

<b>Document:</b>	<b>Minutes FINAL &amp; APPROVED</b>	
<b>Meeting:</b>	<b>Board of Directors (session in public) Thursday 30 October, 13.00 – 15.15, The Dove Suite, The Ark, Turners Hill, West Sussex RH19 4RA</b>	
<b>Present:</b>	Peter Griffiths (PAG)	Chairman
	Lester Porter (LP)	Non-Executive Director
	John Thornton (JT)	Non-Executive Director
	Ginny Colwell (GC)	Non-Executive Director
	Richard Tyler (RT)	Chief Executive
	Stuart Butt (SB)	Interim Director of Finance
	Amanda Parker (AP)	Director of Nursing & Quality
	Steve Fenlon (SF)	Medical Director
<b>In attendance:</b>	Graeme Armitage (GA)	Head of Human Resources & Organisational Development
	Lois Howell (LH)	Interim Head of Corporate Affairs & Co Sec
	Brian Goode (BG)	Governor Representative
<b>Apologies:</b>	Beryl Hobson (BH)	Non-Executive Director and Chair Designate
	Jane Morris	Interim Head of Operations

## WELCOME

<b>256-14</b>	<p><b>Welcome, apologies and declarations of interest</b> The Chairman opened the meeting and welcomed everyone present.</p> <p>Apologies had been received from the Beryl Hobson (attending an FTN induction event for new Chairs) and Jane Morris, Interim Head of Operations.</p> <p>There were no declarations of interest.</p>
---------------	---

## PATIENT STORY

<b>257-14</b>	<p><b>Patient Experience</b> AP shared details of feedback received through the NHS Choices website about care on Margaret Duncombe ward. The patient in question had reported excellent and compassionate care at all stages of her experience, but made emphatic comments about the quality of the food she had been offered as an in-patient.</p> <p>AP reminded the board that there was a project in hand to improve the food provided to patients.</p> <p>The Chairman thanked AP for her update and the board <b>NOTED</b> its contents.</p>
---------------	---

## STANDING ITEMS

<b>258-14</b>	<p><b>Draft minutes of the meeting session held in public on 25 September 2014 for approval</b> GC sought to correct minute 225-14 to read: “GC apprised the board of an update to her declaration of interests. GC is a non-executive director of CSH Surrey, a social enterprise providing services to the NHS in Surrey. In partnership with BUPA, CSH Surrey has won a contract to provide musculo-skeletal services in the region. Queen Victoria Hospital NHS Foundation Trust may in future provide services under or in connection with that contract.”</p> <p style="text-align: right;"><b>ACTION - LH</b></p> <p>AP provided an update to minute 238-14 – since the board approved a statement of readiness in respect of emergency preparedness, resilience and response at its last meeting,</p>
---------------	---

	<p>the Deputy Director of Nursing, Ali Strowman had attended a regional meeting of the Emergency Planning and Resilience Forum, at which QVH's submission to NHS England had been well received.</p> <p>Subject to GC's revision, the minutes of the meeting were <b>APPROVED</b> as a correct record.</p>
<p><b>259-14</b></p>	<p><b>Matters Arising &amp; Actions Pending</b> The board reviewed the current record of matters arising and actions pending and the document was updated as appropriate.</p> <p>The update was received and <b>APPROVED</b>.</p>
<p><b>260-14</b></p>	<p><b>Update on behalf of the Chief Executive</b> RT drew attention to the fact that this was his first written report to the board, and replaced his usual verbal update. The written report will also be passed to the Governors as a useful summary of key board issues and concerns.</p> <p>RT's report drew attention to staffing issues, noting a current vacancy rate of 12.4%, leading to increased use of bank and agency workers to ensure that staff levels remained safe. Although safety had been maintained, an increase in feedback about 'uncaring' staff had been seen in the Friends and Family Test results and for these reasons collectively, RT had asked the Head of Human Resources and Organisational Development (HR &amp; OD) to review and as necessary revise the Trust's approach to recruitment and retention urgently.</p> <p>RT also commented on below plan levels of income in August and September, arising from reduced levels of in-patient activity. The Director of Finance has been asked to examine the reasons for this so that the Head of Operations can take remedial action in months 7 to 12.</p> <p>In respect of the 18 week wait issues, RT was able to confirm that the number of patients waiting more than 18 weeks had reduced, but that the trust had not reached the sustainable position it had hoped to have reached by the end of Q2. A plan to address the continuing backlog had been produced for board approval (later on the agenda) and commissioners had agreed to pay for extra activity during November.</p> <p>RT reported on a number of developments related to the trust's future business plans. He had responded supportively on behalf of the trust to the local Clinical Commissioning Group's consultation document, the <i>Five Communities Plan</i>, and it was noted that plans for the possible development of community services would be discussed by the board under a separate agenda item. NHS Specialised Commissioning had sanctioned a further year of derogation from the national standard for burns units following a very positive review of the trust's service by the London and South-East Burns Network. The Trust will be working with an offshoot of the Department of Health and UK Trade to consider ways in which it can develop products and services for the overseas market.</p> <p>In respect of international and national concerns about the Ebola virus, RT advised that the trust will be participating in a county-wide resilience exercise on the day of the board meeting in order to ensure that it is in a position to contribute effectively to counter-measures.</p> <p>As an aside to recent press reports concerning low levels of achievement by many trusts against the standards required by the Care Quality Commission (CQC), RT reminded the board that he had commissioned the Director of Nursing and Interim Head of Corporate Affairs to review levels of compliance, and associated evidence of that compliance, within the trust in anticipation of an inspection at some point next year.</p>

	<p>RT’s written report concluded by highlighting two recent publications which may be of interest to board members – the Dalton Review and Monitor’s Board Strategy Guide.</p> <p>RT also brought two additional items, not covered in his report, to the board’s attention.</p> <p>Simon Stevens, Chief Executive of the NHS, had recently published his “5 Year Forward View” (5YFV). RT noted that the trust’s own plans for the same period fit well with the NHS-wide plan.</p> <p>AP and RT attended a meeting with Jamie Reed, Shadow Health Minister, about the shadow government’s views on the role small hospitals will play in the future of the NHS. RT had been reassured to note that the Labour party seems broadly to value the benefits that smaller hospitals can bring to the national health economy, particularly in collaboration and partnership with others.</p> <p>The chairman thanked RT for his report and invited comments. The non-executive directors expressed their thanks for the report and said they found it very helpful.</p> <p>GC asked how the current review of compliance with CQC standards mentioned in the report will be fed to Quality &amp; Risk (Q&amp;R) Committee. AP advised that this will happen later, once the review of evidence has been completed. It was noted that this may lead to a review of the way in which the Q&amp;R Committee operates.</p> <p>BG sought, and received, confirmation that RT’s new style report would be routinely distributed to Governors as a stand-alone document, in accordance with discussions which took place at the Governor Forum earlier in the month.</p> <p>Board members agreed, in reference to the Dalton Review, that the mutual model may well be a useful vehicle for Trust activities in future, notably in respect of partnerships and collaborations for the delivery of GP and community service. Further statements about mutual models and associated funding streams would be considered as and when they are published.</p> <p>LP asked about the extent of the investigation of overseas markets as mentioned in RT’s report. RT advised that all options, including the potential both for overseas patients to be treated privately at QVH and QVH satellite clinics to be established abroad, were under general consideration at this stage.</p> <p>The Chairman thanked RT and the board <b>NOTED</b> the contents of his update.</p>
--	---

RESULTS AND ACTIONS	
<b>261-14</b>	<p><b>Patients: safe staffing and quality of care</b></p> <p>AP presented the monthly update on Patient care, highlighting the following issues:</p> <ul style="list-style-type: none"> <li>• <u>Safe staffing</u> Safe staffing levels were achieved throughout September; however, there are relatively high levels of vacancies, leading to increased use of bank and agency staff. As indicated in the Chief Executive’s report, the Head of HR and OD is to address these issues as a matter of urgency. AP noted that difficulties in recruitment are national – QVH has particular issues because of its small scale and its associated lack of ability to “cross-cover” between wards and departments.</li> </ul> <p>PG asked about the impact of staffing levels on quality, but was advised by AP that</p>

although there had been two grade two pressure ulcers in the last month and numbers of falls had increased (mainly falls that did not cause harm), it was difficult to link these to increased use of agency and bank staff.

In response to a query, AP confirmed that the Safe Staffing table set out at page 20 was the dataset the trust is required to submit to Department of Health every month indicating the percentage of shifts during which safe levels of staffing were maintained.

RT drew attention to the fact that although the trust could generally deliver safe levels of staffing during any given shift by moving individual nurses and healthcare assistants around, the employees involved did not necessarily experience those circumstances as optimum working arrangements because they could be working with unfamiliar teams and colleagues and in unfamiliar environments. The resulting pressure may have a detrimental impact on both staff and patient experience, and should be avoided where possible.

- Quality & risk management

AP reported back on the results of an investigation into a previously reported Never Event involving the erroneous extraction of a tooth from a 15 year old patient at a QVH run clinic at Medway Maritime Hospital. The investigation showed that the surgeon had removed an already erupted tooth, but had failed to take into account an un-erupted tooth when counting to identify the correct tooth to extract. AP advised that changes had been made to procedures and documentation to reduce the risk of this happening again.

AP also advised that a serious incident involving a patient fall in the car park, resulting in a fractured hip, had occurred, and had been reported to the Clinical Commissioning Group (CCG) as appropriate.

- Complaints, claims and patient experience

Complaints had increased during September, and staff attitude had been identified as a theme. Action had been taken in respect of individual members of staff found to be at fault, and good customer care is emphasised during staff induction and other training. AP advised that the net promoter score for the Friends and Family Test (FFT) would be abandoned nationally next month so in future the FFT figures would be easier to understand. AP also drew attention to the trust's cancer survey results, which were extremely good and had resulted in some very positive press coverage for the trust. Action plans were being developed for the areas where improvement on the scores was possible.

- Commissioning for Quality and Innovation (CQINs)

The trust is continuing to score well against most CQINs, although there was a drop in levels of positive feedback in the Friends and Family Test and the number of responses received. The results reflect the issues associated with the increase in complaints and will be addressed in the same ways.

PG asked why some areas were experiencing only low levels of completion of FFT forms by patients. AP assured the board that despite this, the trust had achieved the response rate necessary to trigger the associated CQIN payment. Nevertheless, the trust is continuing to seek to increase participation, including in outpatient areas (which it will be required to do from April 2015). It was clear that there is a need to switch from the current paper based methodology because it is too resource intensive. A mixture of methods including electronic, text/SMS and paper means of feedback is likely to be introduced in next few months, subject to the outcome of a current assessment of the associated costs and benefits.

AP also indicated some concerns about achievement of CQUIN payments associated with the quality of trust food; although there is improvement work in train it is unlikely to have a significant impact until the Quarter 3 scores.

Compliance against the World Health Organisation (WHO) checklist was also noted as a risk because of lower than expected levels of completion in the last quarter.

- Quality account priorities

Performance against priorities 1 and 4 was reported as in line with plans, although some concerns about achievement of the targets for the number of operations cancelled on the day and booking patients three weeks in advance of their treatments were noted. AP reported that she was working with the interim Head of Operations to address these issues.

- Clinical indicators

Two grade 2 pressure ulcers had been reported; both were under investigation. A fall which occurred in the hospital car park has been reported as a Serious Incident (SI) as it had resulted in a fracture.

Two other SIs had been reported in the week before the board and were under investigation; one involved a permanent loss of sight, possibly arising as a complication of surgery, and the other was associated with a former patient who had been admitted to Worthing Hospital with possible Legionella. An urgent investigation was under way to establish whether there could be any links between the patient's previous spell in QVH and his current condition – all early indicators suggested that QVH is not the source of his infection.

AP advised that an apparently poor score against prompt falls assessments appears to be due to poor wording on the audit sheet (the question asks whether the patient has had an assessment within the last 24 hours, rather than within 24 hours of admission, as required), and as a result the audit would be repeated once the audit tool had been revised.

Investigation of the two previously reported Never Events continues, and has already resulted in the introduction of checklists to improve preparation for procedures.

AP was pleased to report that there had been no further infection outbreaks in the Burns Unit.

AP's report also included a schedule setting out the governance framework and indicating the fora in which safety, patient experience and clinical effectiveness, the three main elements of quality, are considered.

JT drew attention to the ten complaints received in September and asked whether this was a usual number. AP advised that the trust usually receives about six complaints in a month. AP went on to say that setting a target for the reduction of complaints can be counter-productive; it is important that patients feel able to raise concerns and give honest feedback and that working to suppress complaints would mean that the trust and board did not get an accurate picture of patient experience.

BG noted that there was a significant difference in the number of falls which occurred on Ross Tilley ward and Margaret Duncombe ward. AP explained that this was associated with the patient mix in these areas. Margaret Duncombe ward usually looks after more elderly patients who are more prone to falls.

	<p>The Chairman thanked AP for her update, the contents of which were <b>NOTED</b> by the board.</p>
<p><b>262-14</b></p>	<p><b>Operational performance: targets, delivery and key performance indicators</b>  On behalf of JM, SB reported that trust income was, regrettably, below plan for September, and that during the month all three aggregate 18 week wait targets had been missed. It was also unlikely that the targets will have been met in October, or can be met in November. However, there had been a reduction in the number of patients waiting more than 18 weeks for treatment.</p> <p>SB outlined the measures being put in place to support delivery against the 18 week targets from December, which included:</p> <ul style="list-style-type: none"> <li>• increasing administrative resource to relevant teams</li> <li>• employing agency staff to complement trust rotas</li> <li>• pooling lists between consultants</li> <li>• putting on extra clinics and operating lists</li> <li>• improving the reliability and timeliness of coding</li> </ul> <p>The trust had also failed two key cancer targets during August:</p> <ul style="list-style-type: none"> <li>• 31 day subsequent treatment</li> <li>• 62 day wait</li> </ul> <p>JM’s report highlighted the fact that low patient numbers meant that problems in only a very small number of cases had a significant impact on the percentage compliance scores. The trust is also vulnerable because referrals often come via other organisations and do not reach QVH promptly. Actions in hand to address cancer waiting times include:</p> <ul style="list-style-type: none"> <li>• resolving listing issues with administrative and junior medical staff</li> <li>• liaising promptly with other trusts when late referrals are received</li> <li>• covering a sickness absence</li> <li>• reviewing data collection processes to streamline them more effectively</li> </ul> <p>SB referenced the impact on cancer services of the level of service received from other trusts, including pathology and surgeons. SB highlighted the difficulties in getting value for money under existing service level agreements (SLAs), and noted that it was difficult to manage performance in this area and a number of others. RT agreed that there is a need to review SLA and “hub and spoke” arrangements generally as they have a significant impact on the Trust’s ability to deliver against a number of targets.</p> <p>RT also noted that it is important to ensure that there is someone in the QVH commercial team who “owns” each arrangement, with support from the operational and clinical teams. LP said that in his experience, relationship management is as important as contract management to getting value for money and key deliverables out of a contract or similar agreement. RT observed that at a senior level the relationship between the Trust and its partner Brighton &amp; Sussex University Hospitals NHS Trust (BSUH) was strong and ever improving, but that it was necessary to ensure that there is a good combination of strong relationships and robust contract management.</p> <p>AP drew attention to problems at a national and regional level with recruitment, which had led to lack of some of the necessary resources on the provider side. SF noted that in other arrangements QVH is the provider and may itself be guilty of causing similar issues in consumer organisations for similar reasons.</p> <p>The Chairman thanked SB for presenting JM’s report, the contents of which were <b>NOTED</b> by the board.</p>

263-14

**Financial performance: monthly update**

SB advised that board that the trust remains £342k ahead of the planned surplus for the year, but that income in September had been £225k below plan as a result of a downturn in patient related income. A review of the elective patient pathway is underway to help identify causes and solutions for the lower than plan performance.

SB also drew attention to difficulties in forecasting income levels over the next few months, but noted that if current surplus levels can be maintained, the remainder of the year should align with recent predictions for year-end.

SB went on to discuss the outcome of the Board's previous request for him to look at the potential release of 2013-14 provisions and the options for supporting additional non-recurrent expenditure. He advised that there are two main sources of non-recurrent funds likely to become available this year: firstly, c£200k-£400k from improved debt collection, and secondly c300k-£600k could be released from the provision set aside for the potential non-payment of the emergency rate threshold by Clinical Commissioning Groups (CCGs).

The Trust's contract now provides for the emergency rate threshold to be applied on a QVH-wide basis, ie, once the Trust reaches the levels of activity provided for in the contract, 70% of income will be re-paid to the commissioning CCGs. However, some of the 21 CCGs with which the Trust contracts still wish to recoup funds if QVH activity related to their own patients (rather than all patients from all CCGs) goes above contractual levels. As a result, a £600k provision had also been made in case of insistence by individual CCGs on application of emergency rate threshold.

SB reported that the lead CCG is happy with the current contractual arrangement, but that those CCGs which send a lot of work to QVH, and might therefore expect to receive a significant rebate, are less so. However, the contract is now in place and the provision should not therefore be needed.

Therefore, there is now a potential for the Trust to have £300k - £400k of debt provision, plus £600k of unneeded reserve, available and could consider or plan to spend half of that.

Suitable potential projects had been identified, including removal of the PKL building and demolition of the Maud Barclay building. Each of these items would cost in the region of £200k - £250k. Both would be non-recurrent, and both beneficial to the Trust because they would take costs (rent in the case of the PKL building, maintenance costs in respect of the Maud Barclay building) off the Trust books for the coming year. SB advised that if the board is in broad agreement with these options, he would continue to investigate them.

SB suggested it would be prudent to plan on releasing around £500k and that these funds could be used to pay for the disposal / demolition mentioned above and provide additional operational support in improving waiting times. The Board accepted the proposal to utilise these funds and was assured that the remaining provisions fully reflect the financial risk for which they were created.

SB reminded the Board of the review of income levels associated with elective activity mentioned in RT's report. It was important to establish whether the below plan performance was due to over-ambitious planning, a drop-off in referrals or unhelpful case mix. One of the potential reasons identified so far was the late opening of Theatre 11.

In respect of the balance sheet SB advised that the Trust's cash balance continued to be strong, due in part to slippage of spending plans and to debt recovery.

	<p>GC asked whether demolition of the Maud Barclay building would reduce fixed assets. SB confirmed that this would be the case but not materially so. The PKL building is not an asset, but the Trust would need to pay for its removal.</p> <p>LP noted that the Maud Barclay building's association with the Trust's history would always be an emotive issue and SB assured the board that any content of archival value would be removed and retained. RT added that Maud Barclay's name, which was particularly dear to the League of Friends, would not be lost from QVH.</p> <p>PG asked whether Monitor would have concerns about the Trust's current high levels of cash. SB advised that this was unlikely as long as the Trust was meeting other financial targets and requirements.</p> <p>BG queried the size of the sum that could potentially be recovered by the CCGs under the Emergency Rate Threshold. SB indicated that the reserves would cover it, and that negotiation of challenges to invoices issued by the Trust to the CCGs last year had been successful.</p> <p>JT commented that costs are above plan, adding to the impact of below plan income, and drew attention to the report's mention of action plans which reference controls on pay and increased accountability for spending. SB advised that in general costs were being reasonably well controlled under each budget, but there had been a few one-off, difficult to control, costs. The main problem had been extra payments to medical staff to ensure appropriate levels of cover. As currently set, budgets do not include provision for absences arising from holiday, sickness or training amongst medical staffing, unlike nursing staff. It is difficult not to cover medical staff absences because of the associated loss of income and poor patient experience if lists and clinics are cancelled. The largest element of the £250k overspend was £200k spent on junior medical staff cover.</p> <p>RT noted additionally that using registrars to cover consultant absences is not always beneficial because it often results in a reduction in case mix. It was agreed that the Trust needs to plan more realistically, and that consultants are not on site 52 weeks per year.</p> <p>The Chairman thanked SB for his comprehensive update the contents of which were <b>NOTED</b> by the board.</p>
<p><b>264-14</b></p>	<p><b>Workforce</b></p> <p>GA presented the Workforce report for the month, highlighting areas of significance as follows:</p> <p><u>Turnover</u></p> <ul style="list-style-type: none"> <li>• Turnover remains above plan and higher than 12 months ago; the issue is not trust-wide, but localised to Burns, ITU, Theatres and the wards in the Canadian Wing.</li> <li>• High vacancy levels are leading to increased use of bank and agency staff to ensure safety.</li> <li>• A recruitment 'task and finish group' has been established to identify and tackle the problems of recruitment in hot-spot areas, and to improve the recruitment process. The new Deputy Head of HR is focussing on the development and implementation of initiatives on recruitment.</li> <li>• The Medical Staffing team has revised the tracking system which provides detail on vacancies and appointments – some managers can now see this at all times, and this level of access will be rolled out to other managers in due course.</li> <li>• The recruitment metrics set out in the report are a work in progress, but it is planned to include headlines from tracking systems in all future papers.</li> </ul>



	<p><u>Sickness</u></p> <ul style="list-style-type: none"> <li>Sickness absence increased during September but the number of cases associated with stress (a concern in previous months) has reduced considerably. GA noted that sickness absence rates have actually improved during October. Better analysis of trends, and prompt action to address short term absence. Plus focus on supporting managers to deal with long term</li> </ul> <p><u>Training</u></p> <ul style="list-style-type: none"> <li>Training levels have improved again in September, and work to ensure that staff are only required to complete the training appropriate to their role continues. Support for managers in monitoring and ensuring compliance is also improving, although the systems and metrics are still work in progress.</li> </ul> <p>GC said she was pleased to hear that there is someone in post in HR to focus on recruitment, but reminded GA that the Trust must also address the issue of staff leaving within a short time of their appointment. She stressed that it is important for the Trust to understand why some staff leave so quickly, and wondered whether it is because there are high levels of core stability meaning that there is a cohort of very long standing staff in some areas, working in very close clinical teams – it may be difficult for new staff to settle into these teams.</p> <p>GA agreed that in general stability is high, and recruitment and turnover issues are limited to a few specific areas. The task and finish group will look at known issues, such as grade mix and the incentives on offer in other organisations (recruitment and retention premia). He noted that there are also quite high levels of movement within the organisation. GA told board members that in his view a healthy turnover rate would be around 11 – 12%, but that the Trust’s is currently nearly 15%, and that since the end of July 90 people had left the Trust and 99 people had started. It was noted that 43 of the leavers had been junior doctors moving on as part of their rotation, but nevertheless it would be important for the trust to hold on to those 90 new employees.</p> <p>RT noted that the turnover section of the report (at p 83) gives a number of reasons for people’s departure from the Trust; many are leaving for career progression reasons. QVH has limited opportunities for progression because of its size. RT suggested that there may need to be a review of job descriptions, for example moving administrative tasks (eg clerking out-patients etc) out of junior doctor roles into others to make more medical capacity, and making other roles more attractive.</p> <p>JT observed that a focus on retaining staff to reduce turnover costs would have other benefits, such as increased commitment to the trust and lower levels of sickness absence.</p> <p>LP asked about exit interviews and whether these are used routinely. GA confirmed that staff who leave are offered the opportunity to provide hard-copy feedback on a form, but that from now on the trust would be offering exit interviews or surveys to everyone who resigns.</p> <p>The Chairman thanked GA for his update, and the board <b>NOTED</b> its contents.</p>
--	---

STRATEGIC PRIORITIES	
<b>265-14</b>	<p><b>Quarterly update on delivery of Key Strategic Objective (KSO) 3: Operational Excellence</b></p> <p>RT presented the report in the absence of Jane Morris, Interim Head of Operations.</p> <p>The report focussed on the three key elements of KSO 3:</p> <ul style="list-style-type: none"> <li>pathway re-design</li> <li>capacity review</li> </ul>

	<ul style="list-style-type: none"> <li>• delivery of the annual operational plan and provided an update on progress against the shorter term goals in these areas.</li> </ul> <p>JM's report identified three main areas of challenge in delivering against the objectives described in more detail in the appendix to the report:</p> <ul style="list-style-type: none"> <li>• staff vacancies, leading to delays in bringing Theatre 11 into full operational use</li> <li>• diversion of resources from development of new services into management of 18 week waiting time issues</li> <li>• national delays to the introduction of a new e-referral system (to replace choose and book)</li> </ul> <p>SB noted that the principal feature of “delivering operational excellence” over the next few months would be meeting the 18 weeks targets, which will probably require leaner systems and processes, and the reduction of waste.</p> <p>The board <b>NOTED</b> the contents of the quarterly update.</p>
266-14	<p><b>Quarterly update on delivery of Key Strategic Objective (KSO) 4: Financial Sustainability</b></p> <p>SB presented his report, which set out details of progress made against the targets underpinning delivery of KSO 4.</p> <p>He drew particular attention to the actions in hand, and reminded the board that these will be mid- to long-term actions, rather than start and finish actions. One red area was the performance management framework; previous work had clearly not been effective given the trust's 18 weeks issues.</p> <p>With regard to financial planning, SB noted that it might appear odd to say that plans are complete for 14/15, but that this was the case, and the planning process now needed to be replicated for 15/16: draft annual budgets, cost improvement plans (CIPs) and contract plans will be coming to the board in January, with a view to formalisation in February and submission in March.</p> <p>SB also drew attention to the accountability agreements mentioned in the report. These had not been finalised this year because they had been based on historical plans which were the subject of dispute. SB advised that his department would be looking to the future instead and focussing on the 15/16 budget, workforce and planned services. After budget setting, cost improvement plans can be agreed. It was noted that the trust is carrying out capacity planning in a different way for 15/16, based on the planned budget and resources included in the 15/16 plan. SB advised that he will be bringing a discussion about the planned 15/16 surplus to the board in January, and the estates strategy in November or December.</p> <p>RT noted that it had been a mistake to ask operational teams to plan with two variables last year, and that for 15/16 they had been asked to plan based on a fixed budget and fixed staff resource.</p> <p>The board <b>NOTED</b> the contents of the quarterly update.</p>
267-14	<p><b>Electronic patient record (EPR) update</b></p> <p>The paper had been prepared by JM, but in her absence from the meeting was presented by RT.</p> <p>It is anticipated that the providers selected as a result of the current procurement process will be on site from April 2015, but that this may be subject to change, given that three separate</p>

	<p>boards and the Trust Development Authority each need to approve the selection. It was noted that the estates strategy is based on the premise that records will be kept electronically, but that the strategy needs to be realistic about the fact that this is unlikely to be before 2016, and to make some sensible estates provisions in meantime.</p> <p>RT announced that a decision had been made on 23 October (before the report had been written) that Kainos Software Limited had been identified as the preferred bidder for a key element of the project.</p> <p>The board <b>NOTED</b> the contents of the update.</p>
<b>GOVERNANCE</b>	
<p><b>268-14</b></p>	<p><b>Corporate Risk Register (CRR)</b></p> <p>AP presented the Corporate Risk Register (CRR) and asked the board to note the top six risks and in-month changes set out in the report. The updates had been approved by the Q&amp;R Committee.</p> <p>JT observed that the form of the register was starting to improve, and that the top six risks identified were reflected in the board's discussions; as a result the corporate risk register feels more realistic. AP confirmed that it is utilised and updated very regularly and frequently.</p> <p>The Chairman thanked AP for her update the contents of which were <b>NOTED</b> by the board.</p>
<p><b>269-14</b></p>	<p><b>Board Assurance Framework (BAF)</b></p> <p>AP presented the updated BAF to the board for consideration and approval, along with a summary of the development it had undergone since the last Audit Committee. She highlighted the introduction of a summary page, introduced to show how the risks contained in the full BAF are prioritised. Each time the BAF is reported a different set of risks would be expanded to provide background on the BAF – this month, those allocated to AP had been explained in this way. The form of the BAF remains a work in progress.</p> <p>JT added that the first three or four pages of the BAF show the risks under each KSO, and suggested that the Board will want to examine these in more detail at some point, especially at during planning for next year, to ensure that the risks identified are accurate and appropriately described, ready for agreement at the beginning of each year. AP noted that the trust's auditors have offered to provide workshop to carry out that exercise, and JT agreed that this would be very helpful.</p> <p>The Chairman thanked AP for her update and the board <b>APPROVED</b> the latest edition of the BAF.</p>
<p><b>270-14</b></p>	<p><b>Board Governance Assurance Framework - action plan update</b></p> <p>LH reminded the board that an action plan had been drawn up following the self-assessment against the Board Governance Assurance Framework model conducted earlier in the year. The report set out the latest update on the required actions, and sought approval to revise the deadlines for a number of the actions contained therein.</p> <p>LH advised that the majority of the changes required arose not from failure to complete agreed actions but from decisions to change the way in which the needs identified in the self-assessment would be met. The majority of outstanding actions would now be addressed by completion of the current governance review (led by the Chair Designate) and associated action planning, and by the board development self-assessment and consequent work programme planned to commence in December. Both of these projects would reflect the</p>

	<p>requirements of Monitor's "Well-led" review framework.</p> <p>LH pointed out that she had recommended in the report that the next update be presented in six months rather than three, as planned, because there would be very little progress to report by January given that these two large areas of work were not due to deliver results until the end of March.</p> <p>The board <b>NOTED</b> the update and agreed to the changes of deadline proposed therein.</p>
<b>271-14</b>	<p><b>Monitor Q2 declaration (A) and monthly return (B)</b></p> <p>SB presented the report on the quarterly return, indicating that the trust was able to make a finance declaration that "The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months", and that as a result, the trust's continuity of service risk rating (COSRR) is submitted as 4: no evident financial concerns.</p> <p>In the annual plans submitted to Monitor the planned rating from Q3 onward is 4 and the forecast remains at 4.</p> <p>However, SB advised that for the governance rating the trust would be unable to declare that "The board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards", as a result of the failure to achieve the 18 week target during this calendar year.</p> <p>SB also drew attention to an additional declaration concerning the trust's capital: the forecast for 14/15 had increased by £240k because of the League of Friends' contribution to the purchase of new anaesthetics machines, and there had been investment in IT infrastructure.</p> <p>The board <b>APPROVED</b> both the declaration and the monthly return for submission to Monitor.</p>
<b>REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD</b>	
<b>272-14</b>	<p><b>Clinical Cabinet</b></p> <p>RT commended the summary included in the papers to the board, and drew particular attention to the review of the trust's trauma service, noting that an options review was due back at Clinical Cabinet in December, after which it would come to the board.</p> <p>RT also indicated that the very useful head and neck service presentation made by Brian Bisase to the Clinical Cabinet would be repeated at the board in due course.</p>
<b>273-14</b>	<p><b>Board outcomes group</b></p> <p>LP reported that the group had received a very informative presentation from East Kent University Hospitals NHS Foundation Trust's Dr Mark Farr. Dr Farr had emphasised the need to consider the applications end of outcomes work as well as infrastructure. He had said that QVH was unlikely to have the infrastructure, capacity or capability to handle automated outcomes work in the immediate future. The Board Outcomes Group had realised that the trust will need to continue to have to produce data etc manually for the foreseeable future, and recommended that the board recognises that data production will not be automated for at least 12 months.</p> <p>SF confirmed this view, noting that there is no standard product currently in existence to deliver this work. JT noted that Dr Farr had been very encouraging about the way QVH is working on this topic, and LP advised that the group will continue to progress with current</p>

	facilities.
<b>274-14</b>	<b>Charitable Fund Advisory Committee</b> LP confirmed the contents of the summary report on the committee's last meeting included in the board papers, and advised that a proposal concerning further funding of the research post will be presented to the corporate trustee's meeting in November.
<b>STAKEHOLDER AND STAFF ENGAGEMENT</b>	
<b>275-14</b>	<b>Feedback from events and other engagement with staff and stakeholders</b> RT reported that he had attended routine executive to executive meetings with Horsham, Mid Sussex and Crawley CCG, and that he felt there was good engagement between the trust and the CCG's board. The CCG had raised queries about levels of sickness absence associated with stress amongst QVH staff, as noted by local GPs. RT had reassured the CCG about measures in hand to combat stress. RT felt that it had been a positive meeting.  JT commented on a 'compliance in practice' visit he had completed, during which he had focused on staff. He noted that it is always valuable to spend time on the wards and see the reality of practice and staff experience. Referring back to the previous discussion about staff retention JT said that he had spoken to two nurses and observed a sense of pressure and reluctance to recommend the trust as place to work. He advised that there is a lot for the trust to do to improve morale, culture and staff engagement, and that the trust must make sure that the changes ahead are managed effectively to ensure that they amount to a positive experience – the process of managing change can exacerbate potentially negative impact of the actual changes.
<b>GOVERNOR REPRESENTATIVE &amp; NON-EXECUTIVE DIRECTORS</b>	
<b>276-14</b>	<b>Observations from the Chairman, Non-Executive Directors and Governor Representatives</b> BG commented on the Governors' Forum held on 16 October, advising that broadly most governors were happy with the system of governor representatives at the board and on board committees, but that it was likely that there would be some changes to the way in which governors' meetings are held. The Governor Steering Group will meet less frequently and be used to set the Council of Governors' agenda.  PG passed on a message from BH, confirming that in the previous month the governance review had got underway, involving BG, RT, LP and LH. She had been meeting staff members and consultants in order to support her induction to QVH, and meeting weekly with RT and PG.
<b>MEMBERS OF THE PUBLIC</b>	
<b>277-14</b>	<b>Observations from members of the public</b> There were none
<b>278-14</b>	Further to paragraph 39.1, and annex 6 of the Trust's Constitution, it was agreed that members of the public should be excluded from the remainder of the meeting in order to enable the board to discuss confidential information concerning the trust's finances and matters of a commercially sensitive nature

Chairman..... Date.....