Document:	Minutes (final & approved)	
Meeting:	**Board of Directors (session in public)** **Thursday 03 March 2022 11:00 via videoconference**	
Present:	Anita Donley (AD)	Trust Chair (voting)
	Gary Needle (GN)	Senior Independent Director (voting)
	Lawrence Anderson (LA)	Interim Director of workforce (non-voting)
	Tania Cubison (TC)	Medical director (voting)
	Paul Dillon-Robinson (PD-R)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Abigail Jago (AJ)	Director of operations (non-voting)
	Karen Norman (KN)	Non-executive director (voting)
	Steve Jenkin (SJ)	Chief executive (voting)
	Michelle Miles (MM)	Director of finance (voting)
	Nicky Reeves (NR)	Chief Nursing Officer (voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
In attendance:	Hilary Saunders (HS)	Deputy company secretary (minutes)
Members of the public:	Two, including lead governor	

Welcome	
32-22	**Welcome, apologies and declarations of interest** The Chair opened the meeting and welcomed TC to her first public meeting since being appointed medical director. The Chair also welcomed two members of the public, including the lead governor. There were no apologies and no new declarations of interest. There was no patient story this month due to changes in the team, but it was anticipated that this will restart as a regular Board item from May.
Standing items	
33-22	**Draft minutes of the meeting held on 06 January 2022** The draft minutes of the meeting held on 6 January were **approved** as a correct record.
34-22	**Matters arising and actions pending** The Board **received** the latest matters arising update. There were no matters outstanding this month.
35-22	**Chair's report** The Chair opened by thanking the Deputy Company Secretary who would be leaving the Trust at the end of March after 18 years with QVH. The Chair moved on to discuss the Board's approach to the recommendations of the independent review. This would be a broad strategic approach and consider the future of QVH as a provider of specialist services nationally and internationally, as a hospital for its local population and as a partner in the ICS. Certain things had changed over the last year and it would be appropriate to consider the sustainability of the organisation in the light of these futures as well as the established five tests (widely expressed in communications as "QVH will only merge if …"). The CEO would be updating the Board around action planning. The Chair also thanked GN who, as senior independent director, was working with NEDs to consider how the relationship between NEDs and governors could be reset and improved.

	There were no further comments and the Board **noted** the contents of the report.

36-22	**Chief Executive's report**
	SJ opened by noting this would be AJ's last meeting as director of operations. He commended her attention to detail, planning, ability to connect to people, and espousal of the QVH values and thanked her for everything she had achieved during her time here.
	
	SJ went on to commend efforts by the executive team and frontline staff during the recent water shortage.
	
	The Board received the CEO's report, seeking additional clarification as follows:
	• That the main implications for QVH arising from the 'Delivery plan for tackling the COVID-19 backlog of its elective care would include:
	  • A key challenge due to theatre capacity constraints and workforce capacity is to deliver around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer. Commissioners were leading on efforts to secure additional long term capacity within the independent sector but this remained an ongoing challenge.
	  • Good progress had been made in respect of theatre productivity, particularly around late starts but there was always room for improvement and efforts were ongoing. Theatre utilisation is reviewed monthly via the Surgical Pathway and Performance Group. Early finishes have been significantly impacted recently by short notice patient cancellations and the challenge to fill vacant slots. Work is currently being undertaken with Pre-Assessment to create a group of patients who would be available at short notice.
	  • QVH is an early adopter for a community diagnostic centre; the NHS has committed to rolling out more than 100 diagnostic centres.
	• The integration white paper sets out the government's ambition to accelerate the delivery of joined-up health and social care at place level as a way of improving health and care outcomes, and making best use of public resources.
	  • The Secretary of State had told integrated care systems (ICS) to draw up detailed plans for a single electronic patient record, with a target of 90% of trusts to have installed an EPR by December 2023 and the remaining 10% to be in the implementation phase by that point. Support would be offered to help all providers reach a minimum level of digital maturity; QVH is quite some way behind other trusts in Sussex, having been unable to secure capital to do the work and the Board will shortly be receiving more detail on work required.
	
	There were no further questions and the Board **noted** the contents of the report.

Trust strategy	
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services	
37-22	**Board Assurance Framework** The Chief nurse and medical director presented their respective BAFs. The Board **noted** that there were no significant changes to either KSO1 or KSO2 on this occasion.
38-22	**Quality and governance committee assurance** Due to reporting deadlines this month, KN had been unable to submit a written report of the February Q&GC meeting; instead she provided a verbal update highlighting the following: • The Committee had undertaken its annual effectiveness review, assessing performance against objectives. Good assurance had been received on the whole. As Chair, KN

	would work with the Chief Nurse to take forward suggestions to strengthen decision making processes and ensure their timely execution.
	• The Committee wished to have an update on our anticipated system of quality improvement; it was noted that SJ had subsequently circulated a proposal for consideration.
	• A discussion around CQUIN targets. These were not set by the Trust and the Committee recognised a balance between national and local priorities.
	• The latest Quality and safety report including:
	  • An external review of the Sleep Disorder Unit which was now complete.
	  • Health Education England (HEE) funding for plastic surgical trainees
	  • Ongoing challenges with recruitment and turnover of nursing staff; this remained one of the top corporate risks.
	
	There were no further comments and the Board **noted** the content of the update.

39-22	**Corporate risk register (CRR)** The Board received the latest corporate risk register. In response to a question about the unusually high number of new risks on the register, the Chief nurse explained that the Trust encourages a positive reporting culture. The register is dynamic with many risks moving on and off relatively quickly. Changes in personnel also result in an increase in reporting as they review risks from a different perspective. Scoring is appropriate and we should avoid dis-incentivising anyone from reporting. Noting new risks (1247, 1251 and 1253) the Board sought assurance as to whether a systematic problem was emerging in the patient tracking and records systems. AJ provided the following assurance: • 1247: The wording around this risk was ambiguous and would be amended. Most tertiary referrals come into the Trust via email but on this occasion a small cohort of patients had been referred via letter and had not been actioned immediately. This oversight had been identified at the monthly PTL meetings. All patients had now been reviewed and checked and work was underway to improve the system. • 1251: some patients are referred via a non-cancer pathway and then escalated. They are still managed as urgent cases but an upgrade to the tracking system is required which is why this is currently on the risk register. To ensure compliance, risk has been fully cascaded to teams within the Trust, as well as the Cancer Board. • 1253: Patients have been added to the waitlist and are all awaiting surgery on the PTL. There are some areas where the process is 'clunky' and the team is working towards managing this cohort electronically. • A recent data quality audit showed substantial assurance. The Board was advised that action is being taken following increased awareness of potential cyber-attacks. Additional detail would be added to the register to reflect the actions being taken. A risk rating of 15 would be in place for the foreseeable future. The Board was also assured that risk 1250, (additional licence conditions), will be updated to make clear that the independent review was jointly commissioned by NHSEI and QVH interim Chair, and the target risk should read zero. There were no further comments and the Board **noted** the contents of the recent update.
40-22	**Quality and safety report** The Board received the latest Quality and safety report and sought additional clarification as follows: : • Although only recently appointed to the role of medical director, TC had worked closely with NR throughout the pandemic and both were already clear on clinical engagement

	priorities. They would also ensure that nursing and medical teams worked collaboratively. The Board was reminded that the term 'Clinical' refers to all staff not just doctors, and work was underway to determine how best to align teams at executive level and throughout the wider organisation. • TC described the actions being taken to ensure compliance with essential antimicrobial stewardship standards. A new microbiology pharmacist was now in post. Clinical leadership from consultants was key and plans were underway to maximise clinical engagement throughout the wider organisation. • A regular topic raised at Board was the Clinical Harm Reviews (CHR) and assurance was sought around the impact of the new requirement for all 52-week waits to be reviewed every three months. TC stated that in order for clinicians to prioritise their time appropriately it was important to understand the risks associated with delay. Work was ongoing to ensure the process was easier and more transparent, but time would be needed to gather important data for a better understanding of the different type of patients under review. NR reminded the Board that CHR is a high priority, with the process continually evolving, but in line with other organisations, QVH would continue to target resources where most needed. It was again highlighted that the CHR tool identified only potential physical, not psychological, harm. There were no further comments and the Board **noted** the contents of the latest update.
41-22	**Approval of updated corporate risk strategy** The Chair noted that that together with the CRR and BAF, this was an important foundation for the way in which a Board considers its risk appetite. NR stated that a number of iterations to reflect feedback had been made since this document was reviewed at the Board seminar in December. Board members had received the draft reviewed at this week's Quality and governance committee meeting. The strategy was presented for approval today subject to the following small amendments: • A check to ensure that risk management was reflected throughout the whole document; • Rewording of part of the risk management approach, with patient and staff safety during the pandemic to include reference to accelerated recovery and transformation plans. • The Board would monitor the three corporate risks via the CEO report; any confidential matters would be considered during a closed session. • Clarity on risk appetite; • Sections 6 and 7 to be combined. • Narrative around how the Board collates evidence to measure performance, maybe as an appendix. This would also be included in the annual risk management report. The Board considered the latest update, noting that: • Inclusion of the Good Governance institute six principles of risk management was helpful, with principles 1 and 3 of particular priority to enhance our ability to mitigate and manage risk effectively. • An item for a future seminar might be areas where the Board is prepared to take more risk and whether our risk appetite needed a reset in the light of the pandemic and of the new risks being introduced on a regular basis. There were no further comments and the Board **approved** the corporate risk strategy, subject to the agreed amendments.
42-22	**Health care worker flu vaccination information** The Board received an annual update regarding the 2021/22 seasonal flu campaign; this highlighted an overall increase in vaccination numbers across the workforce, a decrease in seasonal flu vaccination uptake in some staff groups and the plans to address challenges for the 2022/23 campaign.

	There were no further comments and the Board **noted** the contents of the report.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
43-22	**Board assurance framework** The Board received the latest BAF for KSO3, **noting** there were no material changes on this occasion. The Board received the BAF for KSO4, **noting** that there were currently no material changes. However, a significant review would be undertaken shortly, aligned to the new 2022/23 financial regime.
44-22	**Financial, operational and workforce performance assurance** Due to reporting deadlines this month, the report within the papers related to the January F&PC meetings; therefore, PDR provided a verbal update on the February meeting, highlighting in particular: • Whilst not complacent, the committee had strong received assurance that QVH continued to perform very well against national targets. • Overall waitlist numbers are increasing which will inevitably result in problems in the summer. • Staff vacancies remain a concern and will continue to be monitored. • Originally the Trust was forecasting breakeven at MO09; at MO10 however, it was predicting a £1.2m surplus, with c£300k for technical adjustments. Expenditure was under control and the run rate remained consistent, however there is still significant uncertainty around income. • Whilst business planning was a later agenda item, the Board noted that the finance regime would be much tougher next year, with the block contract being discontinued. There was still a lack of clarity around income, dental commissioning etc. but more information should be available next month. Demand and capacity modelling was underway and the new modular theatre block would provide additional capacity. The Trust would also await the impact of the ICB after it comes into operation. There were no further comments and the Board **noted** the contents of the report.
45-22	**Operational performance** The Board received the latest operational report. There was a brief discussion as to whether the Trust was meeting NHS constitutional requirements in respect of the RTT18 figures and the requirement to identify alternative providers. AJ explained that: • Given the change in focus away from 18 weeks, the Trust had deliberated as to whether or not to retain reference to this within the report but had concluded this was still a useful comparator for waitlists. • It was difficult to identify alternative providers, firstly because other trusts were in an equally challenged position and secondly due to the nature of our work as regional providers for many services. • The Trust has tried to locate additional independent sector capacity but with limited success. • The Trust had worked with the wider system and provided mutual aid for diagnostics and in respect of cancer services. QVH had played an important role in the pandemic, ensuring cancer patients received vital urgent surgery at times when other trusts had significant numbers of covid patients; this had meant surgeons from other hospitals in Kent, Surrey and Sussex working with the QVH theatres team at QVH. The Board was assured that all cases were managed around clinical urgency and long waits; no decisions were made on the basis of where a patient was from.

	The Board welcomed the health inequality workstream on early diagnosis. AJ explained that IMD is the Index of Multiple Deprivation (national official scoring of deprivation which ranks every small area in England, with 'one' as the most deprived). There were no further comments and the Board **noted** the contents of the report.
46-22	**Financial performance** MM presented the latest financial performance report; the Trust now predicted a £1.2m surplus, with c£300k a technical adjustment. Changes were as a result of the Trust stepping up to operate as a cancer hub earlier this year, and also staff vacancies (which had remained static). Capital surplus had increased and efforts were being made to reduce this before the end of the financial year. The Board considered the update and received the following assurance: • That the organisation was reasonably confident it had the capacity to deliver projects funded from successful in-year bids, noting that the majority of goods were due for delivery this month. • That the transfer of activity/case mix to QVH in Q4 as a cancer hub had meant the usual run rate was not as high as in previously quarters; hence the enhanced forecasting this financial year. • A reminder that the current surplus was due to a significant increase in income due to block arrangements, but fundamentally the run rate had not changed in the last three years. There were no further questions and the Board **noted** the contents of the report.
47-22	**2022/23 planning update** The Board received a summary report of the planning principles being applied and the local and national milestones in the planning process for 2022/23. The Board noted: • No risks were currently identified to delivering against these principles; triangulation between workforce, activity and finance was ongoing. • Although work was already underway, the organisation would find it difficult to deliver efficiencies of around 3-4%. • First submission of the operating plan was due on 17 March, with the final due on 28 April. A draft plan would be considered at the board seminar in April. Due to the submission deadlines, the Board **agreed** to delegate authority to the Finance and performance committee to approve the plan at the end of April. There were no further questions and the Board **noted** the contents of the report.
Key strategic objective 5: organisational excellence	
48-22	**Board Assurance Framework** LA reported that there were no significant changes to the BAF for KSO5. Reference to 'Vaccination as a condition of employment' would remain until regulations had been formally reviewed. The Board asked what action was being taken to manage staff appraisal targets, and what were the consequences of staff not meeting pay progressions due to lack of appraisal. LA explained that appraisal rates and quality were assessed and assurance sought as part of performance review meetings. The Trust's pay progression and appraisal policy has been in place for some time and to date no one had been refused pay progression as a result of not yet having had an appraisal. Workforce teams are proactive in identifying any staff at risk and take the necessary action.

	There were no further comments and the Board **noted** the contents of the BAF.
49-22	**Workforce monthly report** The Board received the latest report, seeking additional clarification as follows: • The decision to introduce a new starter premium payment was taken by the Executive management team, alongside the introduction of revised bank rates and a winter shift supplement payment. This now formed part of our attraction package on posts advertised that are included on the Trust's Risk Register. • Staff survey results are embargoed until 30 March; however, detail will be provided to board members in confidence prior to national publication. There were no further comments and the Board **noted** the content of the report.
Governance	
50-22	**Board effectiveness review** As a requirement of the FT code, the Board reviewed a formal evaluation of its performance; this had been structured to identify areas for improvement and to consider any actions needed to ensure that it retained the skills and experience needed to lead the organisation. The report was structured around the eight key lines of enquiry of the Care Quality Commission's well led domain. There were no further comments and the Board: • **Agreed** the contents of the review, noting that detail would be included in the 2021/22 annual report and accounts. • **Approved** the Board sub-committee terms of reference for the next twelve months which would come into immediate effect, noting that these would be updated to reflect the Chief Nurse title.
51-22	**Changes to Trust constitution** A series of changes to the Constitution relating to the lead governor role had been approved by the Council of governors at its meeting on 21 February. As required by the Constitution the Board now also **approved** these changes which could take immediate effect. A second set of changes relating to the governor steering group were also proposed. The Board **approved** these noting that they would be presented for approval to Council at its meeting on 11 April after which time they would also take effect.
52-22	**Annual report on use of Trust seal** The Board noted the contents of the annual report on the use of the Trust seal.
53-22	**Nomination and remuneration assurance** The Board noted the contents of the Chair's report.
Any other business (by application to the Chair)	
54-22	There was none.
Members of the public	
55-22	**Questions from members of the public** There were none.
56-22	**Exclusion of members of the public** Aligned to paragraph 39.1 and annex 6 of the Trust's Constitution, members of the public and representatives of the press were excluded from the remainder of the meeting for the purposes of allowing the board to discuss issues of a confidential or sensitive nature.

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