give advice on the formal complaints process. The Trust recognises the value that learning from complaints and concerns brings. It is vital to make the process simple and easily accessible and leaflets and posters are displayed throughout the hospital to help facilitate feedback. These were restricted due to COVID-19 infection controls and the Trust's website has also been expanded during this time to invite feedback.

The following pages provide an indication of the Trust's position for complaints and concerns.

Complaints handling and any trends or themes identified from them are shared and discussed regularly at a number of forums including the Clinical Governance Group and the Quality and Governance Group. The Medical Director and a Non Executive Director chair these respectively and they are also attended by the Chief Executive, Chief Nurse and other members of the board, governors and staff.

All complaints should be acknowledged within 3 working days. In this period, 79% of complaints were acknowledged within 3 working days. The Trust endeavours to respond to all complaints within 30 working days in an honest, open and timely manner. If it is clear on receipt of the complaint or at any point during the investigation that the investigation cannot be completed on time, for example when a complaint is more complex or requires a joint response from services/organisations a new timeframe will be agreed with the complainant.

During this period the Trust managed 71% of complaints within timescales (30 working days) which is a very similar result to last year. However, the figure remains far below the target of 95% that the Trust strives to achieve.

The main reasons for a late response are specialty or clinical delays with the investigation, further details being requested following the review and third party involvement. This is similar to findings last year and may have been affected by the COVID-19 response. This will be monitored by the Patient Experience Manager.

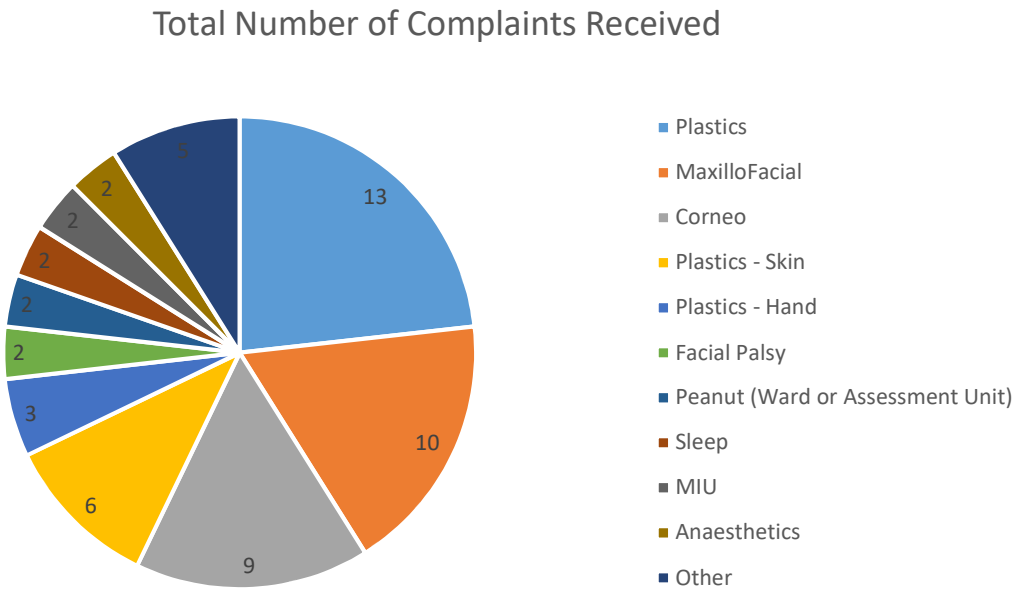
The Trust is committed to learning from any complaint received and considerable focus is placed on this aspect of the complaints process. We try to ensure that all complaints are robustly investigated and that, where action is needed to improve the care or service a patient receives, this is reflected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

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

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

Throughout this period, face to face training sessions for staff on both handling complaints and concerns on the frontline was put on hold. All new staff have received a condensed

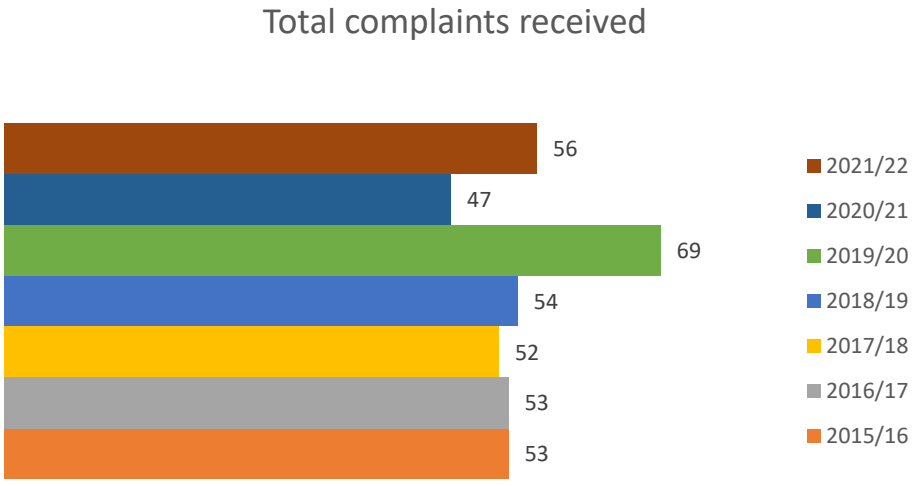
session about customer care and handling concerns at the Trust induction programme and a training leaflet was developed to accompany this training.



The chart above shows a breakdown of the complaints received this period by specialism. Only those areas where more than one complaint was received are noted. All other areas are captured in an other category. During the period reporting was improved and plastics was broken down further into subcategories. This has been captured within the chart.

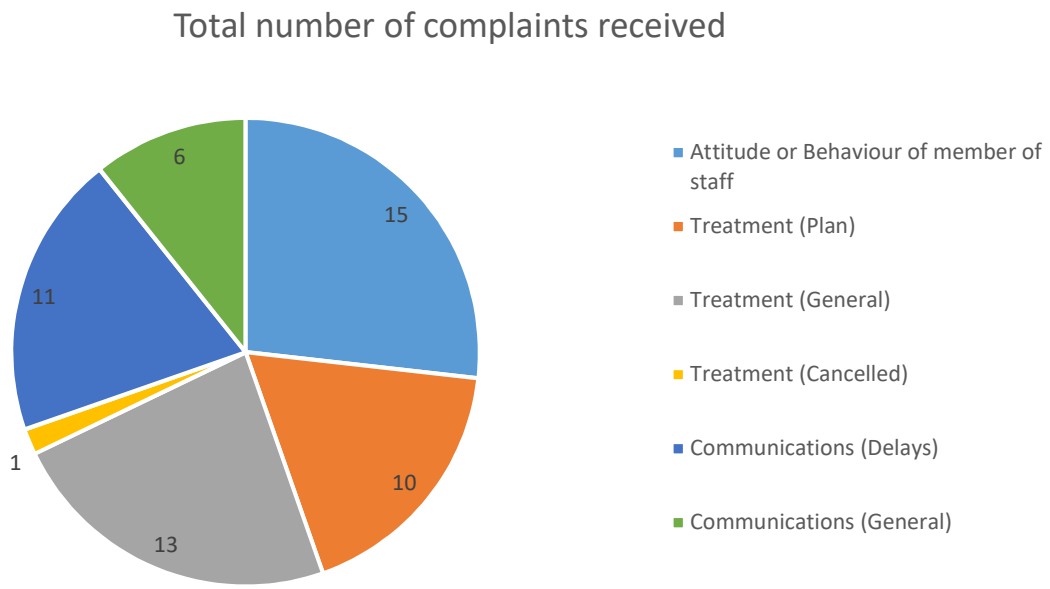
We take all negative feedback very seriously and our Chief Executive reviews all complaint responses personally before they are sent. Complaints handling and any trends or themes identified from them are shared and discussed regularly by the Executive Team and the Board of Directors.

The following is a comparison chart showing the number of complaints received since 1 April 2015 broken down into financial years.



8.3 Investigation outcomes

The following information is displayed without specialism or distinction between different teams such as nursing and medical. Additionally, treatment has been broken down into general, cancelled and plan (i.e. concern raised about the treatment plan offered/not offered and options considered) subcategories. These changes from previous reports are to make the information easier to understand at a glance and show commonality of themes that have been identified within investigations over this period.



On completion of a complaint investigation, we state whether a complaint is upheld, upheld in part or not upheld within our reporting suite. Establishing if a complaint is upheld/not upheld can be complex, as often there are a number of concerns/allegations within an individual complaint, some of which may prove to be unfounded whilst other elements are. Identifying this information helps us to better understand any training needs and the demand for any changes identified throughout the complaint investigation.

Complaints received during this period included the following themes and whether the complaints was upheld, upheld in part or unsupported:

- The ten complaints that identified as upheld included concerns relating to service failure. This is categorised for example as appointment cancellations and communication.
- The twenty two complaints identified as upheld in part were categorised as such due to clear concerns about a patient's experience being poor. This included poor communication, certain aspects where care could be improved and expectations not being met.
- The twenty four complaints that were identified as not upheld included concerns that were objective with examples like the offer, or not, of treatment. Incidental learnings were identified through the complaint investigation to improve services in conjunction with the feedback presented.

8.4 Learning from complaints, concerns or feedback
There is an organisational emphasis on both quality and timeliness of complaint handling which is re-enforced by the Board.

All complaints, together with their respective responses, are quality/accuracy checked and challenged by the Chief Executive and Head of Risk, Clinical Quality and Patient Safety. This includes recommendations for incident reporting or other independent clinical review where appropriate.

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

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

Below are examples of actions and learning identified from complaints:

- Those with additional support needs have been identified and a working group has been formed to consider this further. As a result of this group changes will be made to improve our service to help those with additional needs.

- Appointment letters have been improved to give greater clarity where clinics are what current covid measures are in place at the hospital.

- Additional support and guidance is available to members of staff. The pandemic has impacted us all differently and we recognise that supporting our staff to help them in their lives leads to them providing a better service to our patients.

8.5 Further analysis of formal complaints

- None of the 56 patients who had raised a formal complaint, approached advocacy services to support them through the complaints process.

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

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

- The Trust received two formal complaints where the complainant

stated that they had further support needs.

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

8.6 Communicating the actions we have taken

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

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

8.7 Parliamentary and Health Service Ombudsman (PHSO)

A complainant may refer their complaint to the PHSO if they do not feel that the Trust has responded to all of their concerns or they are unhappy with the way in which we have dealt with their complaint.

The PHSO gives the Trust the opportunity to ensure that all local resolution has taken place to try and resolve the issues and will give an independent view on the complaint.

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

- the Trust made mistakes or provided a poor service that amounted to maladministration or service failure and
- this has had a negative impact on an individual which has not yet been put right.

They might partly uphold a complaint if:

- they found that the Trust got some things wrong, but not all the issues that were complained about or
- the mistakes made did not have a negative effect on anyone.

If not upheld this could meant that they found:

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

There was one case referred to the PHSO in this period and it was found to be not upheld.

9. Patient Advice and Liaison Service (PALS)

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

The PALS lead works closely with the service leads to resolve problems and concerns quickly and effectively. If it becomes clear that the patient wishes to raise the issue as a

complaint, we will ensure that the concern is addressed through the complaints process. It is made clear that concerns received from, or on behalf of patients in no way affects how they are treated, and are seen as valuable information to help improve services for all patients and carers.

During the period of 1 April 2021 to 31 March 2022, there were 92 PALS enquiries which is an increase of 79% from last year, and may be attributable, in part, to record keeping improvements made by the new Patient Experience Manager:

- 58 of these were dealt with as initial complaints (one of these was referred as a formal complaint).
- 34 of these were for advice and information

The majority of these enquiries were related to appointment cancellations and operations being deferred directly or indirectly due to COVID-19. One of these enquiries was escalated and became a formal complaint.

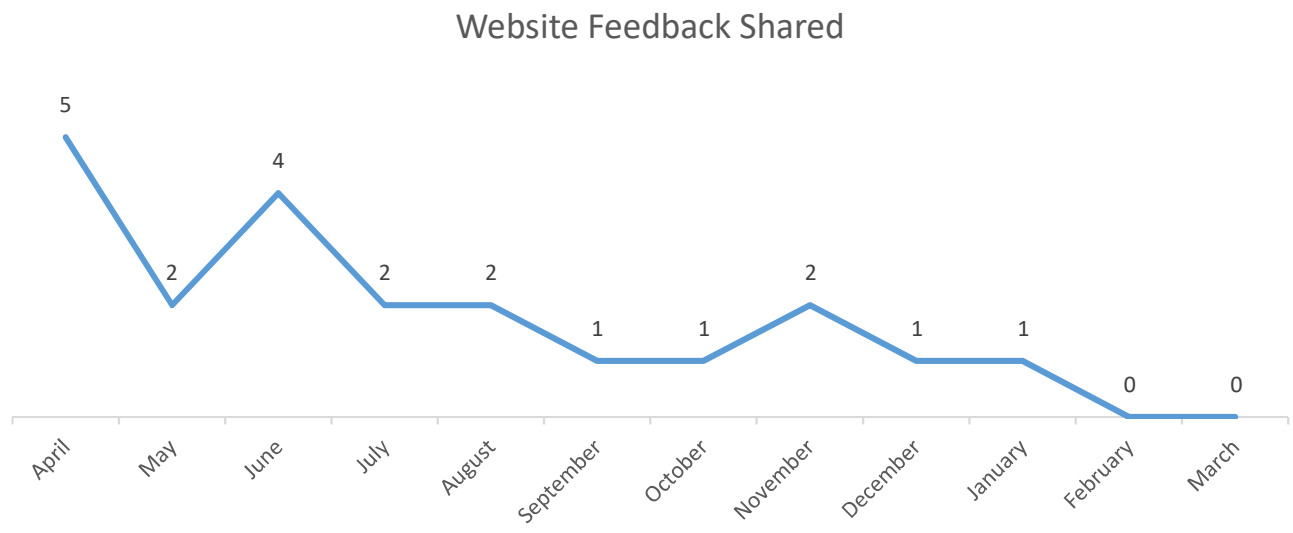
We continue to build relationships with external partners and other NHS Trusts. PALS has also continues to ensure that learning is passed on to members of staff and general managers.

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

10. Website feedback

As well as the formal feedback methods on offer, visitors to the Trust also comment about their experience using popular web and social media sites. Patient and carers can exercise the option of leaving details of their experiences / views about the providers of healthcare services they have recently used on websites such as Care Opinion.

The Patient Experience Manager responds to patients leaving feedback on online forums such as Care Opinion and the NHS website. Over the course of the financial year, 21 comments have been posted.



11. Future Development for the year ahead

- Roll out and embed high quality shared decision making (SDM) conversations between clinicians and patients;

- Consistently achieve 75% of complaints managed within agreed timescales;

- Implement the action plan resulting from the Internal Audit of the Patient Experience Service, due to be finalised in quarter one of the 2022/23 financial year.

We will do this by:

- Roll out the use of Patient First quality improvement methodology for a consistent recognised approach across the Trust
- Continue to refine the patient experience reporting
- Improve the monitoring of complaint action plans post-investigation
- Improve the response timescales by adjusting timeframes to build contingency into 30 working day turnaround
- Continuing to be open and transparent in complaint responses
- Develop ownership with operational and clinical leads that learns lessons from complaints to embed service improvement
- advise and support staff with tools and techniques with which to capture feedback, involve patients and carers and act on what they learn
- Continue to explore and refine our approach to gathering data on themes

Report cover-page					
References					
Meeting title:	**Board of directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**135d-22**	
Report title:	**Emergency Preparedness Resilience and Response and Business Continuity Annual Report 2021/22**				
Sponsor:	Nicky Reeves, Chief Nurse				
Author:	Nicky Reeves, Chief Nurse				
Appendices:	None				
Executive summary					
Purpose of report:	Annual report with 2021/22 assurance				
Summary of key issues	The 2021/22 NHS England annual assurance review has found QVH to have ***substantial compliance*** Identification of administration support for the EPRR function Covid vaccine roll out Evidence of incidents, risks and learning				
Recommendation:	The Board is asked to **note** the annual 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:	BAF reviewed when compiling this report				
Corporate risk register:	CRR reviewed when compiling this report				
Regulation:	National requirement working with NHSE and local CCG				
Legal:	The Civil Contingencies Act 2004 places a number of duties on responding agencies in the event of a Major Incident				
Resources:	Additional administration resources have been allocated to support the Trusts EPRR function				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	25.7.22	Decision		
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Emergency Preparedness Resilience and Response and Business Continuity Annual Report

Queen Victoria Hospital NHS Foundation Trust

Report covering the period from
April 2021 to March 2022

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

Author: Nicky Reeves

Date: July 2022

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

1.	Executive Summary
	The emergency preparedness resilience and response (EPRR) annual report highlights the significant EPRR events and activities during 2021/22. It also identifies the background to the duties placed on the trust regarding emergency planning. The 2021 NHS England annual assurance review process was carried out in full. The review was undertaken in conjunction with our Clinical Commissioning Group (CCG) (appendix 1).

2.	Introduction
	The Civil Contingencies Act 2004 places a number of duties on responding agencies in the event of a Major Incident. QVH is defined as a Category One responder which include the following responsibilities: • To carry out a risk assessment of our operational areas • To make emergency plans • To make business continuity plans • To warn and inform the public • To cooperate with other responders through a Local Resilience Forum • To share information with other responders During 2021/22, EPRR and Business Continuity executive leadership within QVH was held by the Chief Nurse who represented the organisation at the Local Health Resilience Partnership Executive Group (LHRP) which were held virtually due to the pandemic. The Deputy Chief Nurse attend the Sussex Health Resilience Group (SHRG) This report provides a summary of the work undertaken in relation to Emergency Planning and Business Continuity within QVH in 2021/22.

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

4.	Activity analysis/ achievement
	Policy Emergency Preparedness policies are held centrally on the Trust intranet pages

accessed via a "tile" within the Policies section; for ease they are divided into sections to reflect specific guidance. Policy review is ongoing; seasonal policies (Cold Weather and Heatwave) have been changed in line with national guidance.

All EPRR sections are currently in date or have plans to take through the governance routes at QVH.

Winter Planning

No adverse weather impact during winter of 2021/22

Storm Eunice in February 2022 was impactful and referenced in the incident section.

Seasonal Flu

The 2021/22 flu vaccination programme concluded in March 2022 with all data submissions to IMMFORM uploaded successfully.

Reasons for refusal and opt out were reviewed and updates were taken to the Trust Board.
Final uptake for staff receiving the vaccination was 66.62% this was a drop from the previous year (2020/21) where uptake had been significantly improved due to anxiety linked to the pandemic and no national covid vaccine programme at that time.

As at end March 2022

Staff Group	Vaccinated	Not Recorded	Declined	Grand Total
All Doctors	119	97	7	223
All other Professional Qualified	114	30	15	159
Qualified Nurses	180	64	20	264
Support to Clinical staff	242	89	29	360
Non patient facing	207	56	25	288
Grand Total All Staff	**862**	**336**	**96**	**1294**

Training

Training continues to be delivered at trust induction and via mandatory training There has been no significant change in compliance in both clinical and non-clinical staff groups.

Emergency planning non clinical as at 31 March 2022

Staff group	Assignment Count	Required	Achieved	Compliance %
Perm staff	396	396	377	95.20%

Emergency planning clinical as at 31 March 2022

Staff group	Assignment Count	Required	Achieved	Compliance %
Perm staff	636	636	571	89.78%

	Business Continuity Maintaining the effective continuity of our business operations is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management capability in line with BS 25999 Business Continuity Management. This includes the development of business continuity plans for core business activity. All business continuity plans can be accessed by the on call managers and site practitioner team via folders on the "N" drive and hard copies of the emergency plan area available in the incident control room in the event of a power or IT failure and all departmental leads have a copy of their individual plans. **Other activity undertaken over the year:** • Training sessions on Emergency Planning Preparedness were delivered for all new employees on induction and current employees at mandatory training as an ongoing rolling programme. • Bi monthly meeting for on-call managers, control personnel and bleep holders. • The Trust maintained its membership with the Sussex Resilience forum • Attendance at the LHRP executive Group • Additional administration support with EPRR function • Improvement in capturing Business Continuity risks

5.	**Involvement & Engagement**
	Assurance process *Internally:* Bi-monthly on-call manager meetings continue with all managers and directors who undertake on call duties being invited to the meeting. At these meetings the on-call logs and incidents are reviewed and learning is shared and actioned. As previously, new managers receive an induction session from the EPRR lead and to facilitate the transition into the element of their role. A buddy system for new on-call managers to 'test' decisions is offered for the first couple of on-call periods. There is also a system in place for non-clinical on-call managers without an operational remit to have the contact details of a manager with a clinical background to call for advice as required. EPRR updates have been discussed at Quality and Governance Committee and the annual report is presented for information at Board. *Externally:* All NHS Trusts who are category 1 and 2 responders (Civil Contingencies Act 2004) are required to complete a self-assessment and submit a statement of readiness to NHS England stating compliance against the national requirements of EPRR. The 2021/22 assurance process was formally completed with review visits and assessments by the CCG EPRR team. QVH was found to have substantial compliance, an improvement on previous years. The confirmation letter and areas for improvement are in appendix 1

6.	Learning from Experience

Practice Exercises and Live Events

During 2021/22 QVH has tested its emergency planning resilience during a number of "live" incidents as identified below.

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

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

Incidents

QVH has had a particularly challenging year with regards to managing incidents both unexpected and also planned business continuity issues.

The most severe of these was the three day break in mains water supply following Storm Eunice in February 2022. This impacted the Trust significantly and the debriefing identified learning points to assist the Trust with making changes moving forwards.

There have been a number of "planned" but impactful IT upgrades over the course of the year which have allowed us to exercise our IT disaster recovery plan and business continuity plans for all departments.

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

Risks

There are currently 28 risks related to EPRR or Business Continuity issues.

There are 8 which are considered to be severe enough to be captured on the Corporate risk register with the remaining 20 locally managed.

Of the 8 corporate, these are all considered to be risks to business continuity including IT challenges.

Covid 19 Pandemic

During 2021/22 QVH has been continued to be fully involved and engaged in the national response to COVID 19. Throughout the period and still, the incident room is open as mandated seven days per week. QVH complies with all requests for situation reports (Sitreps) and has robustly managed numerous competing demands during this time. Gold command for this incident has been held by Chief Nurse, ensuring the provision of consistent senior clinical and managerial decision making. An extensive integrated governance system has been embedded to take forward actions and decisions required from the external incident control as well as the internal ones and monitor progress and outcomes.

Covid 19 Vaccination Programme

QVH ran a successful Covid booster vaccination programme and will be commencing planning for any autumn boosters shortly.

7.	Future plans and targets
	The EPRR lead has reviewed the actions highlighted in the 2021/22 EPRR assurance document to ensure the organisation has satisfactory arrangements in place to meet the requirements of the EPRR function. The assurance process for 2022/23 has not yet been agreed but QVH will endeavour to achieve improved compliance with the standards.

8.	Conclusions and assurance
	The Trust currently has effective policy and systems in place for the effective management of expected and unexpected EPRR and business continuity incidents. It meets the requirements of the category one responder as evidenced in appendix 2. Due to the specialist and particular nature of the Trust, full compliance with national EPRR standards may always be a challenge.

Report cover-page					
References					
Meeting title:	**Board of directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**135e-22**	
Report title:	**Research & Innovation Annual Report 2021-22**				
Sponsor:	Tania Cubison, Medical Director				
Author:	Sarah Dawe, Head of Research				
Appendices:	None				
Executive summary					
Purpose of report:	To summarise R&I activity in 2021-22				
Summary of key issues	• Our focus during 2021-22 has very much been on recovering from the pandemic and rebuilding our programme of research studies, which had to be curtailed during the height of COVID19. This led to a considerable expansion in activity, with our key performance metric of recruitment increasing by **63%**. • Last year R&I were able to make a favourable contribution to the Trust's bottom line for the first time, and we were pleased to have been able to repeat this in 2021-22, with **a £10,705** contribution. We also ended the year **£75,169** ahead of budget. • In 2021-22 we recruited **575** participants, of which **535** were to National Portfolio studies. This represents an increase of **63**% in recruits over the previous year, reflecting the bounce back from the pandemic. We expect this increase in activity to continue throughout 2022-23. • We continued to support followups for the important national SIREN study, which informed government policy regarding the pandemic. • In common with much of the NHS, we had challenges with staff sickness, which did impact on our capacity to undertake research, but we now have a highly experienced, full research nurse team to support studies going forwards. • We took part in the national anonymous Participant in Research Experience Survey, which showed that **98%** of our respondents felt that their participation was valued; **99%** agreed that research staff always treated them with courtesy and respect; and **88%** said that they would consider taking part in research again. Respondents commented on the friendliness and professionalism of research staff, and of the benefits of taking part - both for themselves and for future generations.				
Recommendation:	The Board is asked to **note** the annual 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:	None
Corporate risk register:	None
Regulation:	All research at QVH is conducted under the UK Policy Framework for Health and Social Research
Legal:	All research at QVH is conducted under the UK Policy Framework for Health and Social Research
Resources:	None

Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	25.7.22	Decision:		
Next steps:	N/A				

Queen Victoria Hospital
NHS Foundation Trust

Holtye Rd
East Grinstead
RH19 3DZ

Queen Victoria Hospital NHS Foundation Trust
Research & Innovation Annual Report

Report covering the period from
April 2021 to March 2022

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1. Executive Summary

- Our focus during 2021-22 has very much been on recovering from the pandemic and rebuilding our programme of research studies, which had to be curtailed during the height of COVID19. This led to a considerable expansion in activity, with our key performance metric of recruitment increasing by **63%**.

- Last year R&I were able to make a favourable contribution to the Trust's bottom line for the first time, and we were pleased to have been able to repeat this in 2021-22, with **a £10,705** contribution. We also ended the year **£75,169** ahead of budget.

- In 2021-22 we recruited **575** participants, of which **535** were to National Portfolio studies. This represents an increase of **63**% in recruits over the previous year, reflecting the bounce back from the pandemic. We expect this increase in activity to continue throughout 2022-23.

- We continued to support the important national SIREN study, which informed government policy regarding the pandemic.

- In common with much of the NHS, we had challenges with staff sickness, which did impact on our capacity to undertake research, but we now have a highly experienced, full research nurse team to support studies going forwards.

- We are proud that three of our clinicians acted as Chief Investigators on National Portfolio studies (Charles Nduka, Raman Malhotra, Baljit Dheansa). These are studies that we have initiated and designed ourselves, and which have been adopted onto the prestigious National Portfolio – the UK gold standard for high quality clinical research.

- We took part in the national anonymous Participant in Research Experience Survey, which showed that **98%** of our respondents felt that their participation was valued; **99%** agreed that research staff always treated them with courtesy and respect; and **88%** said that they would consider taking part in research again. Respondents commented on the friendliness and professionalism of research staff, and of the benefits of taking part - both for themselves and for future generations

2. Introduction

As the Director of Research & Innovation, it gives me great pleasure to introduce the annual Research and Innovation Report for 2021/2022.

The Research & Innovation team has worked hard to implement the post COVID-19 recovery plan. We have continued to support a diverse range of existing studies, as well as initiating new research projects. The department continues to grow a robust research portfolio with an active presence as part of the regional CRN and at a national level. We have seen an increase in patient recruitment, which has contributed to a positive financial position.

I would like to thank the researchers, research nurses and the administrative team. I also would like to pay tribute to all the members of the Research Governance Group, who continue to support the research we run at the Queen Victoria Hospital .

Mr Zaid Sadiq

3.	Service aim, objectives and expected outcomes
	Research & Development improves outcomes for patients both at QVH and in the wider NHS. This is achieved through a research programme which focuses on quality, transparency and value for money. R&I at QVH is performance-monitored by our local CRN. Research activity is tracked on a daily basis via an interactive online system (Edge), as well as via regular meetings and written reports. One key objective by which the CRN measures our performance is a 'Value For Money' (VFM) measure. This year, our VFM greatly improved as we began to recover activity following the pandemic, with a cost-per-weighted-recruit of around £140 – a 19% improvement over the previous year.

4.	Activity analysis/ achievement

Research Activity

The number of patients receiving NHS services provided or sub-contracted by the Queen Victoria Hospital NHS Foundation Trust in 2021-22 that were recruited during that period to participate in research approved by the Health Research Authority was **575** of which **535** were recruits to National Portfolio studies. This represents a 63% increase in National Portfolio activity over the previous year, reflecting the significant increase in activity following the pandemic.

Participation in clinical research demonstrates QVH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

QVH was involved in conducting 23 clinical research studies in 2021-22, as per the tables below.

Study ref in appendix	Project Short title	Start date	Principle Investigator	National Portfolio study	Recruit-ment in 2021-22
1	SNAP3	21/03/2022	Fiona Ramsden	Yes	48
2	MIDI (MR Imaging abnormality Deep learning Identification)	04/10/2021	Ian Francis	Yes	115

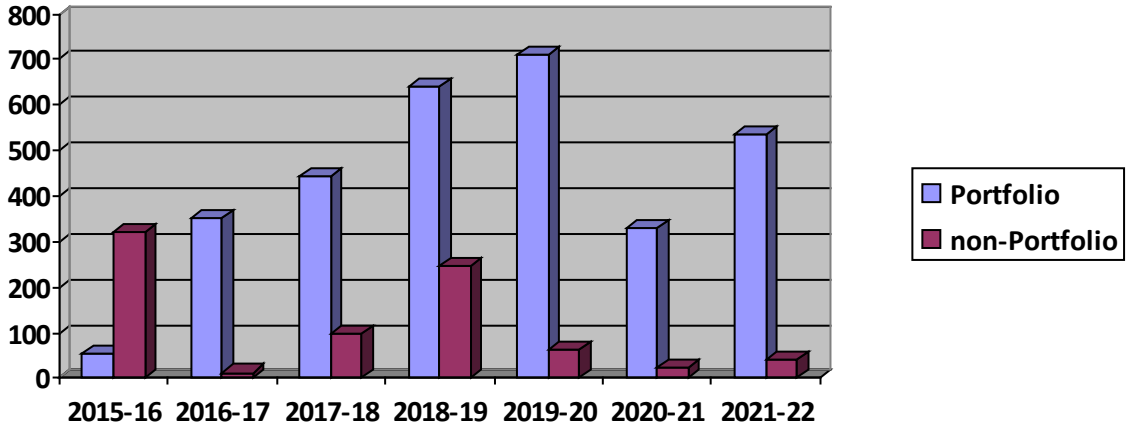
3	Organisational resilience questionnaire development and validation	24/01/2022	external	Yes	0	
4	Dystonia grading scales study	01/07/2021	Raman Malhotra	No	38	
5	QoL and functional outcomes after Mandibulectomy Reconstruction	30/04/21	Jag Dhanda	No	0	
6	SAVER	29/10/2021	Zaid Sadiq	Yes	1	
7	SARS-COV2 immunity and reinfection evaluation (SIREN)	17/08/2021	Julian Giles	Yes	In follow up	
8	The COVID-19 Resilience Project	22/05/2021	N/A	No	0	
9	GenOMICC	05/05/2021	Julian Giles	Yes	0	
10	NEON - digital NErve, suture Or Not	18/11/2021	Rob Pearl	Yes	5	
11	Are subjective pain scores related to facial muscle activity? - EMG pain scores	15/09/2021	Charles Nduka	Yes	53	
12	The anatomy of flexor tendon repair-IRP student study	01/10/2018	Rob Pearl	No	0	
13	TEARS	12/11/2018	Raman Malhotra	Yes	39	

14	XEN45 in Angle Closure Glaucoma	22/11/2018	Gok Ratnarajan	Yes	Closed to recruitment
15	Haemostatic markers in ECMO (HAE) study	25/01/2018	N/A	Yes	0
16	Smartmatrix SMA0217	10/09/2018	Baljit Dheansa	Yes	In follow up
17	Perioperative Quality Improvement Programme: Patient Study	03/05/2017	Julian Giles	Yes	191
18	Validation of MIRROR application for facial paralysis	11/03/2021	Charles Nduka	Yes	paused
19	Investigation of Potential Biomarkers in the Role of Scar Formation	16/03/2016	Baljit Dheansa	Yes	16
20	SUBMIT	21/09/2016	Asit Khandwala	Yes	Closed to recruitment
21	Molecular basis of chronic inflammatory and degenerative diseases	30/11/2015	Asit Khandwala	Yes	67
22	Clinical Characterisation Protocol for Severe Emerging Infection	03/02/2021	N/A	Yes	1
23	Is MGI or upper marginal entropion a contributing factor in the development of SLK	25/02/21	Raman Malhotra	No	2

Our work on NIHR Portfolio studies

Recruitment to NIHR National Portfolio studies is recorded and monitored via a national database, and the level of CRN funding received by the Trust is partly determined by these accrual figures. In the past six years, the number of Portfolio participants recruited has greatly exceeded the number of non-Portfolio recruits, reflecting a strategic push to increase the proportion of Portfolio studies we undertake. This year activity bounced back from the COVID19 pandemic with a **63%** increase in participant recruitment over the previous year, at **535** recruits.

Research Participant Recruitment 2015-2022



External Funding

Core funding

The CRN awarded the Trust **£193,273** core funding in 2021-22, plus £5835 contingency funding, and £6000 Specialty Lead Funding. The CRN determines its level of funding partly using an algorithm based on the number of patients recruited to Portfolio studies over the previous two years. This activity-based funding formula is a key driver for how research work is prioritized at QVH.

Funding was allocated according to CRN guidelines in the following way:

Resource	Allocation
Lead Research Nurse B7	30,078
Research Nurse B6	43,468
Research Nurse B6	41,918
Research Nurse B6	26,301
CRN Specialty Leads	6000

Head of Research	44,256
Office/IT/consumables/training	2169
Overheads	10,913

The Trust also received **£750** from the Brighton and Sussex Medical School to support the IRP students who undertake fourth-year research projects at the hospital.

R&I has been working towards a cost neutral position for the past few years, by reducing costs and increasing income, and last year we were in a position for the first time to make a favourable contribution at year end. We have managed to improve this contribution in 2021-22, with a contribution of £10,705 to the Trust's bottom line. We also ended the year £75,169 ahead of budget.

5. Involvement & Engagement

Patient and Public Involvement and Engagement

QVH continues to work to find meaningful ways to involve patients and members of the public in its research activity. We are fortunate to have on our R&I Governance Group two very involved patient representatives, who take an active role in advising on and monitoring the research activities of the Trust. Patients are also sometimes involved in the early stages of research projects via focus groups, which feed into protocol development.

As we gradually took on more research activity, the opportunities for public involvement increased, and we were able to take part in the national anonymous PRES (Participant in Research Experience Survey) questionnaire, and received 68 completed questionnaires.

Data from PRES is reviewed regularly throughout the year and helps us better understand the experience of research participants and how we might improve their experience. The results are shared both internally and with our CRN. Overall, the PRES survey paints a positive picture of people's experiences of taking part in research. Respondents comment on the friendliness and professionalism of research staff, and of the benefits of taking part, both for themselves and for future generations. **98%** of people felt that their participation was valued; **99%** felt that research staff always treated them with courtesy and respect; **88%** said that they would consider taking part in research again.

Clinical Research Network (CRN)

The Trust is a member of the Kent, Surrey, and Sussex Clinical Research Network (CRN). We work with the CRN to maximize opportunities for Portfolio studies, identify new studies the Trust may participate in, and implement new national systems and structures. The CR N distributes R&I resources amongst its members according to an activity-based algorithm. The CEO sits on the CRN Partnership Board, and the Head of Research and the Director of Research & Innovation regularly attend CRN finance and performance meetings, working closely with the CRN Link Manager and her team. Meeting CRN targets is a priority area for the Trust.

Our people

Clinical Research Staff

We are proud that three of our clinicians acted as Chief Investigators on National Portfolio research studies in 2021-22 (Charles Nduka, Raman Malhotra, and Baljit Dheansa).

In 2021-22, the Trust supported one Lead Research Nurse (0.6WTE), one B7 Research Nurse (0.7WTE), three B6 Research Nurses (2.61WTE), and one Research Assistant (0.2WTE). Our B7 Research Nurse was seconded to the Staff Testing Lab throughout most of 2021-22 in order to support the COVID effort.

Some clinical departments also each have their own arrangements for Research Fellows. These are funded by the departments themselves and are not managed by the R&I Department. In addition, we have identified nurses within different clinical areas who have been trained up to support research in their own department.

Research Management and Governance

The R&I Department presently consists of one Director of Research & Innovation, one Head of Research (0.66WTE) one Research Governance Officer (13.8h/wk), and one Research Assistant (0.2WTE).

Funding was received from the Clinical Research Network (CRN) to support research management and governance. Other income to support the R&I infrastructure comes from commercial studies, which in addition to paying general Trust overheads, contribute a fee for R&I Department services in assessing applications, setting up contracts, and implementing and monitoring studies.

Intellectual property and Innovation

The Trust has engaged the services of NHS Innovations South East to assist with commercializing and developing its intellectual property.

Training and Development

Local Training
Individual support tailored to the individual is provided by the R&I Department to all new researchers who require guidance developing their protocols, navigating the approvals process and setting up their studies.

It is a legal requirement that all staff involved in clinical trials complete Good Clinical Practice (GCP) training, and the Trust has facilitated this for staff – either by enabling access to off-site courses at other Trusts, or by paying for staff to do an individual online course. Commercial companies also regularly run refresher GCP courses for staff involved in the clinical trials they run at the Trust.

This year our research staff also attended courses on ACCORD cost attribution, Evolve,

special needs for learning disability and autism awareness, Covid 19 vaccination, risk assessments, paediatric consent, Lab training, as well as attending the British Burns Association Conference, an Ophthalmic Study Day, and a Plastics Study Day

CRN training
The Trust also has access to training provided by the CRN for any studies which are accepted onto the National Portfolio. A wide range of courses are offered, including GCP training.

Research Design Service
The NIHR Research Design Service South East offers a very good service in supporting staff making grant applications. They provide us with invaluable advice on study design and methodology.

Governance

R&I at the Trust is overseen by a Research & Innovation Governance Group. Its members include: Director of Research & Innovation, Chief Pharmacist/Clinical Trials Pharmacist, Anaesthetics Lead, Burns Lead, Corneoplastics Lead, Hand Surgery Lead, Maxillofacial Lead, Director of Nursing, Oncoplastics Lead, Healthcare Science Lead, Orthodontics Lead, Head of Research, Finance Department Representative, Designated Individual with Responsibility for Human Tissue Authority License, and External Academic Advisors from the University of Brighton. The Group also has two very active patient representatives who play a valuable role in advising on new projects.

The R&I Governance Group reports to the Quality and Risk Committee.

The Director of Nursing acts as the Trust's Nominated Consultee for research participants unable to consent.

***Trust policies which cover R&D*:** Adverse Event Reporting Policy, Research Fraud Policy, Code of Practice for Researchers, Pharmacy policy for Clinical Trials, Intellectual Property Policy.

R&I approvals and targets

QVH has effective, streamlined systems for managing R&I approvals in proportion to risk, and our turnaround times are generally swift. The R&I Dept provides guidance with using the national IRAS applications system, and works with the Health Research Authority (HRA) to approve studies and ensure they meet national guidelines. We use the Edge online system to manage and monitor research here at the Trust.

Sponsorship status

Some research carried out at QVH is investigator-led ie designed and conducted by our own staff, and these require the Trust to provide structures to support pre-protocol work and peer-review, as well as the subsequent management of active projects. We currently have two Chief Investigators at the Trust who have initiated QVH-Sponsored National Portfolio studies (Raman Malhotra and Charles Nduka), as well as two Chief Investigators for non-Portfolio studies.

No research study may begin in the NHS without a Sponsor being identified. The Trust continues to offer its researchers the benefits of providing Sponsor status for the studies they initiate. QVH believes that it is right to support its researchers in developing new projects, and

	to encourage the spirit of intellectual enquiry, and so continues to provide Sponsorship status for all single-site non-CTIMPs.

6.	Learning from Experience
	This year we have focussed our efforts on rebuilding our research programme following the pandemic. There remains work to be done, but we have made good progress. Despite the challenges of the past year, R&I has maintained its financial stability, and has made a £10,700 favourable contribution to the Trust's bottom line.

7.	Recommendations
	Research has made a significant step in getting back to our pre-pandemic levels of activity, with a 63% increase in recruitment over the previous year. We need to continue this good work in the coming year and sustain our focus on supporting and developing Portfolio studies in order to achieve our pre-pandemic levels of activity.

8.	Future plans and targets
	Specific targets for 2022-23: • Continue to rebuild our research programme with the aim of getting back to our pre-pandemic level of activity • Maintain at least a cost-neutral position Progress towards these targets will be monitored by the CRN and by the R&I Governance Group.

9.	Conclusions and assurance
	Research recovered well from the challenges of the Covid19 pandemic, with a 63% increase in activity. We expect to get back to our full pre-pandemic levels of activity by the end of 2022-23. On the front line and behind the scenes our research team continued to work collectively on rebuilding our research programme. COVID-19 has forced us to do things differently and to be flexible, but the team has responded well to this. R&I maintained robust finances despite the challenging environment. This year we were able to make a £10,700 favourable contribution to the Trust's bottom line, and ended the year £75K ahead of budget.

10.	Appendices

Registered research projects (with HRA Approval) ongoing in 2021-22

1 SNAP3

More older people are undergoing surgery as the population ages and surgical care improves. Frailty is an agerelated syndrome that increases an individual's vulnerability to adverse outcomes in response to illness, injury and surgery. Delirium is a period of temporarily altered, fluctuating consciousness, triggered by illness, surgery or environment. There is evidence that surgical outcomes are worse in patients with these conditions. The purpose of SNAP3 is to investigate which patients are frail and which are at risk of delirium. It will investigate current perioperative care and its outcomes.

The research includes three parallel studies which will run in NHS hospitals within the UK. S2 and S3 are service evaluation surveys for clinicians and are included for completeness:

2 MIDI (MR Imaging abnormality Deep learning Identification)

There is a wide variation in how incidental findings (IFs) discovered in 'healthy volunteers' are managed. Routine reporting of 'healthy volunteer' scans by a radiologist is a challenging logistic and financial burden. It would be valuable to devise automated strategies to ensure that IFs can be reliably and accurately identified potentially removing 90% of scans requiring routine radiological review, thereby increasing the feasibility of implementing a routine reporting strategy.

An automated strategy could also address the unmet clinical need in identifying abnormalities quicker, potentially allowing for early intervention to improve short and long-term clinical outcomes. Radiologist shortages and increased demand for MRI scans mean delays in reporting, particularly in the outpatient setting.

Deep learning is a new technique in computer science that automatically learns hierarchies of relevant features directly from the raw inputs (such as MRI or CT) using multi-layered neural networks. A deep learning algorithm will be trained on a large database of head MRI scans to recognise scans with abnormalities. This algorithm will be trained to classify a subset of these scans as normal or abnormal. The technique will then be tested on an independent subset to determine its validity.

If the tested neural network has a high diagnostic accuracy, future research participants may benefit as currently not all institutions review their research scans for incidental findings. Similarly, in those cases where scans may not be reported for weeks, patients may benefit. In both research and clinical scenarios, an algorithm would quickly identify abnormal pathology and prioritise scans for reporting.

In summary, the aim is to develop a deep learning abnormality detection algorithm for use in both the research and clinical setting.

3 Organisational resilience questionnaire development and validation

This research involves exploratory testing of a widely used, but poorly tested concept of organisational resilience in a healthcare context. Resilience refers to the ability of an organisation to 'bounce back' or recover from an unexpected event. Unexpected events, such as infection outbreaks have a significant adverse impact on many hospitals.

Understanding what constructs constitute resilient approaches at organisational level will help improve hospitals' preparedness and response to unexpected events.

A questionnaire designed to ascertain the constructs comprising organisational resilience will be developed from the literature and a case study and then validated across a sample of hospital staff from England. The results from the questionnaire will be collated and statistically analysed. The analysis will attempt to validate the questionnaire as a tool to test organisational resilience in a hospital context. The research aims to provide an improved understanding of organisational resilience in healthcare with the aim of developing practical strategies that can be adopted by hospitals to become more resilient and maintain or improve their healthcare outcomes.

4 Dystonia grading scales study

Essential blepharospasm (EB), hemifacial spasm (HFS) and aberrant regeneration of the facial nerve (AFR) are all movement disorders treated with botulinum toxin. Botulinum toxin (BoNT) was first approved for medical use on extraocular muscles to treat non-accommodative strabismus and, subsequently, efficacy was demonstrated in EB, HFS and AFR. A number of different measurement tools and scales have been used to evaluate the effects of BoNT on various aspects of blepharospasm, including force of eyelid closure, severity of muscle spasms and patient functional status.

Today the rating instruments have coalesced into several main clinical scales including the Jankovic Rating Scale and the Blepharospasm Disability Index (BSDI).
Instruments that assess activities of daily living or patient functional status are rated by the patients themselves. These scales recognise the importance of improvement in activities of daily living as an outcome of therapy. Whilst the validity of the BSDI is well documented to date the FDS has not been fully validated by any other centre apart from the original describer.

The principle aim of this study is to repeat validation of the FDS against the BSDI which has been validated by several groups since its original description. In particular we aim to compare the rating scales with respect to their metric properties in patients with EB, HFS and AFR. The metric properties of the scales, with special regard to their usefulness for assessment of treatment efficacy, include evaluating the internal consistency (as an aspect of reliability), convergent validity and equivalence in comparison to the other scales and sensitivity to change with treatment as another aspect of validity.

5 Quality of Life and functional outcomes after Mandibulectomy Reconstruction

Traditionally, fibula free flap is used for reconstruction of segmental mandibulectomy defects. However, donor site morbidity is a recognized problem with Momoh et al., (2011) reporting donor site complications as high as 30%. This has significant implications on patients (pain and mobility) and the NHS due to increased hospital visits and costs associated with treating these complications.

Bowe et al. (2020) published a cohort of 30 patients who have undergone reconstruction of posterolateral segmental mandibulectomy defects (Brown Class I Defects) with a mandibular reconstruction plate (MRP) and anterolateral thigh (ALT) axis free flap with a low incidence of complications, demonstrating its feasibility of use as an appropriate reconstructive option in this specific cohort of patients.

This retrospective questionnaire-based study aims to compare donor site morbidity and patient experience in terms of functional outcomes and quality of life for those patients who underwent ALT or FFF for the reconstruction of segmental mandibulectomy defects. We will be using three standardized questionnaires that have been validated for use in head and neck cancer patients.

In a separate arm of the study, we will also be looking at the role of vacuum-assisted closure (VAC) compared to simple pressure dressings + split-thickness skin grafts (STSG) in influencing these outcome measures. We recently presented a retrospective audit investigating the role of VAC dressings which demonstrated a reduction in healing time and re-admission rates to hospital in relation to the donor site. We are keen to build upon this preliminary work in this study.

The eventual aim of this project would be a work-up to a prospective randomized controlled trial to investigate donor site morbidity and functional outcomes of ALT versus FFF in reconstruction of segmental mandibulectomy defects.

6 SAVER

Individuals can develop patches (oral dysplasia) on the lining of the mouth which are at risk of developing into cancer. Standard treatments include surgery or close surveillance, although these treatments are not completely effective, as up to 25% of patients progress to oral cancer even after surgery. Oral cancer treatments can be curative, especially when caught early, but the side effects include damage to speech, swallowing, appearance and reduction in quality of life, which are permanent. Additionally treatment for oral cancer carries a high economic burden and the World Health Organisation has recommended a shift in policy towards early diagnosis and prevention. Survival rates for oral cancer have remained largely unchanged for decades, at around 50-55% overall survival by 5 years. There is, therefore, a need to develop and evaluate new prevention treatments for this condition. It is thought that more effective treatment for oral dysplasia would reduce the incidence of oral cancer.

SAVER is a phase II clinical trial with embedded mechanistic and feasibility studies. It is randomized, double blind and placebo controlled with a planned recruitment of 110 patients. The randomisation is in the ratio 2 SV (73 patients) :1 placebo (37 patients). The study population includes patients with premalignant oral lesions that have a histological diagnosis of oral epithelial dysplasia (OED) and are at high risk (considered to be at least 20% over 5 years of malignant transformation).

The aim of this phase II trial is to investigate the effects of sodium valproate as epigenetic chemopreventive therapy on high risk oral dysplasia. In particular, we will establish: clinical activity, mechanism of action and, feasibility of conducting such research in the NHS, in order to inform a decision on a larger phase III trial.

7 SARS-COV2 immunity and reinfection evaluation (SIREN)

This study aims to find out whether healthcare workers who have evidence of prior COVID-19, detected by antibody assays (positive antibody tests), compared to those who do not have evidence of infection (negative antibody tests) are protected from future episodes of infection. In this study, we will recruit healthcare workers to be followed for at least a year and study their immune response to the virus causing COVID-19, called SARS CoV2. We will do this by collecting data on their history of COVID-19 infection and any new symptoms. All NHS staff who deliver care to patients are being asked to have a nose and throat swab every other week in order to detect mild cases or cases who do not have symptoms. This is the main test that is currently used to detect and diagnose infection. It looks directly for the virus in the nose and throat. Once the infection is cleared, we cannot detect virus in samples. Therefore, we will also ask these individuals to have blood samples taken every other week to determine whether they have antibodies to the infection. These blood samples allow the previous infection to be detected as the response to infection in the body is to produce small particles in the blood called “antibodies”. It takes up to 4 weeks to make enough antibodies to fight the infection. But once someone recovers, antibodies stay in the blood at low levels– this is may help prevent us from getting infected with the same infection again. However, for SARS CoV2 infection we do not know yet if the detection of antibodies protects people from future infections. Through this study, we will provide this very important information which will help to understand the future impact of COVID-19 on the population.

8 The COVID-19 Resilience Project

It is vital that we explore the immediate and longer-term psychological impact of COVID-19 on NHS staff in order to better understand how to effectively support staff psychological wellbeing and mental health during this time.

This self-report questionnaire project will aim to: Evaluate the impact of COVID-related stressors on a range of mental health outcomes of interest, including anxiety, depression, post-traumatic stress, general well-being and compassion fatigue/burn-out; To investigate the effect of relevant psychological markers of risk and resilience that might aggravate or buffer the impact of COVID-related stressors on mental health and well-being outcomes; Evaluate impact of COVID-19 on post-traumatic growth and compassion satisfaction; Follow-up the impact over time, by inviting participants to re-complete the questionnaires after 4, 8, and 12 months; Gather follow-up qualitative data to further explore the above topics

9 GenOMICC

The GenOMICC (Genetics of Susceptibility and Mortality in Critical Care) study will identify the specific genes that cause some people to be susceptible to specific infections and consequences of severe injury. Our hope is that identifying these genes will help us to use existing treatments better, and to design new treatments to help people survive critical illness. To do this, we will compare DNA and cells from carefully selected patients with samples from healthy people.

10 NEON - digital NErve, suture Or Not

Digital nerves are small nerves that pass along the side of each finger and provide sensation to the fingertips. These nerves can be accidentally cut when handling sharp objects like a knife or broken glass. The NEON study aims to find out whether sewing the ends of the cut nerve surgically is beneficial or even needed. Thoroughly cleaning the cut wound before closing the skin is a much simpler procedure, and may be satisfactory for patients.

There is some evidence that both treatments give good results. There is also some evidence that patients may not fully recover the feeling in their injured finger, even after the nerve has been sutured. Research so far has been conflicting and is of varying quality. For example, some studies do not directly compare treatments, or do not ask patients about their views of recovery.

NEON will compare surgical procedures for digital nerve repair, with or without stitches (also known as sutures). 478 patients with a single digital nerve injury will have one of these two treatment options by random allocation. Patients will complete questionnaires measuring fingertip sensation, quality of life and health resource use up to 12 months after the operation. They will also attend clinic visits at 3 and 12 months. Longer term follow up (12-24 months after randomisation) to determine re-operation rates will be collected using routine hospital data.

11 Are subjective pain scores related to facial muscle activity? EMG pain scores

This study aims to discover if we can compare the pain felt by patients with a measurement of how their faces move. Facial movements will be assessed using muscle activity sensors worn like a pair of glasses/ goggles that measure underlying muscle activity. Past studies show facial expression is sensitive to the intensity of pain. Laboratory studies looking at pain in volunteers suggest facial electromyography (EMG) to measure muscle activity could be a

useful tool to determine the pain an individual is suffering. This may have particular relevance to patients where communicationis limited eg dementia.

This is a small-scale study to validate an experimental model in the clinical environment. We propose studying at patients receiving a local anaesthetic injection before planned hand operation. Whilst they are receiving the injection we will record the facial muscle response non-invasively using specialized goggles containing muscle sensors. Simultaneously we will record the patients experience of pain using a self-reported visual analogue score (VAS). Importantly pain expectation will also be considered, and we will also be assessing participant anxiety traits and status prior to intervention.

50 adult patients requiring hand surgery under a local anaesthetic block at the Queen Victoria Hospital will be studied. The study will be the observation and recording of data from patients undergoing routine clinical care only. It will not involve any additional procedures. The study will run for 6 months and we will publish all the findings within 1 year

12 anatomy of flexor tendon repair-IRP student study

13 TEARS Grading scale: grading the clinical severity of epiphora

Epiphora (watery eye) is a common presentation to the ophthalmology clinic, with most patients being amenable to surgical (61-69%) or non-surgical treatment. Surgically-amenable epiphora affects an estimated 16/100 000 persons rising to 100/100 000 in 75-84 year olds. While in some, the epiphora represents no more than a tolerable nuisance, in others it significantly affects their quality of life. At the more severe end of the spectrum, some cases require repeat medical attendances and hospital admissions for systemic infection. With ever-increasing financial constraints on healthcare providers, there is a need for clinicians and healthcare commissioners to better prioritise patients for surgical intervention.

The ‘TEARS scale’ was developed through extensive literature review, patient focus groups and consultation with an expert panel of consultant ophthalmologists. Disease severity is graded based on 4 subscales: symptom frequency, the effects on patients and healthcare providers, patients’ functional status, and the compounding effect of ocular surface disease. This prospective study aims to validate the TEARS scale by recruiting adult patients presenting to oculoplastic clinics with epiphora. Two clinicians will complete the TEARS grading scale at the study entry point. Patients will complete two questionnaires: The Watery Eye Quality of Life score (WEQOL) and The Lacrimal Symptom Questionnaire (Lac-Q).
In a subset of patients who have previously agreed with their clinician to undergo either surgical or non-surgical intervention, the TEARS scale will again be completed at their clinical review by two clinicians between 3 and 6 months after their initial visit. Patients will again complete the WEQOL and Lac-Q, as well as the Glasgow Benefit Inventory (a measure of change in quality of life).

The scale’s reliability will be evaluated through statistical testing of inter-rater agreement. Construct validity will be assessed by the scale’s correlation with patient-reported outcome measures and by evaluating its responsiveness to surgical intervention.

14 XEN45 in Angle Closure Glaucoma

Glaucoma is an eye condition where the optic nerve is damaged by the high pressure of the fluid in the eye (aqueous humour). Aqueous humour is produced by a ring of eye tissue called the ciliary body, located behind the iris (coloured part of the eye). It flows through the pupil and drains out through a spongy network of holes called the trabecular meshwork (which sits in the angle formed where the iris meets the cornea). In Angle Closure Glaucoma (ACG), the outer edge of the iris and cornea come in contact, closing the drainage angle. This prevents the aqueous humour from draining and causes the pressure in the eye to build up.

Currently available treatment for ACG consists of procedures to reduce eye pressure, including laser treatment, lens extraction, eye pressure-lowering medications, and incisional surgeries. There are no minimally invasive glaucoma surgery options available for ACG. XEN45 Glaucoma Treatment System (referred to as XEN) potentially alleviates this unmet need. XEN comprises of the Gel Implant and the Injector. The Gel implant is a soft gelatinous implant, approximately 6 mm long and as wide as a human hair. After implantation in the eye, it acts as a conduit for the drainage of aqueous humour in the eye.

The current study, sponsored by Allergan, is a prospective, multicentre, single arm, open-label (the participants and study team will know which treatment the participant is assigned to) clinical trial in patients with ACG. Approximately 65 patients will be implanted with XEN in one eye and followed for 12 months to evaluate its safety and effectiveness. Participants will be enrolled at approximately 15 research sites in the Asia-Pacific and European regions

15 **Haemostatic markers in ECMO (HAE) study**

Multicentre, prospective cohort study of haemostatic activation markers and correlation with bleeding and thrombotic complications in patients receiving extracorporeal membrane

16 Smartmatrix dermal replacement

This is a multi-centre, non-comparative, prospective study to demonstrate that the Smart Matrix dermal replacement scaffold has an acceptable safety profile and enables healing in full-thickness surgical wounds. Approximately 40 patients scheduled for elective surgical excision of suspected or histologically proven BCC or SCC lesions who meet the inclusion and exclusion criteria and provide written informed consent will be enrolled in the study.
The study will be conducted in 2 stages, with the first 12 patients (the safety cohort) reviewed by the Data Monitoring Committee (DMC) to assess the safety and performance of Smart Matrix.

When the safety cohort reaches the Week 6 post-operative time point, safety and the requirement for rescue therapy, in the opinion of the Investigator, will be assessed to decide if the study should continue to full enrolment.

17 Improving perioperative care through the use of quality data: Patient Study of the Perioperative Quality Improvement Programme (PQIP)

Over ten million operations take place in the UK NHS every year. The number of patients which are at high risk of adverse postoperative outcomes has grown substantially in recent years: this is attributable to a combination of an ageing population, the increased numbers of surgical options available for previously untreatable conditions, and the increasing numbers of patient presenting for surgery with multiple comorbidities. Estimates of inpatient mortality after non-cardiac surgery range between 1.5 and 3.6% depending on the type of surgery and patient related risks. Major or prolonged postoperative morbidity (for example, significant infections, respiratory or renal impairment) occur in up to 15% of patients, and is associated with reduced long-term survival and worse health-related quality of life; this signal has been consistently demonstrated across different types of surgery, patient and healthcare system.

Data from the US demonstrate wide variation in risk-adjusted mortality & morbidity rates between healthcare providers, suggesting that at least some complications after surgery could be avoidable if standards of care were improved. It is likely that the same is true in the UK; however, there is currently no unified national system for measuring complications or patient reported outcomes across different types of major surgery in the NHS. In order to address this gap, the National Institute for Academic Anaesthesia's Health Services Research Centre (NIAA-HSRC) has launched the Perioperative Quality Improvement Programme (PQIP) for the UK. PQIP will measure risk-adjusted morbidity and mortality, as well as process and patient-reported outcome data in adult patients undergoing major surgery (eg lower GI resection,

upper GI resection, liver resection, cystectomy, major head and neck reconstructive surgery, thoracic resection).

18 Validation of the MIRROR facial expression tracking application in healthy subjects and facial paralysis patients

Facial paralysis (FP) presents from either a peripheral nervous abnormality (most commonly Bell's Palsy) or a central nervous lesion (usually a cerebro-vascular accident). Bell's Palsy accounts for 60% of cases of facial palsy, causing up to 24,800 new UK cases annually, leaving upwards of 100,000 people living with permanent disability. Of the 152,000 CVAs per year in the UK, many patients suffer resultant chronic facial movement problems. Current methods for tracking facial expression recovery include subjective measures, e.g. doctor-delivered grading systems, and objective measures, e.g. 2D / 3D imaging (photography and/or stereophotogrammetry) or videos of dynamic facial function. However, a consensus method for objectively measuring initial paralysis and monitoring progress towards normal facial expressions remains elusive. Gold standard treatment for FP includes daily rehabilitative exercises, but patients often fail to perform these regularly due to lack of feedback on exercise efficacy leading to demotivation and non-compliance with the prescribed physiotherapy. This in turn reduces patients' likelihood of recovery of normal facial function.

A new iPad-based non-invasive physiotherapeutic software application (MIRROR) has been developed, allowing FP patients to objectively track their paralysis / facial expressions in real-time via MIRROR's immediate feedback on exercise performance. To validate MIRROR, a study has been designed to analyse the facial movements of healthy and FP patients pre- and post-administration of Botulinum toxin (BT). Each subject's response to BT over the period of action of the injected BT will be assessed. Subjects will have their facial expressions quantitatively analysed via subjective grading scales validated for use in FP analysis, 2D / 3D imaging, via surface-electromyography and using MIRROR

19 Investigation of Potential Biomarkers in the Role of Scar Formation

The reason for the development of a scar is not clearly understood and the causes are multi-factorial. In simple terms, scarring may be a direct consequence of evolutionary changes that have lead to a rapid healing of the wound site in order to prevent infection. As a consequence of this speed of wound epidermal closure, the cells in the dermis of the skin are prone to produce inappropriate amounts of extracellular matrix molecules. It is this over production that leads to the formation of a scar.

The only example of scar-free healing is in utero. Surgery performed on a foetus in the third trimester (and these often save lives of unborn children) do not leave any traces of surgical intervention. A child is born without a scar. This amazing ability is lost shortly after birth and for the rest of adulthood, any post-traumatic event to the skin results in the production of a scar. The Queen Victoria Hospital (QVH) is a regional centre for burns and plastic surgery. The hospital treats patients with acute wounds and those undergoing surgical reconstruction or scar revision. As part of this treatment scar tissue will often be removed and disposed of as clinical waste. This redundant scar tissue offers the possibility of developing a clearer understanding of the mechanisms of scar formation.

20 SUBMIT

Metacarpal fractures are common, accounting for 40% of all hand injuries and many can be treated non-operatively. However, surgery is reserved for cases in which an adequate reduction of both angular and rotational deformity cannot be maintained or where an adjacent ray is damaged.

A variety of surgical strategies exist, including percutaneous kirschner wiring, intramedullary

fixation, and fixation with plate and screw construction. A plate secured along the dorsal midline of the metacarpal has been shown to be the best biomechanical method of fixation, and allows early aggressive hand therapy post-operatively.

Traditionally, bicortical fixation is the standard practice, where both dorsal and palmar cortices of the metacarpal are drilled though. However, such practice is not without risk. In this method, the flexor tendons and neurovascular bundles at risk from over-zealous drilling through the palmar cortice. Correct screw size selection is also critical as overly long screws can irritate and cause rupture of flexor tendon. More recently, with the advent of a new generation of locking plates, unicortical fixation, where only the near cortex is drilled, has been used to treat fractures. Unicortical fixation is a surgically less complex operation, can theoretically cause less damage to surrounding soft tissues and avoids the complications associated with incorrectly sized screws.

This trial aims to compares the functional outcomes and complications of patients having unicortical versus bicortical fixation for diaphyseal metacarpal fractures.

21 Molecular mechanisms and pathways of chronic inflammatory and degenerative diseases

Using synovial tissue in explant cultures obtained from rheumatoid arthritic patients undergoing joint replacement surgery, the Kennedy Institute was the first research laboratory in the world to identify the pathogenic role of the inflammatory cytokine tumour necrosis factor alpha (TNF) in Rheumatoid Arthritis (RA). Biological therapies that block the function of TNF are now clinically proven and over one million people worldwide have been treated successfully with this drug. However, this is not a cure for RA, so current research activities at the Kennedy are aimed at understanding those events that trigger RA, and developing better therapies for this disease.

Patients scheduled to undergo a surgical procedure as a result of arthritis or other inflammatory diseases, will be given the option to take part in our study. In addition, waste tissue will be obtained from an amputation as a result of a traumatic injury and adipose as a result of an abdominoplasty. A qualified clinician / GCP trained team member will take written, informed consent prior to surgery. Waste tissue from surgery is collected in a sample pot and couriered to the Kennedy Institute. This waste tissue includes joints (cartilage and bone), periarticular tissue, connective tissue (muscle and fascia) and other soft tissue such as skin.

The tissue will be processed ex vivo to liberate single cell suspensions, which will then be cultured for up to 5 days or long term lines will be derived. Cell supernatants will be analysed for cytokine, MMP and other inflammatory mediators by ELISA and cell phenotype determined by Flow cytometry. In addition, mRNA will be harvested and gene expression determined by TaqMan PCR. The histopathology of the tissue will also be looked at.

22 Clinical Characterisation Protocol for Severe Emerging Infection

This is a standardized protocol for the rapid, coordinated clinical investigation of severe or potentially severe acute infections by pathogens of public health interest. Patients with a spectrum of emerging and unknown pathogens will be enrolled. This protocol has been designed to maximize the likelihood that data and biological samples are prospectively and systematically collected and shared rapidly in a format that can be easily aggregated, tabulated and analysed across many different settings globally. The protocol is designed to have some level of flexibility in order to ensure the broadest acceptance and has been initiated in response to the recent cases of novel coronavirus (nCoV) in 2012-2013, Influenza H7N9 in 2013 and viral haemorrhagic fever (Ebolavirus) in 2014. Information will be circulated by the Investigators and disseminated by the NIHR Clinical Research Network to clarify the eligibility criteria in the event of the emergence of a pathogen of public health interest. The study is now recognised by the NIHR as being an Urgent Public Health Research study

23 Is MGI or upper marginal entropion a contributing factor in the development of SLK

The Corneoplastic Unit at the Queen Victoria Hospital often manages patients with superior limbic keratoconjunctivitis (SLK). We hypothesise that meibomian gland inversion (MGI) and/or upper marginal entropion is a major contributing factor in the development of SLK, and is currently under-recognised. This prospective observational cohort study aims to answer the research question: "Is MGI or upper marginal entropion a contributing factor in the development of SLK?". This study will take place over six months, within the Ophthalmology department of an NHS site, and include all patients identified as possessing features of SLK.

New projects which are expected to start in 2022-23

- LOOC – lymphatic mapping of oropharyngeal cancer
- FIRST – splints for flexor tendon repairs
- Mucograft in maxfacs patients
- MelMart II
- MAGIC = paediatric melatonin prior to anaesthesia
- PATHOS
- FRONTIER corneo microstent
- RAPTOR – treatment of mandibular osteoradionecrosis following H&N cancer
- Laser imaging of flaps in breast reconstruction

11. Report approval and governance

This annual report has been reviewed by our R&I Governance Group, as well as by the Quality and Governance Committee.

Report cover-page					
References					
Meeting title:	**Board of directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**135f-22**	
Report title:	A Framework of Quality Assurance for Responsible Officers and Revalidation – Queen Victoria Hospital NHS Foundation Trust Annual Board Report 2021/22 and Annual Statement of Compliance				
Sponsor:	Tania Cubison, Medical Director				
Author:	Katie Ally, Medical Appraisal & Revalidation Support Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance that the statutory functions of the Responsible Officer were appropriately fulfilled. To report on performance in relation to those functions; to update on the progress since 2020/2021 annual report; to highlight current and future issues and to present action plans to mitigate potential risks. This report forms part of the Medical Director's duties as Responsible Officer (RO).				
Summary of key issues	In March 2022, Miss Tania Cubison was appointed Responsible Officer and whilst medical appraisals were reinstated in 1 October 2020 they resumed to normal levels of activity from 1 April 2021. As at 31 March 2022, QVH was the designated body for 116 GMC registered doctors. 97 medical appraisals were conducted during the year, 5 missed approved and 14 missed unapproved. 52 revalidation recommendations submitted was 52. During the year, medical appraisals focused on the doctor's professional development and wellbeing and simplifying expectations around supporting information and pre appraisal paperwork. The redesigned appraisal 2020 format was published and responsible officers were encouraged to adopt this new appraisal model and to think creatively about how appraisals help doctors maintain the highest possible standards of patient care in prevailing circumstances. The new format has been welcomed across our medical workforce. We now hope to build on the approach to take appraisal forward as an opportunity for doctors to reflect on their experiences and consider their own wellbeing, with less emphasis on written documentation. Current issues relate to purpose of appraiser update sessions, appraisal inputs/outputs, availability of appraisers. Areas for improvement will focus on renewing appraisal and revalidation policy, fully adopting the new 2020 appraisal model, and quality appraisal inputs/outputs over coming year.				
Recommendation:	The Board is asked to **note** the contents of this annual 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:	KSO2
Corporate risk register:	
Regulation:	The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'
Legal:	As above
Resources:	This annual report was produced using existing resources.

Assurance route				
Previously considered by:	Quality and governance committee			
	Date:	25.7.22	Decision:	
Next steps:				

A Framework of Quality Assurance for Responsible Officers and Revalidation – Queen Victoria Hospital NHS Foundation Trust Annual Board Report 2021/22 and Annual Statement of Compliance

Covering reporting period
1st April 2021 to 31st March 2022

Document Control: Quality and Governance Committee

Executive Sponsor: Tania Cubison, Medical Director

Author: Tania Cubison, Medical Director
Katie Ally, Appraisal & Revalidation Support Officer

Date: June 2022

Type: Annual Report Medical Appraisal and Revalidation

Version: V2

Pages: 14

Status: Public. Written and prepared for the Trust Board

Circulation: Quality & Governance Committee
QVH Trust Board

Contents List

1 Executive Summary

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

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 Annual Organisational Audit (AOA) exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, in their annual Board report and Statement of Compliance.

This report provides appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

2 Recommendation

The Committee is asked to receive this report on behalf of the Trust Board, noting that it will be shared with the South East Higher Level RO no later than 24 September 2022.

The Committee is asked on behalf of the Trust Board to note the Statement of Compliance item 5, Section 7 of this report confirms the Trust, as a Designated Body, is compliant with the regulations. The Chief Executive is requested to sign this on behalf of the Trust.

3. Purpose of the Paper

The purpose of the report is to help the Trust review and demonstrate compliance with the responsible officer regulations. It simultaneously helps assess the Trust's effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.

The intention is therefore to help meet the requirements of the system regulator as well as those of the professional regulator.

The over-riding intention of the report is to guide the Trust by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the Trust can demonstrate not only basic compliance but continued improvement over time. The report will therefore:

- help the Trust in its pursuit of quality improvement,
- provide the necessary assurance to the higher-level responsible officer, and
- act as evidence for CQC inspections.

Report on performance in relation to those functions; to update the Committee on the progress since 2020/2021, to highlight current and future issues and to present action plans to mitigate potential risks. This report forms part of the Medical Director's duties as Responsible Officer (RO).

4. Background

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

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

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

- Audit of Appraisals 2021-2022
- Effective Appraisal
- Recommendations to the GMC
- Medical Governance
- Employment Checks
- Summary and overall conclusion

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

Doctors on training rotations are connected to the Local Education and Training Board (LETB) with the relevant Dean as their Responsible Officer. All other doctors who perform the majority of their practice at Queen Victoria Hospital (QVH) are connected directly to the Trust. Doctors connected to Queen Victoria Hospital fall under the responsibility of Tania Cubison, Medical Director, as the Trust's Responsible Officer (RO) appointed on 19 March 2022.

This report is based on 116 doctors whose prescribed connection is with the Trust as at 31 March 2022. The last report submitted to the Committee was in July 2021 for the appraisal year 2020/2021. This report covers the year 1 April 2021 to 31 March 2022.

5. Annual Report

Section 1 – General

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None identified Comments: Appointed Medical Director in January 2022, after completion of the Responsible Officer Training course on 19 March 2022, Tania Cubison replaced Mr Keith Altman as Responsible Officer. Action for next year: The RO will attend quarterly intervals during the coming year. Receiving updates on professional standards relating to appraisal and Framework of quality assurance matters from the South East's Higher Level Responsible Officer and General Medical Council's (GMC) Liaison Officer

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/No: Yes Action from last year: Recruit and appoint Medical Workforce Manager to support the RO, Deputy Medical Director with Appraisal Lead responsibilities, Lay Representative and Medical Appraisal and Revalidation Support (MAAR) Officer.

Comments: Throughout the year, the RO role has been supported by the MAAR Officer, Lay Representative and the HR Advisory team (including the Medical Workforce Manager). Providing support on wider issues i.e. procedural expertise, advice on employee relations and employment law, resources for case management and case investigation and training and induction.

Action for next year: The Trust is seeking to introduce a role within the Medical Director office to oversee and provide administrative leadership and oversight to Medical Appraisal, Revalidation and Job Planning in light of the Medical Director structure having been reshaped over the past 12 months.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue using GMC portal.

Comments: The GMC Connect portal is utilised to ensure an accurate record of all doctors with prescribed connection is maintained and regularly monitored by the RO and the MAAR Officer.

Action for next year: Continue using GMC portal during coming year.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Monitor and review published policies in line with renewal and monitoring schedules.

Comments: All policies that support medical revalidation are actively reviewed and monitored by the RO, supported by the MAAR Officer and the wider Workforce Department.

Action for next year: The Trust's policy Medical Appraisal, Revalidation and Remediation is due for renewal in September 2022. Review policy in consultation with RO, Clinical Directors and Operational Managers. Policy to be ratified and agreed by appropriate committees by end of Q4 22/23.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Awaiting peer review from Higher Level RO (HLRO) paused since 2020 due to pandemic.

Comments: The previous HLRO peer review took place in August 2018 with a follow up review scheduled but subsequently paused in 2020. Areas to be reviewed included update on areas of development, current position, successes and challenges relating to the RO Regulations.

Action for next year: None pending - awaiting further peer review meeting date from HLRO office.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Clinical Lead and General Managers are fully aware and support doctors in local processes to continue professional development, appraisal, and revalidation.

Comments: Throughout the year, new doctors including locum and short-term placement doctors receive guidance on the process at Induction, they are made aware of the expectation to undertake an annual appraisal. They are provided with feedback from patients and colleagues and supported to remain up to date with learning and development to make the appraisal process simpler. Monthly compliance reports are reviewed and monitored by Clinical Lead and General Managers and any issues escalated to RO.

Doctors with a prescribed connection to another organisation, will be provided with data

relating to QVH incidents and complaints to support their appraisals and revalidation using the Medical Practice Information Transfer (MPIT) Form. During this reporting period, 36 MPIT forms were completed compared with 13 in the previous appraisal year.

Action for next year: Continue with current processes.

Section 2a - Effective Appraisal

1. All doctors at QVH have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For those using the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings.

Action from last year: To utilise Qnet to provide all relevant documentation, guidance and signposting doctors to all relevant information relating to the doctor's fitness to practice, including information about complaints, significant events and outlying clinical outcomes.

Comments: During the year, all doctors had the choice of using either the 2020 Appraisal documentation or the older MAG form. Both forms were published on QNet for ease of access. The older style MAG form was also improved with embedded prompts highlighting sections no longer required reducing the paperwork burden. In addition, all doctors contact the Risk Team and the Patient Experience Manager to obtain governance data on complaints and significant events. Data gathered in a timely fashion and shared with appraisers for the purposes of reflective practice discussions. Medical Transfer of Information form and/or Letters of Good Standing are mandatory appraisal input requirements from each organisation where a doctors practices providing assurances to the appraiser and RO on fitness to practice issues. During the year 49% of appraisals were completed using the new 2020 appraisal model.

Action for next year: Fully adopt use of 2020 appraisal model documentation.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue with early escalation process to Appraisal Lead.

Comments: During the year, there were 14 unapproved incomplete or missed appraisals and 5 agreed exceptions recorded i.e. maternity, career break, military secondment. The 14 unapproved appraisals consists of 10 doctors who have yet to fully engage in the appraisal process since it re started in April 2021 plus 4 short term doctors whose appraisals were not conducted at their previous Trust as a result of the pandemic.

Reasons given for delays are recorded and escalated to Medical Appraisal and Revalidation Panel at quarterly meetings and intervention/action plans agreed with RO or Appraisal Lead. Issues relating to appraisers availability cited as delays due to different working days/patterns.

Action for next year: Action required to re-engage those doctors yet to complete appraisals following pause due to pandemic by end Q3. Develop standard operating process for reallocation of appraisers and reduce issues relating to diary conflicts.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: annual monitoring schedule ensuring compliance with national policy and approved by the Board.

Comments: The current policy approved by the Local Negotiating Committee on behalf of the Board on 23 September 2019 is due for renewal in September 2022. The policy will be reviewed by the RO, Medical Workforce Manager and Revalidation Officer during Q1 & Q2 2022. Maintaining compliance with The Medical Profession (Responsible Officers) Regulations, 2010/2013 and the GMC (Licence to Practice and Revalidation) Regulations 2012.

Action for next year: Revised policy to be submitted by the RO to the Local Negotiating Committee for ratification and approval on behalf of the Board prior to 23 September 2022

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Develop standard operating process for the allocation of appraisers so workload is fairly and evenly distributed throughout the calendar year and across the Trust. Reduce timescale allocating/communicating appraiser details to new doctors.

Comments: The Trust currently has 19 trained appraisers, decreased by 2 during the year.

During this reporting period, in light of the pandemic and the continued pressure it was agreed not to reallocate appraisers and instead maintain existing appraisers for a further year. Thus maintaining established appraiser/doctor relationships supporting discussions focusing on maintaining health and wellbeing, key to the ability to offer high quality, safe care in challenging times. Whilst encouraging reflection on this aspect of professionalism and signposting doctors to suitable resources if needed.

Action for next year: Action carried forward to 2022/2023 action plan: to develop standard operating process for the allocation of appraisers so workload is fairly and evenly distributed throughout the calendar year and across the Trust. Reducing the timescale allocating/communicating appraiser details to new doctors by end of Q3 in preparation for next appraisal year.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers1 or equivalent).

Action from last year: Proposal to record future training sessions to allow those unable to participate on the day to do so at another time by accessing the recording.

Comments: During the year, 2 appraiser updated sessions were held, 1 presented by Tania Cubison as Appraisal Lead and subsequently as the RO. Both were presented virtually in September 2021 and February 2022. Attendance at the live sessions was low. The February 2022 session was recorded and saved to be viewed at a later time by appraisers. On reflection, the lack of attendees significantly deduced useful shared experience discussion opportunities.

Action for next year: Formalise/structure the Appraiser Update sessions with aims and objectives, guest speakers i.e. GMC Liaison Officer, Representative from Academy of Medical Royal Colleges.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: the appraisal outputs of 2 appraisers will be audited each month by the Appraisal Lead using the Appraisal Summary and PDP Audit Tool (ASPAT) published by NHS England. The outcomes together with results from appraisal feedback questionnaires would be reviewed and findings reported to the Board.

Comments: The ASPAT was specially designed for auditing the inputs and outcomes of the MAG appraisal document. The absence of an audit tool for the newer 2020 Appraisal document plus the vacant Appraisal Lead role prevented a formal quality assurance process from being conducted during the year. Instead, informal discussions were included at the Appraiser Update sessions held in September 2021 and February 2022. Points covered included ensuring evidence of whole scope of practice, number of appraisal to be completed, timeliness of completion of documentation, the quality of the outputs, the structured feedback from

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

colleagues and patients, evidence of complaints and significant events. Plus training/development needs of the appraisers.

Action for next year: Going forward, the RO or deputy's will utilise the Appraiser Update sessions and focus on appraiser's outputs across the Trust with continuing professional development and review of performance. Guest speakers from the GMC and/or the Academy of Medical Royal Colleges, will be invited to share knowledge and experience plus medical training providers. With the absence of a national audit tool, the RO or deputy will define a local review process to include as a minimum; scope of appraisal work undertaken, the number of appraisals undertaken, the timeliness of completion of documentation, the quality of outputs of appraisal, feedback from doctors appraised, any complaints and significant events any relevant continuing professional development the medical appraiser has undertaken and the opportunity for the medical appraiser to consider their individual development needs.

NHS England and NHS Improvement have begun work on systems to support professional governance that support assurance. This will take shape in 2022-23 and we await the outcomes.

Section 2b – Appraisal data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Queen Victoria Hospital	Nos.
Total number of doctors with a prescribed connection as at 31 March 2021	116
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	97
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	19
Total number of agreed exceptions	5

2. Completed appraisals by documentation type recorded in table below.

Completed appraisal by documentation type	Nos.
Older MAG form (pre pandemic)	38
New 2020 Appraisal model	48
Completed at previous Trust or ARCP	11
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	97

Section 3 – Revalidation Recommendations

1. Timely recommendations are made to the GMC about the fitness to practice of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Due to the large number of recommendations in year 2021/2022, additional Medical Appraisal & Revalidation panel meetings have been scheduled.

Comments: Over the course of the year, the Medical Appraisal & Revalidation Panel met on 9 occasions to consider revalidation portfolios, appraisals documents and supporting information in accordance with the GMC requirements and responsible officer protocol and submitted 52 recommendations (see Figures 1-4 below). With 1 late recommendation caused by delayed communication between RO and Revalidation Officer due to annual leave. The recommendation was 1 day late.

Figure 1

Total Number of Recommendation during period 1/4/2021 to 31/3/2022

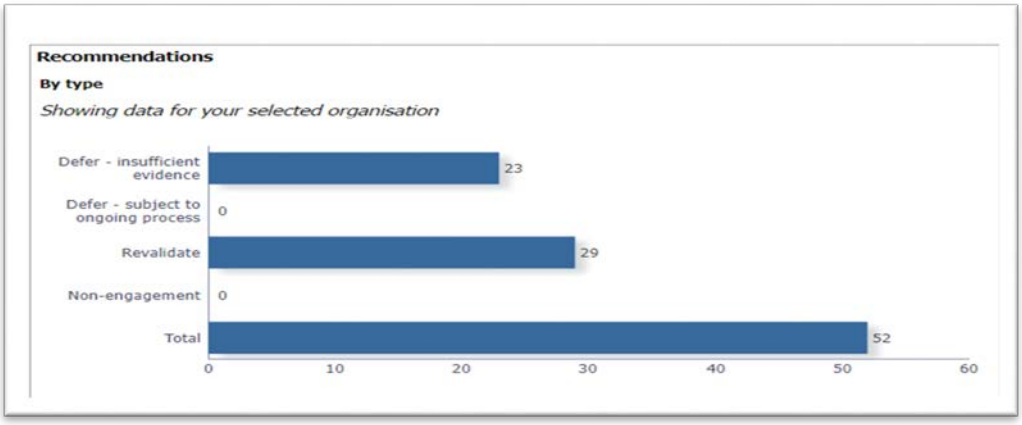
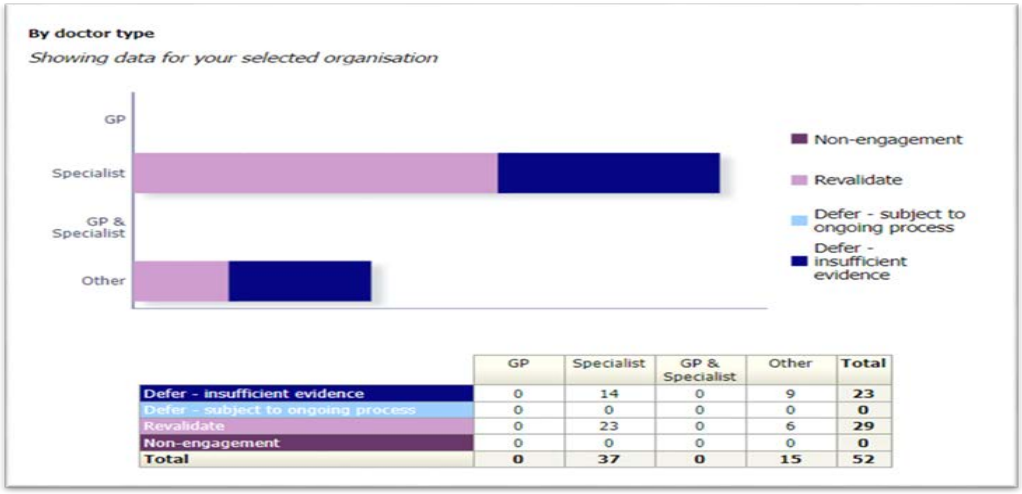


Figure 2

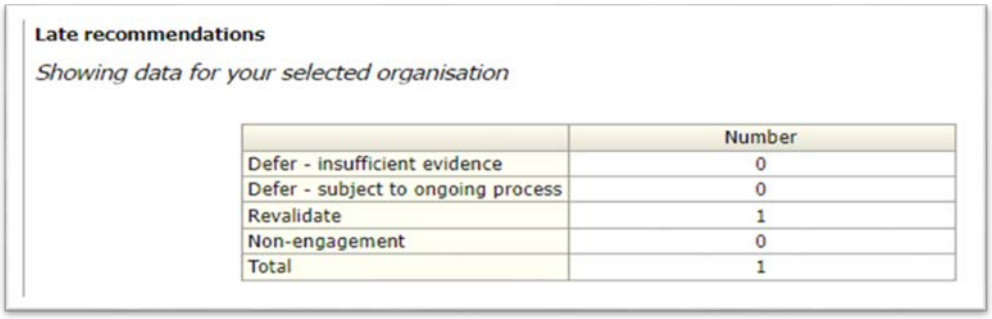
Total Number of Recommendation during period 1/4/2021 to 31/3/2022 by doctor type



	GP	Specialist	GP & Specialist	Other	Total
Defer - insufficient evidence	0	14	0	9	23
Defer - subject to ongoing process	0	0	0	0	0
Revalidate	0	23	0	6	29
Non-engagement	0	0	0	0	0
Total	0	37	0	15	52

Figure 3

Number of Late recommendations during the period 1/4/2021 to 31/3/2022



	Number
Defer - insufficient evidence	0
Defer - subject to ongoing process	0
Revalidate	1
Non-engagement	0
Total	1

Action for next year: Continue with additional panel meetings during 2022/2023 to ensure the expected 37 recommendations are made on time.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: to maintain current practices.

Comments: Revalidation panel agree all recommendations prior to revalidation date. Ongoing progress is continuously monitored for upcoming revalidations. Doctors are advised of the outcome either positive or deferral on the same day. For all deferrals, an explanation is given to the doctors and a plan is agreed on how to obtain the missing evidence, progress monitored until all the missing information has been obtained. At which time a further recommendations is submitted.

Action for next year: Maintain current practices.

Section 4 - Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: we will continue to work with teams to share information on compliments, complaints, involvement in incidents and similar items for the medical appraisal process.

Comments: All doctors work within the clinical governance framework of the Trust and fulfils all CQC patient safety, risk and quality improvement requirements. Clinical incident reporting is monitored by the Medical Director and Quality & Governance committee to ensure any conduct and capability concerns are reported and acted on promptly. When preparing for their appraisal, doctors are instructed to contract the Patient Experience Manager and Risk teams to request data relating to compliments, any complaints and significant events for inclusion in reflective practice discussion with the appraiser.

Action for next year: We will continue to work with teams to share information on compliments, complaints, involvement in incidents and similar items for the medical appraisal process.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Maintain current process.

Comments: Conduct and performance concerns reported via direct reports to the Medical Director, through patient and staff complaints, clinical governance, including audit and outcome measurement and incident reporting. The responses are monitored through annual appraisal and direct intervention by the RO where needed with additional support provided by the GMC Employment Liaison Officer if necessary.

Action for next year: Maintain current process.

3. There is a process established for responding to concerns about any licensed medical practitioner's1 fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Continue to follow our agreed policies and procedures

Comments: The Trust's approach to identifying and responding to concerns is set out in its policy based on the national 'Maintaining High Professional Standards (MHPS)' and GMC guidance. Recently revised and ratified at Local Negotiating Committee in May 2022. Due for review in May 2025. .

Action for next year: Continue to follow our agreed policies and procedures.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Action from last year: Continue with current procedures.

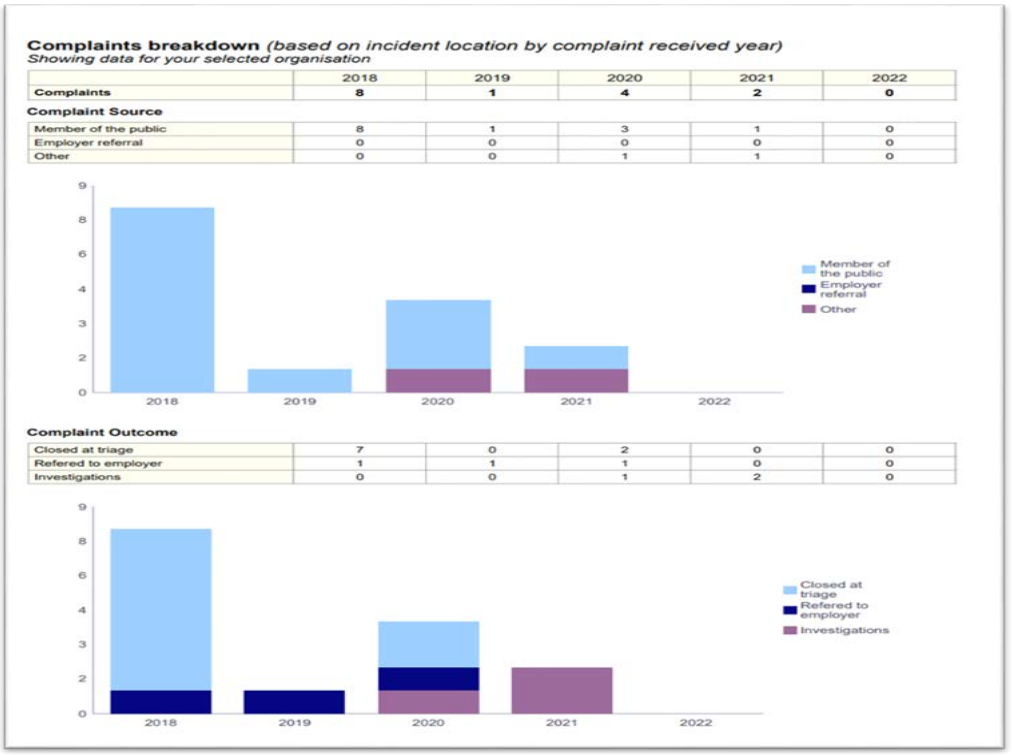
Comments: Responding to concerns is undertaken by the Medical Director, supported by the Director of Workforce and discussed with the GMC Employment Liaison Officer and PPA (NCAS) - NHS Resolution as required.

Regular meetings are held with GMC Employment Liaison Officer and take place at least 3 times per year. Any investigation conducted is overseen by a non-executive board member. Numbers and type of complaints are reported annually through this report. (see Figure 4)

In 2021/22 there were 2 cases raised with the GMC, both closed without hearings, 1 closed with No Action and 1 with warning – (see Figure 4)

Figure 4:

Complaints Breakdown for period 1/4/2021 to 31/03/2022



Complaints breakdown *(based on incident location by complaint received year)*
Showing data for your selected organisation

	2018	2019	2020	2021	2022
Complaints	8	1	4	2	0
Complaint Source					
Member of the public	8	1	3	1	0
Employer referral	0	0	0	0	0
Other	0	0	1	1	0

Complaint Outcome					
Closed at triage	7	0	2	0	0
Refered to employer	1	1	1	0	0
Investigations	0	0	1	2	0

Action for next year: Continue with current procedures.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: Continue with current process and monitor compliance.

Comments: Managed by the RO with support from the MAAR Officer, timely Medical Practice Transfers of Information requests from other organisations are received and completed. QVH's generic email address is published on the GMC website to such requests. Information transfer requests are supported by the PALS and Risk Teams who readily respond. The RO reviews requests before sign off and release. During the year 36 transfers of information were processed compared to 14 in year 2020/2021.

As Transfers of Information requests are not provided for HEE doctors when appointed as Trust doctor the last ARCP outcome form is provided for assurance purposes and requested at recruitment stage.

Action for next year: Continue with current process and monitor compliance.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Continue to follow agreed policies and procedures

Comments: The Disciplinary policy for medical and dental staff continues to adhere to national MHPS and GMC / NHSE guidance on managing concerns. Concerns managed by the RO and Medical Director, supported by Director of Workforce and OD, and the HR Advise team as required.

Action focr next year: Continue to follow agreed policies and procedures

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Continue to current processes and monitor compliance

Comments: All doctors employed by QVH including the medical and dental Bank are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, via Trac recruitment system ensuring visibility and consistency. There is a local memorandum of understanding between Trusts within the ICS where doctors are able to move more freely with the confirmation of checks confirmed by the previous substantive employer in place to avoid duplication and unnecessary checks.

In addition to the standard clinically based questions at interview, questions based on the Trust's values are included. Thereby ensuring applicants are able to converse and understand medical terminology at an appropriate level in English. Employment references follow a set format and include past employer and most recent Responsible Officer declaration.

For consultants, a more extensive assessment conducted including Stakeholder Panels with feedback presented to the Advisory Appointment Committee provide assurance

Action for next year: Continue to current processes and monitor compliance

Section 6 – Current issues, New Actions and overall conclusion

Current Issues

- 100% adoption of 2020 appraisal model
- Quality of appraisal inputs/outputs using the 2020 Appraisal model appraisal
- Logistical issues with the availability of appraisers due to different working
- days/patterns
- Lack of clarity on purpose of Appraiser Update sessions

New Actions

- Fully adopt use of 2020 appraisal model documentation
- Renew appraisal and revalidation policy adopted the new 2020 appraisal model
- Re-engage doctors yet to complete appraisals following pause due to pandemic by end Q3.
- Develop standard operating process for reallocation of appraisers plus remove issues relating to diary conflicts.
- Deliver focused appraiser sessions with guest presenters and quality appraisal outputs
- Revise policy to be submitted by the RO to the Local Negotiating Committee for ratification and approval on behalf of the Board prior to 23 September 2022.
- In absence of national assurance process implement local quality process.

Overall conclusion:

In conclusion, during another challenging year the opportunity to utilise appraisal as a supportive measure has been welcomed across our medical workforce. We now hope to build on the approach to take appraisal forward as an opportunity for doctors to reflect on their experiences and consider their own wellbeing, with less emphasis on written documentation. Maintaining health and wellbeing, key to the ability to offer high quality and safe care.

In the coming year, focus appraiser training around the updated appraisal 2020 model. Alongside a standard operating process for the re allocation of appraisers ensuring the workload is fairly distributed across the pool of appraisers. Whilst still ensuring that revalidation requirements are met.

Section 7 - Statement of Compliance

The Quality and Governance Committee of Queen Victoria Hospital NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)

Signed on behalf of the Queen Victoria Hospital

[(Chief executive or chairman (or executive if no board exists)]
Queen Victoria Hospital NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Report cover-page					
References					
Meeting title:	Board of directors				
Meeting date:	01/09/2022		**Agenda reference:**	**136-22**	
Report title:	Quality and governance committee assurance				
Sponsor:	Karen Norman, Committee Chair				
Author:	Karen Norman, Committee Chair Leonora May, Deputy company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of the report is to provide assurance on matters considered and discussed by the quality and governance committee at its meetings on 04 July, 25 July (extraordinary annual reports meeting) and 22 August 2022				
Summary of key issues	• Summary of points to raise to the Board regarding annual reports received at an extraordinary meeting on 25 July 2022 • Cancer patient experience survey results demonstrate that the Trust provides good care to cancer patients • Work in progress to ensure lessons are learned following recent inquest • Growing waiting lists and potential for patient harm remain a significant risk • CQC visit due and preparation underway, reflecting the new CQC framework				
Recommendation:	The Board is asked to **note** the contents of the report, the assurance where given and risks identified.				
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:	KSO3- outstanding patient experience- quality and supply issues with providers, ongoing workforce challenges KSO2- World class clinical services- restricted facilities to manage more complex patients				
Corporate risk register:	Potential 104 day cancer wait risk to be added to the corporate risk register				
Regulation:	Health and Social Care Act 2008 CQC standards of quality and safety				
Legal:	As above				
Resources:	None				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	4.7.22 25.7.22 22.8.22	Decision:		
Next steps:	N/A				

Report to:	Board Directors
Agenda item:	136-22
Date of meeting:	1 September 2022
Report from:	Karen Norman, Committee Chair
Report author:	Karen Norman, Committee Chair Leonora May, Deputy company secretary
Date of report:	22 August 2022
Appendices:	None

Quality and governance committee assurance

Introduction
This purpose of this report is to provide the Board with assurance on matters considered and discussed at the quality and governance committee at its meetings on 04 July, 25 July (extraordinary annual reports meeting) and 22 August 2022.

04 July 2022

Commissioning for Quality and Innovation (CQUIN)
The committee received an update on the planned CQUINs for 2022/23 which were changed to reflect suitable measures more relevant for our specialist services within the Trust. The following indicators were identified as most relevant for QVH:
• Staff flu vaccinations
• Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
• Cirrhosis and fibrosis tests for alcohol dependent patients
• Achieving high quality Shared Decision Making (SDM) conversations in specialised pathways to support recovery

Compliance in practice visits (CIP's)
A full Compliance in Practice inspection had been undertaken based on CQC criteria. The Committee's attention was drawn to the following:
• A compliance score of 92% (rating 'Good') was achieved Trust-wide.
• The highest scoring department achieved 98% (rating 'Outstanding').
• The lowest scoring department achieved 88% (rating 'Good').
• A criterion identified for improvement was the limited display of patient experience data available in public areas across the Trust. This is being rectified.

Learning from Deaths Review
The annual Learning from Deaths report provided assurance in relation to QVH compliance with National Guidance on Learning from Deaths. The committee was assured that:
- There was no unwarranted variation in the number of deaths or within specialities included within the scope of the report
- Every death had an appropriate initial review
- A Structured Judgement review (SJR) was undertaken by as per Trust Policy
- None of the reviews/ SJRs during this time raised concerns or identified any lapses in care which required further formal Trust investigations
- The actions to address any learning points identified will be appropriately tracked to completion through the Trust's Governance process
- That QVH provides good quality, MDT led palliative care for patients with un-survivable burns injuries

- SJRs consistently identified that family involvement in shared decision making and communication between the MDT and family/loved ones was excellent

Quality Priorities
The committee approved the choice of Quality Priorities for 2022/23 which are informed by the views of the QVH governors, patient feedback and suggestions from staff across the organisation. These are patient safety, clinical effectiveness and patient experience.

Covid report
The Q&GC noted an increase in cases and assurance was taken from actions taken.

Clinical harm
Increasing waiting times across the NHS remained a major risk and gives rise for concern. The committee noted three reported cases of potential 'moderate' harm, with one categorised as a Serious Incident (SI), which is subject to further investigation.

25 July 2022 (extraordinary annual reports meeting)

Annual reports
The committee received the following annual reports.

- Patient safety annual report 2021/22
- Health and safety annual report 2021/22
- Infection prevention and control annual report 2021/22
- Clinical audit annual and quality improvement report 2021/22
- Research and development annual report 2021/22
- Safeguarding (adults and children) annual report 2021/22
- Patient experience annual report 2021/22
- Emergency preparedness, resilience and response annual report 2021/22
- Information governance annual report 2021/22
- Antimicrobial annual report 2021/22
- Appraisal and revalidation annual report 2021/22
- Guardian of safe working annual report 2021/22

Patient Safety Annual Report 2021/22
Assurance was given in respect to plans to further develop comparative data reporting and the committee noted work done on clinical harm reviews as a means of managing the risks associated with the significant rise in waiting lists. This was a priority corporate risk on the Board Assurance Framework and will be kept under review for ongoing assurance and risk management in 2022/23.

Health & Safety Annual Report 2021/22
Assurance was given with respect to plans to further develop comparative data reporting.

Infection Prevention & Control Annual Report 2021/22
Assurance was taken from the detailed evidence provided regarding our infection control rates, risks and management during the pandemic and additional assurance provided by the bi-monthly updates of compliance against the standards set out in the NHSE Infection prevention and control board assurance framework. Further assurance was given with respect to plans to strengthen compliance with antibiotic prescribing practices.

Clinical Audit Annual and Quality Improvement Report 2021/22
Assurance was taken with respect to the achievement of most objectives and evidence of strong clinical commitment from to auditing and improving. It is intended that future reports will show how audits undertaken support the QVH key strategic objectives and consideration given to pro-actively commissioning relevant strategic audits. Further information and assurance was sought on the progress and future plans for Getting It Right First Time (GIRFT), the national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

Research & Development Annual Report 2021/22
Further assurance was requested about progress against the QVH Research and Innovation strategy objectives, and the research projects for which the QVH is a sponsor.

Emergency Preparedness, Resilience & Response Annual Report 2021/22
Q&GC noted the report, taking assurance on our response to, and management of, the covid pandemic. QVH attained substantial compliance in the EPRR peer review and assurance process for 2022, a movement from 'partial compliance' against standards in recent years. Q&GC commended the Chief Nurse for her role in leading on this.

Information Governance Annual Report 2021/22
The committee noted that the Trust achieved a 'Standards Exceeded' rating in the Data Security and Protection Toolkit, the outcome of the Clinical Coding Audit 2021 assessed as 'exceptional' and gaining the Cyber Essentials PLUS certification in May 2022.

Antimicrobial Annual Report 2021/22
Further assurance was sought regarding ongoing challenges in meeting compliance with antibiotic prescribing guidelines. A re-audit is planned to monitor progress.

22 August 2022

Clinical quality and patient safety
The committee noted an increase in the number of patient safety incidents reports during July 2022 and received assurance that there were no ongoing themes or additional causes for concern within the cases reviewed. Further assurance is forthcoming regarding any potential correlation with the annual influx of new staff at this time of year. One 'Never event' was recorded. Reassurance was given that this was under investigation and being managed appropriately. The majority of incidents were reported as 'no harm' or a 'near miss'.

The committee received an update on the progress and learning from a recent coroner's inquest, details of which are included within the regular quality and safety report to Board.

The committee noted the new CQC framework and that a CQC inspection is due. The Executive will prepare a statement of readiness for the next meeting.

Clinical harm
The committee received an update on potential harm which may have occurred as a result of increased waiting lists and treatment delays. Assurance was given that

further investigation is underway regarding the systems and processes for harm reviews and waiting list management to identify any areas for further improvement. A formal investigation is underway in response to a patient who was identified as having suffered severe harm. This has been declared as a serious incident and is being formally investigated.

Mutual aid patients from other trusts were not included within the data but the committee sought and received assurance that completed clinical harm reviews are being requested and completed for these patients. A national mutual aid plan is being developed.

Getting it right first time (GIRFT)
The committee noted that GIRFT methodology is being used in the Trust's clinical services review to ensure alignment with national standards. The medical director will schedule a GIRFT progress reports on priority specialisms into the committee work plan for this year for further assurance.

Medicines management and optimisation
The committee approved the medicines management and optimisation strategy. The importance of the Trust having provision to set up an effective e prescribing service was noted and the committee received assurance that additional funding is being sought for the provision of e prescribing and patient records. The Digital Board, a new subcommittee of the finance and performance committee will have oversight of this.

Other

- The cancer patient experience survey results are positive and demonstrate that the Trust provides good care to cancer patients
- The agreed CQUIN's had previously been reported to the Board. CCG9 Cirrhosis and fibrosis tests for alcohol dependent patients is no longer part of the Trust's CQUIN programme as it was identified as not being achievable at QVH. Assurance was given on good progress in quarter two on the remaining three priority CQUINs
- The committee noted the infection prevention and control board assurance framework and the changes to Covid guidance and requirements for staff and patients. The committee was assured that where guidance has changed the Trust has implemented necessary changes using an evidence based risk assessment process
- The committee noted that there is poor compliance with the Trust's antibiotic prescribing guidelines, which aim to deliver standards in line with the World Health Organisation's global action plan on antimicrobial resistance (AMR). The committee received reassurance that this risk was on the corporate risk register and was being managed appropriately. A task and finish group had been reinstated to further improve compliance
- The committee agreed that there is a need to improve the Trust's minor injuries unit site and the Board should consider this in the context of an estate strategy for the whole site
- The committee noted that there had been six out of hours surgery patients during the last two months and sought and received assurance that the team were working to provide confirmation regarding the reasons for this

Recommendation

The Board is asked to **note** the contents of the report, the assurance where given and the risks identified.

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed : 22.8.22

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~~ ceased usage
- Increasing staff gaps due to COVID-19 isolation requirements
- Isolation requirement impact
- Patient choice
- Vacancy levels in sleep [CRR 1116]
- Specialist nature / complexity of some activity
- DNAs
- 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
- Increased demand in skin referrals
- Increased numbers of referrals and current ptl size
- McIndoe Q2 & Q3 capacity – tbc

Future risks

- Further COVID-19 & Winter Flu surge
- National Policy changes to access and targets
- NHS funding ERF 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 Mutual Aid
- ~~McIndoe theatre capacity – Q2~~

Future Opportunities

- Closer ICS working
- New Modular theatres – July 2022
- Closer working between providers including opportunities with Kent & Surrey
- Partnership with UHSx
- ~~Mutual aid – breast theatre procedures~~

Controls / Assurance

- Mobilising of virtual outpatient opportunities to support activity during COVID-19
- Transformation Board established, initially focusing on Outpatients
- Plastics Recovery Action plan & weekly meetings
- Additional reporting to monitor COVID-19 impact
- Recovery planning and implementation ongoing
- Weekly RTT and cancer PTL meetings ongoing
- Waiting list process review from Medway and Darrent Valley
- 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

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 23/08/2022**

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 4)

- As at Month ~~3~~ 4 the Trust is reporting breakeven against actuals
- 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 at present unsigned contracts
- Potential changes to commissioning agendas
- Unknown costs of redesigned pathways.
- Increased efficiencies required to deliver breakeven.

Future Risks

NHS Sector financial landscape Regulatory Intervention

- 22/23 is interim contract year between block funding and move to API contracts – reviews of activity delivery against commissioner spend may lead to reduction in income for 23/24 where activities have reduced compared to 19/20
- 5% productivity gain in elective PODs required to achieve payment of ERF funding, risk of no ERF funding if productivity gains not realized
- 22/23 Tariff benefit seen for QVH above national 2.4~~-1.7~~% uplift will ~~may~~ not be fully realised in commissioner contract values. ~~due to commissioners only receiving 1.7% national allocation~~
- Capped expenditure process
- Capital resources
- Commissioning intentions – Clinical effective commissioning
- Central control total for the ICS which is allocated to organisations
- Significant development work for the potential merger
- Greater than anticipated Increased costs for inflationary pressures.
- 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.
- Retention and recruitment of staff due to uncertain future with potential merger, loss of local knowledge.

Future Opportunities

- New workforce model, strategic partnerships; increased trust resilience / support wider health economy
- Single Oversight framework – ICB in effect from July 2022, greater system collaboration and partnership
- 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
- Development of increased partnership working through the potential merger to include greater economies of scale and efficiencies for work load and also potential cash savings in the longer term

Controls / Assurances

- Performance Management regime in place and performance reports to the Board.
- Contract monitoring process and CIP Governance processes strengthened.
- Strengthened reporting with triangulated activity, workforce and finance monthly reports
- Finance & Performance Committee in place, forecasting from month 3 onwards subject to caveats with regards to the NHS environmental changes
- New Business case group in place with governance in place.
- Audit Committee with a strengthened Internal Audit Plan

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
- Establishment and vacancy control reviews

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**138-22**	
Report title:	**Operational Performance Report**				
Sponsor:	Shane Morrison-McCabe, Director of Operations				
Author:	Shane Morrison-McCabe, Director of Operations				
Appendices:	None				
Executive summary					
Purpose of report:	To provide an update regarding operational performance and recovery.				
Summary of key issues	Key items to note in the operational report are: • Operational performance in month • Raised 2WW referrals • Current DMO1 position and improvement plan • Increased numbers of patients on waiting list • Elevated levels of patient choice impacting cancer and RTT trajectories				
Recommendation:	The committee is asked to **note** the contents of the report				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	**KSO3:** ***Operational excellence***	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	BAF 3				
Corporate risk register:	**Risks:** As described on BAF KSO3				
Regulation:	CQC – operational performance covers all 5 domains				
Legal:	The NHS Constitution, states that patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, (i.e. patients should wait no longer than 18 weeks from GP referral to treatment) or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'.				
Resources:					
Assurance route					
Previously considered by:	Finance & Performance Committee				
	Date:	30.08.22	Decision:	Noted	
Next steps:					

Operational Performance Report

Shane Morrison-McCabe, Director of Operations

August 2022

Trust Board

Contents

Performance Summary

Queen Victoria Hospital NHS Foundation Trust

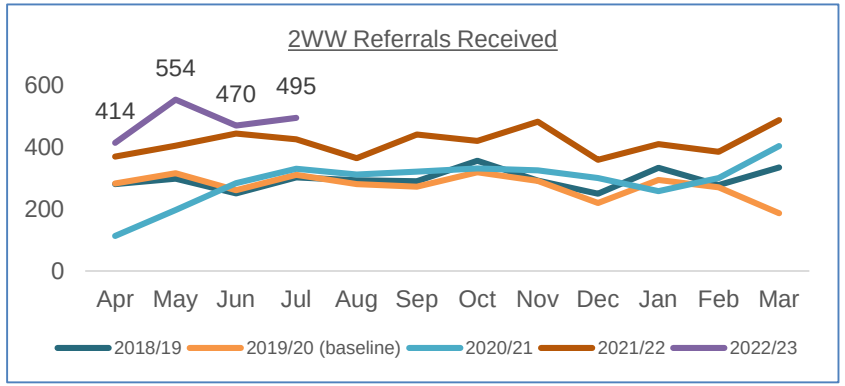
	KPI	TARGET / METRIC	SOURCE	AUG21	SEP21	OCT21	NOV21	DEC21	JAN22	FEB22	MAR22	APR22	MAY22	JUN22	JUL22	Change from last month
CANCER	Cancer 2WW	93%	National	89.2%	89.7%	90.2%	88.8%	94.8%	93.0%	93.9%	91.2%	83.4%	94.9%	89.5%	-	↓
	Cancer 62 day	85%	National	91.7%	91.7%	85.5%	88.0%	85.5%	92.3%	90.7%	95.1%	87.5%	89.2%	85.1%	-	↓
	Faster Diagnosis	75% (by March '24)	National	82.5%	80.5%	83.0%	82.1%	88.2%	80.3%	87.4%	86.6%	82.4%	85.3%	85.5%	-	↑
	Cancer 31 day DTT	96%	National	95.6%	96.0%	96.5%	94.9%	94.0%	95.3%	96.7%	95.6%	94.4%	94.8%	96.7%	-	↑
	31 Day Sub Treat	94% (surgery)	National	88.9%	93.3%	100%	87.5%	62.5%	89.5%	72.5%	80.0%	83.3%	77.3%	58.3%	-	↓
	Cancer 104 day	Internal trajectory	ICS	6	6	6	4	3	7	9	3	3	7	7	5	↓
	Cancer 62 day+ backlog	Internal trajectory	ICS	28	30	30	28	24	26	21	18	23	23	23	23	→
	Cancer 62 day+ backlog	<5% of PTL	Local	5.6%	5.7%	6.0%	5.5%	6.0%	6.6%	4.4%	3.7%	4.9%	4.5%	4.2%	4.1%	↓
DIAGNOSTICS	DMO1 Diagnostic waits	99% <6 weeks	National	86.89%	86.24%	87.88%	91.06%	87.60%	89.70%	92.02%	89.88%	87.96%	88.9%	88.7%	72.06%	↓
	Histology TAT	90% <10 days	Local	96%	95%	93%	98%	98%	92%	96%	96%	96%	95%	83%	97%	↑
	Imaging reporting	% <7 days	Local	97.1%	98.1%	97.2%	95.4%	95.7%	98.0%	95.0%	98.7%	90.0%	99.6%	98.1%	98.9%	↑
RTT WAITS	Total Waiting List Size	N/A	N/A	11,242	11,224	11,271	11,438	11,541	12,241	12,711	13,544	14,121	14,290	14,782	15,275	↑
	RTT104	0 by March '22	ICS	7	4	6	4	6	1	3	1	0	0	0	0	→
	RTT78	0 by March '22	Local	106	74	49	23	22	15	13	10	8	6	7	6	↓
	RTT52	0 by March '23	ICS	272	225	213	206	229	192	197	198	200	229	273	301	↑
	RTT18	92%	National	75.52%	73.53%	71.80%	70.31%	67.82%	68.10%	67.16%	65.40%	64.27%	66.63%	65.27%	63.50%	↓
ACTIVITY	Elective Recovery Increase	22/23 Activity Plan	ICS									93%	101%	98%	94%	↓
	Elective Recovery Reduction	22/23 Activity Plan	ICS									-4%	+2%	-4%	-12%	↓
	Non Elective Total	22/23 Activity Plan	ICS									108%	111%	116%	115%	↓
MIU	MIU	95% discharged <4hrs	National	99.6%	98.9%	99.5%	99.7%	99.1%	99.7%	99.9%	99.8%	99.5%	99.9%	99.2%	99.6%	↑
RAG	Deteriorating position or plans / cause for concern			Improving position or plans / local trajectories on track						Delivery of national / local standard						

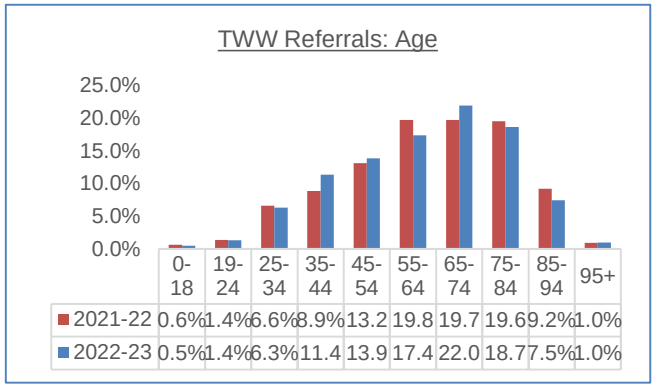
Cancer

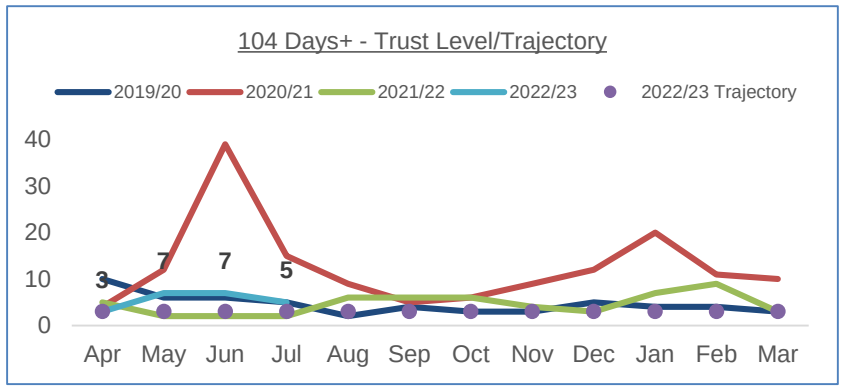
CANCER NATIONAL POSITION: *(Jun-22)*

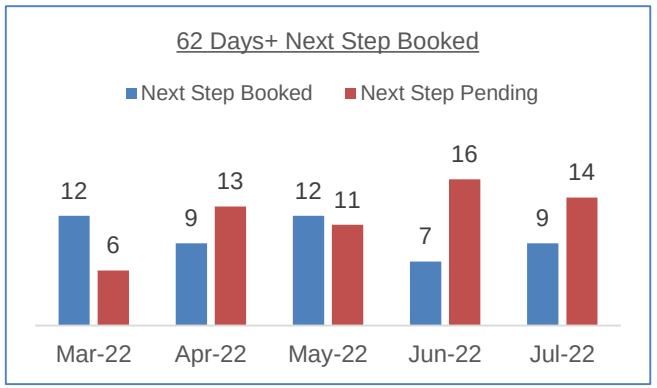
2WW:	FDS:	62 Day:	31 Day:
49 out of 139	**13** out of 139	**10** out of 144	**54** out of 142

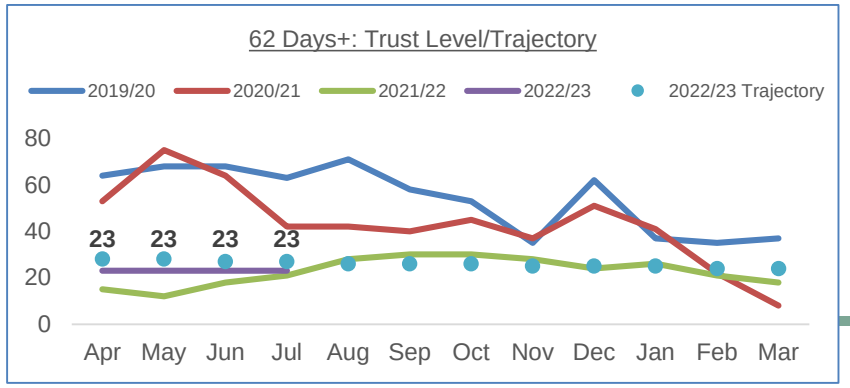
Queen Victoria Hospital NHS Foundation Trust

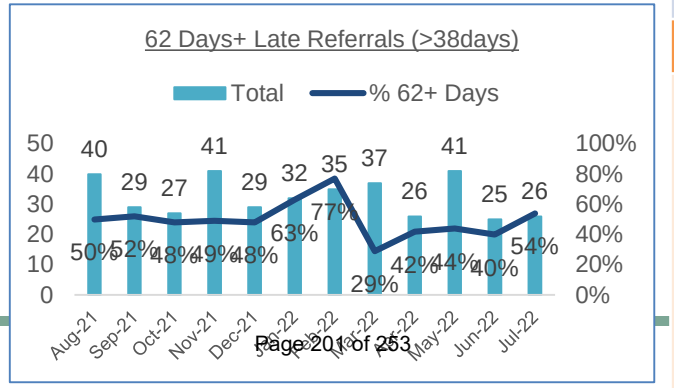












PERFORMANCE COMMENTARY

- **2WW** – standard not met; 50% of breaches were patient choice, 38% were clinic capacity. Patients seen in days 0 to 7 for their first outpatient appointment has decreased by 12% to 26%.
- **2WW referrals** – In month skin referrals reported a 71% increase (amounting to 115 referrals), and head & neck reported a 48% increase (amounting to 69 referrals), both compared to baseline.
- **62 day referral to treat** – met standard.
- **Faster diagnosis** – met standard.
- **31 day decision to treat (DTT)** – standard met.
- **31 day subsequent** – standard not met, with skin reporting 18 breaches, 15 due to sentinel lymph node biopsy capacity.
- **62 day+ backlog** – trajectory and PTL % met; although the PTL size is increasing due to the significantly higher than baseline 2WW referrals. Patients with a next step pending decreased by 2 compared to last month; impacted by medical delays, patient choice and delays in informing patients of their results.
- **104 day+** – trajectory not met, with all three specialties reporting patients over 104 days, 1 was a late referral and the remaining 4 were complex pathways.
- **Health Inequalities** – YTD skin has seen a 3.7% increase in referrals of those aged 35-44, and a 3.9% decrease in referrals of those aged 85-94. Head & neck have seen a 4.3% decrease in the number of referrals in the age bracket of 55-64.

FORWARD LOOK / PERFORMANCE RISKS

- The unvalidated July performance for **FDS** and **62 day** is achieving the standard.
- The unvalidated July performance for **2WW, 31 day DTT** and **31 day subsequent** is below plan, due to ongoing medical and capacity related delays.
- **62 day+ backlog** – Patient initiated delays continue to increase, particularly due to holidays, which remains a key risk to achieving the trajectory.
- **Over 104 day** – Continuing to see complex pathways as well as an increase in late referrals past 80 days.

Diagnostics and MIU

Queen Victoria Hospital NHS Foundation Trust

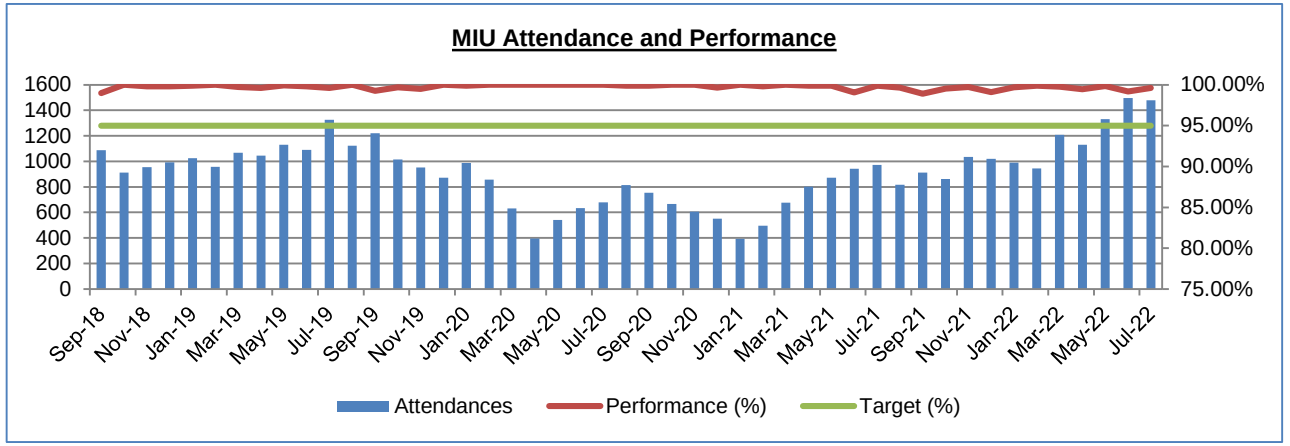
DMO1:

- National target not met; impacted by challenges within Sleep.
- Radiology only DMO1 performance is **99.8%**.
- Sleep only DMO1:
  - Performance has increased by 9.6% in month to **39.9%**, however is behind trajectory by 2.1%. The position will continue to remain challenged whilst recruitment into various posts continues into August.
  - All Sleep DM01 patients wait time data has been uploaded and we will report against all 5 DM01 tests from August 2022.
  - Procurement process underway to secure additional external capacity required to tackle waiting list & meet demand from increased referral rates.

DMO1 NATIONAL POSITION: *(look back – Jun-22)*	
National DMO1:	**QVH DMO1:**
72.5%	88.7%

MIU

- MIU attendance have remained at consistently high level, similar to last month, and we continue to meet the 4 hour clinical standard.

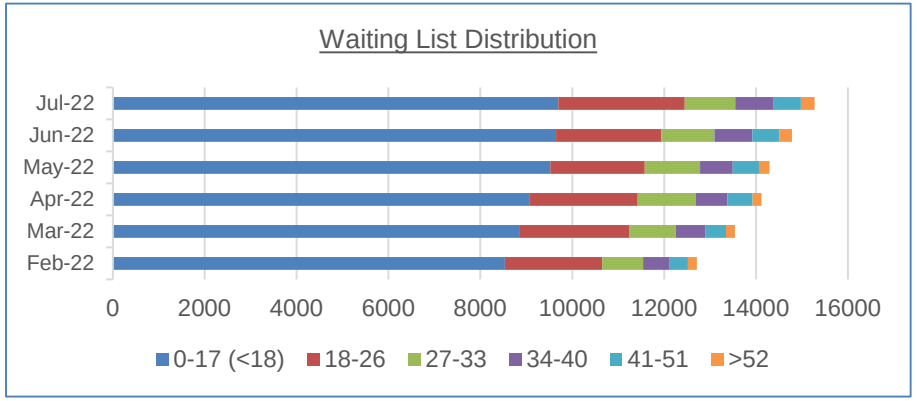


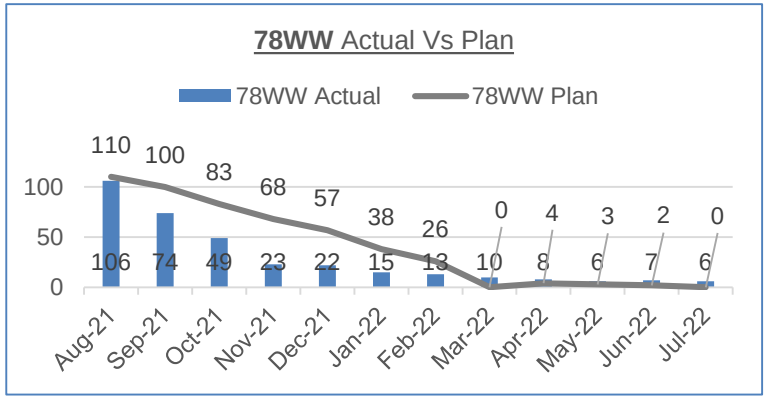
RTT Waits

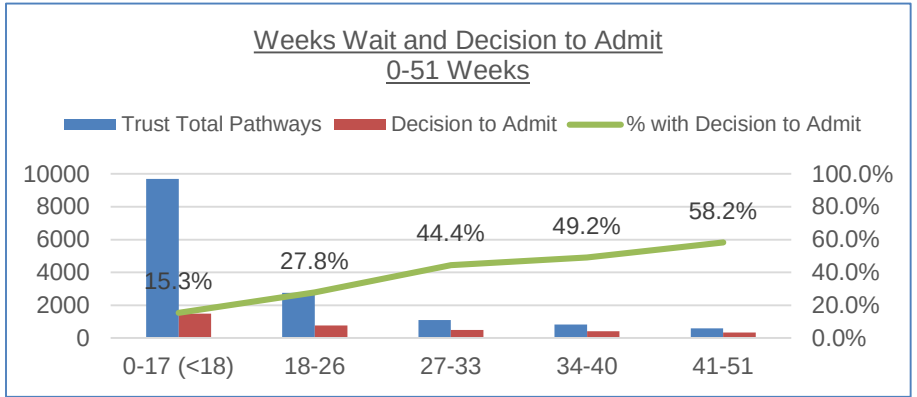
RTT NATIONAL POSITION: *(look back – Jun-22)*	
National RTT18: 62.2%	**QVH RTT18:** 65.3%

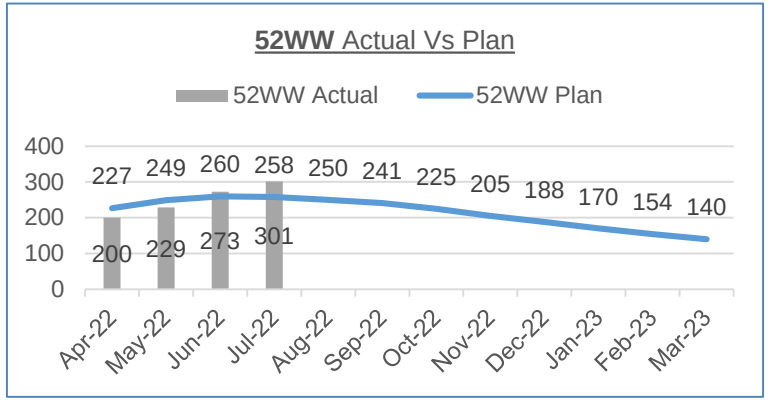
52WW NATIONAL POSITION: *(look back – Jun-22)*	
National % >52WW: 5.3%	**QVH % >52WW:** 1.8%

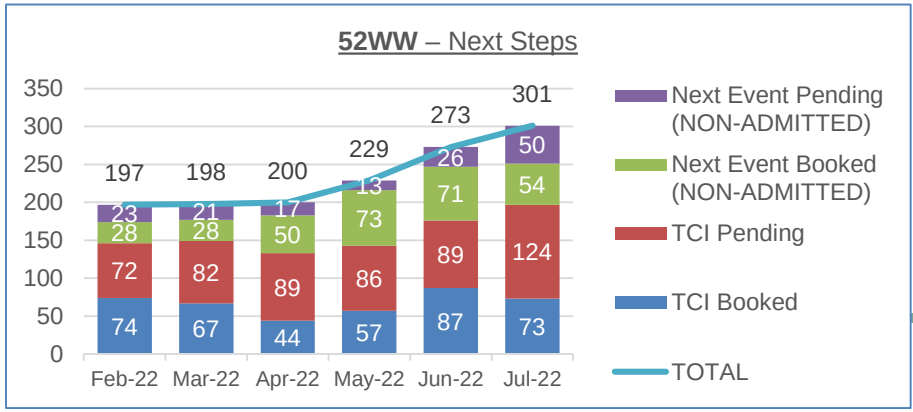
Queen Victoria Hospital NHS Foundation Trust











PERFORMANCE COMMENTARY

- **78WW** – Trajectory not met, however a reduction of 1 patient to 6; MaxFacs - 1, Plastics – 5.
- **52WW**:
  - Trajectory not met, in month increase of 28 patients to 301 with Plastics being the main challenge.
  - 45 are patient choice and 41 of these are plastics patients. Trust trajectory would have been achieved without these levels of patient choice.
  - 24% of patients have a TCI booked which is a reduction from last month.
  - Of the total number waiting 65% are Plastics, 31% are MaxFacs, 2% are Corneo and 2% are Sleep.
- **Plastics** – action plan is being developed with a key focus on the increase in patients with a TCI pending.
- **Decision to admit** – starting to monitor our waiting list by decision to admit to understand and highlight the delays we are seeing in outpatient capacity for our non-admitted pathways. The main challenges are with MaxFacs and Plastics.

FORWARD LOOK / PERFORMANCE RISKS

- **78WW** – performance is expected to remain stable into August, however we are not expected to achieve zero.
- **52WW** – performance remains challenged into August with a further increase in patients waiting more than 52 weeks expected. We are not expected to achieve the planned trajectory.
- All trajectories exclude patient choice.
- Ongoing risk around patients delaying treatment for Covid and Non-Covid reasons.

Activity Vs Plan

QVH Site / Independent Sector

Queen Victoria Hospital NHS Foundation Trust

Elective Recovery Group	POD Grouping	M4 Activity Plan	M4 22/23 Activity	% Activity Plan against 22/23 M4 Activity	19/20 M4 Activity Baseline	19/20 Activity Baseline % against 22/23 M4 Activity
Elective Recovery Increase	Day Case Total	1092	908	83%	1058	86%
	Elective Total	260	239	92%	304	79%
	Elective (excl Sleep)	*184*	*177*	*96%*	*184*	*96%*
	First Outpatients Total	3763	3182	85%	3609	88%
	Outpatient Procedures Total	2160	2503	116%	2461	102%
Elective Recovery Increase Total		**7275**	**6832**	**94%**	**7432**	**92%**
Elective Recovery Reduction Total	Follow Up Outpatients Total	**10194**	**8981**	**-12%**	**9896**	**-9%**
Non Elective Total		**575**	**661**	**115%**	**414**	**160%**

PERFORMANCE COMMENTARY

- **Day Case** – 83% of plan and 86% of 19/20 baseline delivered as a Trust.
- Delivery in excess of plan seen in Max Fax (105%). Ophthalmology delivered 72% of plan. Shortfall owing to a continued reduction in demand for cataract procedures as well as staff vacancy. However, Ophthalmology casemix is showing a higher complexity against 19/20 baseline. Plastics delivered 88% of plan. Underperformance driven by falling short of the elevated plan in the independent sector and through the modular theatres (both at approx. 89% of plan). However plastics daycase activity reflects 121% of 19/20 baseline.
- **Elective** – 92% of plan and 79% of 19/20 baseline delivered as a Trust.
- Underperformance against plan seen in Sleep and Ophthalmology with Plastics and Max Fax broadly delivering plan. Casemix showing higher case complexity in Max Fax and Ophthalmology against 19/20 baseline.
- Total Inpatient activity (combined daycase and elective plans) - the Trust delivered activity of 1147 cases against a plan of 1352 (85%).
- **First Outpatients** – 85% of plan and 88% of 19/20 baseline delivered as a Trust.
- Underperformance largely driven by Max Fax and Ophthalmology. Underperformance in both areas due to staff vacancy and annual leave. Improved recording of diagnostics carried out in clinics in Ophthalmology converting a small number of first appointments to outpatient procedures.
- **Outpatient Procedures** – 116% of plan and 102% of 19/20 baseline delivered as a Trust.
- Over performance against plan seen in Ophthalmology (due to improved recording of diagnostics carried out in clinics) as well as Sleep and Plastics.
- **Follow Up Outpatients** – Trust position at 88% against plan representing a performance of -12% against plan and a 9% reduction against 19/20.
- **Non-Elective** - 115% of plan and 160% of 19/20 baseline delivered as a Trust

FORWARD LOOK / PERFORMANCE RISKS

- **Corneo** – Ongoing risks related to staffing - recruitment underway for Fellow, Optometrists and locum consultant. Review of cataracts demand underway. Estimated 80% delivery of daycase and elective plan expected in M5. Underperformance also expected in new patient activity into M5. Additional nurse led new patient clinics being organised. Improvement not expected until M6. Over performance in outpatient procedures and a significant reduction in follow up activity owing to improved recording of diagnostics.
- **Plastics** – Expected to continue delivering against 19/20 baseline for M5 with a slight underperformance in daycase and elective against plan. Risks of delivery continues to include an increasing level of demand for cancer.
- **Max Fac** – Delivery of daycase and elective activity against plan expected in M5. Recruitment underway for vacant junior posts. Consultant back from long term leave and new ENT consultant starting in M6 which is expected to improve new patient delivery, however further junior vacancy from M6 presenting a further challenge.
- **Orthodontics** – Workforce challenges continue with multiple vacancies and absences resulting in significant loss of capacity. Recruitment to cover posts continues to be challenging. Fewer waiting list initiative evenings and weekends in M4 leading to slight underperformance but more planned for M5.
- **Sleep** – A number of technician posts have been filled although others are still going through recruitment. We expect to see increased elective capacity and activity from September. Locum medical capacity has been increased with a view to recruiting to fixed term positions in September. Temporary staffing in place to support CPAP set up during the working week. DMO1 position now reporting all elements of sleep diagnostics, trajectory reviewed and implemented.
- **Independent sector** – Level of capacity will determine delivery of activity targets in the later half of 22/23. Potential Uckfield capacity for daycases and Sevenoaks for See and Treat clinic also being explored.

Community Diagnostic Centre (CDC)

PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
• Referrals continue to be received through the digital platform Bleepa (which connects QVH with primary and secondary care colleagues), for the breathlessness pathway. • Patient feedback using LIME survey to gather patient feedback and experience of the pathway is underway, although numbers are small as patient feedback received via email only. Due to the cohort of patients within this pathway digital access can be challenging, this survey is not available in another format at this time. • The Full Business Case (FBC) has been submitted to NHSE, awaiting confirmation of approval status over the next few weeks. • Breathlessness Pathway rolled out to Ship Street and Judges Close consortium of practices. Referrals being received and working well.	• Digital platform task and finish procurement group established to identify specification for full procurement process for a long term digital solution. Short term interim contract almost complete for the continued support of the CDC Breathlessness pathway. • Individual work streams have been identified to support the long term development of the CDC as soon as funding approved. Task and finish groups set up including; estates and workforce. The first meeting for some of the work steams have taken place, others are diarised within the next couple of weeks. • KPI development remains ongoing. • Alliance Steering Group to be set up by commissioners tor the Crawley spoke site aspect of the QVH CDC. Draft FBC has been shared with QVH, although Steering Group now required to ensure full governance structures are in place prior to approval. • Changes to funding streams have been identified by NHSE, initial feedback relates to revenue funding over the next 2-3 years. Within 2022/23 revenue funding will be allocated as per business case once approved, although any further funding will need to be applied for in January 2023 and 2024.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**139-22**	
Report title:	**Community Diagnostic Centre (CDC) full business Case**				
Sponsor:	Shane Morrison McCabe, Director of operations				
Author:	Shane Morrison-McCabe, Director of operations				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of the report is to seek approval of the CDC full business case and provide an update on work completed to date and next steps				
Summary of key issues	Key items to note: • The CDC business case final document has been submitted and sets out the service model as part of the National and system delivery of CDCs • The aim of the QVH CDC would be to improve patient outcomes for the North Sussex population through improved access to early diagnostics • Consideration is also being given to provision of a spoke site CDC in Crawley support by QVH				
Recommendation:	The Board is asked to confirm that it has reviewed and **approved** the community diagnostic centre full business case and **note** the summary of work completed to date and next steps				
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:	**Controls / Assurance:** As described on BAF KSO3				
Corporate risk register:	**Risks:** As described on BAF KSO3				
Regulation:	CQC – operational performance covers all 5 domains				
Legal:	The NHS Constitution, states that patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, (i.e. patients should wait no longer than 18 weeks from GP referral to treatment) or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'.				
Resources:	Nil above current resources				
Assurance route					
Previously considered by:	QVH Board				
	Date:	7.7.22	Decision:		
Next steps:	NA				

Report to: Board Directors
Agenda item: 139-22
Date of meeting: 1 September 2022
Report from: Shane Morrison-McCabe
Report author: Shane Morrison McCabe
Date of report: 22 August 2022
Appendices: None

Community Diagnostic Centre (CDC) full business case

Background

In October 2020, NHS England published a report by Professor Sir Mike Richards, which reviewed diagnostic services as part of the NHS Long Term Plan. The report recommended that community diagnostic hubs or 'one stop shops' should be created across the country, so that patients can receive life-saving checks close to their homes. The report suggested that new services would need to be implemented over time, requiring significant investment in facilities, equipment and workforce.

All health systems are now working to include a network of community diagnostic centres (CDCs), allowing patients to access planned diagnostic care nearer to home without the need to attend acute hospital sites where emergency care can lead to delays and cancellations.

The six primary aims of a CDC are:

- To improving population health outcomes
- To increase diagnostic capacity
- To improve productivity and efficiency of diagnostic activity
- To contribute to reducing health inequalities
- To deliver a better, more personalised, diagnostic experience for patients
- To support integration of care across primary, secondary and community care.

Activity in CDCs may include Imaging (CT, MRI, X-ray), endoscopy (gastroscopy, flex sigmoidoscopy), physiological measurements (echocardiography, spirometry) and pathology (phlebotomy and point of care testing).

As QVH does not have an A&E, the hospital is well placed to establish a CDC providing a broad range of elective diagnostics (including checks, scans and tests), reducing pressure on other hospitals, providing quicker access to tests and greater convenience to patients across the local area.

Current Community Diagnostic Centre service at QVH

Through investment in existing facilities, QVH is working closely with some local GPs practices to provide swift access to diagnostic tests. Access to the CDC is via local GPs. Once the diagnostic test has been carried out, the results are sent to the GP electronically for discussion of next steps with the patient.

The QVH CDC has been a pioneer in the development of the Breathlessness Pathway for patients requiring both respiratory and cardiology diagnostics. This work is set to be rolled out in the coming months to other Primary Care Networks and GP Federations across Sussex.

Proposed investment in Community Diagnostic Centre at QVH

QVH is working with commissioners on plans for a new dedicated diagnostic facility on the QVH site, to open in 2024/25.

This would involve investment in a modular build and additional equipment to provide further enhancement of the imaging modalities available as well as clinical space to allow the provision of a wide range physiological and pathology testing. Significant investment will also be required in workforce to deliver a 12 hour per day, 7 day working model.

The QVH CDC services would be closely aligned to the specialist services currently provided at QVH, such as diagnostics related to the skin pathway and eye diagnostics. Developments would also include respiratory physiology including full lung function tests.

The aim of the QVH CDC would be to improve outcomes for the North Sussex population through improved access to early diagnostics in a 'one stop shop' model.

Consideration is also being given to provision of a spoke site CDC in Crawley, supported by QVH. This would reduce health inequalities by providing increasing access to underserved communities and addressing local place-based needs. The local population in Crawley currently tend to access health services later, have higher acuity when they do and have poorer health outcomes than other areas of West Sussex.

Next steps
QVH has submitted a business case for this work and secured capital funding, revenue funding is also required.

The Board of QVH are reviewing the full business case for investment in private on 1 September 2022 due to the commercial sensitivity of the detail.

If the Board of QVH supports the business case it will go forward for regional and national consideration.

Further development of proposals will be needed, including work around estates, IM&T, workforce and timeframes.

Recommendation
The Board is asked to confirm that it has reviewed and **approved** the community diagnostic centre full business case and **note** the summary of work completed to date and next steps.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**140-22**	
Report title:	**Finance Report 2022/23 – Month 04**				
Sponsor:	Michelle Miles, Director of Finance and Performance				
Author:	Michelle Miles, Director of Finance and Performance				
Appendices:	Finance Performance Report Month 04 - Report				
Executive summary					
Purpose of report:	To provide the Board with an overview of the Trust's financial performance.				
Summary of key issues	Month 4 YTD The Trust I&E position is breakeven against actuals. Income YTD is £0.2m favourable to plan. No expectation of ERF claw-back from commissioners included with the YTD position. Associates commissioners income under plan as contracts are still to be finalized. Expenditure run rate (both Pay and Non-Pay) is broadly in line with last 12 months averages. The cash position of the Trust remains favourable due to the level and timing of the block payments arrangement this year. The Trust position on Debtors and Creditors continues to improve. Work is ongoing concerning the over 90 day's debtors. The Trust capital plan for the year is £6.5m; YTD M4 capital spend is £0.5m over plan due to the earlier than planned completion of the Theatre pods.				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	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:	EMT				
	Date:		Decision:		
Previously considered by:	F&P				
	Date:	27/06/22	Decision:		
Next steps:					

Financial Performance Report

Michelle Miles, Director of Finance & Performance

July 2022

Trust Board

Income & Expenditure Month 4

Queen Victoria Hospital NHS Foundation Trust

Income and Expenditure

	In Month £'000				Year to Date £'000				Forecast Outturn		
	21/22	Plan	Actual	Variance	21/22	Plan	Actual	Variance	Plan	Forecast	Variance
Income											
Patient Activity Income	5,842	7,213	7,142	(71)	21,581	28,852	29,332	480	85,934	86,648	714
Other Operating Income	980	322	771	449	1,544	1,288	1,030	(258)	3,893	3,294	(599)
Total Income	**6,822**	**7,535**	**7,913**	**378**	**23,125**	**30,140**	**30,362**	**222**	**89,827**	**89,942**	**115**
Pay											
Substantive	(4,243)	(4,805)	(4,259)	546	(15,205)	(19,183)	(17,329)	1,854	(57,164)	(50,038)	7,126
Bank	(278)	(136)	(416)	(281)	(1,061)	(543)	(1,279)	(736)	(1,665)	(3,836)	(2,172)
Agency	(68)	(10)	(88)	(78)	(836)	(38)	(302)	(263)	(112)	(905)	(794)
Total Pay	**(4,589)**	**(4,950)**	**(4,763)**	**187**	**(17,103)**	**(19,764)**	**(18,909)**	**855**	**(58,940)**	**(54,779)**	**4,161**
Non Pay											
Clinical Services & Supplies	(797)	(470)	(960)	(490)	(2,152)	(1,880)	(3,711)	(1,831)	(6,758)	(11,132)	(4,374)
Clinical Services & Supplies - Med & Surg	(568)	(614)	(713)	(99)	(2,182)	(2,456)	(2,393)	62	(7,275)	(7,178)	97
Drugs	(123)	(129)	(122)	6	(496)	(514)	(475)	39	(1,512)	(1,425)	87
Establishment Expenses	(224)	(275)	(340)	(64)	(1,077)	(1,101)	(1,085)	16	(3,182)	(3,256)	(74)
Consultancy	(47)	(5)	0	5	(4)	(21)	0	21	0	0	0
Other non pay	(627)	(665)	(557)	108	(1,551)	(2,674)	(1,998)	676	(6,450)	(6,805)	(354)
Total Non Pay	**(2,386)**	**(2,158)**	**(2,693)**	**(535)**	**(7,462)**	**(8,644)**	**(9,661)**	**(1,017)**	**(25,176)**	**(29,796)**	**(4,619)**
Non Operational Expenditure	(148)	(140)	(122)	17	(533)	(560)	(499)	61	(1,676)	(1,497)	178
Non Operating Income	0	0	8	8	6	0	32	32	7	95	89
Depreciation and amortisation	(420)	(284)	(363)	(79)	(1,174)	(1,136)	(1,404)	(268)	(4,289)	(4,212)	77
Total Expenditure	**(7,543)**	**(7,531)**	**(7,933)**	**(402)**	**(26,265)**	**(30,104)**	**(30,442)**	**(337)**	**(90,074)**	**(90,189)**	**(115)**
Surplus / (Deficit)	**(721)**	**4**	**(20)**	**(24)**	**(3,141)**	**35**	**(80)**	**(115)**	**(247)**	**(247)**	**(0)**
Adjusted financial performance											
Technical		*20*	*21*	*1*		*83*	*80*	*(3)*	*247*	*247*	*0*
Adjusted Surplus / (Deficit)	***(721)***	***24***	***1***	***(23)***	***(3,141)***	***118***	***(0)***	***(118)***	***(0)***	***(0)***	***(0)***

QVH PERFORMANCE COMMENTARY

Income YTD £0.2m favorable to plan

Overachievement due to non recurring income in Q1.

No expectation of ERF claw-back from commissioners included with the YTD position. Associates commissioners income under plan as contracts are still to be finalized.

Expenditure £0.3m adverse to plan

- YTD Pay is £0.9m under plan, due to vacancies and service developments not yet started.
- YTD Non pay £1m over plan, ongoing monitoring of expenditure for the impact of inflationary pressures.

QVH FORWARD LOOK / PERFORMANCE RISKS

Forecast

At M4 The Trust is predicting a breakeven position, Forecast will be reviewed monthly to understand the impact of ERF and service changes in year.

Risks

- The trust operational performance is to deliver activity to 104%.
- Staff challenges and vacancies, may impact service delivery
- Inflationary costs greater than allocation.
- Income risk with non delivery of Elective activity
- Efficiencies under delivery and reliance on non recurrent savings

Mitigations

- The Trust will be reviewing establishment and vacancies through the year to ensure Budgets reflect resources required for delivery of activity performance
- Ongoing review of efficiencies, with the identification and delivery of recurrent savings.

SOFP - Balance Sheet 2022-23 Month 04

Queen Victoria Hospital NHS Foundation Trust

Statement of financial position

£000's	Prior Year End: March 2022	April	May	June	July	Change In Month	Change In Year
Non Current Assets							
Fixed Assets	59,920	59,558	59,705	59,654	59,875	221	(45)
Other Receivables	332	339	339	339	339	0	7
Total Non Current Assets	**60,252**	**59,897**	**60,044**	**59,993**	**60,214**	**221**	**(38)**
Current Assets							
Inventories	1,154	1,137	1,150	1,137	1,153	16	(1)
Trade and other Receivables	3,440	3,380	3,969	5,363	6,456	1,093	3,016
Cash and Cash Equivalents	17,547	10,267	9,487	8,763	9,435	672	(8,112)
Total Current Assets	**22,141**	**14,783**	**14,607**	**15,264**	**17,044**	**1,780**	**(5,097)**
Current Liabilities							
Trade and other Payables	(17,387)	(9,853)	(10,017)	(10,673)	(12,486)	(1,813)	4,901
Borrowings	(888)	(897)	(906)	(863)	(868)	(5)	20
Provisions	(52)	(78)	(78)	(78)	(78)	0	(26)
Other Liabilities	(644)	(644)	(642)	(682)	(928)	(246)	(284)
Total Current Liabilities	**(18,971)**	**(11,473)**	**(11,644)**	**(12,297)**	**(14,360)**	**(2,064)**	**4,611**
Subtotal Net Current Assets	**3,170**	**3,310**	**2,962**	**2,967**	**2,684**	**(283)**	**(486)**
Total Assets less Current liabilties	**63,422**	**63,208**	**63,006**	**62,960**	**62,898**	**(62)**	**(524)**
Non Current Liabilties							
Borrowings	(2,795)	(2,808)	(2,808)	(2,420)	(2,377)	43	418
Provisions	(1,048)	(1,022)	(1,022)	(1,022)	(1,022)	0	26
Total Non Current Liabilties	**(3,843)**	**(3,830)**	**(3,830)**	**(3,441)**	**(3,399)**	**43**	**444**
Total assets Employed	**59,579**	**59,378**	**59,176**	**59,519**	**59,499**	**(20)**	**(80)**
Tax Payers' Equity							
Public Dividend Capital	24,546	24,546	24,546	24,546	24,546	(0)	0
Revaluation Reserve	16,004	16,004	16,004	16,004	16,004	0	0
Income and Expenditure Reserve	19,029	*18,828*	*18,627*	18,969	18,949	(20)	(80)
Total Tax Payers' Equity	**59,579**	**59,378**	**59,176**	**59,519**	**59,499**	**(20)**	**(80)**

QVH PERFORMANCE COMMENTARY

- Non current assets: Capital spend YTD of £1.4m is ahead of plan, against depreciation and amortisation of £1.4m YTD.
- Other Non Current Receivables: This is matching the provision in relation to the central funding for the clinical pension tax scheme
- Trade receivables: Increase in month reflects accrued NHS income.
- Cash: The reduction in cash year to date of £8m reflects the payment of March invoices including £3m of capital and £4m of revenue and loan instalment paid.
- Trade payables: have decreased year to date by £5m reflecting the payment of March items (see cash movement) and additional £1.8m accruals in month.
- Borrowings:(current and non current) consist of the theatre capital loan and the outpatient pod finance lease. Instalments on the principal are payable in June and December (£0.4m).
- Provisions: (current and non current) relate to early retirement pension costs and the clinical pension tax scheme.
- Public Dividend Capital: represents the Department of Health's equity interest in the Trust.
- Revaluation reserve: reflects historic estate revaluations
- Income and expenditure reserve: reflects the historic and current statement of comprehensive income.

Efficiencies Month 04

Queen Victoria Hospital NHS Foundation Trust

RAG	No of Scheme	Annual Contribution FYE £	Sum of Contribution 2022/23 PYE £	RAG RATED Contribution 2022/23 PYE £	YTD Plan Contribution £	YTD Achievement £	YTD Variance £
Red	2	3,000	1,500	150	-	-	-
Amber	12	1,957,094	1,595,344	797,672	108,460	108,460	-
Green	4	134,000	134,000	107,200	35,733	35,733	-
Blue	1	20,000	20,000	20,000	-	-	-
TBC	11	65,840	16,395	-	-	-	-
Grand Total	**30**	**2,179,934**	**1,767,239**	**925,022**	**144,193**	**144,193**	**-**
Trust Target		**3,463,562**	**3,463,562**	**3,463,562**			
Variance (under)/over identified		**(1,283,628)**	**(1,696,323)**	**(2,538,540)**			

Business unit2	No of Scheme	Annual Contribution FYE £	Sum of Contribution 2022/23 PYE £	RAG RATED Contribution 2022/23 PYE £	YTD Plan Contribution £	YTD Achievement £	YTD Variance £
Clinical Support	4	46,000	44,500	21,650	7,167	7,167	0
Non Clinical Infrastructure	5	156,094	147,344	113,872	36,916	36,916	0
Operational Nursing	2	15,190	7,595	-	-	-	0
Oral, Maxillofacial And Corneo	6	170,000	155,000	87,500	21,667	21,667	0
Perioperative Care	9	58,650	12,800	2,000	667	667	0
Plastics	3	334,000	-	-	-	-	0
Trustwide	1	1,400,000	1,400,000	700,000	77,778	77,778	0
Grand Total	**30**	**2,179,934**	**1,767,239**	**925,022**	**144,193**	**144,193**	**0**

QVH PERFORMANCE COMMENTARY

The Trust has a total Efficiency target of £3.5m with plan net of efficiencies:

- Cash releasing £2.1m
- Productivity 5%, activity increase to achieve 104% elective activity target c. £1.4m with delivery against this target is expected to commence once the modular Theatres are operational.

- The Trust full year contribution target is £3.5m, to date £1.8m has been identified as impacting in 22/23. The RAG rated contribution of these schemes is however circa £0.9m.
- 30 schemes identified to date across the Trust, 11 schemes are to be confirmed in terms of financial impact and rag rating.

- YTD efficiencies is showing full delivery to plan, however further work is ongoing to ensure the delivery achievement is recurrent.

QVH FORWARD LOOK / PERFORMANCE RISKS

- The Trust historically has not been able to deliver cash releasing efficiencies and has had an reliance on non recurrent savings delivery.

- The Trust continues work to understand how the productivity and efficiencies currently being delivered can convert into recurrent savings.

Cashflow Report Month 04

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 04 2022/23

Cashflow Report

	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Forecast £'000							
	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Opening Balance	**17,547**	**10,267**	**9,487**	**8,764**	**9,435**	**6,739**	**6,221**	**4,598**	**4,163**	**4,159**	**4,224**	**4,289**
Receipts												
NHS Block & System income	6,724	6,656	6,659	6,859	6,807	6,807	6,807	6,807	6,807	6,807	6,807	6,809
Receipts from other income	553	288	274	197	310	237	237	237	237	237	237	251
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	0
PDC Cash Support Received	0	0	0	0	0	0	0	0	0	0	0	0
Total Receipts	**7,277**	**6,943**	**6,932**	**7,055**	**7,117**	**7,044**	**7,044**	**7,044**	**7,044**	**7,044**	**7,044**	**7,060**
Payments												
Payments to NHS Bodies	(4,464)	(582)	(359)	(146)	(676)	(663)	(663)	(602)	(603)	(602)	(603)	(602)
Payments to non-NHS bodies	(5,359)	(2,501)	(2,359)	(1,653)	(4,546)	(1,522)	(3,413)	(2,287)	(1,373)	(1,786)	(1,785)	(1,266)
Net Payroll Payment	(2,736)	(2,434)	(2,475)	(2,575)	(2,575)	(2,575)	(2,575)	(2,575)	(2,575)	(2,575)	(2,575)	(2,575)
Payroll Taxes	(1,275)	(1,478)	(1,293)	(1,293)	(1,293)	(1,293)	(1,293)	(1,293)	(1,293)	(1,293)	(1,293)	(1,293)
Pensions Payment	(723)	(728)	(732)	(717)	(723)	(723)	(723)	(723)	(723)	(723)	(723)	(723)
PDC Dividends Payment	-	-	-	-	-	(786)	-	-	-	-	-	(787)
Loan Interest & Repayment	-	-	(438)	-	-	-	-	-	(481)	-	-	-
Total Payments	**(14,557)**	**(7,723)**	**(7,656)**	**(6,384)**	**(9,813)**	**(7,562)**	**(8,667)**	**(7,480)**	**(7,048)**	**(6,979)**	**(6,979)**	**(7,246)**
Net Cash Movement	**(7,280)**	**(780)**	**(724)**	**671**	**(2,696)**	**(518)**	**(1,623)**	**(436)**	**(4)**	**65**	**65**	**(186)**
Closing Balance	**10,267**	**9,487**	**8,764**	**9,435**	**6,739**	**6,221**	**4,598**	**4,163**	**4,159**	**4,224**	**4,289**	**4,103**

QVH PERFORMANCE COMMENTARY

- Cash balances increased in month 4 by £0.7m, balances remain in line with forecast. Cash is forecast to reduce to meet the capital programme.
- There is currently a cash balance in excess of one and a half month of average spend; which is considered to be the minimum sufficient short term balance held, 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

- Forecast is based on 22/23 plan values.
- Cash balances are expected to reduce in H2 to support capital programme spend.

Debtors Month 04

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 04 2022/23

Debtors

	Jul 21 £'000	Aug 21 £'000	Sep 21 £'000	Oct 21 £'000	Nov 21 £'000	Dec 21 £'000	Jan 22 £'000	Feb 22 £'000	Mar 22 £'000	Apr 22 £'000	May 22 £'000	Jun 22 £'000	Jul 22 £'000	In Month Change £000
NHS Debtors														
0-30 Days Past Invoice Due Date	114	6,381	474	184	194	402	1,272	1,526	573	294	55	651	1,249	**598**
31-60 Days Past Invoice Due Date	32	29	12	177	252	116	300	94	97	58	266	24	13	**(11)**
61-90 Days Past Invoice Due Date	353	37	14	11	195	189	53	250	94	97	49	265	8	**(257)**
Over 90 Days Past Invoice Due Date	873	1,004	842	939	871	993	1,200	657	610	663	752	630	822	**193**
Total NHS Debtors	**1,371**	**7,450**	**1,341**	**1,311**	**1,511**	**1,699**	**2,825**	**2,527**	**1,374**	**1,111**	**1,122**	**1,570**	**2,091**	**521**
Non NHS Debtors														
0-30 Days Past Invoice Due Date	76	117	112	305	14	374	110	130	155	119	42	63	102	**38**
31-60 Days Past Invoice Due Date	22	45	79	48	31	26	6	64	4	38	68	6	9	**3**
61-90 Days Past Invoice Due Date	14	12	14	67	57	65	6	`	20	4	1	49	3	**(45)**
Over 90 Days Past Invoice Due Date	475	489	445	367	516	438	486	423	242	256	234	200	249	**49**
Total Non NHS Debtors	**587**	**663**	**650**	**787**	**618**	**903**	**608**	**617**	**420**	**417**	**345**	**318**	**362**	**45**
Total Invoiced Debtors	**1,958**	**8,113**	**1,991**	**2,098**	**2,129**	**2,603**	**3,433**	**3,143**	**1,794**	**1,528**	**1,467**	**1,887**	**2,454**	
NHS : Total NHS & Non NHS ratio	*0.70*	*0.92*	*0.67*	*0.63*	*0.71*	*0.65*	*0.82*	*0.80*	*0.77*	*0.73*	*0.76*	*0.83*	*0.85*	

QVH PERFORMANCE COMMENTARY

- The month 04 total debtor balance of £2.45m is 3% lower than the average monthly running balance of £2.52m.
- The month 04 debtor balance is £0.57m higher than reported at month 03. This is mainly due to the invoicing of new debt.
- At M04 close, debtors owed more than £0.1m:-

  Brighton And Sussex University Hospitals NHS Trust - £0.2m
  Guy's And St Thomas' NHS Foundation Trust -£0.15m
  Health Education England £0.8m
  University Hospitals Sussex NHS Foundation Trust £0.3m

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 2021-22.

Creditors Month 04

Queen Victoria Hospital
NHS Foundation Trust

Financial Performance 2022/23

Trade Creditors

	Jul 21 £'000	Aug 21 £'000	Sep 21 £'000	Oct 21 £'000	Nov 21 £'000	Dec 21 £'000	Jan 22 £'000	Feb 22 £'000	Mar 22 £'000	Apr 22 £'000	May 22 £'000	Jun 22 £'000	Jul 22 £'000	In Month Change £'000
NHS Accounts Payable Creditors														
0-30 Days Past Invoice Due Date	93	116	341	87	93	95	190	83	291	384	86	76	50	(26)
31-60 Days Past Invoice Due Date	28	16	97	29	2	14	38	33	3	79	51	58	5	(53)
61-90 Days Past Invoice Due Date	25	25	40	18	17	2	27	31	24	1	11	2	58	56
Over 90 Days Past Invoice Due Date	634	490	480	497	419	424	358	380	358	517	273	247	239	(8)
Total NHS Accounts Payable Creditors	**781**	**646**	**958**	**631**	**530**	**535**	**612**	**527**	**676**	**982**	**421**	**383**	**352**	**(31)**
														0
Non NHS Accounts Payable Creditors														0
0-30 Days Past Invoice Due Date	363	200	682	454	465	458	772	815	4,215	979	1,100	837	770	(66)
31-60 Days Past Invoice Due Date	89	36	30	29	33	119	67	71	9	54	172	33	119	86
61-90 Days Past Invoice Due Date	92	58	34	32	6	25	23	15	37	3	36	140	26	(114)
Over 90 Days Past Invoice Due Date	150	112	166	153	43	53	46	60	46	50	35	38	179	141
Total Non NHS Accounts Payable Creditors	**694**	**406**	**912**	**668**	**547**	**657**	**907**	**960**	**4,308**	**1,086**	**1,343**	**1,048**	**1,094**	**46**
Total Accounts Payable Creditors	**1,474**	**1,052**	**1,870**	**1,299**	**1,077**	**1,191**	**1,520**	**1,487**	**4,984**	**2,069**	**1,765**	**1,431**	**1,446**	14
NHS : Non NHS ratio	***0.53***	***0.61***	***0.51***	***0.49***	***0.49***	***0.45***	***0.40***	***0.35***	***0.14***	***0.47***	***0.24***	***0.27***	***0.24***	

QVH PERFORMANCE COMMENTARY

- The invoiced creditors balance at month 3 is £1.4m which is £0.4m lower than the annual running average of £1.8m.
- NHS balances 61-90 days have reduced by £0.1m following resolution and settlement of aged invoices. Non NHS balances have decreased overall by £0.3m both due to settlement.
- There are 3 creditors with a balance over £0.1m:

  Medway NHSFT (£0.2m) Disputed historic radiology SLA
  Insight Direct (UK) Ltd (£0.1m) Disputed due to delivery delays for part of invoice.
  Resmed (UK) Ltd £0.16 – Invoices are current month.

QVH FORWARD LOOK / PERFORMANCE RISKS

- Financial services will continue to review older NHS SLA balances with our key partner Trusts and escalate to the Income and Contracting Teams 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 04

Queen Victoria Hospital NHS Foundation Trust

Better payment practice code							BPPC	
Compliance target: 95% of invoices being paid within 30 days of receipt	Current YTD July Invoice Quantity	Current YTD July Invoice Value £000	Previous Month YTD June Invoice Quantity	Previous Month YTD June Invoice Value £000	Current Month July Invoice Quantity	Current Month July Invoice Value £000	Prior Year 2021-22 Invoice Quantity	Prior Year 2021-22 Invoice Value £000
Non NHS								
Total bills paid	5,568	14,267	4,267	11,315	1,301	2,952	17,865	39,589
Total bills paid within target	5,312	13,758	4,067	10,901	1,245	2,857	17,000	38,156
Percentage of bills paid within target	**95.4%**	**96.4%**	**95.3%**	**96.3%**	**95.7%**	**96.8%**	**95.2%**	**96.4%**
NHS								
Total bills paid	416	5,204	358	5,076	58	128	1,179	5,933
Total bills paid within target	391	5,107	334	4,981	57	126	1,080	5,740
Percentage of bills paid within target	**94.0%**	**98.1%**	**93.3%**	**98.1%**	**98.3%**	**98.3%**	**91.6%**	**96.7%**
Total								
Total bills paid in the year	**5,984**	**19,471**	**4,625**	**16,391**	**1,359**	**3,080**	**19,044**	**45,522**
Total bills paid within target	**5,703**	**18,865**	**4,401**	**15,882**	**1,302**	**2,983**	**18,080**	**43,896**
Percentage of bills paid within target	**95.3%**	**96.9%**	**95.2%**	**96.9%**	**95.8%**	**96.8%**	**94.9%**	**96.4%**
Compliance target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Above (below) target	0.3%	**1.9%**	**0.2%**	**1.9%**	**0.8%**	**1.8%**	(0.1%)	**1.4%**

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 as follows;
  - Number of invoices: 95.3 % (compliant)
  - Value of invoice 96.9% (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 04

Queen Victoria Hospital NHS Foundation Trust

Capital Programme	CPG Capital Plan 22/23	Plan YTD M4	Spend YTD M04 July 2022
	£k	£k	£k YTD
Top Slice Staffing	450	51	64
Contingency	250		-40
Non Clinical Refurbishments	75		
Total top sliced	**775**	**51**	**24**
21/22 Schemes Brought Forward			
IM&T PACS/RIS/VNA	55	27	27
Patient Comms	220		
Cyber Security	144		
Digital Dictation & Voice Recognition	45		
ICE	37	37	37
Subtotal IMT	**501**	**64**	**64**
Burns ward wall protection	40	40	31
Radiology Pillars	50		
Cashiers office	15	15	6
Main Outpatient walls & Flooring	70		
Theatres Power supply / Phase 1	65	20	18
Subtotal Estates	**240**	**75**	**54**
Equipment Corneal Topographer	76	76	76
Balance on Microvascular - ENT microscope			-13
Subtotal Equipment	**76**	**76**	**63**
Modulars PortaKabin	870	542	775
Medical gases	17		4
Mechanical works	75		
Electrical works	75		56
Natural Gas network / Meter Relocation	75		
Power Supply / UKPN	300		284
Subtotal Portakabin Theatres	**1,412**	**542**	**1,119**
Total 21-22 projects b/f & Top sliced	**3,004**	**808**	**1,324**
22/23 Estates			
Subtotal	**1,120**	**0**	**0**
22/23 IM&T			
Subtotal	**2,080**	**30**	**30**
22/23 Medical Equipment			
Subtotal	**700**	**22**	**0**
Total 22-23 programmes	**3,900**	**52**	**30**
Total planned programme: topslice, 21-22 & 22-23 projects	**6,904**	**860**	**1,354**
ICS Allocation 22-23	**6,548**		
Management of allocation required (over programming)	**-356**		

QVH PERFORMANCE COMMENTARY

- The 2022-23 ICS original allocation for the Trust was £4,874m. This has now been formally increased by £1,674m to £6,548.
- The allocation is not cash backed but a share of the national DHSC capital expenditure limit. As such cash will be met by the Trust from previous surpluses.
- The position to date shows an overspend against plan of £494k this is due to the early than planned completion of the Theatre pods.
- The allocation approved by the HMT is currently over subscribed and the plan will be reviewed to manage the gap, maintain reserve and prioritize achievable bids.
- Plans and business cases are underway for Estates and IT and a number of smaller projects have commenced. Equipment business cases are yet to be developed to initiate projects.
- The phasing of the 22/23 programmed schemes is still significantly weighted in quarters 3 and 4.
- The Trust is currently working on a capital bid for PDC funding (cash backed) to support a new Community Diagnostics Centre £8.4m.

QVH FORWARD LOOK / PERFORMANCE RISKS

- The ICS will require Trusts to provide quarterly returns and mitigations for any underspend against plan. Where underspends cannot be mitigated by the Trust the allocation is to return to the ICS for redistribution.
- Delays in the submission of capital bids to the Capital Programme Board and potential Procurement lead times could impact the Trust in the ability to deliver its capital programme.

KSO5 – Organisational Excellence

Risk Owner: Interim Director of Workforce & OD
Date 17th August 2022

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 high vacancy rates.
- Trust establishment and vacancy levels and ability to meet required activity levels
- Staff Survey results relating to WRES and WDES indicators and Metrics

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
- 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 stability in a challenging operational environment. The 2021 survey outcome remained stable with improvements seen for team working, however challenges are being seen in our results for our staff with protected characteristics
- Overseas nurses having a positive impact, further engagement with UHSx in place
- Workforce KPI's highlight workforce stability over sustained period of time
- Availability and willingness of staff to undertake additional activity with Trust initiatives such as WLI and Bank Shift Supplements
- Ongoing requirement for COVID-19 risk assessments for all vulnerable staff, with heightened risk to BAME workforce

Initial Risk 3(C)x 5(L)=15, moderate
Current Risk Rating 4(C)x 4(L)=16, 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
- Impact of future waves of the pandemic and associated variants including potential vaccination booster programme requirements
- 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.
- On going discussions with UHSussex and collaboration for key roles and support teams which lack capacity and agility
- Exploration of overseas nursing recruitment with UHSussex
- Exploring Medical Support Worker initiative to support Medical Vacancies

Controls / assurance
- more robust workforce/pay controls as part of business planning and weekly vacancy control
- Leading the Way, leadership development programme to be revisited and launched for our staff with line management responsibilities
- 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

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:	**01/09/2022**		**Agenda reference:**	**142-22**	
Report title:	**Workforce monthly report**				
Sponsor:	Lawrence Anderson, Interim Director of Workforce and OD				
Author:	Evelyn Falaye, Deputy Director of Workforce 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:	• Workforce Report – KPI's and narrative				
Executive summary					
Purpose of report:	To provide a monthly update of Workforce KPI's and OD activity				
Summary of key issues	August 2022's Workforce report marks the commencement of a new reporting format for the Workforce metrics and assurance. This report provides a concise update and assurance on the key areas within Workforce and OD, signalling Compliance, Risks, Mitigations and Actions being taken. This also allows the Trust to align itself the NHS People Promise. Key highlights this month show a slight increase in Bank usage in July compared to June leading to a under utilisation of establishment of 3.3%. The report also introduces visibility to our Band 5 nursing vacancy levels, our Bands 2 and 3 HCSW and support staff vacancies and our AHP vacancies. The Trust's Monthly sickness rate has increased from 2.49% to 3.55%. We have also introduced a 12 month sickness rate for the trust to the report which is currently at 4.03% (the Trust sickness target is 3%)				
Recommendation:	The committee is asked 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:	-KSO5. Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care -Engaged and motivated staff deliver better quality care (KSO1)				
Corporate risk register:	Impact of pandemic on workforce availability				
Regulation:	Well Led				
Legal:	n/a				
Resources:	Managed by HR/OD with support from finance, operations and nursing				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	30.08.2022	Decision:	TBC	
Next steps:					

Workforce and Organisational Development Report

Presented by:
Lawrence Anderson, Interim Director of Workforce &OD

August 2022 (July 2022 Data)

Contents

Workforce KPI Summary

Queen Victoria Hospital NHS Foundation Trust

	KPI	Jul-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Establishment WTE		1091.29	1116.48	1116.88	1116.88	1057.42	1057.42	1057.42	**1057.42**
Staff In Post WTE		922.66	932.11	937.56	939.56	932.66	938.84	941.24	**939.88**
Agency Total worked in month WTE		12.89	10.44	10.39	10.50	9.42	8.44	8.14	**8.27**
Bank WTE Total worked in month WTE		78.37	77.85	77.65	91.93	63.86	66.24	67.79	**74.33**
Staff in Post Vacancy WTE		134.85	147.52	142.47	140.47	42.30	36.12	33.72	**35.08**
Vacancies % Including Bank & Agency Usage	8%	**7.09%**	8.61%	8.17%	6.71%	4.87%	4.15%	3.81%	**3.30%**
Staff in Post Vacancies %	8%	**12.75%**	13.66%	13.19%	13.01%	4.34%	3.70%	3.46%	**3.60%**
Band 5 Nurse Vacanies WTE									**0.87**
Band 2 & 3 HCSW Vacancies WTE All clinical and non clinical support to clinical staff									**15.92**
Qualified AHP Vacancies WTE									**5.54**
Trust rolling Annual Turnover % Excluding Trainee Doctors	10%	13.15%	15.23%	15.90%	15.40%	15.51%	16.34%	15.28%	**15.25%**
Starters WTE In month excluding HEE doctors		5.80	9.15	11.12	11.01	8.96	10.04	8.85	**6.80**
Leavers WTE In month excluding HEE doctors		12.46	10.18	7.39	7.61	12.52	10.21	6.45	**13.07**
12 Month Rolling Stability % Remained employed for the 12 month period	85%	85.09%	83.83%	83.04%	83.43%	83.61%	83.20%	84.27%	**84.44%**
12 month sickness rate (all sickness)	3%	3.04%	3.59%	3.73%	3.90%	4.05%	4.04%	**4.03%**	TBC
Monthly Sickness Absence % All Sickness		3.17%	4.72%	4.34%	4.70%	4.28%	2.49%	**3.55%**	TBC

	KPI	Jul-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
% staff appraisal compliant All perm	90%	85.17%	80.61%	82.85%	82.66%	81.69%	82.33%	83.30%	**83.21%**
% staff appraisal compliant AfC only		87.64%	84.45%	85.47%	84.36%	83.78%	84.75%	86.02%	**86.32%**
% staff appraisal compliant M&D only exc		68.70%	60.82%	68.15%	73.84%	70.48%	69.28%	68.67%	**66.67%**
Statutory & Mandatory Training All perm	90%	91.98%	91.27%	91.03%	91.05%	90.69%	91.60%	92.28%	**92.54%**
Statutory & Mandatory Training Bank only (excl. honorary/locum)		81.83%	78.03%	79.84%	80.04%	79.41%	80.24%	81.00%	**81.80%**
Statutory & Mandatory Training AfC only		93.93%	93.34%	93.04%	92.65%	92.14%	93.09%	93.64%	**93.94%**
Statutory & Mandatory Training M&D only (excl. honorary/locum)		83.40%	82.61%	81.86%	84.35%	84.35%	85.12%	86.30%	**86.47%**
Staff Engagement (1/4ly Survey)		TBC	Qtr 4 7.5 out of 10 Top 25% quartile			Qtr 1 7.5 out of 10 Top 25% quartile			

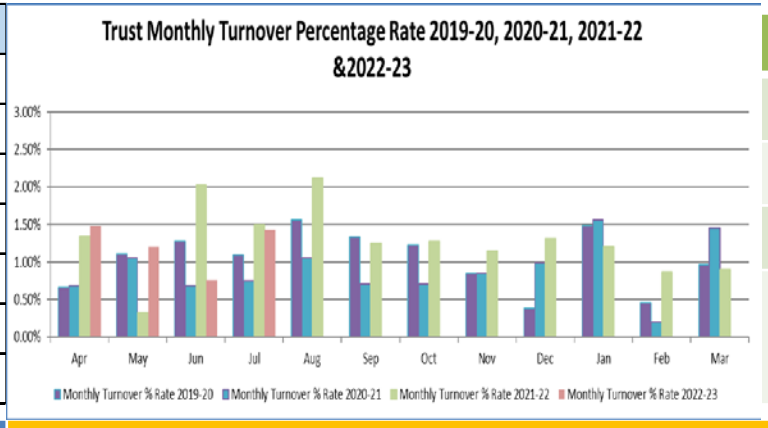
National Quarterly Pulse Survey - Treatment
Quarterly staff survey to indicate likelihood of recommending QVH to friends & family to receive care or treatment

2020-21 National Survey
Of 594 responses:
94% : 2%

Vacancies, Turnover and Stability

Queen Victoria Hospital NHS Foundation Trust

	Stage	KPI	Feb	Mar	Apr	May	Jun	Jul	Trend Line
T19	From Advert open to ready to start	45	66.57	45.87	63.07	84.25	65.03	64.18	
T23	From conditional offer to ready to start	18	41.37	22.7	34.7	56.85	31.77	41.62	
T16	From authorised to ready to start	53	55.93	50.38	64.7	65.92	106.03	68.5	
T17	From authorised to start date	70	97.73	72.13	82.95	104.8	74.13	75.75	
T1a	Time to authorise	5	5.37	6.3	6.18	5.1	5.1	7.71	
T1b	From authorised to advert live	2	2.47	1.3	3.73	1.33	4.15	1.92	
T4	Time to shortlist	3						7.05	



Future initiatives/Successes

- Improving and fast tracking vacancy authorisation process
- Consolidation of forms for ease for users – ECF/Change and EPF
- Bank to substantive process to be reviewed
- Invited to meet with NHS England about how we retain our HCSWs – we have a good retention in comparison to other trusts nationally

You Said We Did

35% of staff in the National Staff Survey said there were not enough people to do their role so we have reviewed our recruited process and we have our time to recruit from taking 86.68 average days (Jul 21) from vacancy authorisation to start date to 75.75 average days in Jul 22.

We are reviewing the vacancy approval process to enable vacancies to be advertised faster to avoid gaps from when a staff member leaves the Trust to when their replacement starts.

Highlights

- This month we saw continued reduction in time to hire (advert open to ready to start) at 64.18 which is an improvement from last but 19 average days over target of 45 average days.
- There was 40 WTE advertised in July 2022- 13 Nursing, 12 Admin and 8 M&D
- 12 months rolling turnover is at 15.27% which is 5.27% above target
- We had 13.07 WTE leavers and 6.80 WTE starters (external only)
- This month stability rate is 84.8% against target of 85% a non significant variance of 0.6%

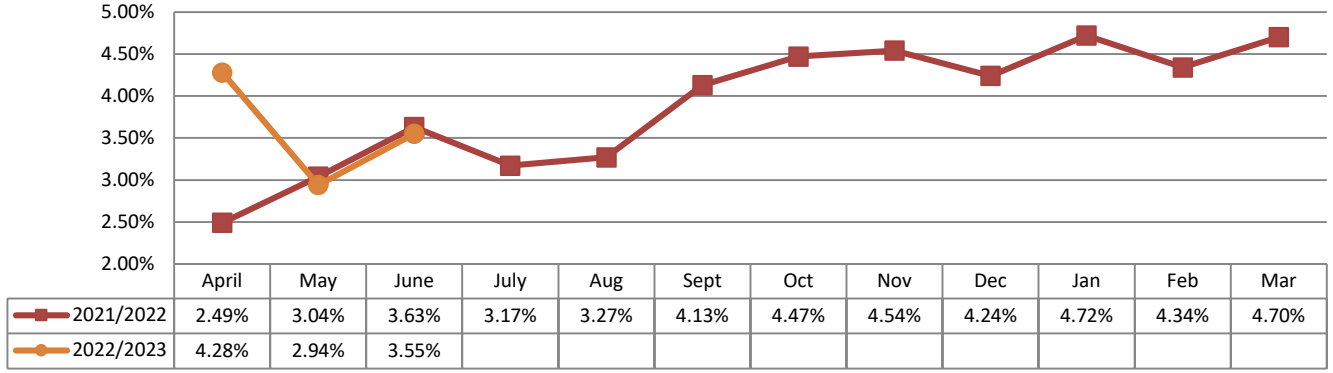
Hot Spots

- Highest vacancy rate is in Sleep at 18.39% and Director of Nursing at 16.84%
- Qualified AHP's continue to be hard to recruit along with Consultant Histopathologist and Admin roles in Plastics
- Clinical Support, Non Clinical Infrastructure and Periop saw the highest number of leavers (6, 5 and 4respectively)

Action Plan	Owner	Due by	Progress - RAG	Update
Implement National (6) WRES Actions – Diverse Interview panel (8a and above) value based questions	EF/SO	Sept 2022		
Smarter working with continuous improvement on paperwork and processes for stakeholders	SO	Sept 2022		Draft paperwork out for review
Work with advisory team on retention project to ascertain why thinking of leaving or likely to leave	SO/GF	Nov 2022	Not started	
Make contact with local Job Centre for direct recruitment activity for hard to fill admin roles (substantive and bank)	SO	Oct 2022	Not started	

Health and Wellbeing

Queen Victoria Hospital NHS Foundation Trust



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021/2022	2.49%	3.04%	3.63%	3.17%	3.27%	4.13%	4.47%	4.54%	4.24%	4.72%	4.34%	4.70%
2022/2023	4.28%	2.94%	3.55%									

Future initiatives/Successes

- Care first (EAP) visit to QVH departments arranged for September 2022
- Staff in Mind, Project Wingman (Wellbee/ Wingbee) visit to QVH to be arranged
- Wellbeing event in October to coincide with World Mental Health Day
- Supporting Health in the Workplace Policy published to replace Attendance Policy
- Engaged with ICS stakeholders for a shared Occupational Health service
- Next round of Work Related Stress Indicator Tool (WRSIT) to commence

Highlights

- Sickness absence reduced to 2.94% (May 2022) after 12 months above the Trust KPI of 3%
- NHS Employers changes to pay for Covid related absences effective from 18th July 2022 at QVH and will be included in monitoring from 1st September 2022
- Occupational Health service with Cordell Health improved in recent weeks through weekly collaborative meetings

Hot Spots

- Departments in Access and Outpatients saw a significant increase in short and long term sickness absences April to May (1.75% overall), with Eyes being the only other Business Unit to see an increase in month (0.66%).

Action Plan	Owner	Due by	Progress - RAG	Update
Staff in Mind visit to QVH to be arranged	GF	31/08/2022		Call arranged for 19/08/22
Wellbeing Calendar to be published (April 2022 to March 2023)	GF	31/08/2022		In progress
Advisory team to engage with managers in Access OPD, and Eyes to advise on sickness management	GF	31/08/2022		
Wellbee/ Wingbee visit to QVH to be arranged or other initiative	GF	31/08/2022		Call to be arranged w/c 15/08/22
Wellbeing event in October – Stay Well team in collaboration with Healthy Workplace Allies network	GF	October 2022		Met 11/08/22

OD & Learning (inc. library) and Medical Education

Queen Victoria Hospital NHS Foundation Trust

Compliance summary data up to 31 July 2022					
Organisation	Assignment Count	Compliance %	Change	PDR Compliance %	Change
All QVH (Inc. Bank)	1228	**91.27%**	**0.26%**	**83.21%**	**0.09%**
AfC (excl. bank)	894	**93.94%**	**0.30%**	**86.32%**	**0.30%**
Non-perm (bank only)	128	**81.80%**	**0.80%**	N/A	N/A
Medical & Dental	206	**86.47%**	**0.17%**	**66.67%**	**2.00%**

Future initiatives
Scheduled 4 bespoke development events
Due to LSM retiring, an options paper will be considered by EMT
Appraisal reassurance for the board
Plastics Hand Teaching – August and September, with practical sessions
Planning SAS doctors training day funded by HEE SAS CPD money

Highlights

- Corporate Induction held for 22 attendees (1 DNA and 1 W/D)
- Procured Picker for 2022 NHS Staff Survey
- Procured for Improvement Technician Apprenticeship provider
- Successfully applied for funding for Excel courses for staff
- GMC survey of doctors in training results were excellent for QVH – 20 green flags, QVH commended by HEE Deputy Dean at LAB meeting
- HEE Education contract self-assessment return completion underway, led by Med Ed

Hot Spots

- Of 343 course bookings, 196 attended (57%) and 52 DNA (15%)
- Library Services manager (LSM) retiring 30/09/22
- Medical Education Coordinator leaving 31 August – recruitment underway
- Planning for August Junior Doctors' induction – largest induction of the year

Action Plan	Owner	Due by	Progress - RAG	Update
MAST policy	KB	23/09/22		In progress
2022 NHS Staff Survey pre-work activity	AB	03/10/22		In progress
Work Experience policy	AB	Feb 2023		Scoping phase
NHS Elect membership	LA	TBC		Negotiation stage

Staff Experience and Inclusion –

People Promise 1: We are Compassionate and Inclusive

We are compassionate and inclusive

We do not tolerate any form of discrimination, bullying or violence.
We are open and inclusive.
We make the NHS a place where we all feel we belong.

NHS
Queen Victoria Hospital
NHS Foundation Trust

	Theme	2021
WRES (BME)	Bullying & Harassment or abuse from staff /colleagues	29.2% (15.3%)
	Personally experienced discrimination at work from manager or team leader	18.3% (5.3%)
	Bullying and Harassment or abuse from managers	12.9% (2.9%)
	My organisation respects individual differences e.g. culture, backgrounds etc.	66% (74.9%)
WDES	Bullying & Harassment or abuse from staff /colleagues	55.77% (44.3%)
	Extent to which org values my work	59.3% - No
	My organisation respects individual differences e.g. culture, backgrounds etc.	30.6% - No

Future initiatives/Successes

- Complete Gender Pay Gap submission and analysis report (due March 2023)
- Continue to work closely with Sussex Race Equality Transformation board - ICB
- Work closely with the Trust NED for equality and wellbeing
- New role - EDI & HWB co-ordinator
- Cultural day event

Highlights

Objective – Tackle areas of poorer work experience for our people to enable them bring their true self to work

- Improve Partnership working with staff-side, networks
- Empower people to speak up
- Streamline HR processes
- Implement National WRES Actions
- Encourage disability network
- You said we did Poster – CED and Workforce Director

Hot Spots

Though on the whole the 2021 staff survey was a very results but some staff are reporting negative experiences that we are looking into to improve poor work experience in the Trust

- Deep dive into the issues faced by 29.2 % of ethnically diverse staff who reported that they are bullied, harassed or abuse by their colleague and 55.72% of our disabled staff reported same.
- Ethnically diverse staff also stated that they have faced discrimination at work from manager or team leader (18.3%) and 12.9% reported that they have faced bullying and harassment from managers

Action Plan	Owner	Due by	Progress - RAG	Update
Complete Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) analysis reports	GF	October 2022		
Streamline the Job evaluation process	EF	September 2022		
Staff network framework – guidance for staff	EF/GF	August 2022		EMT approval
Local union representation in the Trust – Liaise with regional reps to recruit Trust rep –Event on site	EF			
EDI Policy	EF	September 2022		
Video blog to promote invitation for staff to start network in collaboration with the FTSUG and Guardian of Safe Working	EF/SP/ JC	September 2022		

Staff Engagement & Staff Survey -
People Promise 3: We have a voice that counts

We each have a voice that counts

We all feel safe and confident to speak up. We take the time to really listen – to understand the hopes and fears that lie behind the words

NHS Queen Victoria Hospital NHS Foundation Trust

QVH Most declined scores	Trust 2021	Trust 2020
q3i. Enough staff at organisation to do my job properly	35%	45%
q22b. I am unlikely to look for a job at a new organisation in the next 12 months	53%	59%
q22a. I don't often think about leaving this organisation	46%	52%
q4a. Satisfied with recognition for good work	59%	64%
q4d. Satisfied with opportunities for flexible working patterns	56%	60%

Most improved scores	Trust 2021	Trust 2020
q13d. Last experience of physical violence reported	75%	55%
q11e. Not felt pressure from manager to come to work when not feeling well enough	78%	71%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	61%	55%
q9b. Immediate manager gives clear feedback on my work	66%	62%
q7b. Team members often meet to discuss the team's effectiveness	59%	56%

Future initiatives/Successes

- A confidential service that staff can call to speak up that to enable management bring positive changes
- Encourage team huddles so managers and team leaders can demonstrate active listening skills
- Enable /equip managers to have sensitive and supportive conversations
- Electronic thank you cards connected to weekly Connect – from any of the execs

Highlights

- Significant improvement in violence reduction – 75% of staff reported that they haven't experience violence compared to 55% in 2020
- Improved engagement with staff on decisions that affect their jobs and feedback on work done.
- You said we did poster to inform of staff survey action plan progress
- Video blog from director of workforce about QVH commitment to continuously listen to staff and empower staff to speak up without fear of retribution. Using the opportunity to introduce 2022 National Staff Survey
- Retention project by the ER team

Action Plan	Owner	Due by	Progress - RAG	Update
• Arrange the video blog session with the media and communications team	EF	31st August 2022		
• Investigate Microsoft Teams electronic thank you card option	GF/EF	31st August 2022		

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**1st September 2022**		**Agenda reference:**	**143-22**	
Report title:	**Workforce Race Equality Standards (WRES 2021): Data Report 2021/22**				
Sponsor:	Lawrence Anderson, Interim Director of Workforce & OD				
Author:	Gemma Farley, Employee Relations & Wellbeing Manager				
Appendices:	None				
Executive summary					
Purpose of report:	The Workforce Race Equality Scheme (WRES) provides data to facilitate the Trust's ability to make informed decisions and take action to actively promote equality of opportunity. This report is data as at 31st March 2022 which is to be submitted nationally by the Trust. A further report will be submitted that will analyse the data, highlight the improvements that have been made and the areas that may require further action.				
Summary of key issues	The data is for the following indicators: indicator 1 - % of staff in non-clinical and clinical workforce; indicator 2 – relative likelihood of appointment from shortlisting; indicator 3 – relative likelihood of formal disciplinary process; indicator 4 – relative likelihood of accessing training; and indicator 9 – Board voting membership. (indicators 5-8 is data from the NHS Staff Survey which has been reported earlier in 2022)				
Recommendation:	Approval for National Submission of data and to publish externally				
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:	KSO5. 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. The 2021 survey outcome remained stable with improvements seen for team working, however challenges are being seen in our results for our staff with protected characteristics				
Corporate risk register:	N/A				
Regulation:	N/A				
Legal:	N/A				
Resources:	None				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	25th July 2022	Decision:	Reviewed	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

NHS Workforce Race Equality Standards (WRES) As at 31st March 2022

NHS Data Submission

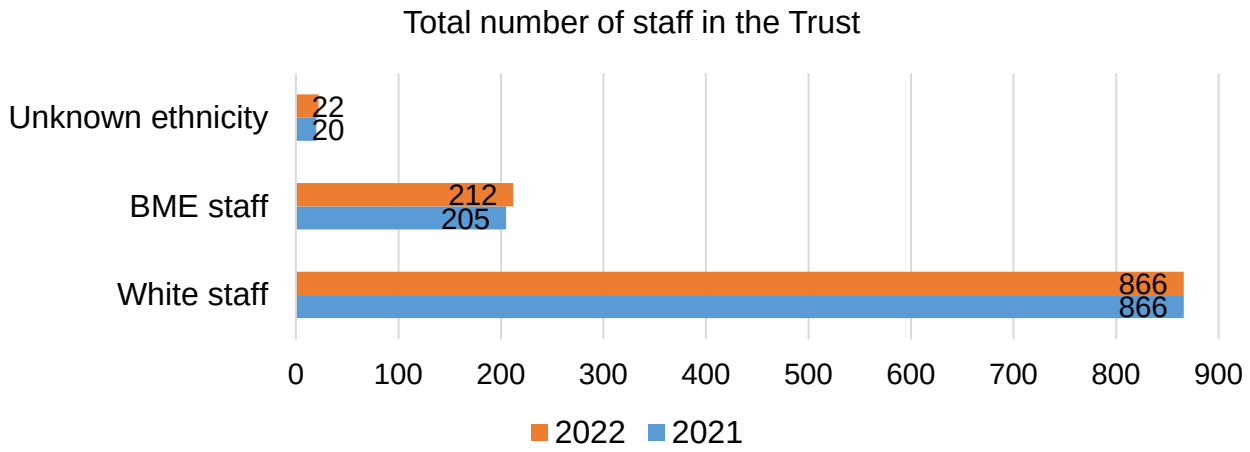
Author: Gemma Farley, Employee Relations and Wellbeing Manager
Date: June 2022

Reporting period for this report

This report contains a data snapshot comparison between 1st April 2021 and 31st March 2022.

Background information

The total number of staff in the Trust in 2022 was 1,100 compared to 2021 where there were 1,091 staff. Overall in 2022, 98% of the workforce had declared their ethnicity, which is comparable to 2021. This is broken down as below:



How is BME defined under the WRES?

In line with the categories taken from the 2001 Census:

The BME category includes:	The White category includes:	The unknown category includes:
• D – Mixed white and black Caribbean • E – Mixed white and black African • F – Mixed white and Asian • G – Any other mixed background • H – Asian or Asian British – Indian • J – Asian or Asian British – Pakistani • K – Asian or Asian British – Bangladeshi • L – Any other Asian background • M – Black or black British – Caribbean • N – Black or black British – African • P – Any other black background • R – Chinese • S – Any other ethnic group	• A – White – British • B – White – Irish • C – Any other white background	• Z – not stated • Null (NHS Electronic Staff Records code) • Unknown (NHS Electronic Staff Records code)

Workforce Race Equality Indicators

The standard compares the metrics for white and BME staff (using declared status).

Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

*The overall percentage in the tables is compared to the 19.27% representation of BME staff in the overall workforce.

For non-clinical workforce

Pay banding	White	BME	Unknown ethnicity	Total	White %	*BME %
Under Band 1	0	0	0	0		
Band 1	0	0	0	0		
Band 2	85	10	4	99	85.9%	10.1%
Band 3	77	8	2	87	88.5%	9.2%
Band 4	93	2	0	95	97.9%	2.1%
Band 5	18	4	1	23	78.3%	17.4%
Band 6	22	1	1	24	91.7%	4.2%
Band 7	17	2	2	21	81.0%	9.5%
Band 8a	15	2	0	17	88.2%	11.8%
Band 8b	2	1	0	3	66.7%	33.3%
Band 8c	5	1	0	6	83.3%	16.7%
Band 8d	1	1	0	2	50.0%	50.0%
Band 9	2	0	0	2	100.0%	0.0%
VSM	8	1	0	9	88.9%	11.1%
All non-clinical roles	**345**	**33**	**10**	**388**	**88.9%**	**8.5%**

For clinical workforce

Pay banding	White	BME	Unknown ethnicity	Total	White %	*BME %
Under Band 1	0	0	0	0		
Band 1	0	0	0	0		
Band 2	63	10	2	75	84.0%	13.3%
Band 3	30	5	0	35	85.7%	14.3%
Band 4	30	1	1	32	93.8%	3.1%
Band 5	79	40	1	120	65.8%	33.3%
Band 6	101	30	1	132	76.5%	22.7%
Band 7	85	13	1	99	85.9%	13.1%
Band 8a	18	3	0	21	85.7%	14.3%
Band 8b	8	1	0	9	88.9%	11.1%

Band 8c	4	0	0	4	100.0%	0.0%
Band 8d	1	0	0	1	100.0%	0.0%
Band 9	2	0	0	2	100.0%	0.0%
Of which Medical & Dental						
VSM	1	0	0	1	100.0%	0.0%
Medical: Consultants	57	30	2	89	64.0%	33.7%
***of which Senior medical manager*	*5*	*2*	*0*			
Medical: Non-consultant career grades	11	18	1	30	36.7%	60.0%
Medical: Trainee grades	31	28	3	62	50.0%	45.2%
All clinical roles	**521**	**179**	**12**	**712**	**73.2%**	**25.1%**

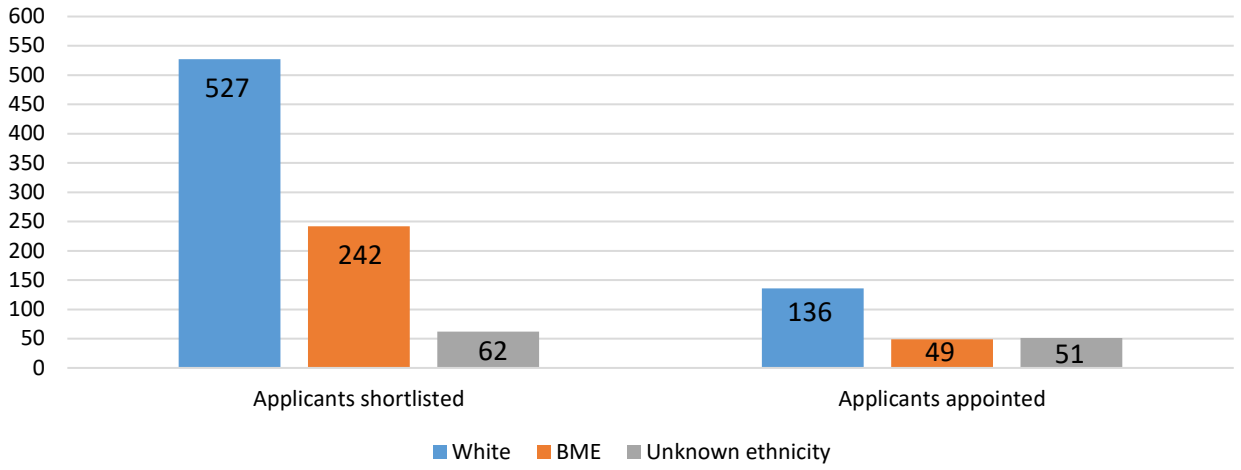
**Business Unit Clinical Directors (n=4), Deputy Medical Director & Clinical Director of Strategy (n=1), Clinical Director of IT (n=1), Clinical Director of Research (n=1)

Indicator 2 - Relative likelihood of applicants being appointed from shortlisting across all posts

The relative likelihood of white candidates being appointed from shortlisting compared to BME staff is 1.27*** times greater. In this instance, the data suggests white candidates are more likely than BME candidates to be appointed from shortlisting.

***calculation is 0.26 (white candidates) / 0.20 (BME candidates)

Applicant ethnicity	**White**	**BME**	**Unknown ethnicity**	**Total**
Applicants shortlisted	527	242	62	**831**
Shortlisted %	*63.42%*	*29.12%*	*7.46%*	
Applicants appointed	136	49	51	**236**
Appointed %	*57.63%*	*20.76%*	*21.61%*	
Relative likelihood of appointment from shortlisting	25.81%	20.25%	82.26%	
Relative likelihood of being appointed	**0.26**	**0.20**	**0.82**	**1.27**



Indicator 3 – Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Note: this indicator is based on data from a two year rolling average of the current year and the previous year.

The likelihood of white staff entering the formal disciplinary process: 0 / 866 = 0.00%

The likelihood of BME staff entering the formal disciplinary process: 0.5 / 212 = 0.24%

We are unable to define the relative likelihood of BME staff entering the formal disciplinary process compared to white staff in 2022.

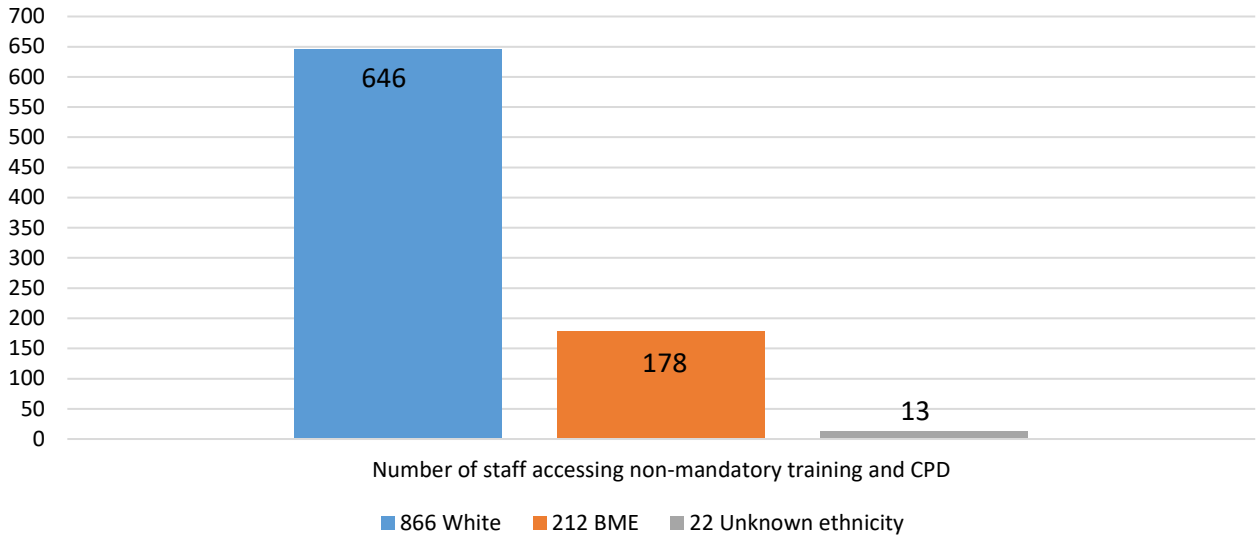
Staff Ethnicity	Number of Disciplinary Procedures	Number in Workforce	Relative Likelihood of entering procedure
White	0	866	0.0000
BME	0.5	212	0.0024 (0.24%)
Unknown	0	22	0.0000

Indicator 4 – Relative likelihood of staff accessing non-mandatory training and CPD

The relative likelihood of white staff accessing non-mandatory training or CPD compared to BME staff is 0.89*** times greater. In this instance, the data suggests white staff are more likely than BME staff to access non-mandatory training or CPD.

***calculation is 0.75 (white candidates) / 0.84 (BME candidates)

	White	BME	Unknown ethnicity	Total
Number of staff accessing non-mandatory training and CPD	646	178	13	837
Likelihood of staff accessing non-mandatory training and CPD	74.60%	83.96%	59.09%	
Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	**0.75**	**0.84**	**0.59**	**0.89**



Indicator 9 – Percentage difference between the organisations' Board voting membership

Note: only voting members of the Board are included when considering this indicator.

There was no BME representation of voting Board members in 2022 or 2021.

	White	BME	Unknown	Total
Total Board members	11	1	0	12
of which voting	*4*	*0*	*0*	*4*
of which non voting	*7*	*1*	*0*	*8*
Total Board members:	11	1	0	12
of which Exec	*6*	*1*	*0*	*7*
of which Non-Exec	*5*	*0*	*0*	*5*

	White	BME	Unknown
Number of staff in overall workforce	866	212	22
Total Board members - % by Ethnicity	91.7%	8.3%	0.0%
Voting Board Member - % by Ethnicity	100.0%	0.0%	0.0%
Non Voting Board Member - % by Ethnicity	87.5%	12.5%	0.0%
Executive Board Member - % by Ethnicity	85.7%	14.3%	0.0%
Non Executive Board Member - % by Ethnicity	100.0%	0.0%	0.0%
Overall workforce - % by Ethnicity	78.7%	19.3%	2.0%
Difference (Total Board - Overall workforce)	12.9%	-10.9%	-2.0%

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**1st September 2022**		**Agenda reference:**	**143-22**	
Report title:	**Workforce Disability Equality Standards (WDES 2021): Data Report 2021/22**				
Sponsor:	Lawrence Anderson, Interim Director of Workforce & OD				
Author:	Gemma Farley, Employee Relations & Wellbeing Manager				
Appendices:	None				
Executive summary					
Purpose of report:	The Workforce Disability Equality Scheme (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff. This report is data as at 31st March 2022 which is to be submitted nationally by the Trust. A further report will be submitted that will analyse the data, highlight the improvements that have been made and the areas that may require further action.				
Summary of key issues	The data is for the following metrics: metric 1 - % of staff in non-clinical and clinical workforce; metric 2 – relative likelihood of appointment from shortlisting; metric 3 – relative likelihood of formal capability (performance) process; metric 9b – response to question; metric 10 – Board voting membership; and answers to the survey questions required to be submitted with the data. (metrics 4-9 is data from the NHS Staff Survey which has been reported earlier in 2022)				
Recommendation:	Approval for National Submission of data				
Action required	Approval	Information	Discussion	Assurance	**Review**
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	**KSO5:**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	***Organisational excellence***
Implications					
Board assurance framework:	KSO5. 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. The 2021 survey outcome remained stable with improvements seen for team working, however challenges are being seen in our results for our staff with protected characteristics				
Corporate risk register:	N/A				
Regulation:	N/A				
Legal:	N/A				
Resources:	None				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	25.7.22	Decision:	Reviewed	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

NHS Workforce Disability Equality Standards (WDES)
As at 31st March 2022

NHS Data Submission

Author: Gemma Farley, Employee Relations and Wellbeing Manager
Date: June 2022

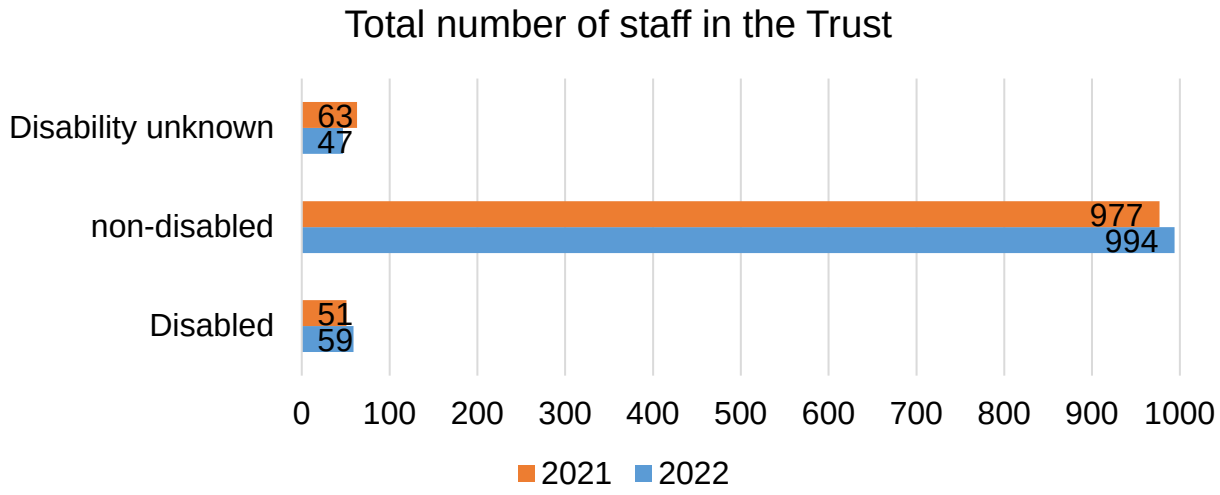
Reporting period for this report

This report contains a data snapshot comparison between 1st April 2021 and 31st March 2022.

It should be noted that within the WDES metrics the term 'Disabled compared to non-disabled', analyses the differences in experience between those staff who have responded 'Yes' and 'No' to monitoring questions about whether they have a disability. The label "Unknown" is used to refer to the other options recorded on ESR, namely "Prefer not to answer", "Not declared" and "Unspecified".

Background information

The total number of staff in the Trust in 2022 was 1,100 compared to 2021 where there were 1,091 staff. Overall in 2022, 95.7% of the workforce had declared their Disability status, compared to 94.2% in 2021. This is broken down as below:



Workforce Disability Equality Metrics

The standard compares the metrics for Disabled and non-disabled staff (using declared status).

Metric 1 - Percentage of staff in AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce

Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff, and present in Pay banding clusters as defined by the NHS WDES team.

*The overall percentage in the tables is compared to the 5.4% representation of Disabled staff in the overall workforce.

For non-clinical workforce

Pay banding	Disabled	non-disabled	Unknown	Total	*Disabled %	non-disabled %
Under Band 1	0	0	0	0		
Band 1	0	0	0	0		
Band 2	8	85	6	99	8.1%	85.9%
Band 3	4	81	2	87	4.6%	93.1%
Band 4	4	90	1	95	4.2%	94.7%
Band 5	1	21	1	23	4.3%	91.3%
Band 6	1	23	0	24	4.2%	95.8%
Band 7	3	17	1	21	14.3%	81.0%
Band 8a	2	15	0	17	11.8%	88.2%
Band 8b	0	3	0	3	0.0%	100.0%
Band 8c	0	6	0	6	0.0%	100.0%
Band 8d	0	2	0	2	0.0%	100.0%
Band 9	0	1	1	2	0.0%	50.0%
VSM	0	9	0	9	0.0%	100.0%
Other	0	0	0	0		
Cluster 1 (Bands 1-4)	16	256	9	281	5.7%	91.1%
Cluster 2 (Bands 5-7)	5	61	2	68	7.4%	89.7%
Cluster 3 (Bands 8a-8b)	2	18	0	20	10.0%	90.0%
Cluster 4 (Bands 8c-9 & VSM)	0	18	1	19	0.0%	94.7%
All non-clinical roles	**23**	**353**	**12**	**388**	**5.9%**	**91.0%**

For clinical workforce

Pay banding	Disabled	non-disabled	Unknown	Total	*Disabled %	non-disabled %
Under Band 1	0	0	0	0		
Band 1	0	0	0	0		
Band 2	7	68	0	75	9.3%	90.7%
Band 3	1	34	0	35	2.9%	97.1%
Band 4	1	31	0	32	3.1%	96.9%
Band 5	6	106	8	120	5.0%	88.3%
Band 6	7	120	5	132	5.3%	90.9%
Band 7	7	90	2	99	7.1%	90.9%
Band 8a	0	21	0	21	0.0%	100.0%
Band 8b	0	8	1	9	0.0%	88.9%
Band 8c	0	3	1	4	0.0%	75.0%

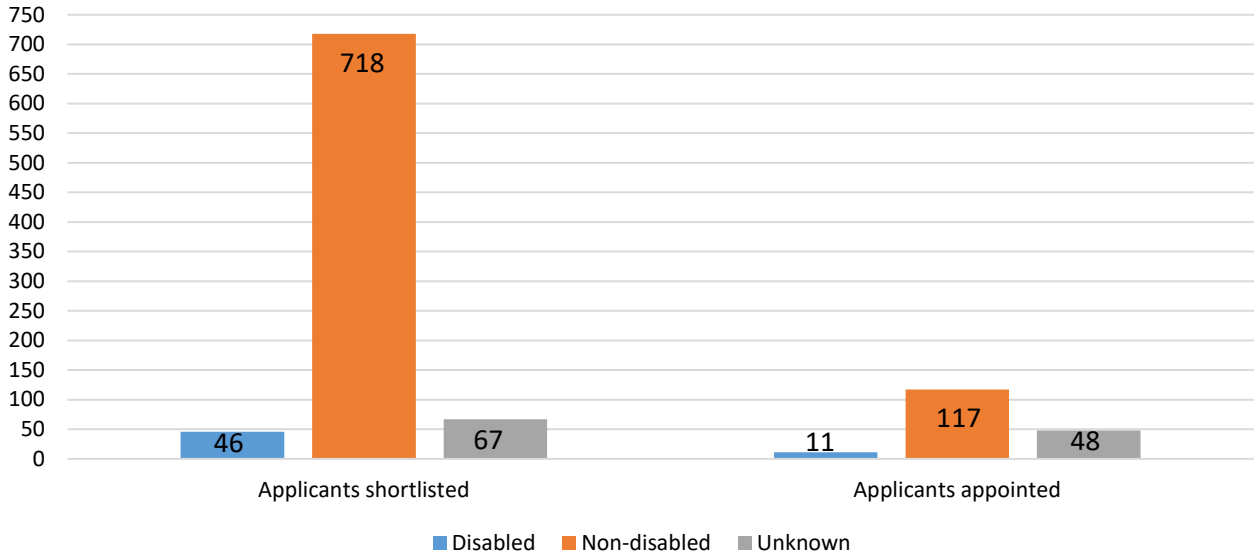
Band 8d	0	1	0	1	0.0%	100.0%
Band 9	1	1	0	2	50.0%	50.0%
VSM	0	1	0	1	0.0%	100.0%
Other	0	0	0	0		
Cluster 1 (Bands 1-4)	9	133	0	142	6.3%	93.7%
Cluster 2 (Bands 5-7)	20	316	15	351	5.7%	90.0%
Cluster 3 (Bands 8a-8b)	0	29	1	30	0.0%	96.7%
Cluster 4 (Bands 8c-9 & VSM)	1	6	1	8	12.5%	75.0%
Total clinical	**30**	**484**	**17**	**531**		
Medical & Dental: Consultants	2	74	13	89	2.2%	83.1%
Medical & Dental: Non-consultant career grades	0	27	3	30	0.0%	90.0%
Medical & Dental: Trainee grades	4	56	2	62	6.5%	90.3%
Cluster 5 (M&D: Consultants)	2	74	13	89	2.2%	83.1%
Cluster 6 (M&D: Non-Consultant career grades)	0	27	3	30	0.0%	90.0%
Cluster 7 (M&D: trainee grades)	4	56	2	62	6.5%	90.3%
Total Medical and Dental	**6**	**157**	**18**	**181**		
All clinical roles	**78**	**1439**	**88**	**1605**	**4.9%**	**89.7%**

Metric 2 - Relative likelihood of non-disabled applicants compared to Disabled being appointed from shortlisting across all posts

The relative likelihood of non-disabled candidates being appointed from shortlisting compared to Disabled staff is 0.68** times greater. In this instance, the data suggests non-disabled candidates are more likely than Disabled candidates to be appointed from shortlisting.

**calculation is 0.16 (non-disabled candidates) / 0.24 (Disabled candidates)

	Disabled	Non-disabled	Unknown	Total
Applicants shortlisted	46	718	67	**831**
Shortlisted %	*5.5%*	*86.4%*	*8.1%*	
Applicants appointed	11	117	48	**176**
Appointed %	*6.3%*	*66.5%*	*27.3%*	
Relative likelihood of appointment from shortlisting	24%	16%	72%	
Relative likelihood of being appointed	**0.24**	**0.16**	**0.72**	**0.68**



Metric 3 – Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into a formal capability procedure

Note: this metric is based on data from a two year rolling average of the current year and the previous year. This metric looks at capability on the grounds of performance, rather than ill-health, and for 2022 how many of these were on the grounds of ill-health.

*** calculation is:
The likelihood of Disabled staff entering the formal capability process: 0 / 59 = 0.00%
The likelihood of non-disabled staff entering the formal capability process: 3 / 994 = 0.30%

	Number of Formal Capability Processes	On the grounds of ill-health	Number in Workforce	***Relative Likelihood of entering procedure
Disabled	0	0	59	0.0000
Non-disabled	3	0	994	0.0030 (0.30%)
Unknown	0	0	47	0.0000

We are unable to define the relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff in 2022.

Metric 9b – Has the organisation taken action to facilitate the voices of Disabled staff to be heard?

Note: if yes, provide at least one practical example of current action being taken. If no, include what action is planned to address this gap.

Yes:

- Recruitment process – Disabled applicants are guaranteed interview if they meet a percentage of the criteria as part of being a Disability Confident Employer. Reasonable adjustments to enable candidates to attend interview.
- Organisation Development interventions – accessibility requirements identified when implementing the OD intervention, such as method of programme delivery can be offered in various formats
- Employee Relations – such as response to Occupational Health recommendations for reasonable adjustments in the workplace, engagement with Access to Work, etc.

Metric 10 – Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

	Disabled	Non-disabled	Unknown	Total
Total Board members	**1**	**11**	**0**	**12**
of which voting	*1*	*3*	*0*	***4***
of which non-voting	*0*	*8*	*0*	***8***
Total Board members	**1**	**11**	**0**	**12**
of which Executive	*1*	*6*	*0*	***7***
of which Non-Executive	*0*	*5*	*0*	***5***

Survey questions

Does your organisation participate in any programmes or initiatives that are focused on disability equality and inclusion?

Yes –

- Leadership programmes – Stepping Up
- Other –Dead Awareness training, Autism Awareness training

Do your staff have access to the ESR self-service portal?

Yes

Since you published your action plan last year, have any steps been taken within your organisation to improve the declaration rate for disability status?

Yes –

- Promotion of ESR self-service to encourage staff to update details
- Other internal communication activities (e.g. staff emails, intranet, posters)
- Include an ESR "How to" guide in induction pack or on intranet
- Other – on the intranet there is equality information and forms to update manually rather than through ESR self-service

What level of Disability Confident accreditation does your organisation currently hold?

Level 2 – Employer

Are you working towards obtaining a higher level of accreditation?

Yes – Level 3 Leader

Do you encourage Disabled people to apply for jobs by offering an interview to any applicant who declares they have a disability and meets the minimum criteria? Yes

Please add any examples of interventions that have impacted positively on the recruitment of Disabled staff

- Review of the implementation of the commitment to interview an applicant who declares they have a disability and meets the minimum criteria
- Review of recruitment policy and procedures
- Refresh of website to encourage Disabled applicants

Has your organisation compared any of the following other datasets you hold to the WDES Metric 4 (Harassment, Bullying or Abuse)?

- Grievance data
- Disciplinary data
- Other – NHS Staff Survey

Please add any actions taken since your action plan was published last year to reduce harassment, bullying or abuse in relation to Disabled staff

- Dignity at Work Campaign
- Champions/ ambassadors/ advisors

Does your organisation provide any targeted career development opportunities for Disabled staff?

Not at present but planned in the next 12 months – investigating the possibility of a career development programme for Disabled staff

Does your action plan from last year set out any targeted actions to reduce presenteeism, i.e. feeling pressured to come to work when not feeling well?

Yes –

- Staff wellbeing service – Employee Assistance Programme, Stay Well
- Promotion of health and wellbeing – Healthy Workplace Allies and Stay Well promotions
- Training for managers – Non-attendance at Work training

Does your action plan from last year set out any targeted actions to increase the workplace satisfaction of Disabled staff?

Not at present but planned in the next 12 months –

- Line manager disability awareness training
- All staff disability awareness training
- Implementing changes following staff survey

Does your organisation have a reasonable adjustments policy?

Yes

Evidence shows workplace adjustments are more effective when costs are met from central budgets. Are costs for workplace adjustments in your organisation met through centralised or local budgets?

Local budgets

Have you undertaken any actions in the last 12 months to improve the reasonable adjustments process?

Yes –

- Training for managers
- Guidance and support provision
- Sharing best practice examples through induction/ intranet/ training
- Disability/ Workplace adjustments passport

Please list any actions contained in your action plan from last year that have not been completed

Actions 2021	Progress	Achievement
Further increase staff engagement to disclose their Disability status to the Trust, including changes to status • Targeted communication to all staff who have not disclosed	There was an increase of 25% in the disclosure of a disability between 2021 and 2022	Yes

• Understand what barriers prevent disclosure		
Further increase line management engagement in supporting employees with a declared Disability through reasonable adjustments in the workplace	Line manager training includes how to support employees with a declared Disability. Support and guidance to managers to implement reasonable adjustments from Occupational Health recommendations	Yes
Ensure the Trust's Disability Confident status is retained and renewed	The Disability Confident – Employer status was retained and renewed	Yes
Encourage recruiting managers to consider reasonable adjustments to enable appointment of applicants with a declared Disability • Understand what are the barriers to appointment • Mandate recruiting managers to attend training • Mandate recruiting managers to comment on why applicants have not been appointed	There was an increase of 450% in the appointment of applicants with a declared disability between 2021 (n=2) and 2022 (n=11)	Yes
Monthly review of rejected applicants from shortlisting and interview stage with a particular focus on Disability	To be implemented in 2022/23	No

Are there plans for your Trust to merge with another Trust in the next 12 months?

Yes – University Hospitals Sussex expected April 2023 to improve patient care, achieve statutory standards and financial sustainability

When did the Board most recently review progress in delivering the action plan from last year?

Between 6 months and 1 year

Do annual Health and Wellbeing conversations take place with all staff which include opportunity to discuss disability?

Yes – included in the annual appraisal and managers attend NHS Wellbeing Conversation training; which will be rolled out at QVH in the next 12 months

What has been done specifically to support Disabled staff through the COVID-19 pandemic?

Risk assessments undertaken with vulnerable/ clinically vulnerable staff.
Reasonable adjustments discussed and implemented in the workplace including flexible working arrangements and agile working arrangements.

Have you taken specific actions to support staff with "Long COVID"?

Yes – reasonable adjustments discussed and implemented in the workplace including flexible working arrangements and agile working arrangements.

Do you have any further comments?
[insert]

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**144-22**	
Report title:	**Financial, operational and workforce performance assurance**				
Sponsor:	Paul Dillon-Robinson, committee chair				
Author:	Paul Dillon-Robinson, committee chair				
Appendices:	None				
Executive summary					
Purpose of report:	Board Assurance on matters discussed at the committee's meeting on Monday 25th July, with update to be given at the Board meeting on matters discussed by the committee on Tuesday 30th August.				
Summary of key issues	Operational performance: Concerns about the ability to deliver the planned activity for the year, given increased levels of referrals in some areas, increase in the overall waiting list size and pressure on achievement of targets. Further analysis and trajectories being carried out. Workforce: Known level of concerns over vacancies, although utilisation (including bank and agency) is within KPI Financial results: Break-even year to date and within plan Business planning update: Risks to delivery (as per Operational) as well as some uncertainty on final contractual position				
Recommendation:	The Board is asked to **NOTE** the contents of the report, the **ASSURANCE** (where given), and the risks to delivery.				
Action required	Approval	Information	**Assurance**	**Assurance**	**Assurance**
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:	KS05 – Organisational Excellence – strong indicators of successful management, but aware of critical dependencies KS04 – Financial Sustainability – short-term break-even is the result of specific funding, longer-term is not resolved KS03 – Operational Excellence – risk remains high as dependent upon productivity developments				
Corporate risk register:	Committee is looking in detail at allocated corporate risks, on a rotational basis				
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:	Finance and performance committee				
	Date:	25.7.22	Decision:		
Next steps:					

Report to: Board of Directors
Meeting date: 1 September 2022
Reference no: 144-22
Report from: Paul Dillon-Robinson, Committee Chair
Report date: 19 August 2022

Financial, operational and workforce performance assurance

Introduction

The finance and performance committee met on 25th July and covered its standard topics on performance assurance as well as an update on business planning. The majority of the meeting was spent on operational matters and it was agreed that an August meeting would be called for more detailed analysis. Matters arising from this meeting will be raised at the Board .

Operational performance

The committee noted that there were some areas with higher levels of referrals (Sleep, MIU, Skin, etc.) than historically seen, but that there were ongoing concerns about delivery (covid, patient choice, leave, etc.). Whilst progress is being made on some waiting list time targets the overall size of the waiting list is growing and there are risks about the ability to deliver the agreed activity plan for the year, including the 52ww target reduction.

The committee agreed that there would be an August meeting to review projections for the rest of the year, including activity from the new modular theatres and independent sector. There was a need to understand the risks and dependencies in delivering this activity, as well as the implications for workforce and finances.

Further analysis of elective activity was requested, noting that the activity for day cases was above plan.

The committee also discussed the management of issues with the sterile services contract and the draft business case for the Community Diagnostic Centre.

Workforce performance

The committee focused on vacancy levels, sickness & absence, and appraisals.

It was noted that vacancy levels are within target, with the utilisation KPI including cover from bank and agency staff. Particular vacancies are in Sleep and Community Services, but the trust remains at risk from vacancies in individual posts. It was also noted the work being done on retention of staff.

An improvement in sickness absence levels was noted, although this might reverse with recent covid absences.

The committee questioned the target of 95% for appraisals, but were informed that this is the CQC expectation and performance reviews were looking to increase this level.

Financial performance
The trust reported a break-even position for the year to date and has submitted a revised plan for break-even at the year-end. The main risks are that: some contracts have not been signed and so there may be uncertainty about final requirement, under delivery of activity plan (see Operational performance above), system changes to ERF income, as well as agency and bank staff costs.

The trust continues to develop a programme to review efficiencies.

Business Planning
A final plan was submitted in June. Uncertainty remains about how Elective Recovery Funding will be allocated, which is leading to delays in contract agreement.

Some discussion was held about the risks for 2023/24 planning as discussions on allocations are commencing. The move from fixed contract values, to some form of aligned payment incentive contract poses risks to the trust.

Other
The committee continued to review corporate risks allocated to it, this meeting looking at Speech Language staffing and data security risks. Updates were also provided on IM&T, cyber security, data quality, staff survey, WDES/WRES data, Green plan and EDM.

A number of policies were agreed, with others being given a time extension with assurance that this was more for administrative purposes than any significant changes required. Concerns were noted that differential reimbursement (for higher polluting cars and staff categories) in the travel and subsistence policy appeared inconsistent, but it was noted that these are national rates. The matter has been escalated nationally.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**146-22**	
Report title:	**Audit Committee Assurance update**				
Sponsor:	Kevin Gould, Audit Committee Chair				
Author:	Kevin Gould, Audit Committee Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance to the Board in relation to matters discussed at the Audit Committee meeting on 26 July 2022				
Summary of key issues	The Committee received a report on the assurance framework for KSOs 1 &2. Updates on Internal Audit and Counter Fraud were received from RSM.				
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:	Internal audit reports were received and the assurance framework for KSOs 1& 2 were reviewed				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	None				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 1 September 2022
Reference number: 146-22
Report from: Kevin Gould, Committee Chair
Author: Kevin Gould, Committee Chair
Appendices: N/A
Report date: 23 August 2022

Audit Committee report
Meeting held on 26 July 2022

1. The Committee received an update on the assurance framework for KSOs 1 and 2 from the Chief Nurse. This included details of the key risks, sources of assurance, including clinical audit, and potential gaps in assurance. The discussion included mitigation for fragile services, staffing levels and investigation processes. The Chair of the Quality and Governance Committee provided further insight and assurance.

2. The Committee approved the updated Standards of Business Conduct Policy.

3. RSM presented an update on the Internal Audit plan. One report had been completed since the previous meeting:
   - Temporary Staffing Page (Reasonable Assurance, no High priority actions)

   The Committee approved a change in the plan to accommodate a requirement for all NHS trusts to have an internal audit to review processes in line with a recent HFMA publication.

4. The Committee received a report on the progress of Counter Fraud activity.

5. The Committee reviewed financial reports including details of waivers. There was a specific report on the waiver required for covid testing.

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

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**01/09/2022**		**Agenda reference:**	**146-22**	
Report title:	**Nomination and remuneration committee assurance update**				
Sponsor:	Gary Needle, Senior independent director				
Author:	Leonora May, Deputy company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance to the board in relation to matters discussed at the nomination and remuneration committee meeting on 7 July 2022.				
Summary of key issues	The committee received updates on the chief executive and executive director's appraisals for 2021/22 and the clinical excellence awards.				
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:	Local clinical excellence awards are part of the nationally negotiated consultant contract				
Legal:	None				
Resources:	The total level of funding that a Trust must provide in each year is nationally determined				
Assurance route					
Previously considered by:	Nomination and remuneration committee				
	Date:	7/7/22	Decision:		
Next steps:	None				

Report to:	Board of Directors
Meeting date:	1 September 2022
Report from:	Gary Needle, Senior independent director
Author:	Leonora May, Deputy company secretary
Appendices:	N/A
Report date:	5 August 2022

Nomination and remuneration committee assurance report
Meeting held on 7 July 2022

The nomination and remuneration committee met on 7 July 2022. The committee received updates on the chief executive and executive directors' appraisals for 2021/22 and the clinical excellence awards.

The committee received assurance that the chief executive and executive director's appraisals had been completed for the 2021/22 period in line with national guidance and taking into account feedback received from Board members.

Arrangements have been put into place for the payment of local clinical excellence awards to the Trust consultant body for 2021/22. A total of 77 consultants were eligible for and all accepted the award. Under national requirements a total of £290,122.36 has been paid through this scheme, £3,767.82 per eligible consultant to be awarded.

There is no new agreed national position regarding clinical excellence awards for 2022/23; a model that equally distributes the CEAs amongst eligible consultants is therefore likely to continue. QVH will put in place a mechanism in place for consultants that do not wish to receive the additional payment to request that their award is donated to the QVH hardship fund.

The committee will ratify the appointment of the interim director of finance and performance at its meeting on 1 September 2022.