Queen Victoria Hospital
NHS Foundation Trust

Meeting of the public session of the Council of Governors

Monday 25 October 2021

16:00 – 18:00
Via MS Teams

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust
Council of Governors

Membership October 2021

Members	
Gary Needle	Acting Trust Chair
Chris Barham	Public governor
Liz Bennett	Stakeholder governor for West Sussex CC
Elizabeth Bowden	Public governor
Andrew Brown	Public governor
St John Brown	Stakeholder governor for League of Friends
Tim Butler	Public governor
Baljit Dheansa	Staff governor
Miriam Farley	Public governor
Anthony Fulford-Smith	Public governor
Janet Haite	Public governor
Oliver Harley	Public governor
John Harold	Public governor
Anita Hazari	Staff governor
Julie Holden	Stakeholder governor for EG Town Council
Raman Malhotra	Staff governor
Caroline Migo	Public governor
Peter Shore	Public governor
Roger Smith	Public governor
Ken Sim	Public governor
Alison Stewart	Public governor
Peter Ward Booth	Public governor
Thavamalar Yoganathan	Public governor
Invited attendees	
Steve Jenkin	Chief Executive
Nicky Reeves	Director of nursing (interim)
Keith Altman	Medical director
Abigail Jago	Director of operations
Michelle Miles	Director of finance
Lawrence Anderson	Director of workforce (interim)
Clare Pirie	Director of communications and corporate affairs
Hilary Saunders	Deputy company secretary
Gary Needle	Senior independent director
Kevin Gould	Non-executive director
Paul Dillon-Robinson	Non-executive director
Karen Norman	Non-executive director

Annual declarations by governors 2021/22

As established by section 22 of the Trust's Constitution, if a governor of the Trust has a relevant and material interest, or a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose the nature and extent of that interest to the members of the Council of Governors as soon as he/she becomes aware of it.

To facilitate this duty, governors 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 governor has no interests to declare (a 'nil return'). Governors must request to update any declaration if circumstances change materially. By completing and signing the declaration form governors 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.

	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.
Public governors							
Barham, Chris	Transcend Talent Consultancy Ltd Company number 10458748 Non-Executive Director	None	None	None	None	None	None
Beesley, Brian	NIL	NIL	NIL	NIL	Royal Voluntary Service	NIL	NIL
Bowden, Elizabeth	NIL	NIL	Nil	NIL	NIL	NIL	Daughter works in recovery
Brown, Andrew	NIL	NIL	Nil	NIL	NIL	NIL	NIL
Butler, Tim	Innovation Visual Limited – Director Medical Stock Images Company Limited – Director Medical Artist Limited – Director 23 Clarence Square (Cheltenham) Management Limited - Director	Medical Stock Images Company Limited – Director, 50% ownership. Previously used by the NHS, not seeking to do business with QVH. Medical Artist Limited – Director, 50% ownership. Previously used by the NHS, not seeking to do business with QVH.	Medical Stock Images Company Limited – Director, 50% ownership. Previously used by the NHS, not seeking to do business with QVH. Medical Artist Limited – Director, 50% ownership. Previously used by the NHS, not seeking to do business with QVH.	NIL	NIL	NIL	NIL
Farley, Miriam	NIL	NIL	NIL	NIL	NIL	I am employed by University Sussex Hospitals to advise on inquests.	I am married to a consultant at QVH.
Fulford-Smith, Antony	single directorship: property management company with single asset – woodland in Devon	NIL	NIL	NIL	NIL	Vice President Medical Affairs at Ispen – a pharmaceutical company who might sell products to QVH. My role is not related to sales and is above country.	Spouse is a QVH NHS Trust employee. Matron of Maxillofacial outpatients departments.
Haite, Janet	NIL	NIL	Nil	NIL	NIL	NIL	NIL
Halloway, Chris	NIL	NIL	Nil	NIL	NIL	NIL	NIL
Harley, Oliver	NIL	Independent private practice at McIndoe Centre/Horder Health	NIL	NIL	Independent private practice at McIndoe Centre/Horder Health	Independent private practice at McIndoe Centre/Horder Health	NIL
Harold, John	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Lane, Andrew	Director of: Arecor Ltd, VHsquared Ltd, P2i Ltd, IB Ventures Ltd and Void Technologies Ltd none of which have relationships with the NHS or QVH	NIL	NIL	NIL	NIL	NIL	NIL
Migo, Caroline	NIL	NIL	Restore Trustee – Breast Cancer Reconstruction Charity	NIL	NIL	NIL	NIL
Shore, Peter	Director of Peter Shore Ltd Director and Chair Attic Theatre Company Ltd Director of Miller Centre	Owner and Director of Peter Shore Solutions	Owner and Director of Peter	NIL	NIL	NIL	NIL
Sim, Ken	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Smith, Roger	NIL	NIL	NIL	NIL	NIL	NIL	NIL

Stewart, Alison	NIL	NIL	NIL	NIL	Following my retirement, I retain a small partnership share, with a non-clinical role in an NHS general practice partnership in Tunbridge Wells, Kent.	NIL	My step daughter is an extended scope practitioner physiotherapist at QVH.
Ward Booth, Richard Peter	NIL	NIL	NIL	Vice Chair Uckfield League of Friends	Vice Chair Uckfield League of Friends	NIL	NIL
Williams, Martin	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Yoganathan, Thavamalar	Director of Treaanth Healthcare Services. The focus of this company is the provision of healthcare in the private sector. We do not directly receive NHS referrals but do some contract work for Kent Integrated Dermatology Services (KIDS), who is an NHS provider.	NIL	NIL	NIL	NIL	Director at Tresaanth Healthcare Services Ltd. The focus of this company is the provision of healthcare in the private sector. We do not directly receive NHS referrals but do some contract work for Kent Dermatology Services (KIDS), who is an NHS provider.	Spouse of Ruben Kannan (QVH Consultant Plastic Surgeon)

	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.
Staff governors							
Dheansa, Balj	Director of My Plastic Surgeon Ltd. This company manages my private practice in plastic and reconstructive surgery.	Director of My Plastic Surgeon Ltd. This company manages my private practice in plastic and reconstructive surgery. Although I do not intend to seek NHS work through my company it is possible that such work may be offered to me.	NIL	I am patron of Dan's Fund for Burns. The position is not one of authority as I have no voting powers.	NIL	NIL	My wife works in the NHS at a London Hospital in the field of neurosurgery
Hazari, Anita	Private practice (no NHS work) at McIndoe Centre	NIL	NIL	Chair Plastic Surgery at JCIE (Joint Committee on Intercollegiate Examinations)	NIL	NIL	NIL
Malhotra, Raman	NIL	Owner/director of ORBITOFACIAL CLINIC Ltd. This is my private practice related to healthcare of patients with ophthalmic and oculoplastic disorders. Outpatient clinics are carried out at The Mcindoe Centre, Spire Gatwick Park Hospital and Harley Street Specialist Hospital, London. Surgery is carried out at these sites and also at Centre For Sight, East Grinstead. My website is www.ramanmalhotra.coml do not receive NHS referrals. Co-director of PALM VISION LLP. A company set up to grow Palm trees.	NIL	NIL	NIL	NIL	NIL
Appointed governors							
Bennett, Liz	NIL	NIL	Member of East Grinstead Town Council Member of Mid Sussex District Council	Nil	Elected member of West Sussex County Council	Nil	NIL
Brown, St John	ST JB Advisory Ltd	Prostrate Matters Ltd London Uroradiology LLP Lucida Medical Ltd	Prostrate Matters Ltd London Uroradiology LLP Lucida Medical Ltd	League of Friends of QVH	NIL	NIL	NIL
Holden, Julie	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.

	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.
Public governors							
Barham, Chris	NA	NA	NA	NA	NA	NA	NA
Beesley, Brian	NA	NA	NA	NA	NA	NA	NA
Bowden, Elizabeth	NA	NA	NA	NA	NA	NA	NA
Brown, Andrew	NA	NA	NA	NA	NA	NA	NA
Butler, Tim	NA	NA	NA	NA	NA	NA	NA
Farley, Miriam	NA	NA	NA	NA	NA	NA	NA
Fulford-Smith, Antony	NA	NA	NA	NA	NA	NA	NA
Haite, Janet	NA	NA	NA	NA	NA	NA	NA
Halloway, Chris	NA	NA	NA	NA	NA	NA	NA
Harley, Oliver	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Harold, John	NA	NA	NA	NA	NA	NA	NA
Lane, Andrew	NA	NA	NA	NA	NA	NA	NA
Migo, Caroline	NA	NA	NA	NA	NA	NA	NA
Shore, Peter	NA	NA	NA	NA	NA	NA	NA
Sim, Ken	NA	NA	NA	NA	NA	NA	NA
Smith, Roger	NA	NA	NA	NA	NA	NA	NA
Stewart, Alison	NA	NA	NA	NA	NA	NA	NA
Ward Booth, Richard Peter	NA	NA	NA	NA	NA	NA	NA
Williams, Martin	NA	NA	NA	NA	NA	NA	NA
Yoganathan, Thavamalar	NA	NA	NA	NA	NA	NA	NA
Staff governors							
Dheansa, Balj	NA	NA	NA	NA	NA	NA	NA
Hazari, Anita	NA	NA	NA	NA	NA	NA	NA
Malhotra, Raman	NA	NA	NA	NA	NA	NA	NA
Appointed governors							
Bennett, Liz	NA	NA	NA	NA	NA	NA	NA
Brown, St John	NA	NA	NA	NA	NA	NA	NA

	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.
Holden, Julie	NA	NA	NA	NA	NA	NA	NA

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Meeting of the QVH Council of Governors
Monday 25 October 2021
16:00 – 18:00
(Virtual)

Agenda: meeting session held in public				
Standing items				
Ref	**Item**	**purpose**	**page**	**time**
84-21	**Welcome, apologies, declarations of interest and eligibility, confirmation of quoracy** *Gary Needle, Chair*	-	-	*16:00*
85-21	**Draft minutes of the public meeting held on 19 July 2021 for approval** *Gary Needle, Chair*	*approval*	*1*	*16:02*
86-21	**Matters arising and actions pending from previous meetings** *Gary Needle, Chair*	*review*	-	*16:04*
Council business				
Ref	**Item**	**Purpose**	**page**	**time**
87-21	**Future organisational arrangements – strategic case** *Steve Jenkin, Chief Executive*	*information*	*9*	*16:05*
88-21	**Progress update: Merger Evaluation Group** *Clare Pirie, Director of communications and corporate affairs*	*information*	-	*16:25*
89-21	**Information Governance requirements** *Clare Pirie, Director of communications and corporate affairs*	*Information*	*25*	*16:30*
90-21	**Request for independent legal advice** *Caroline Migo, public governor*	*discussion*	-	*16:35*
91-21	**QVH consultants' letter to Chair and NEDs** *Gary Needle, Chair*	*information*	-	*16:40*
92-21	**Motion to pause merger activities** *Oliver Harley, Caroline Migo, Thava Yoganathan, public governors*	*information*	*29*	*16:45*
93-21	**Proposal for changes to membership of Governor Steering Group** *Caroline Migo, public governor*	*approval*	*35*	*16:50*

Trust Constitution

1. Quoracy
   - **21.33** No business shall be carried out at a meeting which is not quorate. (In October 2021 CoG comprises 3 staff governors, 3 stakeholder governors, 16 public governors)
2. Behaviour
   - **21.15** Governors' behaviour at meetings (and generally as a representative of the Foundation Trust) is expected to be exemplary. Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion and the decision of the Meeting Chair on questions of order, relevancy, regularity and any other matters shall be final

94-21	**Current position at Royal Sussex County Hospital, Brighton** *Oliver Harley, public governor*	*information*	*41*	*16:55*
Holding non-executive directors to account for the performance of the board of directors				
Ref	**Item**	**Purpose**	**page**	**time**
95-21	**Executive overview** *Steve Jenkin, Chief Executive*	*information*	-	*17:00*
96-21	**Board of Directors** *Gary Needle, Trust Chair and* *Peter Shore, Lead governor*	*Information*	-	*17:10*
97-21	**Finance and performance committee** *Paul Dillon-Robinson, Committee chair*	*Information*	-	*17:15*
98-21	**Quality and governance committee** *Karen Norman, Committee Chair and* *Antony Fulford Smith, governor representative*	*information*	-	*17:25*
99-21	**Audit Committee** *Kevin Gould, committee Chair*	*information*	-	*17:35*
100-21	**Charity Committee** *Gary Needle, committee Chair*	*information*	-	*17:40*
101-21	**Any other questions for non-executive directors** *All members of Council of Governors*	*Discussion*	-	*17:45*
Any other business				
Ref	**Item**	**Purpose**	**page**	**time**
102-21	*By application to the Chair*	*Discussion*	-	*17:50*
Questions				
Ref	**Item**	**Purpose**	**page**	**time**
103-21	**To receive any questions or comments from members of the foundation trust or members of the public** *We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Hilary.Saunders1@nhs.net clearly marked "Questions for the Council of Governors". Members of the public may not take part in the Council of Governors discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.*	*discussion*	-	*17:55*
Date of next meeting				
Next meeting of the council of governors to be held in public				
10 January at 15:00				

Document:	Minutes DRAFT & UNCONFIRMED	
Meeting:	**Council of Governors session in public** **Monday 19 July 2021, 14:30 – 16:30**	
Present:	Beryl Hobson (BH)	Trust Chair
	Chris Barham (CB)	Public governor
	Elizabeth Bowden (EB)	Public governor
	St John Brown (StJB)	Stakeholder governor
	Andrew Brown (AB)	Public governor
	Tim Butler (TB)	Public governor
	Balj Dheansa (BD)	Staff governor
	Miriam Farley (MF)	Public governor **[part item: 70-21]**
	Antony Fulford-Smith (AF-S)	Public governor
	Janet Haite (JDH)	Public governor
	Oliver Harley (OH)	Public governor
	John Harold (JRH)	Public governor
	Anita Hazari (AH)	Staff governor
	Julie Holden (JWH)	Stakeholder governor
	Raman Malhotra (RM)	Staff governor
	Caroline Migo (CM)	Public governor
	Peter Shore (PS)	Public governor
	Ken Sim (KS)	Public governor
	Alison Stewart (AS)	Public governor
	Peter Ward Booth (PWB)	Public governor
	Thavamalar Yoganathan (TY)	Public governor
In attendance:	Steve Jenkin (SJ)	Chief Executive
	Clare Pirie (CP)	Director of communications and corporate affairs (CoSec)
	Hilary Saunders (HS)	Deputy CoSec (mins)
	Paul Dillon-Robinson (PDR)	Non-executive director
	Kevin Gould (KG)	Non-executive director
	Gary Needle (GN)	Non-executive director
	Karen Norman (KN)	Non-executive director
Apologies:	Roger Smith (RS)	Public governor
Public gallery:	7 members of the public	

Ref.	Item
Standing items	
58-21	**Welcome, apologies and declarations of interest and eligibility** The Chair welcomed everyone to the meeting including seven members of the public. The Chair noted that Liz Bennett would be attending this session as a member of the public whilst awaiting formal ratification of her reappointment as West Sussex stakeholder governor. Apologies were noted as above. The Chair received confirmation that the meeting was quorate and that there were no new declarations of interest or ineligibility.
59-21	**Draft minutes of meeting held on 10 May 2021** The Chair sought approval of the draft minutes of the meeting held on 10 May.

	TB stated that he didn't believe the minutes to be an accurate reflection of the meeting as there were instances where he had made comments which had not been included; he repeated his request for CoG meetings to be recorded. As he was unable to provide the item references in question, the Chair suggested he follow this up via email and noted that the minutes would remain in draft format for now.
60-21	**Matters arising and actions pending from previous meetings** CM sought clarification on item 46-21 of the draft minutes regarding her motion to rescind the amendments to the GSG terms of reference (ToRs). CP reminded CoG of the process, explaining that as GSG ToRs were incorporated into the Trust's Constitution any amendment also required the support of the Board. Only if the Board agreed to the rescindment would the ToRs revert back to their original format. CM argued that this was not her understanding of the term to rescind. CP confirmed that this matter would be considered by the Board at its meeting in August.
Council business	
61-21	**Appointment of Trust Chair** This item had been considered at the preceding private session and was being presented again now for the public record. JH described to Council the process the committee had followed highlighting the following: • That the committee had taken into account the skills and experience important for this role at this stage in the Trust's journey; these included prior experience of chairing an NHS provider and working with governors, as well as experience in managing strategic change, meaningful engagement, system working and good governance. • The committee had agreed to recruit a chair for a six month appointment with the option to extend for a further three months. • Following interviews of 25 June, the panel was unanimous in its decision to appoint Dr Peter Carter. At interview, Dr Carter had demonstrated excellent understanding of the difficulties facing the Trust and the need for effective engagement with staff, patients and the public in the months ahead; the panel were confident that he had the skills and experience needed to lead the Trust through this challenging time. • Details of Dr Carter's CV and experience. GN, who had chaired the interview panel, concurred with JH's statement; he added that the unanimous view of the panel was this candidate was outstanding Council **approved** the appointment of Peter Carter as Chair of Queen Victoria Hospital NHS Foundation Trust by a majority (with a majority of 16 in favour and 3 abstentions). It was noted that the new Chair lived outside the Trust's constitutional area. However, noting Dr Carter's skills and experience, and as recommended by NHSEI, Council **approved** on this occasion only, (again by a majority of 16 in favour and 3 abstentions) a variation to the constitutional requirement for the Chair to be member of the Trust's Public constituency.
62-21	**Chair and NED appraisal process** Council was advised that the process for annual Chair and NED appraisals had taken into account feedback, including that from governors, and was now complete. All documents had been signed off. In line with the approved process, the Chair's appraisal had been submitted to NHSEI. There were no further comments and Council **noted** the contents of the update.

63-21	**Chair and NED remuneration for 2021/22** JH confirmed that the Appointments committee had undertaken its annual review of Chair and NED remuneration for 2021/22 and were now recommending that levels should remain unchanged in 2021/22 for the current NEDs and chair. There were no questions and Council **approved** this recommendation (with a majority of 18 in favour and 1 abstention). The Appointments committee had also noted that the chair's annual remuneration may need to increase to £50k in order to attract the right candidate, and also in recognition that interim posts attract higher remuneration. CP explained that it was hoped that Dr Carter's appointment could be secured at a cost to the Trust of no more than £50k, details were yet to be finalised. Council **approved** remuneration for the new Chair of £50,000, (by a majority of 17 in favour and 2 two abstentions).
64-21	**Assessment of the auditor's 2021/22 work and fees** KG presented a report providing a review of the 2020/21 audit to members of the Council, highlighting: • Whilst a full report on the Trust's annual report and accounts would be provided by KPMG at the AGM, the Audit committee was satisfied with KPMG's quality of output and performance. • In 2020, CoG had reappointed KPMG for 2021/22 with the option for appointment for one further year; CoG were now asked to formally approve the reappointment of KPMG today. In response to questions raised following this report, KG advised: • Fees had not yet been agreed but wouldn't be significantly different to previous years; • There had been additional reporting around 'value for money' this year; • The services provided can vary if required by the Regulator; however, on a fixed piece of work this was unlikely to be more than 5%; • Fees are reviewed before the appointment process starts; KPMG's fees are competitive compared to other organisations. There were no further questions and Council **approved** the reappointment (by a majority of 18 in favour and 1 abstention).
65-21	**Motion to pause all further activities, meetings, dialogue or expenditure, formal or informal, relating to the proposed Acquisition ('merger') of QVH NHSFT by UHS NHSFT** It was noted that this item had been considered in detail in the earlier closed session of Council, where NEDs had explained the reasons why they could not be bound by this motion. PS drew Council's attention to Chapter 4 of the Monitor reference guide '*Your statutory duties'* which stated that '*Governors may not always agree with the decisions taken by the directors. On the other hand, directors do not always have to adhere to the governors' preferences*. He suggested that instead of voting for this motion, a compromise might be for the Board to note that this was the view of governors. OH reiterated that that the current strategy could not be justified and stated that the motion should remain unchanged. CP reminded Council that the Trust had received legal advice stating: *'It is legally not possible for the CoG to restrict the business of the Board of Directors whether relating to a potential merger with UHS or at all'*; therefore any motion passed today would not be legally binding but an expression of the views of governors only.

	In response to a question, CP confirmed that the provision of Trust legal advice was for both the Board and Council, and that this advice is independent. This was contested by some governors who stated: • Browne Jacobson had not been appointed by Council • There was a strong likelihood that this advice was inaccurate • Browne Jacobson would stand to benefit if the merger went ahead and therefore their advice cannot be seen as independent • Governors would be requesting further legal advice following today's meeting. CP reminded Council that the Trust had a fiduciary duty to use public money responsibly. In addition to advice provided by the lawyers, CP reminded Council that the Regulator had also indicated that it would not be reasonable for the Board to act in accordance with this motion. There were no further comments and Council **approved** (with a majority of 12 in favour, five against and two abstentions) the motion for the Trust Board to pause all further activities, meetings, dialogue or expenditure, formal or informal, relating to the proposed Acquisition ('merger') of QVH NHSFT by UHS NHSFT
66-21	**Motion to review format and content of Council of Governors Agendas** The Chair addressed the second motion put forward by CM which stated that the current CoG Agenda format was not fit for purpose and proposing it be reviewed. BH reminded Council that the agenda was drawn up by the Governor Steering Group on behalf of the full Council of Governors and in line with their remit. She also noted that much of what had been requested was already covered on today's agenda. CP highlighted the need for Council to be cognisant of future GSG meeting dates which would enable all governors to engage in this process. She then went on to address the request for written reports from NEDs reminding Council that these were already provided at the public board meetings, with latest versions incorporated into today's papers; however, these versions were less current that a verbal update would be, which is the usual process adopted at CoG meetings. It was agreed that GSG would consider the motion and return with a proposal at the next formal CoG meeting.
67-21	**Approval of revised Appointments committee ToRs** JH reported that in 2020, new guidance was issued by the regulator for Trust's to review the process for Chair appraisal. The revised process included feedback from external system partners and put the 'facilitation' of the process with the Senior Independent Director, not chair of the appointments committee. This proposal had been unanimously supported by the Appointments committee and guidance formally adopted by Council. However, it had been noted that when the committee came to undertake its annual review of Terms of Reference this amendment had not been incorporated into the updated version. To rectify this, the ToRs had been amended at the recent Appointments committee meeting and the correct version was now presented for approval. As Senior Independent Director, GN confirmed that the Trust has been following the updated guidance for the past two years and the process has worked smoothly. Some governors who had not been in post when this change was implemented contested the updating of the ToRs, stating that it was important for Council to maintain the lead in the process in order to demonstrate open, honest and transparent process which would not be case if NEDs 'mark their own homework'.

	CP explained that this was not a new change, with the timeline dating back to the Spring of 2020. She reiterated that the Trust had incorporated these changes in 2020 but when the ToRs underwent their annual review this item had been overlooked. At the time the guidance was updated, the Trust had contacted the NHSEI governance lead who had confirmed that the Regulator could not force this upon the Trust but were keen to introduce a consistent approach. Some governors restated that they felt this retrospective approval was inappropriate as it diluted their ability to participate fully in the appraisal process. The Senior Independent Director reminded Council that this process had been in place for two years and expressed concern that the term 'NEDs marking their own homework' brought his integrity into question. It was also noted that it is common practice in the public sector for the Senior Independent Director to undertake appraisals on behalf of stakeholders. Council responded that they had not intended to cast aspersions but were merely seeking greater clarification. It was agreed that the Appointments committee would revisit its recommendation, which could be referred back to Council for approval at a later date. It was noted that this matter was not time critical given that the new Chair had been just been appointed to start in October on a 6-month contract.
68-21	**Approval of governor representative roles 2021** Council **approved** the Chair's recommendation for PS to remain as lead governor this year, noting the following Governor Representative roles for 2021/22 as follows: • Governor Representative to the BoD Finance and performance committee (F&PC) Thava Ruben • Governor Representative to the BoD Quality and governance committee (Q&GC) Antony Fulford-Smith • Governor Representative to the QVH Charity committee Caroline Migo • Governor Representative to the BoD statutory Audit committee Oliver Harley • Stakeholder Governor member of the Governor Steering Group Julie Holden • Chair of the Council of Governors' Appointments committee John Harold New members of the Council of Governors' Appointments committee • Oliver Harley • Caroline Migo • Ken Sim • Peter Ward Booth
Representing the interests of members and the community	
69-21	**FT membership review 2020/21** CP presented the Trust's annual membership update for assurance that that our membership engagement is relevant and appropriate for the size of the Trust, and that we continue to consider opportunities for enhancing current practice. CP highlighted: • Membership is drawn from areas as set out in our constitution; our membership of c7,800 is healthy for a trust of our size; • The 450 increase on the previous year is associated with recruitment of members during the governor election process. • Information governance regulations limit the amount of detail we hold on members, eg we would need a good rationale to ask about somebody's sexual orientation.

	• The Trust does not have the resources for a dedicated membership function. • All members are asked to provide an email address when joining up, but we also have postal members. • The Trust prefers to avoid 'over-communicating' in order to prevent 'engagement fatigue' resulting in members asking to be removed from the database. • Membership is promoted on our website; hard copy application forms will be made available again once Trust infection control teams deem this appropriate. Council sought additional clarification as follows: • There was a 16.8% turnout of the total number of members eligible to vote (7,644) • Those members without email are communicated with by post. • FT membership is no longer expected to grow since there is no longer a distinction at national level between FTs and non-FTs; there is now only one regulator and expectations are the same for both (for example the expectation that FTs would align their Chair's appraisal process to the national standard). There were no further comments and Council **noted** the contents of the report.
Holding non-executive directors to account for the performance of the board of directors	
70-21	**Executive overview** The CEO presented a summary update of activities within the Trust and the NHS as a whole over the last quarter. Highlights included: • An overview of the national scene including details on development of the new ICS framework; • SJ explained that reasons behind delay in publishing the Sussex Acute Collaborative Services review undertaken by KPMG had been compounded by the restrictions on communications activity during May elections; however, publication was anticipated later this week. • An update on our cancer alliances in Surrey, Sussex and Kent and Medway which enable care to be more effectively planned across local cancer pathways. • The current position with regard to our spoke sites in Kent, Surrey and Sussex; QVH is uniquely organised as a specialist Trust, with the majority of care delivered on a regional footprint. • A summary of the rationale behind the @QVH model, with an overview of the proposed super spoke/tier model drawn up by clinical directors and its critical success factors. However, progress to date had been impeded by the focus on recovery. • Summary findings of the staff survey, details of which had been published in the May public board papers. SJ highlighted in particular the finding that, in the midst of the pandemic, 94% of responses had confirmed they would be happy for friends and family to be treated at QVH. • There were several areas for improvement such as links with immediate managers, staff engagement and team working where findings correlated directly with the impact of the pandemic. • The recovery position with risks to performance in the future; whilst numbers of long waiters are coming down, there is real concern that these will increase again in the Autumn. With lockdown restrictions being lifted more people will visit A&E/GPs and we will start to see more referrals coming through. The national picture as a whole was a concern. Council considered the update, seeking additional clarification as follows: • A claim by a staff governor that 1 in 8 staff had refused the COVID vaccine; SJ stated that over 1,000 staff (including bank and volunteers) had been double vaccinated so he did not believe this could be accurate.

	• A presentation had been made to the consultant body last week ahead of the strategic case presentation to the Board on 5 August. This was specific that options were:
	  o QVH and UHSussex to remain as separate organisations (the "Do Nothing" option)
	  o The two trusts to merge through the acquisition of QVH by UHSussex
	  o Collaboration between UHSussex and QVH supported by a management contract.
	In response to a comment that the strategic case had not considered options outside the UHSx proposal, SJ stated that the Board had actively been seeking sustainable solutions since 2017.
	• That the 'do nothing' option has to be included in any strategic case in order to demonstrate the need for change.
	• That the provider collaborative as envisaged in the white paper was not the same as the collaboration as described in the strategic case which doesn't take into account any other options. SJ reminded Council that QVH was already part of the Sussex Acute Collaborative Network where work was proceeding well. In addition, and as described earlier, work on proposed super spoke in Kent was under consideration but progress was hampered by the recovery programme and the Trust had not identified a provider to work with. QVH was also building on the work it had undertaken in the last year as a cancer hub; this had raised our profile and was a rich opportunity to develop further in the future.
	• Confirmation that most of the information contained in today's presentation (with the exception of the spoke sites work), was already in the public domain.
	• Council were advised to ignore rumour and supposition regarding suggestion there would be loss of theatre capacity should the proposed merger go ahead.
	• Guidance on funding for the second half of the year (H2) had still not been published; the Trust was still working on a block arrangement based on 2019 activity levels.
	• There are ongoing discussions with ICS leads in Kent which QVH will be involved with, and the QVH Trust Chair attends the fortnightly Chairs' meeting in Kent. Kent is not as well advanced as Sussex in the ICS process, QVH is not aware of anything in Kent that is the equivalent of the Sussex Acute Collaborative.
	• Kent too is concentrating on its recovery plans; given the current position, it is unsurprising that Kent ICS leads are focusing on their own geographic area at present.
	• Staff survey focus is on team morale, which is entirely separate to the Trust's comms strategy. Not all issues are to do with the proposed merger and there is still more work to do to ensure staff morale is where we would like it to be.
	
	The Chair concluded by summarising the following:
	• As requested, CoG had received written board reports, noting these were not as current as a verbal update would be;
	• GSG would be apprised of how the forward plan is developed;
	• Although already covered on several occasions, the Board will give further thought on how best to help governors understand the background to the Trust's financial deterioration;
	• The GSG will review the CoG agendas to agree if the format should be amended.
	
	The meeting had run over schedule at this stage and the Chair closed it to enable the AGM to start promptly.

71021	**Board of Directors** Due to the time taken to conclude previous items, the meeting closed before this could be addressed.
72-21	**Finance and performance committee (F&PC)**

	Due to the time taken to conclude previous items, the meeting closed before this could be addressed.
73-21	**Quality and governance committee (Q&GC)** Due to the time taken to conclude previous items, the meeting closed before this could be addressed.
74-21	**Audit committee** Due to the time taken to conclude previous items, the meeting closed before this could be addressed.
75-21	**Charity committee** Due to the time taken to conclude previous items, the meeting closed before this could be addressed.
76-21	**Any other questions for non-executive directors** Due to the time taken to conclude previous items, the meeting closed before this could be addressed.
Any other business (AOB)	
77-21	**NEDs letter to Governors dated 5th May** Due to the time taken to conclude previous items, the meeting closed before this could be addressed.
Questions	
78-21	Due to the time taken to conclude previous items, the meeting closed before this could be addressed.

Chair:…… …… Date:

Report to:	Board Directors
Agenda item:	99-21
Date of meeting:	5 August 2021
Report from:	Steve Jenkin, chief executive
Report author:	Clare Pirie, director of communications and corporate affairs
Date of report:	28 July 2021
Appendices:	NA

Future organisational arrangements – strategic case

1. Introduction and background

1.1. QVH and UHSussex (Brighton and Sussex University Hospitals NHS Trust, BSUH, as predecessor organisation) have had a long-standing collaborative relationship and strong clinical links have existed between BSUH and QVH for many years. QVH considers its clinical links with UHSussex amongst its primary relationships, and the two trusts have a number of shared posts and service level agreements in place.

1.2. QVH is a specialist trust providing high quality services for which patients are prepared to travel considerable distances. Patient and staff are very positive about the compassionate and skilled care provided at QVH, but running as a standalone organisation is increasingly challenging. Over the last few years the Board has been considering how to remain wholly independent and can see no way that this can be achieved.

1.3. Without the range of clinical services on site usually found in an acute trust, QVH has contracts for a range of support services. The cultural difference between a service contract and belonging to the same organisation is significant, with clear benefits to reducing time needed for negotiating and monitoring contracts.

1.4. As a small organisation, QVH often has only one person responsible for a role. In some functions it is possible to schedule around planned leave but in others, such as safeguarding or PALS and complaints, even pre-arranged absence is difficult.

1.5. QVH has a growing financial deficit and while staff have worked hard to address that, there are no more easy wins, and the Board of QVH is clear that the Trust will not jeopardise safety or quality through cuts.

1.6. In November 2019, the QVH Board acknowledged that it could not continue to function independently in its current form, and agreed to explore a more formal arrangement with what is now UHSussex.

1.7. The Strategic Case has been developed by UHSussex and QVH together with the support of NHSEI to determine the best approach to working together and the best future organisational form.

1.8. The board of QVH will consider whether the preferred option would help to:

- further develop and invest in services
- maintain and build on QVH's excellent record for patient experience, clinical outcomes and safety

- continue to provide services to patients from the wide area covered currently (including Kent and Surrey as well as patients who travel much further for our care)
- continue to deliver world class research and innovation
- secure the future of the hospital in East Grinstead

1.9. The purpose of the Strategic Case is to consider the strategic rationale for change. If there is a decision to proceed to full business case (FBC) then there is a great deal more detailed work to do before the boards of both organisations are asked to take a decision on whether or not merger should go ahead. This will include further engagement with staff, people who use our services, our commissioners, other healthcare providers, and other stakeholders such as charities closely linked to our work. Both organisations will be explaining what merger would look like, and seeking views on what improvements we should seek to achieve in merger and what concerns we need to address.

2. National and local context

2.1 The long-term vision of the NHS nationally and locally is dependent on NHS organisations working collaboratively to deliver service transformation and create sustainable services.

2.2 Along with other Sussex trusts, QVH and UHSussex operate within the Sussex Integrated Care System and work closely with partner health and social care organisations. The Sussex Health and Care Partnership Strategic Delivery Plan: Response to the NHS Long Term Plan includes the formation of the Sussex Acute Collaborative Network (SACN). The SACN's role is to strengthen strategic partnership between acute trusts, foster collaborative working in development of sustainable services and oversee a programme of work operating across the ICS.

2.3 QVH is a specialist NHS hospital in East Grinstead, West Sussex, and was established as a Foundation Trust in July 2004. The Trust employs circa 1,000 people. In May 2019 the Trust maintained its overall CQC rating of Good and outstanding for caring.

2.4 University Hospitals Sussex was formed on 1 April 2021 from the merger of Brighton & Sussex University Hospitals NHS Trust (BSUH) and Western Sussex NHS Foundation Trust (WSHFT). UHSussex employs nearly 20,000 people across five main hospital sites in Sussex, and has an operating budget of more than £1 billion. The Trust runs seven hospitals in Chichester, Worthing, Shoreham, Haywards Health and Brighton and Hove, as well as numerous community and satellite services. As a new organisation the Trust has not yet had a CQC inspection and until the next inspection WSHFT's CQC ratings stand for the Trust as a whole. At the last CQC inspection in 2019 the Trust maintained its overall rating of Outstanding.

3. Case for change

3.1. In October 2020 QVH published a document called *Securing the long term future of QVH,* setting out the reasons why change is needed, and describing the three key challenges which need addressing in order to continue to develop world class services and outstanding patient care.

3.2. The challenges faced by QVH are primarily due to the small size of an organisation delivering specialist services and can be summarised as fragile clinical services; fragile support functions and financial sustainability.

4. Fragility of clinical services

4.1. There are a wide range of clinical services required to support the specialist services delivered at QVH. For most large organisations these are part of the overall infrastructure that is in place on acute hospital sites. However, due to the size of QVH and the limited range of clinical specialties delivered, QVH does not have the full range of clinical services that would be found in a bigger teaching or general acute hospital.

4.2. In order to remedy this QVH relies on other organisations to provide these services through a range of arrangements to support the delivery of high quality safe care. Currently, QVH has Service Level Agreements (SLA) with a range of different providers including the following with UHSussex;

- Paediatric consultant cover
- Pathology
- Microbiology
- Imaging services
- Support for critical care services
- Support for elderly care
- Support for cardiology
- PACS management
- General medical support

4.3. However, having access to a contractual service from an NHS body is not as flexible and therefore as comprehensive to meet the demands of patients as accessing services from within an organisation. Services delivered in this way involve a level of bureaucracy between organisations and can mean services are not as agile as they could be, and services need to be agile particularly in times of changing demand and circumstances, as seen through COVID-19 pandemic.

4.4. In some cases it is not possible to purchase or contract with other organisations to deliver the service required and therefore there are a number of services that have greater challenges to delivery of safe care and compliance with national service specifications.

4.5. For QVH, as a small specialist mainly surgical hospital, issues of compliance with national specifications relate to both adult and paediatric inpatient burns services, critical care and paediatric inpatient services.

4.6. Whilst robust mitigations are in place to limit the clinical risks, the level of risk appetite against the required criteria and the increased costs of providing a safe service, including accessing support services from other NHS providers, significantly impact on the position of the Trust.

4.7. The absence of a full range of support services on site creates challenges and fragility across QVH clinical services including burns, critical care and paediatric inpatient services which face significant challenges to delivery of safe care and compliance with national service specifications.

4.8. It is recognised that although QVH provides an excellent service the burns service does not meet the National Burns Care Standards (2018) and is non-compliant with 32 of the 317 standards. The standards specify that adult and paediatric burns units must be co-located with a number of other clinical services that are not available on

the QVH site. The position has been recognised by the Trust and its commissioners and the service has been in formal derogation since 2013. Whilst appropriate admission thresholds and transfer criteria for burns patients are well established and can mitigate some of the potential clinical risk, the current levels of clinical cover on the QVH site mean that there is an increased requirement to transfer patients to other providers so they can receive the specialist medical care and access other clinical services that are not available 24 hours a day at QVH.

4.9. The clinical risks for paediatric burns were such that in August 2019 the service temporarily suspended acute inpatient admissions of paediatric burns and children are now admitted to other burns centres outside the region.

4.10. The critical care service does not meet all the Critical Care Service Specification Standards (2019) with a self-assessment identifying compliance with 64 standards, 3 partially met and 18 not met. Challenges include the availability of some support services including on site medical cover, out of hours radiology cover, general surgical cover and ECHO, and the prohibitive cost of collection and submission of data for National Intensive Care National Audit and Research Centre audit. A review by South East Critical Care Network in 2019 found no evidence to suggest poor performance or patient outcomes, and there were no concerns about quality or safety. However, it concluded that whilst the inability to meet a portfolio of national standards does not prohibit the delivery of critical care, it does necessitate discussion with commissioners about expectations of care delivery and future commissioning intentions.

4.11. QVH provides a paediatric surgical and burns service for children from the age of one to 16 years. The service has challenges meeting standards related to, among others, co-location with medical paediatric services, co-location or timely access to other services, availability of paediatric HDU and PICU and paediatric anaesthesia**.** Appropriate admission criteria, the quality and training of staff on site and the service level agreement arrangement with the Royal Alexandra Children's Hospital in Brighton mitigates some of the potential clinical risk, and in this context the Trust ensures children who require an inpatient stay are risk assessed to ensure QVH can deliver safe quality care within the constraints of the medical cover available**.**

5. Fragile support functions

5.1 The size of the Trust means that in a number of areas there is just one person who is responsible for a role in the organisation. This provides a challenge with being able to cover periods of work pressure, annual leave, sickness, and gaps between members of staff leaving the trust and new recruits starting.

5.2 The small size of the Trust and the specialist nature of its work mean that there is limited scope for career progression resulting in staff having to leave to gain further experience and promotion. In addition, this also means staff are highly competent within a specialist range of skills but have limited exposure to a sufficiently broad range of skills in some clinical areas and that this knowledge and experience can only be gained by moving to a different hospital trust.

5.3 There are posts within the Trust where one person is responsible for an activity and this impacts both clinical and non-clinical roles creating a number of issues. This includes:

- The inability to share expertise, experience and ideas within a team. This results in developing ways of doing things in isolation, recognising that there may be other, better ways of doing them.

- A lack of other people with appropriate levels of expertise and seniority to pass work to during periods of absence. Some functions are put on hold when a key individual is absent, and this can have a significant personal impact on the individual themselves. Bringing in agency or locum cover for annual leave adds time and expense in training and familiarisation with the role.

- Some posts have multiple roles or areas of responsibility including multiple statutory or corporate roles that might sit with several individuals or even have their own dedicated teams in a larger trust (for example, complaints, PALS and litigation) to day-to-day responsibilities that might be shared across more people in a larger team (such as data reporting, managing rosters and ordering consumables).

- Pressure points or times of the year that are especially busy impact more significantly on an individual than across a team, including administrative support that could be deployed to support individuals at times of need.

- The impact of having sole responsibility for a function has on staff wellbeing and life outside of work, leading to cancelling leave or work while on leave, unable to switch off fully from work and anxiety about taking sick leave.

5.4 QVH therefore lacks some of the opportunities that can come with larger organisations such as larger teams with overlapping roles or support arrangements providing a more stable basis on which support functions can be provided. These non-clinical functions include but are not limited to:

- Leadership and management teams
- IT services
- HR functions
- Finance and Procurement
- Corporate Governance
- Adult and Paediatric Safeguarding
- PALS and Complaints

5.5 These challenges are not limited to non-clinical services, and clinical services facing similar issues with lack of scale and flexibility include infection control and prevention, dietetics, imaging and nurse specialist roles.

5.6 As a Foundation Trust QVH is legally required to meet the same requirement for standards and reporting as a much larger organisation, and this leads to a disproportionate level of overhead costs compared to other trusts. For example the most recent Corporate Services benchmarking report (2018/19) demonstrates QVH is consistently in the third or fourth national quartile for its corporate functions, meaning the cost of providing these functions is higher per £100m income than most other trusts.

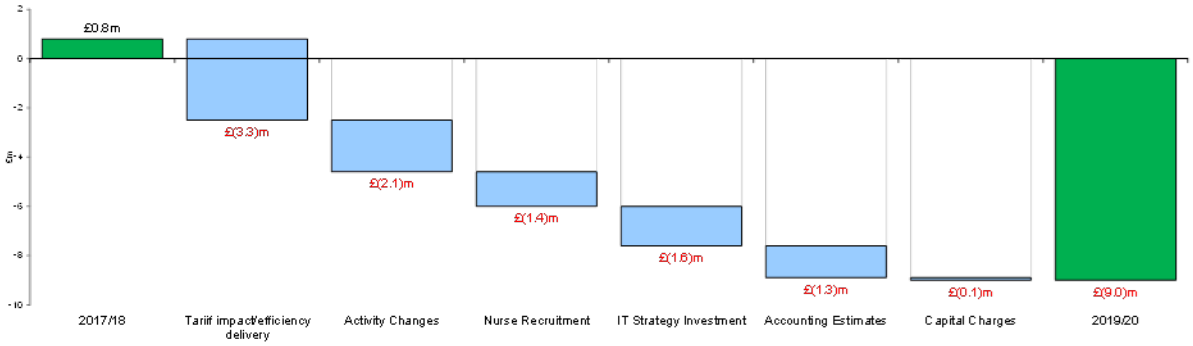
6. Financial sustainability

6.1 Until 2017/18 QVH had delivered a break-even or surplus position, but recognised that this was secured through non-recurrent means in prior years. In 2018/19 and 2019/20 QVH reported an adverse deficit position against its plan and the control totals set by NHSI. QVH has worked hard to secure efficiencies but it is not possible to close the financial gap as a standalone organisation without impacting quality.

6.2 The financial position in 2020/21 showed an improvement under the interim financial framework that was applied during the COVID-19 pandemic. Under this financial framework, which has also extended into the first six months of 2021/22, provider organisations are funded via block payments and a series of top-up payments that reflect historic expenditure levels. The Board of QVH are aware that this level of income will not be maintained and that the underlying position continues to be a deficit projection.

6.3 The reasons for the deteriorating financial position are multiple. The chart below tracks the financial position of QVH from a small surplus of £0.8m in 2017/18 to a deficit of £9.0m in 2019/20 demonstrating the key drivers of the financial deterioration.

QVH Drivers of the Deficit



The key drivers are summarised below.

Driver	Summary
Tariff impact and efficiency delivery	Requirement to deliver real-terms cost savings (national efficient requirement) across two years as a small trust - QVH was able to deliver 61% of what was required. The market forces factor was rebased in 2019/20 and had an adverse impact on income and will continue to have an adverse effect for five years. Non-elective trauma tariff changed and created an income gap. Above average inflationary increases related to premiums for the national clinical negligence scheme for trusts and medical and surgical equipment. As QVH was not able to deliver its full national efficiency requirements and therefore unable to access the national financial recovery fund, it was unable to mitigate these pressures.
Activity Changes	Constant activity over last three years. Case-mix change with minor injuries activity increasing and non-elective (trauma) reducing. Elective and outpatient overall unchanged but reducing maxillofacial activity. No service change or cost release in services reducing activity. Premium rate or outsourced activity to reduce elective backlog via additional capacity.

Driver	Summary
Nurse recruitment	Incurring additional costs for substantive nursing posts that had not previously been covered.
IM&T investment	Upgrade and modernisation of IM&T infrastructure impacting non-pay and depreciation charges on the capital investment.
Accounting estimates	In year benefit of 2017/18 stocktake improved the position that year non-recurrently. Temporary bad debt provision in 2019/20, subsequently reduced in 2020/21.
Capital charges	Increased public dividend capital and financing costs.

6.4. The majority of the drivers are recurrent and will not only continue to impact on QVH financial performance but in certain cases will increase in impact. The small size of QVH and the related inability to be agile when responding to tariff or activity changes will create further challenges as the financial framework in 2021/22 reverts to planning assumptions aligned with NHS Long Term Plan (LTP) and as there is increasing requirement for restoration and recovery of services.

6.5. QVH medium-term financial planning forecasts that this deficit will increase to £9.6m by 2023/24, at the end of the LTP period. This projection includes an assumption that QVH delivers the national efficiency requirement of 1.1%. It should be noted that historic efficiency delivery has been below 1.1% per annum so there is a risk of further deterioration in this projection.

6.6. The LTP expects all organisations to be in recurrent balance by 2023/24. In order to achieve this QVH would need to deliver efficiencies in excess of 4.6% per annum with a high of 5.5% in 2023/24. Delivery of efficiency at this level is considered to be stretching and would be more so in a small organisation. It is therefore unlikely that QVH can deliver a balanced financial position whilst remaining as a separate provider organisation.

7. Strategic options analysis and evaluation

7.1 An options appraisal tested three options against five strategic tests and six implementation tests.

7.2 The three options appraised are:

1. The organisations operate separately (‘do nothing option’)
2. Organisations come together as one organisation (merger by acquisition)
3. Clinical collaboration supported by management contract

7.3 The strategic tests were designed to test options against strategic themes of:

- Provision of high quality care
- Clinical sustainability
- A clear future for staff
- Financial sustainability
- Optimising a future for services across the system

7.4 The implementation tests were designed to test options against:

- Legality of the option

- Alignment to both Boards' strategic direction
- Alignment to the systems strategic direction
- Governance and management capacity to deliver
- Transaction costs
- Implementation difficulty and permanency

7.5 The outcome of the options appraisal process gave a preferred option that QVH and UHSussex come together via merger by acquisition. The main features of this option are one Board and one set of Board subcommittees, one Council of Governors and one organisational structure with support for clear lines of accountability from Board to the frontline. This option would mean all UHSussex staff and QVH staff will be employed by one trust (UHSussex).

7.6 One of the main potential benefits of this option is that it provides a long-term, sustainable future for QVH hospital and staff allowing strengthening of corporate functions and reducing existing QVH fragilities.

7.7 The option supports high quality care by facilitating improved working across Sussex clinical teams, helps support services at QVH which are currently fragile, including burns, critical care, and paediatric services and allows for integration of services which are at risk of being isolated, thus improving their long term sustainability.

7.8 The merger of the trusts would help improve the efficiency of corporate services through greater economies of scale and the reduction of duplication, facilitate greater clinical alignment and support which creates the opportunity to make services more financially sustainable and will eliminate the need for Service Level Agreements between the two trusts, which are expensive and inefficient.

7.9 A summary of evaluation by criteria is shown below.

Criteria	Evaluation
Provision of high quality care	Merger scores the highest as it offers opportunities to maintain quality services at both trusts and facilitates the future development of services. In both other options organisational barriers to change remain and there are limited levers for change. There is significant overlap between these considerations and the clinical sustainability test.
Clinical sustainability	Although many of the clinical sustainability challenges will not be solved by the change in organisation form itself, a merger would give a significantly better platform for services working together, and within a financially sustainable organisation. There is significant overlap between these considerations and provision of high quality care test.
A clear future for staff	The opportunities and certainty merger would offer QVH staff means merger scores significantly higher than the other options. The other options score poorly and similarly as both essentially maintain the status quo in terms of certainty and lack of long-term plan for staff, and that existing fragilities and lack of opportunities remain.
Financial sustainability	Merger offers the best opportunity for addressing the financial challenges, although merger alone will be insufficient to fully resolve them. Collaboration via management contract scores better than separate organisations as it does allow reduction in Board resources and there may be efficiencies in corporate

Criteria	Evaluation
	services but this option is limited in its ability to make significant improvements as QVH remains a separate statutory organisation.
Optimise a future for services across the system	Merger as a permanent and long-term solution offers the greatest benefits in relation to optimising the operational delivery of services and does most to help support opportunities identified in the Sussex Acute Review. The other options are scored equally as collaboration via management contract offers little more than QVH is currently able to do by itself at the moment.
Is it allowed?	All options are allowed and permissible.
Does it align to the Boards' strategic direction?	The scores reflect that QVH Board recognises that change is required and merger offers a permanent strategic solution. UHSussex recognises that merger is in the best interests of the system, but this acquisition is not a UHSussex strategic goal in itself.
Does it align to the system's strategic direction?	Merger is consistent with the ICS strategic direction. Neither of the other options are desirable from a system perspective; collaboration via management contract would only temporarily resolve the issues and doing nothing would not address the issues set out in the case for change.
Governance and management capacity	Doing nothing scores well as the model is a well-established Foundation Trust model. Merger scores slightly higher as it has an overall similar structure, as a Foundation Trust, but also improves resilience and management capacity at QVH. Collaboration via management contract scores poorly as it increases complexity and effort compared to both the other options and introduces time consuming governance arrangements.
Transaction costs	Both merger and the collaboration via management contract options are expected to incur significant transaction costs. Based on experience of UHSussex the costs of merger are likely to be significantly higher than a management contract. There are no transaction costs associated with do nothing so a maximum score is achieved for this option.
Implementation difficulty and permanency	The do nothing option is the least complex and difficult; however it cannot be regarded as permanent, so will result in complexity and difficulty at some future point. Both merger and collaboration via management contract are complex and difficult, with the merger process the most difficult of all. However, merger is the only option which results in a permanent solution and therefore merger scores slightly higher.

8. Preferred option – merger by acquisition

8.1 The preferred option is merger by acquisition where the trusts become one trust expanding the geographical footprint of UHSussex to include QVH catchment area. The description below provides an outline of what a merged organisation would constitute at high level. The specific detail of merger will be developed as part of the next stage (full business case and post transaction integration planning).

8.2 As the acquiring trust, the UHSussex Board would become responsible for all QVH operations and governance, including subcommittee audit, finance and performance and quality structures. As an enlarged Foundation Trust there would be a single Constitution and one Council of Governors, with membership of UHSussex extended to QVH staff, and QVH patients and community would be invited to become members. Alongside the single Board there would be one Executive Team and a

single clinical operating model providing clear lines of accountability from Board to the frontline. Consideration would need to be given to on-site management arrangements at QVH as part of the clinical operating model. Corporate functions could be consolidated achieving economies of scale across the new larger Trust and providing resilience in fragile support services.

8.3 Patient First would be the improvement methodology and strategy deployment approach across the whole Trust and there would be one, potentially strengthened, quality governance and audit approach.

8.4 A single financial framework and budget would be in place and UHSussex would become responsible for all predecessor contracts, assets and liabilities. Transaction and overhead costs between the two Trusts should be reduced with the removal of existing SLAs.

8.5 As a single organisation there would be a single vision, values and strategy, with the Trust acting as one voice at system level. Merger could support consolidation and retention of acute and specialist services across the larger Trust and QVH services would benefit from becoming part of a University Teaching Hospital.

8.6 Future service development could be enhanced overall as a result of the capacity and capability infrastructure in the new trust and within a single clinical strategy. The clinical operating model would determine operational management delivery in the new trust and merger gives the opportunity to integrate services, potentially making them more resilient.

8.7 There is also the potential to maximise capacity across a wider infrastructure in Sussex, giving greater sustainability whilst still providing both local services and specialist services outside of Sussex.

8.8 A merger would mean all UHSussex and QVH workforce are employed by one clinically and financially sustainable employer. One organisational development framework would cover the whole workforce. A permanent future for QVH staff via merger may improve recruitment and retention and will provide access to all in-house training and development in a large teaching trust. There may also be the opportunity to develop job flexibility and pathways across a bigger organisation.

9. Benefits of merger (preferred option)

9.1 The potential benefits of the preferred option are described here in terms of the key system themes identified in the options appraisal, and linked to both the QVH and the UHSussex strategic aims.

System Theme	Key potential benefits of the preferred option
Provision of high quality care	• Facilitates improved working across clinical teams in Sussex, improving patient care benefitting patients through improved access • Supports the future development of services across the whole geography of the new Trust • Maximises capacity across a wider infrastructure and joint executive planning of services may result in better clinical integration
Clinical Sustainability	• Helps support services at QVH which are currently fragile, including burns, critical care, and paediatric services

	• Allows for integration of services which are at risk of being isolated, thus improving their long term sustainability • Brings a proven improvement methodology and approach to QVH • Allows for further development of research and innovation in a university trust
A clear future for staff	• Provides a long term, sustainable future for QVH hospital and therefore for QVH staff • Provides further opportunities for training and rotation of staff to improve both recruitment and retention • Helps strengthen corporate functions at QVH, reducing their fragility
Financial Sustainability	• Helps improve the efficiency of corporate services through greater economies of scale and the reduction of duplication • Facilitates greater clinical alignment and support, which creates the opportunity to make services more financially sustainable • Eliminates the need for Service Level Agreements between the two trusts, which are expensive and inefficient • Facilitates access to investment for specialist services and associated research and development
Optimise a future for services across the system	• Strengthens the provision of head and neck services in Sussex • Provides QVH services with greater influence at system level • Facilitates future strategic planning as services are under one Board • Helps to secure the future of services in Sussex through a strong and stable organisational form

10. Strategic Risks of Merger (preferred option)

10.1 The merger presents a number of strategic risks to the separate trusts and the system as a whole. The following are the most significant strategic risks:

- Clinical sustainability and quality of care
- Financial sustainability
- Culture
- Management capacity
- Reputation

10.2 Clinical sustainability and quality of care

The preferred option of merger does not in itself resolve the challenges related to delivering some clinical services on the QVH site that were outlined in the case for change, in particular burns, critical care and paediatric inpatients.

10.3 However, merger would support the strengthening of the network in which the QVH services operate and would provide more integrated management of services that are currently linked only via service level agreements. Merger would also facilitate delivery of actions resulting from the clinical reviews described below. The operation

of QVH and UHSussex services within one clinical operating model and under the governance of one organisation would lead to an integrated approach to the implementation of any recommendations.

10.4 There is an additional risk that focusing on QVH services would detract UHSussex from responding to its own clinical priorities.

10.5 Financial Sustainability
Joint working across a number of areas should allow services to be delivered more sustainably across both clinical and non-clinical services. However there is a risk that the merger of the trusts could lead to a deterioration of the financial position of UHSussex. UHSussex have an agreed Medium Term Financial Plan (MTFP) and is a financially sustainable Trust; QVH has a number of significant financial challenges.

10.6 Culture
The organisations have different cultures. QVH has a strong internal culture that may make integration with UHSussex challenging, particularly due to the geography and the specialist nature of some of the services at QVH. Organisational Development and strong communication and engagement should help mitigate this risk but it is nonetheless a strategic risk to the merger.

10.7 Management Capacity
Bringing two organisations together through merger requires a significant level of management time. UHSussex have started to integrate the legacy organisations following merger in April 2021, and are developing the new clinical operating model for the new Trust, which will be followed by an aligned corporate operating model.

10.8 Reputation
There are risks to the reputation of both trusts in closer collaboration. For UHSussex there is a risk related to inheriting services that are in derogation and have sustainability challenges. From a QVH perspective there is wide support at local level for the Trust and becoming part of a larger organisation may damage its brand and this connection with its local community.

11. Review of clinical services

11.1 If the decision is taken to proceed to full business case, then in parallel with this work the trusts will jointly review specific clinical services across QVH and UHSussex where there are either opportunities to collaborate or fragilities of service to address. The relevant output from these reviews will form part of the FBC.

12. Financial Assessment

12.1 UHSussex has a sustainable financial position that builds upon the medium term financial trajectories of predecessor trusts. The financial sustainability has been tested both through detailed medium-term financial planning within the ICS and with the support of NHSEI and subsequently through the recent transaction assessment by NHSEI.

12.2 The strong financial performance in WSHFT and the more rapid improvement against the control total trajectory in BSUH has allowed both organisations to plan for the future and invest in service improvement. This level of financial performance has only been sustained through consistent delivery of efficiency savings in excess of the national efficiency requirement.

12.3 QVH delivered a break-even or surplus position until 2017/18. Delivery of this position in 2017/18, and the surpluses in prior years included reliance on a number of

non-recurrent or technical items that were not sustainable. In 2019/20 the deficit was £9.0m.

12.4 A key factor in this deterioration has been the small size of QVH and the challenges of both maintaining sustainable and clinically safe services, and being agile in responding to changes in national payment mechanisms or demand. The interim financial framework in place during COVID-19 has masked these challenges, however QVH recognise that as the financial framework reverts to the planning principles in the NHS Long-Term Plan, QVH will face an increasing financial challenge.

12.5 The QVH medium-term financial planning forecasts the deficit will increase to £9.6m by 2023/24, at the end of the LTP period. The LTP expects all organisations to be in recurrent balance by 2023/24. In order to achieve this QVH would need to deliver efficiencies in excess of 4.6% per annum with a high of 5.5% in 2023/24.

12.6 Delivery of efficiency at this level is considered to be stretching and would be more so in a small organisation. It is therefore unlikely that QVH can deliver a balanced financial position whilst remaining as a separate provider organisation.

12.7 At FBC the medium term financial projections of both trusts will be revisited to update any underlying assumptions and to assess any residual impact of COVID-19 on the underlying financial position.

12.8 Benchmarking data suggests there is the potential through merger to achieve financial efficiencies of £1m to £2m in relation to collaboration and sharing of functions. This opportunity is related to the current position of QVH where it consistently benchmarks above (worse than) median meaning the spend on corporate services at QVH is disproportionate for its relative size. Delivering a balanced position for QVH will require the efficiency from each of these opportunities to be maximised. This will only be possible if QVH is integrated into a larger organisation that has both the economies of scale and the delivery infrastructure to support this level of efficiency.

12.9 The clinical reviews to be undertaken jointly by QVH and UHSussex in line with the FBC may derive some level of financial benefit by closer working and addressing inherent fragilities, but at this stage no assumptions are included on the outcome of this work.

12.10 The main risk to the financial plan is the ability to deliver significant cost savings over multiple years whilst managing the integration of multiple hospital sites, business as usual operational pressures and the restoration, recovery and reformation of services after COVID-19. The interim financial framework in operation during 2021/22 and changes to this framework from October 2021 will also create a level of uncertainty.

12.11 Both trusts expect to incur programme costs and costs in the areas of due diligence, legal fees and organisational development. For the FBC granularity of costs will be required.

13. Stakeholder Engagement

13.1 Both trusts have undertaken stakeholder engagement activities as part of the development of this Strategic Case. QVH has built on the extensive engagement that has been undertaken over the last few years while the future of the trust has been under discussion. Engagement has been undertaken with QVH governors, system partners, MPs and councillors, QVH members and the public, and QVH staff. The

main concerns raised have been about the ongoing availability of QVH's specialist services to the wide area served currently.

13.2 Due to the position of UHSussex having recently gone through merger, UHSussex has concentrated engagement efforts on the Strategic Case including sessions with NEDs, governors and staff.

13.3 The two trusts have worked together and have agreed a plan to develop a full communication and engagement strategy to support the development of the FBC. This engagement will include listening to the hopes and fears of staff and other key stakeholders; working to build understanding of the merger across a range of internal and external audiences; minimising uncertainty or confusion for patients, staff, system partners and the wider public; developing a common vision, values and culture for closer working; and enabling staff of both organisations to shape and become advocates for the merger and the benefits that can be realised as a result.

14. Legal, Competition and Regulatory Requirements

14.1 The proposed transaction between QVH and UHSussex is classed as an acquisition under Section 56A of the NHS Act 2006. This is where a Foundation Trust (UHSussex) acquires another Foundation Trust (QVH). This results in the dissolution of the acquired Trust (QVH) and the transfer of all its assets and liabilities to the acquiring Trust (UHSussex).

14.2 As a 'small' transaction the transaction is not subject to review by NHSEI but an application to NHSEI is required to be completed by both UHSussex and QVH for NHSEI to be able to issue a Grant of Acquisition, the legal process to combine the two organisations. The Grant of Acquisition includes documents to show the requirements of Section 56A have been met including a copy of the proposed Constitution of the acquiring Trust (UHSussex) and evidence the majority of the council of governors of each Foundation Trust involved has approved the application.

14.3 The Competition and Markets Authority (CMA) has a statutory duty under the Enterprise Act 2002 to refer relevant mergers for an in-depth investigation if it believes there is a realistic prospect that the merger would result in a substantial lessening of competition. UHSussex and QVH have consulted with NHSEI on the requirements to engage with CMA. The Health and Care Bill currently before Parliament would exempt mergers between NHS Trusts/FT from the Enterprise Act.

14.4 The trusts do not consider that the proposed transaction needs to be referred to the CMA at this time. Further work and engagement with NHSEI will be undertaken as part of the FBC development when merger and legislative timescales are clearer.

14.5 QVH will seek assurance regarding the position of UHSussex in relation to operational performance, clinical safety, quality and finances. The purpose of this is to provide assurance that QVH staff and services would be joining a sustainable and high quality organisation.

14.6 A merger would mean the following changes in the legal format of both organisations;

14.6.1 UHSussex would submit an amended constitution for the enlarged Foundation Trust as part of the request for a Grant of Acquisition.

14.6.2 The current governors of QVH would automatically cease their roles on completion of the proposed transaction.

14.6.3 Members of QVH would automatically cease on completion of the proposed transaction. Members cannot automatically be made members of UHSussex. UHSussex would work with QVH public members and staff members to give opportunities to become UHSussex members.

14.6.4 UHSussex CQC and NHS Resolution registration would be submitted for effect from transaction date.

15. Delivery and Programme Management

15.1 The Strategic Case is the first stage of the transaction process. If successful and approved by both Boards it will be followed by a Full Business Case (Stage 2) before final approval which includes the regulatory and legal processes (Stage 3).

15.2 Following the review of the Strategic Case, if approved both trusts will progress the development and agreement of the Heads of Terms which will support, with the structure and authority for joint working, development of the Full Business Case. The Heads of Terms will provide a basis for the final Transaction Agreement with an expectation that this will be available for agreement alongside the Full Business Case.

15.3 The trusts will jointly review specific clinical services across QVH and UHSussex where there are opportunities or fragility to inform potential service configuration. The relevant output from these reviews will form part of the FBC.

15.4 Governance for the programme is provided by the Joint Oversight Group and the Joint Executive Group, with the Executive Group reporting to the Oversight Group. The purpose of both groups is to oversee the programme of work needed to manage the process for the potential future relationship between QVH and UHSussex.

15.5 The programme governance arrangements will be revised following approval of the Strategic Case to ensure continued robust governance that facilitates a joint approach to project management, timely decision making and regular reporting.

15.6 A dedicated project management team will be established to manage the merger, which is consistent with the approach to the recent UHSussex merger.

16. Decision making on whether to proceed to FBC

16.1 As there are elements of the strategic case that are commercially sensitive, the full Strategic Case will be considered in private.

16.2 The Strategic Case outlines the current position and challenges at QVH and how merging with UHSussex could provide the opportunity for QVH to secure a viable and sustainable future for its patients and staff.

16.3 With approval of the Strategic Case the Board would be committing to developing a full business case for the merger by acquisition of QVH by UHSussex to the detail required to allow the Board to make a final decision.

16.4 The board of QVH will consider the capacity and resources needed for merger and whether the preferred option would help to:

- further develop and invest in services
- maintain and build on QVH's excellent record for patient experience, clinical outcomes and safety

- continue to provide services to patients from the wide area covered currently (including Kent and Surrey as well as patients who travel much further for our care)
- continue to deliver world class research and innovation
- secure the future of the hospital in East Grinstead

Report to:	Council of Governors
Agenda item:	89-21
Date of meeting:	25 October 2021
Report from:	Clare Pirie, Director of communications and corporate affairs
Report author:	Clare Pirie, Director of communications and corporate affairs and Hilary Saunders, Deputy company secretary
Date of report:	14 October 2021
Appendix:	N/A

Information governance training

Introduction

The Trust is committed to providing training and development for governors to enable them to carry out their role effectively, and likewise governors are expected to participate in such opportunities that have been identified as appropriate.

Governors who joined the Council in 2021 have not taken part in the Trustwide induction programme for staff and are unlikely to be able to do so as social distancing is in place and we need to prioritise places for new staff. This annual update contains the core information needed by governors.

Summary

Governors are required to remain cognisant about information security, privacy and confidentiality whilst carrying out their duties. A summary of the key principles relevant to governors is set out below:

Confidentiality

The Governor code of conduct[1] requires compliance with the Trusts' confidentiality policies and procedures. Governors must not disclose any confidential information, except in specified lawful circumstances, and must not seek to prevent a person from gaining access to information to which they are legally entitled. (This does not, however, preclude governors from making a protected disclosure).

Information

For the purposes of information governance, this can be categorised as:

- Personal (name, date of birth, home address)
- Sensitive (ethnicity, disease, sexuality)
- Corporate (supplier contracts, meeting minutes, financial details)

Caldicott principles

The Caldicott Report was a review commissioned due to increasing worries concerning the use of patient information in the NHS. Its findings were originally published in 1997, with follow up reports in 2012 and 2016. Key principles are:

- Requests for information must justify the purpose
- Patient identifiable information should not be used unless absolutely necessary; in such cases, only the minimum information required should be disclosed.
- Access to patient identifiable information should be on a strict need-to-know basis

[1] Provided by the Trust at induction

- Everyone with access to patient identifiable information should be aware of their responsibilities, and understand and comply with the law
- The duty to share information can be as important as the duty to protect patient confidentiality.

Data Protection Act 2018 (GDPR)
The Data Protection Act 2018 controls how your personal information is used by organisations, businesses or the government. This act is the UK's implementation of the General Data Protection Regulation (GDPR) and requires information to be used fairly, lawfully and transparently. The Trust can be fined for breaches.

Freedom of Information act 2000
This provides public access to information held by public authorities. Anyone anywhere in the world can ask any public authority about any non-personal information they hold by making a written request. The Trust has 20 days to respond to requests

Potential threats to data security
These include social engineering, e-mail phishing and malware.

Email
Whilst stakeholder and public governors at QVH are not provided with an NHS email address, it is useful to be aware that before emailing any external parties, staff and volunteers are required to:

- Check whether it is acceptable to send personal information.
- Confirm the accuracy of the email addresses.
- Check that everyone on the copy list has a genuine 'need to know'.
- Use the minimum identifiable information

Recommendation
The Council of Governors is asked to **NOTE** the contents of this report and the appended information sheet.

Information governance summary for governors

Information Governance (IG) is a combination of legislation, policy, procedure and guidance that dictates how information should be handled by an organisation.

This can apply to any information, including patient information, staff information and financial data.

Information governance issues affect all roles within the Trust; all staff including contractors and governors are required by the Department of Health, via the Data Security and Protection Toolkit to complete annual IG training.

This document looks at the following topics:

- Confidentiality and Caldicott Principles
- The General Data Protection Regulation (GDPR)
- Freedom of Information Act 2000 (FOI)
- Information Security

Confidentiality and the Caldicott principles

Confidentiality is defined as the right of the person to know that information given is not shared freely. Either within the Trust where there is no need, or between agencies.

Generally, information can only be shared when there is consent. There are exceptions to this rule, when we receive a court order or the police request information under the prevention and detection of serious crime.

Each healthcare organisation has an appointed Caldicott Guardian. This is a senior person responsible for protecting the confidentiality of service user's information and enabling appropriate information- sharing. The Caldicott Guardian for our Trust is Nicky Reeves, Director of Nursing.

There are 7 Caldicott Principles that we should all be aware of within line of our duties:

1. Justify the purpose of using confidential information: every proposed use of patient identifiable information should be clearly defined and scrutinised with continuing uses reviewed by the Caldicott Guardian
2. Only use it when absolutely **necessary**: patient identifiable information should only be used if there is no alternative
3. Use the **minimum** required: we should only use the bare minimum information to reduce identifiability
4. All access on a strict **need-to-know** basis: only those who require access should have it
5. Understand your **responsibility**: we should all be aware of our responsibilities and obligations to respect patient confidentiality
6. Understand and **comply** with the law: every use of the patient identifiable information must be lawful
7. The **duty to share can be as important** as the duty to protect patient confidentiality

Confidentiality is the responsibility of **all** roles within the Trust and we should all be aware of our responsibilities to adhere to this.

You should:

Never discuss a service user in a public place, or with your family or friends

Never access data relating to a service user, family or friend unless you have a legitimate reason to do so in line with their care

Never access your own data, as this is an abuse of your position. If you require copies / sight of your own information held by the Trust you may submit a Subject Access Request

Never share passwords to systems or computers

Don't leave personal information unattended

Ensure confidential information is locked away

If you find confidential papers, you should hand them to the company secretary.

Any breaches of personal data or confidentiality could result in the Trust facing a large fine from the Information Commissioner's Office (ICO) of up to 4% of our annual turnover or £17 million, whichever is higher.

GDPR and the Data Protection Act 2018:

The General Data Protection Regulations (GDPR), came into force on 25 May 2018, and it sets out how identifiable data relating to living individuals is processed by Organisations across Europe.

We also must bear in mind the Data Protection Act (2018) during the execution of our duties, and its six principles, specifically principle 6 – Held Securely. This directly relates to how we hold data in any format for example, on paper or electronically.

Service users or employees can request copies or sight of records that we hold about them, under the Data Protection Act (2018). – This is known as a Subject Access Request. The Trust has 30 days to release records to anyone making a written request.

The Data Protection Act sets out six data protection principles, which state that information we hold should be:

1. Processed fairly and lawfully

2. Processed for a specific purpose

3. Adequate, relevant and not excessive

4. Accurate and up to date

5. Not kept longer than necessary

6. Held securely

Freedom of Information Act

Gives the public the right to request all non-personal information held by public bodies, recorded in any format.

All requests must be made in writing.

The Trust has 20 working days to respond to requests.

Exemptions do apply for non-disclosure of information – e.g. if the information is commercially sensitive or if the information requested is already in the public domain.

Freedom of Information and Subject Access Requests are handled by the Information Governance Team.

Report to:	Council of Governors
Agenda item:	92-21
Date of meeting:	25 October 2021
Report from:	Requested by Oliver Harley, Caroline Migo, Thava Yoganathan – public governors
Date of report:	14 October 2021
Appendices:	1. 1 July 2021 motion to pause 2. 27 July 2021 letter to all governors from the Board 3. 9 September 2021 statement from 13 governors

Motion to pause merger discussions

Background

On 1 July 2021 12 governors submitted a motion proposing that all dialogue and activities with University Hospitals Sussex on merger be paused for at least two years (Appendix 1).

On 19 July 2021 this was considered by the Council of Governors. The non-executive directors explained the reasons why they could not be bound by this motion, governors were reminded of legal advice that it is legally not possible for the CoG to restrict the business of the Board of Directors therefore any motion passed would not be legally binding but an expression of the views of governors only, and that the Regulator (NHSEI) had also indicated that it would not be reasonable for the Board to act in accordance with this motion. Twelve governors voted in favour of the motion.

On 27 July 2021 the Board wrote to all governors (appendix 2) explaining in writing: "We believe that acting in line with the motion would place us in dereliction of our duties as directors of the Trust. As directors we are required to 'act to promote the success of the organisation including designing and then implementing the agreed priorities, objectives and the overall strategy of the NHS Foundation Trust' (source: The NHS Foundation Trust Code of Governance). To have our hands tied for two years regarding discussions on the clinical and financial sustainability of QVH would put us in breach of this duty."

On 8 September Anne Eden, regional director of NHSEI met with QVH governors and as stated in the follow up letter explained that: "the Trust Board has rightly concluded that the organisation cannot carry on as it is indefinitely. The resilience of the Trust's workforce, the Trust's ability as a very small NHS provider to address its financial deficit from within its own income base, and the wide range of clinical services required to support specialist services, are three compelling reasons in the Trust's case for change. That is why I have supported the Trust Board's decision to select UH Sussex as its strategic partner, and latterly to develop plans for merger. While recognising that proposals are still being developed, I believe that continuing work on the partnership is the only credible approach to address QVH's sustainability challenges."

On 9 September 2021 13 governors wrote to the Board (appendix 3) stating: "By ignoring the 'motion to pause acquisition activities' we consider that the Non-executive directors (and, by extension, The Board) have committed a serious transgression of the trust constitution, the ethics of foundation trust governance and the laws applicable to it; there can be no excuse for this behaviour and the Non-Executive directors are asked to comply with this motion with immediate effect."

On 21 September 2021 Anne Eden, regional director of NHSEI wrote to the Chair and lead governor in a letter that was shared with all governors stating: “I am truly worried that a number of allegations that have been made by a majority of Governors, for example that the Trust Board is acting outside the Trust’s Constitution, are without proper basis. Having considered the Board’s handling of the 19 July motion to pause merger activities, I do not believe the Board has acted outside the Trust’s Constitution. The Board set out in writing to Governors on 27 July how it has considered the motion and why it would not act in accordance with it. In my view the reasons for delay cited by Governors in the 19 July motion, including the impact of new NHS legislation and the financial landscape in the wake of COVID-19, while significant, will not have any material impact on the drivers for change already identified in the Trust’s own case for change. I do not propose to investigate this further.

“The 19 July motion also referenced the need to assess the success of the recent merger of Western Sussex and Brighton & Sussex. This is if course important, but I do not consider this is a reason for delay. UH Sussex has made good progress in delivering its post-merger plans to date with good feedback from service users and staff, and despite significant urgent and emergency pressures continues to make significant progress in increasing elective treatment for its patients.”

On 29 September 13 governors put forward a requisition for an urgent additional meeting of the Council of Governors with ‘merger/acquisition with UHS should be paused’ as one of the agenda items.

On 6 October 2021 seven governors withdrew their names from the requisition for an urgent meeting meaning the requisition was insufficient to call an additional meeting; a number of these governors stated that they would like the same issue to be on the agenda for the CoG meeting on 25 October.

On 14 October 2021 at the governor steering group Oliver Harley, Caroline Migo, Thava Yoganathan asked for this issue to be included on the agenda for discussion with a paper formed by the appendices attached.

Proposal - No proposal has been made in respect of this paper.

Recommendation - No recommendation has been made in respect of this paper.

Appendix 1 – 1 July 2021 motion to pause

We the undersigned public governors at QVH NHSFT propose that the following motion be discussed and voted on at the next council of Governors meeting (currently scheduled for 19th July 2021) in line with standing orders para 5.1

We move that the QVH NHSFT Non-Executive Directors, including the Chair, pause all further activities, meetings, dialogue or expenditure, formal or informal, relating to the proposed Acquisition ('merger') of QVH NHSFT by UHS NHSFT until:

1. The presentation of a clear, complete, forensic and understandable explanation of the causes and possible solutions, risks and benefits to the 3 'challenges' (as outlined in *why QVH NHSFT is considering joining a hospital group* June 2020) which have been presented as drivers for the Acquisition; especially with regard to the financial deterioration which occurred in financial years ending 2019 and 2020.

2. The NHS and all the work streams and financial streams have returned to a state of pre-covid / 'plain sailing' and 2 full financial cycles can be examined in order to make a clear judgement on the financial drivers for Acquisition.

3. The newly formed UHS NHSFT has properly bedded-in and can demonstrate that it is in good health. (At least 2 financial cycles)

4. A clearer picture / report has emerged about the situation with the run-down of neurosurgical services which were merged / acquired by BSUH NHST some years ago.

5. The new NHS legislation has been completed and passed into law and is properly understood.

6. The trust leadership can provide a transparent account of the quantum of management time and money that is currently being expended on acquisition plans whilst the Trust and the country is still recovering form the covid crisis.

Signed:
Chris Barham, Elizabeth Bowden, Andrew Brown, Tim Butler, Miriam Farley, Oliver Harley, Caroline Migo, Roger Smith, Ken Sim, Alison Stewart, Peter Ward Booth, Thavam Yoganathan

Appendix 2 - 27 July 2021 letter to all governors from the Board

Dear Governors

We are writing to outline the next steps regarding the motion which was voted on at the public Council of Governors (item 65-21) stating
‘’We move that the QVH NHSFT Non-Executive Directors, including the Chair, pause all further activities, meeting, dialogue or expenditure, formal or informal, relating to the proposed Acquisition (‘merger’) of QVH NHSFT by UHS NHSFT until …(6 conditions)’’

With regard to the financial analysis, we have outlined the issues which have led us to the current financial situation on several occasions including at the new governor induction sessions and in a separate meeting between Paul Dillon-Robinson and Oliver Harley, Anita Hazari and Thavam Yoganathan. We will however give further thought on how best to help you understand the background (bearing in mind that financial sustainability is only one of the issues being considered). The motion also makes reference to time and money invested in the process to date. We expect this issue to be covered at the Board meeting and we can of course share with governors after that.

As we mentioned at the CoG meeting we are unable to comply with the broader content of the motion and in particular items 2-5. We believe that acting in line with the motion would place us in dereliction of our duties as directors of the Trust. As directors we are required to ‘act to promote the success of the organisation including designing and then implementing the agreed priorities, objectives and the overall strategy of the NHS Foundation Trust’ (source: The NHS Foundation Trust Code of Governance). To have our hands tied for two years regarding discussions on the clinical and financial sustainability of QVH would put us in breach of this duty.

As you have seen from her letter of 15 July, Anne Eden, NHSI/E Regional Director has indicated that ‘a delay in progressing work on strategic options over such a long time frame will almost certainly have serious adverse consequences for the Trust and its ability to ensure high quality, safe care to its patients’. She also stated that ‘Should the Trust be unable to reasonably make progress in this regard, this may put it in breach of its NHS provider licence, and I would need to consider whether formal intervention by NHSEI is appropriate’.

As board directors of QVH we do not believe that it will be in the best interests of patients if we were to delay any further in seeking a sustainable future for QVH. We will be writing to you shortly outlining the next steps in this journey.

With regard to the motion contained in item 66-21, regarding the Agendas, we have referred this to the Governors Steering Group who are responsible for setting CoG agendas.

With very best wishes
The QVH board

Appendix 3 - 9 September 2021 statement from 13 governors

RE: Board response to Motion for NEDs to Pause Acquisition Activities.

Further to your email of 27th July where you outlined the 'next steps' regarding the Motion to Pause Acquisition activities which was passed at CoG on 19th July.

We strongly disagree with the notion that governors cannot call for a halt to the direction the Board is taking if we as public governors feel that it endangers the long-term provision of services to patients or significantly impacts on the principle purpose of the Trust both of which we strongly believe would be the outcome if the board continues with its acquisition proposal.

To 'hold to account' is defined in English as follows:

To require a person to explain or to accept responsibility for his or her actions; to blame or punish someone for what has occurred.

It therefore follows that until non-exec directors have explained and taken responsibility (and accepted consequences) for their actions they should not continue any activity relating to the Acquisition Strategy.

The board may have chosen to ignore governors concerns however NED's are still obliged to be held to account and proper process followed. Our motion should have been included as an Agenda point at a public meeting, where reasons for the motion were discussed and voted on in an open and transparent manner. As far as we are aware there was no formal vote to uphold, reject, request more information from the CoG or indicate that the motion had been noted and what actions would therefore follow at either the 5th August or 2nd September board meetings.

This motion was passed because we are not at all satisfied or confident in the leadership or direction that the board is taking; nor are we satisfied that the board and NEDs have been following correct processes with regard to the trust constitution.

We are grateful for further recent meetings on 6th and 8th September but **it is our continued and clear position that there is no justification or reason to support Acquisition strategy at present because:**

1. QVH should never even have reached the stage of having to consider acquisition.

2. The distraction and management time related to acquisition plans, must be paused so that the Trust can focus on diagnosing what has happened and explore all possible avenues to return to the financial stability and collaborative independence that QVH enjoyed very successfully in the recent past.

3. A period of time must be allowed for other uncertainties to settle and/or be better understood (Covid, New NHS legislation, recent UHS merger, Neurosurgery department failures, 3T project delays) before reconsidering Acquisition strategy as an option.

4. We are astounded that the 'strategic options evaluation' was only ever intended to consider the option of 'Acquisition' and effectively discounted the other most obvious alternative by calling it a 'do nothing option' - this is entirely inappropriate when, what is really required, a serious, focussed, transparent, competent, management-driven approach to controlling expenditure and improving income and activity capture and

financial efficiencies to return to the financial stability that QVH enjoyed in the recent past.

There has been a serious failure of financial function at QVH and there are serious flaws in the acquisition strategy. This has been compounded by misrepresentation of information refusal to be *held to account* . By ignoring the 'motion to pause acquisition activities' we consider that the Non-executive directors (and, by extension, The Board) have committed a serious transgression of the trust constitution, the ethics of foundation trust governance and the laws applicable to it; there can be no excuse for this behaviour and the Non-Executive directors are asked to comply with this motion with immediate effect.

Yours sincerely

Chris Barham, Elizabeth Bowden, Andrew Brown, Tim Butler, Baljit Dheansa, Miriam Farley, Oliver Harley, Anita Hazari, Raman Malhotra, Caroline Migo, Alison Stewart, Peter Ward Booth, Thavam Yoganathan,

Governors QVH NHSFT

Report to:	Council of Governors
Agenda item:	93-21
Date of meeting:	25 October 2021
Report from:	Caroline Migo, public governor
Date of report:	16 October 2021
Appendices:	1: Revised draft GSG terms of reference 2: Document highlighting extracts from governing documents

Proposal for changes to membership Governor Steering Group

Introduction
The purpose of this paper is to propose amendments to the membership and therefore the Terms of Reference of the Governor Steering Group (GSG).

Executive summary
A number of governors have suggested amendments to the GSG Terms of Reference to allow public governor membership of the GSG to comprise those who have been voted in by the whole Council of Governors. Future voting to be carried out on an annual basis with membership of the GSG open to all Governors

Background
This proposal is being made in light of the Trust's insistence that certain governors sign extra confidentiality agreements to attend the sub committees and the failure to give satisfactory reasons why the confidentiality clauses already contained in the Constitution, standing orders and statutory duties are not sufficient.

Proposal
To amend the Terms of Reference so that public governor membership of the GSG should consist of Governors who have been voted in by the whole Council of Governors.

In order to avoid unnecessary time being spent repeating the voting process carried out in June of this year, we propose that public governor membership of the GSG remains as follows for this term:

Anthony Fulford-Smith
John Harold
Ollie Harley
Caroline Migo
Thavam Ruben
Peter Shore – Lead governor and GSG Chair.

Future voting to be carried out on an annual basis with membership of the GSG open to all Governors.

Recommendation
Council is asked to approve the tracked changes to the GSG Terms of Reference as shown in Appendix 1.

Terms of reference

Name of governance body

Governor Steering Group (GSG)

Constitution

The Governor Steering Group ("the group") is a standing and permanent committee of the Council of Governors established in accordance with paragraph 25 of the Trust's constitution.

Accountability

The group is accountable to the Council of Governors for its performance and effectiveness in accordance with these terms of reference.

Authority

The group is authorised by the Council of Governors to form working groups to facilitate the work of the group, and to support any recommendations they may make to the Council of Governors.

Purpose

The purpose of the group is to:

- Support and facilitate the work of the Council of Governors and make recommendations to it on any aspects of its work
- Facilitate communication between the Council of Governors and the Board of Directors
- Provide advice and support to the Trust Chair, Chief Executive and the company secretarial team
- Initiate appropriate reviews and reports on matters within the remit of the Council of Governors
- Actively engage governors in adding value to the Trust.

Responsibilities and duties

Responsibilities

On behalf of the Council of Governors, the group shall be responsible for:

- Supporting the work of the Council of Governors in order that it might better fulfil its statutory duties, particularly:
    - Holding the Trust's Non-Executive Directors to account for the performance of the Board of Directors
    - Representing the interests of members and the public
- Developing and maintaining close and effective working relationships with the Trust Chair, company secretarial team and Senior Independent Director.

Duties

The group has a duty to consult with and represent the interests of governors and members to:

- Set the agenda for Council of Governors meetings held in public
- Influence the agenda and planning of the annual general meeting and annual members' meeting
- Identity themes and objectives for governor forum meetings.

Meetings

Meetings of the group shall be formal, compliant with the relevant codes of conduct and action notes will be recorded.

The group will meet quarterly in advance of each ordinary meeting of the council of governors. The group Chair may cancel, postpone or convene additional meetings as necessary for the group to fulfil its purpose and discharge its duties.

Chairmanship

The group shall be chaired by the Lead governor

If the Chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the group shall be chaired by the Trust Chair.

Secretariat

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

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

Membership

Members with voting rights

The following ~~governor roles~~ are entitled to membership of the group and shall have full voting rights:

- The Trust Chair, as Chair of the Council of Governors
- The Lead governor
- Up to six public governors, as elected by the Council of Governors
- ~~Governor representative to the committees of the Board of Directors, as elected by the Council of Governors, including:~~
    - ~~Audit~~
    - ~~Finance and Performance~~
    - ~~Quality and Governance~~
    - ~~Charity Committee~~
    - ~~Appointments' Committee, and~~
    - ~~Membership representative~~
- Nominated staff governor, as elected by the Council of Governors
- Nominated stakeholder governor, as elected by the Council of Governors

~~It should be noted that in the event a governor holds more than one role, they are still only entitled to one vote.~~

In attendance with no voting rights

The following posts are invited to attend meetings of the group but shall not be members or have voting rights:

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

- Director of Communications and Corporate Affairs
- Any other individuals as it considers appropriate and as the need arises.
-

Quorum

For any meeting of the group to proceed the Chair or Lead governor must be present along with two other ~~governor representatives.~~governors

Attendance

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

Papers

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

Reporting

Action notes shall be approved formally by the group at its next meeting.

The group shall report to the Council of Governors as required.

Review

These terms of reference shall be reviewed by the group annually or more frequently if necessary. The review process should include the company secretarial team. The Council of Governors shall be required to approve all changes.

The next scheduled review of these terms of reference will take place in ~~December 2020~~October 2022

*** Definitions**

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

Appendix 2: Document from Caroline Migo, public governor, highlighting extracts from governing documents

Constitution
1.4 Matters to be dealt with, following the exclusion of the public and representatives of the press shall be confidential to the Governors or the Directors as the case may be. Members of the Council of Governors, Board of Directors, Officers and/or others in attendance at the request of the Chair shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chair.
5. Confidentiality 5.1. Governors must comply with the Trusts' confidentiality policies and procedures. Governors must not disclose any confidential information, except in specified lawful circumstances, and must not seek to prevent a person from gaining access to information to which they are legally entitled

Standing orders - 21. Confidentiality
21.2 A Governor shall not disclose any matter or business of the Council of Governors notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors shall resolve that it is confidential

Board-level governance: engagement with governors - 3. Guiding principles of engagement
3.4. Governor representatives must observe and maintain confidentiality as directed by the Board of Directors. This will include information that may not be disclosed to other governors and/or to trust staff, foundation trust members and members of the public and press. Advice and support regarding confidentiality can be sought at any time from the Trust Chair/ committee chair(s) and corporate affairs team.

CONDUCT AND BEHAVIOUR POLICY - 4. DISCLOSURE OF INFORMATION AND CONFIDENTIALITY

4.1 Statutory requirements ensure that certain types of information be made available to members of the Board of Directors and Council of Governors, auditors, NHS departments, service users and the public. In addition, the Trust also has guidance on relations with the public and the media, which includes guidance on information which can be regarded as open. Staff and all those persons to whom this policy applies must ensure that they are aware of this guidance and they must act accordingly. If staff are in any doubt, they must consult their immediate supervisor. No confidential information should be released to anyone without proper authorisation. If in doubt, staff should seek advice from the Caldicott Guardian and/or the lead for Information Governance.

Page 23 of Monitors Statutory duties
Provision of information by directors to governors
Directors should ensure that governors receive the information they need to undertake their role effectively. The 2006 Act, as amended, specifies that agendas and minutes of meetings of the board of directors must also be sent to the council of governors. Directors and governors should seek to agree the format for, and level of detail of, such information. Please note that there is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents.

Board meetings held in public
It is a legal requirement for the constitution to provide for meetings of the board of directors that are open to members of the public. However, the constitution may provide

for members of the public to be excluded from a meeting for special reasons. Again this does not mean that governors should not receive the agenda and minutes from these meetings. This imposes a serious duty of confidentiality on governors.

General considerations

Governors have a general duty to represent the interests of members and the public and this includes representing their views in relation to potential: · significant transactions; · mergers; · acquisitions; · separations and dissolutions of the trust; and · increases to non-NHS income. Governors should therefore interact regularly with the members of the trust and the public to ensure they understand their views, and to make sure that they clearly communicate to them information on trust performance and planning. However, governors should take care to disclose only those matters which the trust considers non-confidential.

Report to:	Council of Governors
Agenda item:	94-21
Date of meeting:	25 October 2021
Report from:	Requested by Oliver Harley, public governor
Date of report:	14 October 2021

Current position at Royal Sussex County Hospital, Brighton

Background

At the governor steering group Oliver Harley, public governor, requested that the Council of Governors should ask the NEDs what action they plan to take following a letter (which was leaked to the press) written by consultants working at the Royal Sussex County Hospital, Brighton to their chief executive Marianne Griffiths.

Proposal

No proposal has been made associated with this paper

Recommendation

No recommendation has been made associated with this paper