Bundle Public Board 7 September 2023

Agenda attachments

- A - Front cover
- B - Membership
- C - Register - Updated August 2023
- D - Agenda public-7 September 2023 FINAL

74.23 10:00 - Welcome, apologies and declarations of interest
Jackie Smith, Trust Chair

75.23 10:03 - Patient story

76.23 10:13 - Staff story

77.23 10:23 - Draft minutes of the public meeting held on 7 July 2023
Jackie Smith, Trust Chair
Approval
- 77-23 QVH Board minutes- public- 7 July 2023

78.23 10:25 - Matters arising and actions pending from previous meeting
Jackie Smith, Trust Chair
Review
- 78-23 PUBLIC Matters arising

79.23 10:27 - Chair's report
Jackie Smith, Trust Chair
Assurance
- 79-23 Chair's report
- 79-23.1 Appendix one- PRN00719_Letter re Verdict in the trial of Lucy Letby_180823

80.23 10:32 - Chief executive's report
Abigail Jago, director of strategy and partnerships and acting CEO
Assurance
- 80-23 CEO report
- 80-23.1 CEO appendix media update June and July 2023
- 80-23.2 Integrated Dashboard

81.23 10:37 - Board assurance framework and corporate risk register
Clare Pirie, director of communication and corporate affairs
Nicky Reeves, chief nurse
Review
- 81-23 Risk management and Board assurance framework
- 81-23.1 CRR 24.8.23 for Board 7.9.23

82.23 10:47 - Board sub-committee changes
Clare Pirie, director of communication and corporate affairs
Approval
- 82-23 Board sub-committee changes report
- 82-23.1 Appendix one- Committee memberships 2023-24 from 1 Oct 23
- 82-23.2 Appendix two- Audit and risk committee ToR
- 82-23.3 Appendix three- Quality and safety committee ToR
- 82-23.4 Appendix four- Finance and performance committee ToR

83.23 10:52 - Nomination and remuneration committee terms of reference
Jackie Smith, Trust Chair
Approval
- 83-23 Nomination and remuneration committee ToR report
- 83-23.1 Appendix one- Nomination and remuneration committee ToR

84.23 10:57 - NHS Sussex Shared Delivery Plan
Abigail Jago, director of strategy and partnerships and acting CEO
Approval
- 84-23 NHS Sussex SDP
- 84-23.1 Appendix one- SDP

85.23 11:02 - Strategic development committee assurance
Jackie Smith, Trust Chair
Assurance
- 85-23 SD committee assurance report

86.23 11:05 - Audit assurance
Paul Dillon-Robinson, non-executive director and committee Chair
Assurance
86-23 Audit committee assurance report

87.23 11:08 - Workforce performance report
Rob Stevens, interim chief people officer
Assurance
87-23 Workforce performance report

88.23 11:17 - Financial performance
Maria Wheeler, chief finance officer
Assurance
88-23 Finance performance report

89.23 11:26 - Operational performance monthly report
Shane Morrison-McCabe, director of operations
Assurance
89-23 Operational performance report
89-23.1 Appendix one- Operational performance data

90.23 11:35 - Financial, workforce and operational performance assurance
Paul Dillon-Robinson, non-executive director and committee Chair
Assurance
90-23 F&P committee assurance report

91.23 11:38 - Quality and safety report
Nicky Reeves, chief nurse
Tania Cubison, medical director
Assurance
91-23 Quality and safety report

92.23 11:47 - Annual reports
a) Learning from deaths annual report
b) Safeguarding annual report
c) Patient experience annual report
Nicky Reeves, chief nurse
Tania Cubison, medical director
To note
92-23 Annual reports
92-23.1 QVH Learning from deaths Oct 21- Mar 23.finaldraft
92-23.2 Safeguarding annual report final V2
92-23.3 Patient-experience-annual-report-2022-23v4

93.23 11:52 - Quality and safety assurance
Karen Norman, non-executive director and committee Chair
Assurance
93-23 Q&G committee assurance report

94.23 11:55 - Any other business (by application to the Chair)
Jackie Smith, Trust Chair
Discussion

Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 7 September 2023

Session in PUBLIC
10.00-12.00
Learning and development centre training room (location 29), QVH

MEMBERSHIP
BOARD OF DIRECTORS
September 2023

Members (voting):

Trust Chair	-	Jackie Smith
Senior Independent Director	-	Paul Dillon-Robinson
Non-Executive Directors	-	Karen Norman
	-	Peter O'Donnell
	-	Shaun O'Leary
	-	Russell Hobby
Director of Strategy and acting Chief Executive	-	Abigail Jago
Medical Director	-	Tania Cubison
Chief Nurse	-	Nicky Reeves
Chief Finance Officer	-	Maria Wheeler

In full attendance (non-voting):

Director of Operations	-	Shane Morrison-McCabe
Director of Communications and Corporate Affairs	-	Clare Pirie
Interim Chief People Officer	-	Rob Stevens
Deputy Company Secretary	-	Leonora May

Annual declarations by directors 2023/24

Declarations of interests

As established by section 40 of the Trust's Constitution, a director of the Queen Victoria Hospital NHS Foundation Trust has a duty:

- to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the foundation trust.
- not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.
- to declare the nature and extent of any relevant and material interest or a direct or indirect interest in a proposed transaction or arrangement with the
- foundation trust to the other directors.

To facilitate this duty, directors are asked on appointment to the Trust and thereafter at the beginning of each financial year, to complete a form to declare any interests or to confirm that the director has no interests to declare (a 'nil return'). Directors must request to update any declaration if circumstances change materially. By completing and signing the declaration form directors confirm their awareness of any facts or circumstances which conflict or may conflict with the interests of QVH NHS Foundation Trust. All declarations of interest and nil returns are kept on file by the Trust and recorded in the following register of interests which is maintained by the Deputy Company Secretary.

Register of declarations of interests

	Relevant and material interests							
	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.	Other
Non-executive and executive members of the board (voting)								
Jackie Smith Trust Chair	Directorship of WeNurses	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Abigail Jago Director of Strategy & Partnerships and acting chief executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Paul Dillon-Robinson Non-Executive Director	Trustee/ Director, Hurst Educational Trust Trustee/ Director, Association of Governing Bodies of Independent Schools	Independent consultant (self-employed) – see HFMA	Nil	Nil	Nil	Independent consultant working with the Healthcare Financial Management Association (including writing guidance, HFMA academy, one NHS finance, future focussed finance and coaching and training)	Nil	Nil

Karen Norman Non-Executive Director	Visiting professor, business school, University of Hertfordshire Visiting professor, School of Nursing, Kingston University and St George's, University of London Visiting consultant, School of Life and Health Sciences, University of Roehampton	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Peter O'Donnell Non-Executive Director	Non-executive director for Nottingham Building Society	Nil	Nil	Trustee for Cardiac Risk in the Young	Nil	Nil	Nil	Nil

Shaun O'Leary Non-Executive Director	Nil	Nil	Nil	Chair and Trustee of St Wilfreds Hospice, Eastbourne	Nil	Nil	Nil	Nil
Russell Hobby Non-Executive Director	Director of 5 Lewes Crescent Mgt Co. RVHB Ltd	Nil	Nil	Chief executive officer of Teach First (education charity)	Nil	Nil	Nil	Nil
Tania Cubison Medical Director	Nil	I undertake private practice at the McIndoe Centre and also I am a Medio legal expert. This is as a sole trader, not a limited company.	Nil	National Chair of the Emergency Management of severe burns senate (part of the British Burn Association)	Nil	Nil	Spouse (Ian Harper) is the director of welfare for BLESMA (the military charity for amputees). He is due to retire 17/04/2023 from this salaried post. He has signposted patients to me and the QVH.	Nil
Maria Wheeler Chief Finance Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Nicky Reeves Chief Nurse	Nil	Nil	Nil	Trustee of McIndoe Burns Support Group	Nil	Nil	Nil	Nil
Other members of the board (non-voting)								

Shane Morrison-McCabe Director of Operations	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Clare Pirie Director of Communications & Corporate Affairs	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Robert Stevens Interim Chief People Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Fit and proper persons declaration

As established by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the regulations"), QVH has a duty not to appoint a person or allow a person to continue to be a governor of the trust under given circumstances known as the "fit and proper person test". By completing and signing an annual declaration form, QVH governors confirm their awareness of any facts or circumstances which prevent them from holding office as a governors of QVH NHS Foundation Trust.

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board (voting)							
Jackie Smith Trust Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Abigail Jago Director of strategy and partnerships and acting chief executive	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul Dillon-Robinson Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Karen Norman Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Peter O'Donnell Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Shaun O'Leary Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Russell Hobby Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tania Cubison Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maria Wheeler Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nicky Reeves Chief Nurse	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other members of the board (non-voting)							
Shane Morrison- McCabe Director of operations	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Clare Pirie Director of Communications & Corporate Affairs	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Robert Stevens Interim Chief People Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 7 September 2023
10.00-12.00

Agenda: session held in public		
WELCOME		
74-23	**Welcome, apologies and declarations of interest** *Jackie Smith, Trust Chair*	
STANDING ITEMS		**Purpose**
75-23	**Patient story**	*Assurance*
76-23	**Staff story**	*Assurance*
77-23	**Draft minutes of the public meeting held on 7 July 2023** *Jackie Smith, Trust Chair*	*Approval*
78-23	**Matters arising and actions pending from previous meetings** *Jackie Smith, Trust Chair*	*Review*
79-23	**Chair's report** *Jackie Smith, Trust Chair*	*Assurance*
80-23	**Chief executive's report** *Abigail Jago, acting chief executive*	*Assurance*
GOVERNANCE AND STRATEGY		
81-23	**Board assurance framework and corporate risk register** *Clare Pirie, director of communication and corporate affairs* *Nicky Reeves, chief nurse*	*Review*
82-23	**Board sub-committee changes** *Clare Pirie, director of communication and corporate affairs*	*Approval*
83-23	**Nomination and remuneration committee terms of reference** *Clare Pirie, director of communication and corporate affairs*	*Approval*
84-23	**NHS Sussex Shared Delivery Plan** *Abigail Jago, director of strategy and partnerships and acting CEO*	*Approval*
85-23	**Strategic development committee assurance** *Jackie Smith, Trust Chair*	*Assurance*
86-23	**Audit assurance** *Paul Dillon-Robinson, non-executive director and committee Chair*	*Assurance*
Key strategic objective 5: organisational excellence		
87-23	**Workforce performance report** *Rob Stevens, interim chief people officer*	*Assurance*
Key strategic objective 4: financial sustainability		

88-23	**Financial performance** *Maria Wheeler, chief finance officer*	*Assurance*
Key strategic objective 3: operational excellence		
89-23	**Operational performance monthly report** *Shane Morrison-McCabe, director of operations*	*Assurance*
90-23	**Financial, workforce and operational performance assurance** *Paul Dillon-Robinson, non-executive director and committee Chair*	*Assurance*
Key strategic objectives 1 and 2: outstanding patient experience and world class clinical services		
91-23	**Quality and safety report** *Nicky Reeves, chief nurse* *Tania Cubison, medical director*	*Assurance*
92-23	**Annual reports** **a) Learning from deaths annual report** **b) Safeguarding annual report** **c) Patient experience annual report** *Nicky Reeves, chief nurse* *Tania Cubison, medical director*	*To note*
93-23	**Quality and safety assurance** *Karen Norman, non-executive director and committee Chair*	*Assurance*
MEETING CLOSURE		
94-23	**Any other business (by application to the Chair)** *Jackie Smith, Trust Chair*	*Discussion*
MEMBERS OF THE PUBLIC		
95-23	**Questions from 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 Leonora.may1@nhs.net clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.* *Jackie Smith, Trust Chair*	
Further to paragraph 39.1 and annex 6 of the Trust's Constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the Board to discuss issues of a confidential or sensitive nature. Any decisions made in the private session of the Trust Board will be communicated to the public and stakeholders via the Chair's report. *Jackie Smith, Trust Chair*		

Document:	Minutes (DRAFT)	
Meeting:	**Board of Directors (session in public)** **10.00-12 noon 7 July 2023** **Education centre, QVH**	
Present:	Jackie Smith	Trust Chair (voting) (Chair)
	Paul Dillon-Robinson (PDR)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Karen Norman (KN)	Non-executive director (voting)
	Shaun O'Leary (SOL)	Non-executive director (voting)
	Russell Hobby (RH)	Non-executive director (voting)
	Peter O'Donnell (POD)	Non-executive director (voting)
	Abigail Jago (AJ)	Director of strategy and partnerships and acting CEO (voting)
	Maria Wheeler (MW)	Chief finance officer (voting)
	Nicky Reeves	Chief nurse (voting)
	Shane Morrison- McCabe (SMM)	Director of operations (non-voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
In attendance:	Leonora May (LM)	Deputy company secretary (minutes)
Apologies:	Tania Cubison (TC)	Medical director (voting)
Members of the public:	Three members of public (two for patient story), two governors and two members of staff (one for staff story)	

Welcome

42-23 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board, staff and members of public observing the meeting including two public governors. She welcomed three new non-executive directors (POD, SOL and RH) and the new chief finance officer, MW, to their first Board meeting.

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

Apologies were received from TC and the meeting was declared as quorate.

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

Standing items

43-23 **Patient story**

The Board welcomed a QVH patient and her spouse to the meeting to share their experience of QVH.

The patient explained that following a mastectomy, she was booked in to have breast reconstruction at QVH. Following delays, the surgery was scheduled and then cancelled on the day as the operation was deemed unsafe due to an MRI scan not being clear for required blood vessels. She expressed disappointment that the MRI scan had only been reviewed the night before the operation given that the scan had taken place 15 months before that.

Subsequently, the patient made a complaint about the above, as well as other issues including a lack of referral to the QVH specialist breast reconstruction nurses and not being informed about the 'show and tell' events where former patients share information about different types of reconstruction.

The patient stated that the initial response to her complaint would have benefited from a

	clear apology in the first paragraph for the distress caused, a stronger focus on the issues raised in the complaint rather than clinicians' comments and more about the lessons learnt through the process of reviewing the complaint. Since raising the complaint, the patient had experienced further issues with communication, appointments co-ordination between departments and incorrect BMI and diabetes readings being recorded. The patient expressed thanks for the opportunity to share her story with the Board, and complimented the care that she received on the day of her operation, the specialist nurses, the consultant and the wound clinic. JS and NR apologised to the patient on behalf of the Board for her experience, acknowledging the distress that it would have caused. NR provided the patient with assurance that the Trust will take steps to address and action the learning from her experience to ensure that it does not happen again. She explained that a process is being developed to review all patient stories to Board, triangulate the intelligence and report back actions undertaken as a result. The Board extended sincere thanks to the patient for sharing her experience at QVH and wished her well.
44-23	**Staff story** The Board welcomed the Trust's volunteer co-ordinator to the meeting to give an account of her experience as a member of staff at QVH. The volunteer co-ordinator talked about the work of the volunteer team supporting services throughout the hospital, the significant service provided by volunteers and the benefits for patients, volunteers and staff. She also talked about her experience of joining QVH after developing a disability. This included a positive experience of putting in a flexible working request to gain a better work life balance, which was accommodated. She highlighted the need for awareness that staff working part time have to fit training etc into part time hours; this also impacts on capacity to participate in a network for staff with disabilities. She spoke about a negative experience regarding an occupational health assessment where the person undertaking the assessment had asked her why she was working The volunteer co-ordinator highlighted that not all staff areas are accessible to disabled staff, and suggested that line managers could do more in taking disabled members of staff around the site, looking at access. She emphasised the importance of having meaningful conversations with disabled members of staff about adjustments required before the person starts in the role, and that employees should feel comfortable and supported to talk about their disabilities. JS extended thanks to the volunteer co-ordinator on behalf of the Board for the important work that she does with the volunteers to support the Trust and for sharing her experience as a member of staff at QVH. The Board agreed that it had been useful to understand areas for improvement and acknowledged that there are some actions that could be taken forward quickly to improve staff experience. MW agreed to schedule some time with the volunteer co-ordinator to go around the site and identify some quick wins for improvements to access for disabled staff.
45-23	**Draft minutes of the public meeting held on 4 May 2023**

	The Board noted that the following amendment will be made to the minutes: - 19-23 '72 day' will be amended to '62 day' (first paragraph) Subject to the above amendments being made, the Board **agreed** that the draft minutes of the public meeting held on 4 May 2023 were a true and accurate record of that meeting and **approved** them on that basis.
46-23	**Matters arising and actions pending from the public meeting held on 4 May 2023** There was one pending action and the Board noted that: - 232-23 (gender pay report and actions) has been postponed until September 2023 due to resource constraints
47-23	**Chair's report** JS presented her Chair's report to Board who noted that she is an inspector for the Care Quality Commission (CQC) and that she has recently served on an inspection team. The Board sought advice JS on preparing for the Trust's forthcoming CQC visit based on insights gained from her experience as an inspector. JS explained that she is unable to share any detail about the review she has recently completed, but gave some high level insight. She reported that the CQC are now inspecting organisations on the basis of risks carried, and looking to assure themselves that organisations understand their risks and that appropriate mitigations are in place. Other areas of focus for the CQC are leadership and visibility at every level in organisations, clarity around decision making and culture including how organisations manage staff and patient concerns. The Board noted that the chief nurse is allocating a clinical and non-clinical area to each Board member to visit frequently to increase Board visibility and ensure there is a mechanism in place for collecting soft intelligence. The Board recognised this is an important part of staff engagement and supported the continued development of a mechanism to ensure triangulation between soft intelligence and data regarding staff concerns. The Board **noted** the contents of the report.
48-23	**Chief Executive's report** AJ presented the report to the Board. AJ confirmed that the NHS Sussex shared delivery plan will be presented to the Board for ratification at a future meeting, and agreed that it will be important to provide clarity regarding what it means for QVH. She confirmed that the plan has had engagement from providers. In response to a question, MW confirmed that there is a high degree of confidence that the cost improvement programme will be achieved for 2023/24, and that 5.5% had already been achieved. The Board sought assurance regarding the management of implications of recent strike action. SMM confirmed that there is a robust process in place to plan for industrial action, and that the Trust will continue to prioritise patient safety. She highlighted that industrial action presents a risk to achieving the Trust's operating plan and opportunity for theatre utilisation being lost. SMM agreed to present an update regarding the impact of the upcoming consultant strike to the September Board meeting. **Action SMM.** The Board thanked both AJ and CP, recognising that they had both recently taken on additional responsibility to support the Trust on top of their substantive executive roles.

	The Board **noted** the contents of the report.
Governance	
49-23	**Risk management and corporate risk register** CP presented the report to the Board which outlined work completed to date to transform the Trust's approach to risk management. The Board noted that a new board assurance framework is being developed and will be focussed on strategic risks. The Board agreed with a suggestion that the whole Board should be involved in the development of and ownership of strategic risks. The Board **noted** the contents of the report.
50-23	**Well led report- recommendations and organisational response** JS presented the report to the Board which set out the recommendations and organisational response of the Trust's recent well lev review which was undertaken by Deloitte LLP. The report included six themes and a number of recommendations for action, of which JS confirmed developing the Trust's strategy and vision is a priority. Following a gap analysis, AJ confirmed that the recommendations will be set out within in action plan. Progress against the action plan will be reported to the strategic development committee. The Board emphasised the need for urgency regarding completing priority actions. A Board member highlighted culture as an important priority for the Board, and the fact that it did not feature within the recommendations. JS confirmed that the Board seminar in November will be focussed on organisational culture. The Board **noted** the report, specifically the recommendations and organisational response.
51-23	**Establishment of strategic development committee** CP presented the report to the Board who noted this as an important step in updating governance structures to support the development of the Trust strategy as a priority. She confirmed that the Board will retain its responsibility for defining the strategic aims and objective of the Trust and will continue to contribute to the development of the strategy. The Board: - **Approved** the establishment of the strategic development committee as a sub-committee of the Board - **Approved** the strategic development committee's terms of reference - **Approved** the disbanding of the digital committee as a sub-committee of the Board
52-23	**Standing orders, standing financial instructions and scheme of delegation and reservation of power** CP presented the report to the Board, highlighting that the main changes to the documents relate to the establishment of the strategic development committee. The changes are recommended to the Board for approval by the audit committee. The deputy company secretary will check and update job titles within the documents. The Board **approved** the proposed changes to the standing orders, standing financial instructions and scheme of delegation and reservation of power.
53-23	**Audit assurance**

	KG presented the audit committee assurance report to the Board who noted that the annual report and accounts 2022/23 had been filed with NHS England. The Board **noted** the contents of the report.
Trust strategy	
Key strategic objectives 1&2: outstanding patient experience and world-class clinical services	
54-23	**Quality and safety report** NR presented the report to the Board who noted that the ICB scrutiny committee had reviewed two serious incidents and that the action plans were approved. One serious incident has been downgraded. The Board noted the water ingress in the head and neck department and SOL asked how those incidents link into the estates and preventative maintenance policy, and how the Board can seek assurance that the policies are being managed appropriately. JS agreed to pick this question up in the private Board meeting. PDR suggested that there may be an opportunity to use the clinical audit function to look at how the Trust responds to patient complaints, particularly where there might be a dispute about facts, given recent patient stories at Board meetings. The Board agreed that the contents and tone of complaints responses should be reviewed. NR confirmed that a deep dive into complaints would be completed and presented to the quality and governance committee. **Action NR.** The Board **noted** the contents of the report.
55-23	**Six-monthly nursing workforce review** NR presented the report to the Board, reporting that although model hospital data had been used for benchmarking, some areas are difficult to benchmark due to their specialist nature. NR raised concern regarding the challenges in attracting nurses to QVH due to the location of the hospital and transport links. Discussion was had regarding nursing workforce challenges as follows: - There was a suggestion that the Trust could do more to let members of the public know about positive staff initiatives, training, development and progression opportunities - The Board recognised an opportunity to address these challenges in the workforce strategy - KN highlighted that there are some risks related to workforce in critical areas where there are vacancies which make up a large percentage due to the size of the team - Board members recognise a shift in employees wanting more flexible working opportunities and focussing on personal wellbeing - The Board agreed that there is a need to invest in apprenticeships and support portfolio nurses The Board **noted** the contents of the report.
56-23	**Quality and governance assurance** KN presented the report to the Board. It was agreed that the Board would review the learning from deaths annual report at its next meeting. **Action LM.** The Board noted that the committee is not fully assured on the concerns related to surgical patients who do not fall under the referral to treatment waiting time targets, noting that prosthetics is one of these areas. SMM confirmed that these patients are prioritised

	accordingly, and the Trust continues to be clear to patients regarding waiting times to manage expectations. The Board noted the challenges related to senior medical staff engagement with the safeguarding and Mental Capacity Act process. KN confirmed that further audits are due to be completed to understand the impact of changes in processes and training put in place to address it. She confirmed that this challenge is not unique to QVH. The Board **noted** the contents of the report.
Key strategic objective 4: financial sustainability	
57-23	**Financial performance** MW presented the report to the Board, highlighting that the Trust is on track to break even and meet efficiency targets this year. She explained that continued strike action poses a risk to financial performance and the activity plan. The Board noted that there are limited capital resources until year end, and that the estate requires investment. The Board were assured that the Trust will remain within its capital plan. The Board **noted** the contents of the report.
Key strategic objective 3: operational excellence	
58-23	**Operational performance monthly report** SMM presented report and reported that the industrial action is having an impact on activity. For May, the Trust is ahead of its activity plan to achieve 109% of 2019/20 activity. She highlighted a risk regarding achieving the 62 cancer standard going forward due to continued increased referrals made for the two week suspected cancer pathway. In response to a question regarding whether the RTT waiting list is forecasted and what analysis the Trust has, SMM confirmed that based on the analysis of the waiting list, the outlook for the year end waiting list was likely to be more than 17,000.The Board requested clarity on this position at its next meeting. **Action SMM.** In response to a question regarding which waiting lists are subject to data validation, SMM confirmed that there is partial validation of the waiting list by specialty on a weekly basis but not for plastics. The intention is to get support from the system to be able to validate the whole waiting list. The Board sought clarification regarding how much the waiting list may be reduced following the validation exercise, and SMM confirmed that on average there is an 8-10% reduction. AJ clarified that the validation being undertaken currently is for the non RTT waiting list so will not impact the total RTT waiting list size. AJ and SMM agreed to provide clarity on this position to the finance and performance committee. **Action SMM.** The Board requested a written update on the impact of recent strike action at its next meeting. **Action SMM.** The Board **noted** the contents of the report.
Key strategic objective 5: organisational excellence	
59-23	**Workforce report** CP presented the report to the Board and reported that the interim chief people officer is due to start next week and will bring strategic input into developing a workforce strategy for the Trust.

	Discussion was had regarding appraisals and the Board agreed with a suggestion that team appraisals and setting team objectives should be considered when developing the Trust's approach to appraisals. The Board **noted** the contents of the report.
60-23	**Staff survey results** CP presented the staff survey results to the Board, reporting that the headline results are very positive, but that staff who declare as black or minority ethnic or disabled are less positive than other groups. She confirmed that there focussed work to address this. The Board noted that the interim chief people officer will prioritise looking at the way that we triangulate concerns that we hear from staff through various routes such as the freedom to speak up guardian and 'tell Nicky' with staff survey results and ensuring that we have a robust approach to escalate and address issues identified. The Board agreed that the time delay from when staff complete the survey to when the published hinders the Trust' ability to address issues identified in a timely manner. The Board agreed with a suggestion that the Trust should consider the use of pulse surveys as a tool to get immediate feedback. The Board congratulated management for the good results achieved, recognising that there are areas for improvement. The Board **noted** the contents of the report.
61-23	**Financial, operational and workforce performance assurance** PDR presented the report to the Board, highlighting that the committee has changed the format of performance reporting to an executive summary only which is having a positive impact, encouraging insight and clarity regarding the ask of the committee. The Board were supportive of this approach. The Board **noted** the contents of the report.
62-23	**Digital assurance** KG presented the report to the Board, reporting that this will be the final digital committee assurance report, given that it will no longer be a formal sub-committee of the Board. The Board noted the delays around electronic patient records due to funding. KG thought that the system could be implemented reasonably quickly once selected with the right programme management in place and the Board agreed that clinical engagement will be critical to the success of the implementation. The Board **noted** the contents of the report.
Meeting closure	
63-23	**Any other business (by application to the Chair)** JS stated that it was KG's last Board meeting as he was finishing his second and final term as a non-executive director for QVH at the end of August. She thanked Kevin for what she described as a huge contribution to the Trust as a Board member, for challenging skilfully and sensitively, supporting Board members, caring about staff and being passionate about driving progress. KG thanked all of his colleagues for supporting him in his first non-executive director role. During his six years in post there had been challenges and there are opportunities ahead to

develop the strategy and the Trust's role within the system. He wished the Trust all the best for the future.

There was no further business and the meeting closed.

Members of the public

64-23 **Questions from members of the public**

The Board had received two questions from members of the public. CP read out the questions received and responses which were as follows.

Question	Response
In the interim Chief executive's report it states that 'As a provider within the Sussex integrated care system QVH will be driving forward the relevant initiatives within the (ICS) delivery plan.' My question is, could the Board explain in more detail what specific actions are anticipated/expected by QVH in support of the ICS plans?	The shared delivery plan was publicly launched yesterday (Wednesday 5 July). As mentioned in the chief executive's report QVH has a particular role to play in helping to tackle health inequalities, supporting the reduction of waiting lists and optimising the use of community diagnostic centres. We will be making more reference to our contribution to the shared delivery plan in QVH Board papers going forwards as this work progresses.
The report "Establishment of strategic development committee" is largely self-explanatory. My question is, would there be merit in having stakeholders represented on the committee to support its work and ensure the various constituencies are represented (perhaps ICSs, staff, governors)?	People with an interest in the services of QVH are being engaged meaningfully from the beginning in strategy work, and will be engaged at every stage of the development of ideas and on a continual basis as those ideas become proposals and plans. The strategic development committee is the Board assurance committee and as such is an internal governance committee.

65-23 **Exclusion of members of the public**

Further to paragraph 39.1 and annex 6 of the Trust's constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the Board to discuss issues of a confidential or sensitive nature. Any decisions made in the private session of the Trust Board will be communicated to the public and stakeholders via the Chair's report.

Matters arising and actions pending from previous meetings of the Board of Directors - PUBLIC								
ITEM	**MEETING Month**	**REF.**	**TOPIC**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
1	Mar-23	232-23	Gender pay gap annual report	Provide the Board with the annual gender pay gap report much sooner after year end (March) in order that the Trust can respond to the data and trends in a more timely fashion.	~~**LA**~~ **RS**	~~**6 July 2023**~~ ~~**7 September 2023**~~ **2 November 2023**	March 2023: 2022/23 report scheduled on Board agenda for 6 July 2023 meeting June 2023: Gender pay gap annual report and actions postponed until September due to resource constraints. July 2023: This has been postponed until November.	**Pending**
2	Jul-23	48-23 58-23	Industrial action	Provide the Board with an update regarding the impact of industrial action since June 2023.	**SMM**	**7 September 2023**	July 2023: To be included within operational report to Board at its 7 September 2023 meeting	**Complete**
3	Jul-23	54-23	Complaints	Complete a deep dive into complaints considering triangulation of complaints received for common themes and a review of contents and tone of complaints responses. Deep dive to be presented to the quality and governance committee.	**NR**	**21 August 2023**	July 2023: This is scheduled on the 25 August quality and governance committee agenda.	**Complete**
4	Jul-23	56-23	Learning from deaths	The Board will review the learning from deaths annual report at its next meeting.	**LM**	**7 September 2023**	July 2023: This is scheduled on the agenda for the 7 September Board meeting.	**Complete**
5	Jul-23	58-23	Waiting lists	Provide the finance and performance committee with the position regarding the waiting list position and the forecast for the RTT waiting list.	**SMM**	**7 September 2023**	July 2023: This information was presented to the finance and performance committee at its meeting in July 2023. It is included within the operational report to Board for its meeting on 7 September 2023. Action marked as completed	**Complete**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023		**Agenda reference:**	**79-23**	
Report title:	Chair's report				
Sponsor:	Jackie Smith, Trust Chair				
Author:	Jackie Smith, Trust Chair				
Appendices:	Only need to list appendices if these are in addition to the actual report, (not the report itself)				
Executive summary					
Purpose of report:	The purpose of the report is to update the board of Directors on Chair, non-executive director and governor activities since the last meeting				
Summary of key issues	- Listening to staff concerns - The new fit and proper persons test framework - Non-executive director service visits and increasing non-executive director visibility				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	79-23
Date of meeting:	7 September 2023
Report from:	Jackie Smith, Trust Chair
Report author:	Jackie Smith, Trust Chair
Date of report:	22 August 2023
Appendices:	Appendix one: Letter Re verdict in the trial of Lucy Letby

Chair's report

Strengthening patient safety and hearing staff concerns

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected. Colleagues across the health service have been shocked and sickened by her actions.

The government has ordered an independent inquiry into the wider circumstances around what happened at the Countess of Chester Hospital, including the handling of concerns and governance. We understand that the enquiry will also look at what actions were taken by regulators and the wider NHS. It will ensure the families impacted in this tragic case have the opportunity to engage with the inquiry.

NHS England, chief nursing officer Ruth May said: "On behalf of all of us I would like to express our profound apologies to the families for all they have been through. The NHS is fully committed to doing everything we can to prevent anything like this ever happening again, and we welcome the independent inquiry announced by the Department of Health and Social Care to help ensure we learn every possible lesson from this awful case."

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.
This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes. As Trust Chair, I am accountable for ensuring that the fit and proper persons test is effectively implemented at the Trust. Some elements of the new framework will be used by all trusts from September 2023, with full implementation by 31 March 2024.

At QVH staff can raise concerns in many different ways including through the Freedom to Speak Up Guardian, anonymously to 'Tell Nicky' (our chief nurse) or 'Ask the chief executive' online, as well as through line management. Staff governors are also an important additional way that staff can ask questions or make comments. The Raising Concerns (Whistleblowing) Policy sets out how any concerns staff raise will be handled.

Around 200 QVH staff attended the open staff meetings following the Lucy Letby verdicts to discuss the issues raised and our approach to speaking up. The executive team are considering what else we need to do at QVH to ensure that our culture of raising concerns is well understood, easy to use, and that staff know when their concerns have been heard and acted on.

Service visits

As part of our ongoing work to ensure that Board members are visible throughout the organisation, the non-executive directors have visited theatres, the Canadian wing

and the eye bank since the last Board meeting, getting to know staff from across the Trust and collecting soft intelligence. Any specific issues raised by staff will be followed up with executives or escalated through other routes as appropriate.

We also held a ‘meet the NEDs’ meeting for all QVH staff. Around 40 members of staff came along. There was discussion regarding the different Board roles of non-executive and executive directors, and the skills that the non-executives bring to the Board as well as the vision for the future of QVH and how we should tackle our ambitions to be a net zero carbon hospital.

Board development
The Board remains focussed on building Board cohesion, impact and effectiveness to position it to develop and deliver the Trust strategy.

Governors
I have enjoyed meeting individually with some of our new governors during August. I have also met with governors to discuss the issues raised by the Lucy Letby case and actions described above related to ensuring staff can speak up and action is taken.

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

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023		**Agenda reference:**	**80-23**	
Report title:	Chief executive's report				
Sponsor:	Abigail Jago, acting chief executive and director of strategy and partnerships				
Author:	Abigail Jago, acting chief executive and director of strategy and partnerships Clare Pirie, director of communications and corporate affairs				
Appendices:	Appendix one: media report Appendix two: performance dashboard				
Executive summary					
Purpose of report:	To update the Board on progress against objectives and provide an update on any external issues which may have an impact on the Trust's ability to achieve targets				
Summary of key issues	- Well led recommendations and action plan - NHS 75th birthday - QVH power issue - Digital infrastructure programme - Industrial action - Executive service and team visits				
Recommendation:	It is recommended that the Board **notes** the contents of the report				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	80-23
Date of meeting:	07 September 2023
Report from:	Abigail Jago, acting chief executive officer and director of strategy and partnerships
Report author:	Clare Pirie, director of communications and corporate affairs Abigail Jago, acting chief executive officer and director of strategy and partnerships
Date of report:	25 August 2023
Appendices:	Appendix one: media report Appendix two: performance dashboard

Chief executive's report

Well led recommendations and action plan

A detailed action plan has been developed to support the delivery of the well led recommendations. There has been significant progress in a number of key areas including Board and executive development programmes, strategic engagement, establishing a strategic development committee, risk management and patient engagement plans. Work on the profile of clinical business units and strengthening triumvirate working is pending the arrival of the substantive CEO.

The well led review also contains a recommendation related to the soft intelligence received through formats such as 'Tell Nicky' which is an anonymous reporting line to the chief nurse. In the context of the Lucy Letby verdict we are accelerating existing work ensuring that feedback received through the several different channels staff can use to raise concerns is triangulated and acted upon.

NHS 75th birthday

On 5 July staff and volunteers from QVH joined long-serving NHS staff from around the country at a special service at Westminster Abbey today to celebrate the 75th birthday of the NHS.

Sharron Phillips, hotel services team leader, was one of five people representing QVH at the event and featured in media coverage. Sharron first joined our hospital in 1986 on a YTS training scheme, achieving national trainee of the year in 1988, before leaving and returning again working on our switchboard in 2009.

QVH power issue - restoring IT systems and theatres work

In August part of the QVH site experienced a power issue and additional generators were brought on site. This was a well-coordinated response and I would like to put on record my thanks to the many staff who played their part including those who made sure we kept our patients safe and informed, and those who managed the continuity of our essential data systems.

Digital infrastructure programme

The digital team have successfully completed the implementation of phase 1 of our digital infrastructure programme. This increases wifi coverage across the Trust site, with all wifi access points replaced and a new core network installed. Phase 2 is underway which will configure and migrate all IT servers and clinical applications to new data and storage. This work is key to our digital resilience and I would like to note thanks to the team who have worked hard to implement this with limited disruption to Trust services over recent months.

Industrial Action
Since the last Board meeting there has been further industrial action. I am grateful to all our staff who helped with planning and worked to keep our patients safe.

Executive director service and team visits – July and August
All members of the executive team have a renewed focus on ensuring they are visible to staff across the organisation and all visits to team meetings, work shadowing, presentation of long service awards to individual staff etc. is now logged along with detail of any issues discussed.

Executives have been positively received by staff and patients. Examples of issues addressed include identification of areas where estates minor works are needed, an issue for a member of staff which was relatively easily addressed by the workforce team once communicated, provision of seating for patients. There has also been a recent focus on attending team meetings to discuss with staff any issues raised by the Lucy Letby case.

Board connections to and visibility in services and departments will continue and there are clear benefits in terms of better Board level understanding and knowledge of our frontline and back office services.

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

Queen Victoria Hospital
NHS Foundation Trust

QVH media update – June 2023

Appointing a new chief executive
The announcement of the appointment of James Lowell as chief executive at Queen Victoria Hospital received a number of mentions in the HSJ. This included an HSJ article (behind the paywall) with quote from James, currently chief operating officer at South London and Maudsley FT, about how with support from stakeholders he will be taking the hospital forward into the next chapter of its story; as well as mentions in the HSJ daily insight on 23 June and the HSJ weekly catch-up. The appointment was also mentioned on the Integrated Health website.

Community diagnostic centres hit 4 million checks milestone
The Government issued a press release (also posted on its website) highlighting how the one-stop shop community diagnostic centres have delivered over 4 million additional checks for a range of conditions from cancer to heart or lung disease. Queen Victoria Hospital was mentioned in the list of South East region centres who, as of 21 May 2023, had carried out 798,000 checks, tests and scans since July 2021.

Help us to help you
NHS Sussex issued an ask to Sussex residents to use services wisely during the June period of industrial action by junior doctors. Queen Victoria Hospital's minor injuries unit was listed as an alternative to accident and emergency for medical help that was not an emergency. The advice was also featured on the Sussex World website.

New system for Sussex Pathology Network
The decision by the Sussex Pathology Network, which includes Queen Victoria Hospital, to choose Clinisys to provide a laboratory information system (LIMS) that will help labs collaborate, was featured on two technology websites HT World and Tech Market View. A single LIMS will build on the supportive relationship that developed between trusts during the Covid-19 pandemic. The Sussex Pathology Network serves three trusts: East Sussex Healthcare NHS Trust, University Hospitals Sussex NHS Foundation Trust, and Queen Victoria Hospital NHS Foundation Trust.

Dog attack
Queen Victoria Hospital was mentioned by BBC News (Kent) and the Isle of Thanet News as providing treatment to a patient following a dog attack. Nick Phillipowsky from Margate is receiving treatment from the plastic surgery team for his injuries.

Ad hoc media
Queen Victoria Hospital was mentioned on a number of online investment websites in relation to company Feedback Medical which provides technology currently used by our Community Diagnostic Centre. These include Proactive Investors; Sharecast and Vox Markets.

Press releases
In June we published the following press release:

- Queen Victoria Hospital appoints new chief executive

We also published the following updates on our website:

- Arrangements during junior doctor industrial action – June 2023

QVH media update – July 2023

Sunburn warning
The Sun ran an article citing NHS figures which showed a 60 per cent increase in the number of babies suffering sunburn requiring hospital treatment. Queen Victoria Hospital was mentioned in relation to a press release issued in 2017 when its burns team treated a month-old baby for third-degree burns caused by the sun. The article was also featured in the US Times Post.

Happy birthday to the NHS
To mark the 75th anniversary of the NHS, a special ceremony was held at Westminster Abbey, attended by staff from across the country, including Sharron Phillips, hotel services team leader at Queen Victoria Hospital. She was amongst a number of staff attending from across Sussex. NHS Sussex ran an article on its website which was also shared by Sussex World.

Foundation trust governors
The HSJ's daily insight on 20 July discussed the role of governors, following a dispute about a Chair appointment in London. Queen Victoria Hospital was mentioned in the piece which stated QVH governors previously made a stand against a reconfiguration they disapproved of.

Industrial action
Queen Victoria Hospital was listed amongst other trusts, in relation to staff participating in industrial action. This included on the NHS Employers website regarding British Dental Association members voting to strike, and the NHS England website and BBC News regarding radiographers.

Poppy painting
Local artist Kirsty Chapman, who previously worked at Queen Victoria Hospital, was featured on ITV Meridian regarding a painting she has completed featuring the finger prints of 150 veterans marking out the path to peace. Kirsty was inspired by her grandmother Anna, who used to work alongside Sir Archibald McIndoe at the Queen Victoria Hospital burns unit.

Press releases
In July we published the following press release

- QVH colleagues to be part of a special service at Westminster Abbey to celebrate the 75th birthday of the NHS

We also published the following updates on our website

- Arrangements during junior doctor industrial action – 13-18 July 2023
- Arrangements during consultants industrial action – 20-22 July 2023
- Arrangements during radiographers industrial action – 25-27 July 2023

Integrated Dashboard

KSO1 and KSO2

	KPI	Latest Month Reported	Latest Month Value	Target	Variation	Assurance	Notes & Comments
IPACT	Clostridium Difficile acquired at QVH post 72 hrs after admission	Jul 23	0	3			Four cases in last 12 months
IPACT	MRSA acquired at QVH post 48 hrs after admission	Jul 23	0	0			No cases in last 12 months
IPACT	Lab confirmed cases of E-Coli in QVH Admitted Patients	Jul 23	1	0			Two cases in the last 12 months
IPACT	Lab confirmed cases of Gram-negative BSIs	Jul 23	0	0			No cases in last 12 months
PSS	Serious Incidents (SIs) reported in month	Jul 23	0	0			
PSS	Never Events reported in month	Jul 23	0	0			
PSS	Number of complaints in Month	Jul 23	3	-			
FFT	FFT likely/very likely to recommend Inpatients	Jul 23	100%	90%			
FFT	FFT likely/very likely to recommend Outpatients	Jul 23	96%	90%			
FFT	FFT likely/very likely to recommend MIU	Jul 23	92%	90%			
FFT	FFT likely/very likely to recommend Day Surgery	Jul 23	96%	90%			
FFT	FFT likely/very likely to recommend Sleep	Jul 23	96%	90%			
FFT	FFT likely/very likely to recommend Hand /Plastics Trauma	Jul 23	100%	90%			

KSO3 and KSO5

	KPI	Latest Month Reported	Latest Month Value	Target	Variation	Assurance	Notes & Comments
Performance	MIU <4Hrs	Jul 23	99.5%	95.0%			
Performance	Diagnostic Waits <6weeks All	Jul 23	73.0%	99.0%			As reported including Sleep
Performance	Diagnostic Waits <6weeks sleep only	Jul 23	49.6%	-			For information only - Sleep performance
RTT	Total RTT Waiting List Size	Jul 23	17649	-			
RTT	52 week	Jul 23	338	359			
RTT	65 week	Jul 23	55	0			
RTT	78 week	Jul 23	6	0			
Cancer	62 Day	Jun 23	83.3%	85.0%			
Cancer	Faster Diagnosis (FDS)	Jun 23	85.9%	80.0%			
Workforce	Vacancy Rate	Jun 23	-0.3%	8.0%			
Workforce	Turnover Rate	Jul 23	12.5%	10.0%			
Workforce	Sickness rate	Jun 23	4.0%	3.0%			
Workforce	Appraisal rate	Jul 23	85.4%	90.0%			
Workforce	MAST	Jul 23	93.0%	90.0%			

KSO4 – Headline data

**variation and assurance provided by finance team – no SPC applied

	KPI - KS04 Financial Stability	Month Reported	Value	Target	*Variation	*Assurance	Notes & Comments
Finance	Income	Jul-23	97,322	95,933			Currently no adverse impacts to outturn year to date
Finance	Pay Expenditure	Jul-23	(61,808)	(60,560)			Currently no adverse impacts to outturn year to date
Finance	Non Pay Expenditure	Jul-23	(35,987)	(35,373)			Currently no adverse impacts to outturn year to date
Finance	Surplus/(Deficit)	Jul-23	0	0			Currently no adverse impacts to outturn year to date
Finance	Capital Underspend/Overspend	Jul-23	0	0			Capex is on plan despite a slow start in the 1st half of the year
Finance	Recurrent CIPs	Jul-23	3,437	5,500			The required CIPs are being met non-recurrently via underspends
Finance	Agency Spend % (of Total Pay)	Jul-23	2.71%	3.75%			Agency Spend remains below ICS mandated target
Finance	FTE	Jul-23	1,034	1,065			Vacancy levels remain at a fair amount

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023		**Agenda reference:**	**81-23**	
Report title:	Board assurance framework (BAF) and risk management update				
Sponsor:	Clare Pirie, director of communication and corporate affairs				
Authors:	Clare Pirie, director of communication and corporate affairs Leonora May, deputy company secretary Karen Carter-Woods, head of risk and patient safety				
Appendices:	Appendix one: Corporate risk register (extract)				
Executive summary					
Purpose of report:	To provide an update on the Trust's risk management transformation programme				
Summary of key issues					
Recommendation:	The Board is asked to **note** the contents of the report and agree the eight strategic risks which will form the new Board assurance framework reflect the Trust's risk profile				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs)	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	See detail within report				
Corporate risk register:	See detail within report				
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	Strategic BAF risks previously considered by Board				
	Date:	August 2023	Decision:		
Next steps:	EMT 5 September - risk focused discussion to progress work on BAF and fill key gaps identified within CRR Board sub-committees in September and October – review of relevant extracts of CRR Senior staff (risk owners) training in September and October Board seminar November 2023 - to consider risk appetite for each of the newly identified strategic risks (BAF) Board November 2023 – approval of revised BAF				

Report to:	Board of Directors
Agenda item:	81-23
Date of meeting:	29 August 2023
Report from:	Clare Pirie, director of communications and corporate affairs
Report author:	Clare Pirie, director of communications and corporate affairs Leonora May, deputy company secretary Karen Carter-Woods, head of risk and patient safety
Date of report:	25 August 2023
Appendices:	Appendix one: Corporate risk register (extract)

Board assurance framework and risk management update

1. Executive Summary

This paper provides an update on the risk management transformation being undertaken at the Trust. Key elements of this work include revising the strategic and corporate risk profiles, and an update on both of these is included in this paper.

Recent efforts by the Board have been focussed on developing a revised list of strategic risks for inclusion in the Board Assurance Framework (BAF). The BAF is an important component of the Trust's risk management framework, functioning as the monitoring tool used by the Board to assess how effectively the strategic risks are being managed. An effective BAF also helps to drive the forward work plan and agendas for the Board and its Committees. The Trust has recognised that it requires a revised format for its BAF, and this is currently being developed.

The executive management team is currently focussing on revising the Corporate Risk Register (CRR) to ensure that this reflects the current view of the Trust's key risks. This refresh is being undertaken using a variety of information resources, including the revised strategic risk profile, departmental risks, and externally published risk intelligence. A copy of the current CRR is included at Appendix 1.

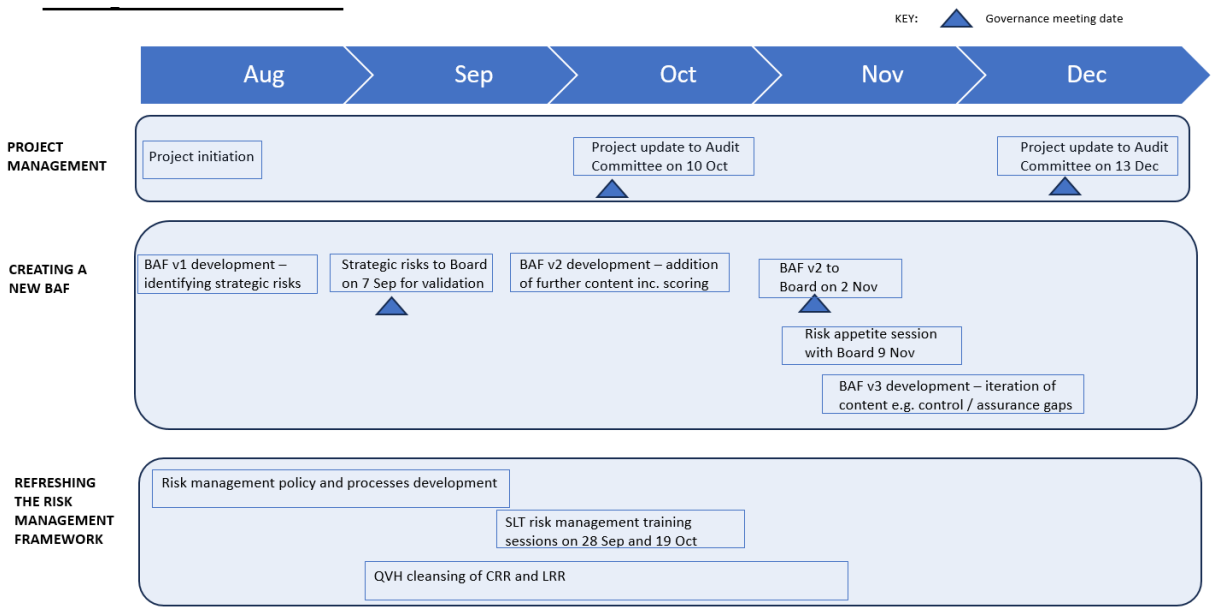
An overview of key next steps in the risk management evolution is set out at Section 6.

2. Background

The Trust is transforming its approach to risk management, revising the scope, content and format of our recording of risk in order to give the Board a clear view of the most material risks facing the Trust and how effectively these are being managed.

External support continues to be utilised to provide the additional capacity and expertise needed for this transformation.

The high-level project outline is shown below.
Diagram 1 – Project Outline



Progress in this work is being overseen by the director of communications and corporate affairs, working closely with the chief nurse. Updates on the progress of this transformation will be provided to the audit and risk committee, as the key oversight forum for this area.

3. Progress to date

The risk management transformation includes revising the overarching risk management policy, developing a revised Board Assurance Framework (refer to section 4) refining the content of the Corporate Risk Register (refer to section 5) and provision of training to increase internal capabilities (refer to section 6).

Activities undertaken to date include:

- Review of existing risk management strategy and policy
- Corporate risk register analysis
- Review of audit committee terms of reference
- Development of revised BAF template
- Identification of strategic risks by the Board for inclusion in the BAF

4. Strategic risks and the revised BAF

Strategic risks are those that could prevent or materially affect, delivery of the Trust's strategic objectives.

A Board workshop in July 2023 identified the key strategic risks. Further consideration of the outputs of this workshop have resulted in a revised list of strategic risks being compiled as follows:

1. There is a risk that the Trust fails to deliver effective, safe, timely and quality patient services
2. There is a risk that the Trust's workforce strategy fails to address the key external and internal challenges to support delivery of its operational and strategic objectives
3. There is a risk that the Trust's physical infrastructure (i.e., estate, equipment, and technology systems), is not fit for purpose to support an effective, efficient and safe environment for operational delivery
4. There is a risk that the Trust fails to secure its long-term sustainability leading to closure of services and /or the site
5. There is a risk that the Trust experiences a material legislative or regulatory compliance breach
6. There is a risk that the Trust is unable to deliver its financial plan
7. There is a risk that the Trust does not implement an effective information governance framework to support delivery of services, fulfil strategic objectives, and reduce the threat of a cyber-attack
8. There is a risk that the Trust does not develop and maintain collaborative relationships with partner organisations built on shared objectives and mutual trust

The Board is asked to note that it is usual, due to the strategic nature of the risks, for there to be crossover between strategic risks. For example, a dedicated strategic risk has been raised in respect of quality patient services, however there can be an impact on patient care outcomes and experiences felt across other strategic risks. It is also noted that some risks, if they materialise, may cause other risks to materialise. For example, an inadequate IT infrastructure can be the cause of an information governance incident occurring, which may also impact on patient services and result in a compliance breach.

It is recognised, given the nature of strategic risks, that each risk on the BAF may not fit neatly into a single executive portfolio. It is proposed that an approach should be implemented whereby each risk included on the BAF has a "principal" executive who is responsible for ensuring that the information presented in the BAF is accurate and up to date. Where applicable, certain risks will have supporting executives listed, for example, where the scope of the risk and accountability for key controls sits across different executive portfolios. These supporting executives will work alongside the principal executive to inform the BAF updates and may be asked to present to the Board in the absence of the principal. As a collective, the executive management team will be responsible for reviewing the BAF in its entirety

prior to presentation to the relevant Board oversight committee and Board itself.

The Board is further asked to note that many of the risks rely on the same mitigations. For example, stakeholder engagement and management is a golden thread running across multiple risks. Given the current position of the Trust and its development of a new strategy, it was felt that including a strategic risk around effective working with partners, specifically within the system, would be helpful.

Another golden thread is our culture and behaviours, and this is an area of particular focus for the Trust currently, specifically in respect of our speak up mechanisms. We will in the weeks ahead be considering what else we need to do at QVH to ensure that our culture of raising concerns is well understood, easy to use, and that staff know when their concerns have been heard and acted on.

The Board is asked to agree that the eight strategic risks above reflect the Trust's risk profile. Further review by the executive management team is required to fully populate the BAF records for each risk, and this will be undertaken as part of the wider work programme in September / October 2023. It is planned that the revised BAF will be included in public Board papers in November.

5. Corporate Risks

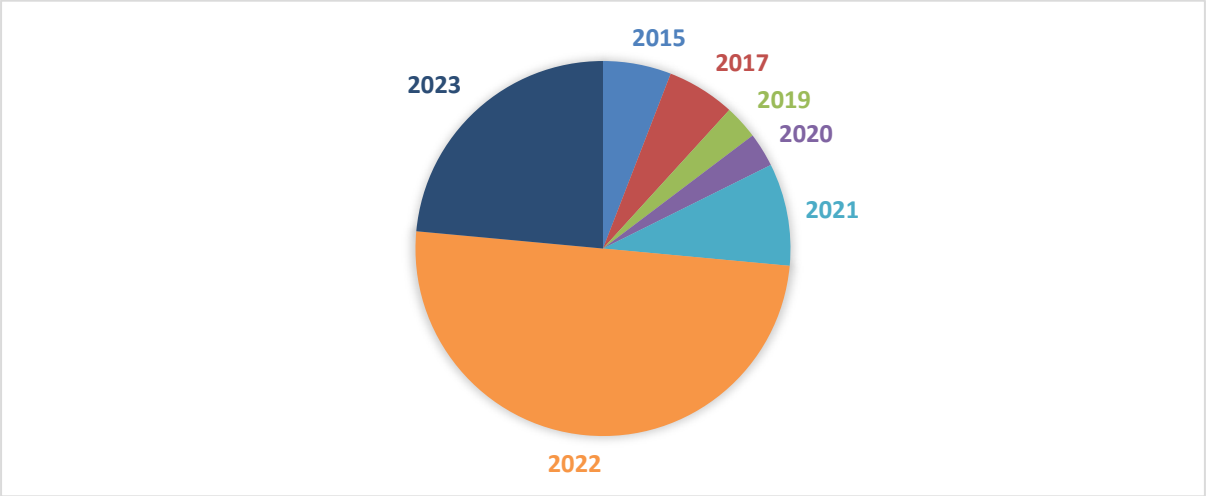
The Trust has recognised that as part of its refresh of the risk management framework, there is work to be completed on refining the content of the Corporate Risk Register, and the reporting thereof to enable the executive management team and Board to have sufficient oversight of the key corporate level risks and how effectively these are being managed.

A review of the Corporate Risk Register has been undertaken, and the need has been identified for the removal of items that are issues (rather than risks), the consolidation of thematic risks, and addition of new risks where there are gaps. The proposed new risks include risks related to patient transfers, major incident handling, and key staff dependency. These updates are being worked through with the executive management team before presentation to Board. New risks will also be reviewed through Board subcommittees.

The executive management team has also been systemically working through a review of existing risks on the CRR, focussing initially on the highest scoring and then looking at the oldest items in order to progress the cleansing of the register.

As shown below in table 1, over a quarter of the risks date from 2015 to 2021. The executive management team will be considering the validity of these risks, and whether there are any long-standing risks that need to be subject to a risk acceptance process.

Diagram 2 – Age analysis of Corporate Risk Register as at 8 August 2023



The risks on the August 2023 CRR have been mapped against the newly identified strategic risks, and the results will be reviewed by the executive management team before full Board review. This information will be maintained going forward to show the linkage between Corporate and Strategic risks and to help identify any gaps in the risk profiles.

Going forward, the Corporate Risk Register will comprise of the key risks, as agreed by the executive management team, that are wider in scope than a single directorate or function and /or significant in terms of their potential severity to warrant executive management team oversight. This will require the executive management team to agree the approach to recording and reporting issues, which have to date been largely captured on the Corporate Risk Register.

A copy of the current Corporate Risk Register is provided at Appendix 1.

Once the content of the Corporate Risk Register has been refined, there will be a standard reporting template prepared to provide insight and analysis for EMT and Board review. This report will include confirmation of newly added risks, risks where scores have been adjusted, and closed risks, alongside information regarding the active management of ongoing risks. Given the extensive work happening on the content of the CRR currently, the Trust is not providing the standard reporting update as per prior Board meetings.

An area of focus for the executive management team is holding their senior leaders to account for providing risk information, particularly in regard to actions to reach the target score. Reporting will include clear ownership and timeframes, and routine progress updates by risk owners to provide assurance over the effective management of the risks.

6. Next steps

The project will continue at pace as per the outline presented at section 2. A key area of focus during September and October 2023 will be on collating the information required for the revised BAF and cleansing of the Corporate Risk Register. There is a dedicated session scheduled with the Board in November 2023 to consider risk appetite for each of the newly identified strategic risks; this is a key component for inclusion in the BAF and to help drive the right conversations at Board meetings.

Training sessions for senior staff have been scheduled in September and October 2023 to ensure that they understand the rationale and benefits of having a consistent approach for identifying and describing risk, how to apply the risk assessment matrix for scoring, how to capture actions and how to create more specific progress updates. This is vital for ensuring the reliability of the risk information at departmental level, which is used to feed into the CRR.

Alongside these activities, the risk assessment matrix will be reviewed and a revised risk management strategy / policy document will be prepared.

An update will be provided at the next Board meeting.

7. Recommendation

The Board is asked to **note** the contents of the report and agree the eight strategic risks which will form the new Board assurance framework reflect the Trust's risk profile

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1319	20/06/2023	Recruitment challenges: Nursing and Allied Health Professionals	1. Risk to patient safety due to insufficient numbers of registered staff to meet the dependency of the patients□ □ 2. Risk to operational delivery due to insufficient numbers of registered staff to support patient flow particularly through Critical Care and peri op□	1. Enhanced bank pay to encourage uptake of shifts□ 2. Use of agency staff to provide "line booked" consistent support□ 3. Use of "break glass" agency in key high risk areas to maintain safety□ 4. Engagement with Health Education England to develop innovative roles to allow QVH to "grow their own" workforce□ 5. In extremis, activity reduced to maintain safety□ 6. Exit interviews to understand reasons for staff leaving□ 7. Bank and Waiting List Initiative task and finish group in place□ 8. Onboarding Task and Finish group in place□	Nicola Reeves	Liz Blackburn	Patient Safety	12	9		KSO1 KSO3 KSO5
1317	02/06/2023	Community Diagnostic Centre	There is a risk of failure to delivery of the CDC programme	Activity and income - working with primary care and commissioners to improve access and ensure referrer engagement and use of service□ Long term funding - CDC revenue to be agreed annually in line national process□ Estates - working with key stakeholders to develop a plan to ensure timeline meets the delivery requirements of new build □ Digital - working with key stakeholders to develop a plan and to ensure a value for money digital solution is in place by January 2024□ Workforce - workforce plan in place and collaborating with other CDCs□ Capital equipment purchasing - procurement process underway□ Strategic risk - governance structure in place to ensure project aims and delivery are monitored and risks are managed appropriately	Abigail Jago	Kathy Brasier	Compliance (Targets / Assessments / Standards)	12	9	**08.08.2023 -**□ Activity and income - remains in a similar position, working with commissioners to agree alternative patient pathways and explore mutual aid options to increase activity numbers. Comms piece underway to advertise short waiting times, etc. with primary care colleagues. Visits planned to engage face to face with local practices also. □ Estates - work continues with BLOOM, design and build team identified, working with procurement and BLOOM to gain Project Manager requirements. □ Digital - digital procurement tender documents being finalised internally, will seek legal advice prior to go live, adhering to procurement timeline, ahead of plan at this time.□ Workforce - no issues reported in month, stable position.□ Capital - funding allocation reviewed with Deputy CFO and capital planning team, linking in with commissioners and ICB.□ 20.07.2023 - □ Activity and income - further discussions underway with commissioners to identify how to grow the demand for physiological tests. meeting with new CFO to discuss options further following escalation of the issues experienced. □	KSO1 KSO2 KSO3 KSO4 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1309	05/05/2023	Fire Damper monitoring and connection	The Fire Dampers are not currently monitored or connected to a fire damper monitoring panel and in turn connected to the Fire Alarm system. The main area of concern is the main theatres plant rooms, although all fire dampers throughout the trust should be included as there is no service contract currently set up on any fire dampers.	Currently there are no controls in place. □ The Fire Team are fully aware of the situation and have initiated surveys and budget cost to solve the issue.	Maria Wheeler	Hugh Barter	Estates Infrastructure & Environment	15	10		KSO3
1307	11/05/2023	QVH Eye Bank: no budgeted establishment for Quality Manager	There is a risk that the absence of an independent Quality Manager for the eye bank will lead to restrictions being place on the QVH service by the MHRA Inspector. At the last MHRA inspection in September 2022 this was noted as a major failing / finding resulting in the provision of this independent role being an essential and unavoidable requirement.□ Termination of Medicines and Healthcare products Regulatory Authority (MHRA) and Human Tissue Authority (HTA) Licenses by the regulators. □ An independent Quality Manager is required to separate the functions of production and Quality Assurance which are currently performed by a single employee. □	Bank Quality Manager available, since April 2023, from Histology Team as is required□ Quality Management duties are currently undertaken by Eye Bank Head of Department who also carries out a production role and means that certain duties and functions are compromised.□ □ The Quality Manager role was put forward as part of Business Planning for 22/23 - not approved, further information required / sought	Shane Morrison-McCabe	Marc Tramontin	Compliance (Targets / Assessments / Standards)	12	6	**31.07.23** - Risk reviewed and updated. A further case will be made for the quality manager post (full-time), a case will also be put to the ICB for system financial support.□ 06.06.23 - POAP updated and benchmarking narrative supplied to Director of Ops for presentation at EMT. Bank employment covering requirements currently.□ 24.07.23 - Paper presented at F&P, request further rationale for wte and request to look at finances.□ 08.08.23 - Dir of Ops, GM, Head of Eye Bank and Finance Business Partner discussed next steps. Short paper being drawn up and methods of financing post from within budget being explored.	KSO1 KSO2 KSO3
1303	11/04/2023	Fire Safety works	Various Fire Safety works to be undertaken, including smoke detector location identification, installation of new fire safety panels new signage.	Work is being undertaken to identify and locate correct locations for smoke detectors and ensure this is recorded correctly on the Fire Panel in switch.	Maria Wheeler	Hugh Barter	Compliance (Targets / Assessments / Standards)	12	9		KSO3

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1299	13/07/2023	Open episodes without 'next event'	Identified circa 90,000 patients with an open episode on Patient Centre without a next event booked dating back to 2011. □ This cohort may include patients who require a next event in order to progress their treatment but have yet to have one organized.□	Initial validation of specialty cohorts underway □ NHS Intensive Support Team information sheet received – NHSE document – validation employed is based upon this NHS IST audit approach.□ This approach enables administration of large volumes of open pathways and managing bulk closures, utilising appropriate sample sizes, where clinically appropriate and in line with NHSE guidance□ Met with Source Group to discuss further validation requirements for the larger patient cohorts – data set shared with source group and awaiting feedback. We do not have indicative costs at this time, but would expect the volume of open episodes discussed initially would be able to complete the validation within 2 weeks.□ DQ workstream ongoing which will in part address episode management issues.□	Shane Morrison-McCabe	Marc Tramontin	Patient Safety	12	9	**08/08/23** - £70k available from the ICB to support validation of open episodes / follow up backlog. Explored options to outsource validation to Source Group and MBI (Luna). Plans being drawn up regarding preferred model to adopt to ensure validation begins at pace.	KSO1 KSO2 KSO4 KSO5
1297	28/02/2023	Shortage of Clinical Cover: Plastics	The Plastics Business Unit are presently short 1.6 WTE Skin Consultants (one of which also provides 2.5 PAs of weekly breast surgical activity), 1 WTE Microfellow, and 1 WTE Burns consultant.	A POAP has been written for backfilling 10.5 PAs of consultant time (a new job plan that needs Royal College approval).□ □ Two agency request forms have been completed and questions answered and returned to EMT. Two agency candidates are being interviewed this week: one for the 6.5 PA backfill and the other for the 10.□ □ A previous Associate Specialist has volunteered to return to the Trust , after having to terminate his contract prematurely. This post could potentially be used to backfill the Burns gap.□ □ A POAP is in process to backfill the 10 PA Skin/Breast post, which was formerly Cancer Alliance Funded.□ □ Cancer Alliance money has been released for a 7.5 PA consultant post, for which a POAP has been written and require further action to	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	9	**29.06.2023** - the picture here has now changed. The service has appointed 2 X new Skin consultants, one of which starts in August, the other in September. The service has appointed a new Burns consultant, who starts in September. The service is interviewing for the Breast consultant replacement on Tuesday 4 July. Once the individuals are in post, this risk can perhaps be stood down.	KSO3

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1296	11/01/2023	Electrical Power Distribution Network QVH: Operational Non Conformity	A dead fault short circuit could occur on the electrical distribution network at the QVH. Resulting from insufficient power supply effecting critical service provision. □ There is a risk that the Trust fails to deliver an effective and timely solution to ensure a efficient power supply is out in place, consequences include further cancellation of patient appointments resulting in reputation damage and income loss.□	The risks have been assessed by an independent specialist, outcomes used to inform an action plan .e.g. specialist equipment to be procured along with a major fault level study to be instated and applied at the QVH. Safer systems of work and training are to be instituted.□ Spike monitoring currently underway.□ Regular testing of generators introduced.□ Business continuity plan in place, with testing on quarterly basis.	Maria Wheeler	Hugh Barter	Estates Infrastructure & Environment	12	6	25/01/2023: To procure and undertake electrical distribution remediation study & fault level discrimination calculations and protection setting requirements by end of February 23.□ 11/04/2023: Work to be undertaken through Chris Dann (Estates Officer)and an Electrical consultant Norman Bromley to identify what are the issues and how these can be resolved to support the Trust Electrical infrastructure. This will also include the knowledge and experience of Alan Parry the electrical contractor used by the Trust over the years.	KSO2
1295	12/12/2022	Green Plan - delivery of project	Ineffective set up and delivery of the Green Plan project results in lack of progress against Trust and national objectives, breach of NHS provider contract requirements, loss of opportunity for accessing investment, and reputational damage	Green Plan actions monitored at monthly meeting, and reported bi-annually to F&P□ Agreed project workstreams	Clare Pirie	Clare Pirie	Compliance (Targets / Assessments / Standards)	12	6	Update April 2023□ QVH Green Plan work includes key elements in NHS Provider contract:□ - Removal of volatile gases in anaesthesia - delivered □ - Sustainability requirements added to tender documents - delivered□ - Renewable energy purchasing outstanding and under review. □ Other initiatives identified:□ - Cars for burns outreach will be replaced with zero or ultra-low emissions cars on contract renewal in 2024. □ - Procurement of onsite EV charging for installation paused due to lack of estates resource. □ - Option for staff to purchase higher emissions cars on salary sacrifice removed, zero emissions only. □ - Working up costed plans to decarbonise the site through insulation, solar panels, ground source heat pump - paused due to lack of estates resource.□	KSO4 KSO5
1294	28/11/2022	Financial Sustainability: contract alignment	Risk of deficit from 23/24 financial year due to convergence adjustment and inflationary cost pressures exceeding allocation impacting Trust ability to invest in services□	Annual Business planning with board approval and executive review of investments and cost pressures. Performance management monthly meetings to review and highlight financial and activity positions. Audit committee reports on internal controls in place. Monthly financial performance to Board and Finance and Performance Committee. Strengthened contract monitoring and efficiency programme process. Business case review group embedding.□	Maria Wheeler	Jeremy Satchwell	Finance	12	8	May 2023: reviewed - □ 22/23 Financial results breakeven Income and expenditure, cash of £11.7m and investments of £6.5m.□ Breakeven Plan for 23/24 submitted delivering 109% of 19/20 activity and 5.5% efficiency. QVH now in position to be enabler for Sussex ICB to deliver strategic plans and targets.□ □ Trust position is not now unsustainable and the risk of non-alignment of the contract income has mainly dissipated.□ Rescored□	KSO4

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1293	24/11/2022	Potential risk to compliance with national cleaning specifications	Increased Risk of infections in clinical areas due to reduced staffing levels.Risk of increased pressures within team. Increased risk of sickness within the team due to pressures	Clinical areas to be prioritised over non-clinical areas Business Continuity Plan in place□	Nicola Reeves	Paul Addison	Compliance (Targets / Assessments / Standards)	12	8	June 2023 - Risk reviewed and reworded to reflect potential risk.	KSO3
1292	22/11/2022	Overarching Corporate Risk - Securing a sustainable future for QVH	There is a risk of not being able to secure a sustainable future for QVH resulting in potential impact on existing services and future of the hospital.	Controls in place include the appointment of a Director of Strategy & Partnerships with the primary remit to develop and deliver the strategic plan. Clinical Services-stock take being carried out to inform clinical strategy	Abigail Jago	Kathy Brasier	Compliance (Targets / Assessments / Standards)	15	10	**August 2023** - Phase 1 engagement strategy underway, with significant engagement with stakeholders both internally and externally. Engagement tracker continues to capture overarching themes to be collated.□ Phase 2 includes three population co-design workshops. All planned and invitations sent for late September into October 2023.□ Resourcing - posts now closed, shortlisted and interviews set up.□ Clinical baseline stocktake including enabling services SWOT analysis to be tabled and socialised for moderation at HMT 21.08.2023.□ Working with CFO and finance team to demonstrate financial baseline position and service level detail, work underway. □ 20.07.2023 - Strategy engagement plan completed following internal and external stakeholder mapping and associated work. Being socialised via face to face and virtual forums. Engagement tracker in place and updated to ensure capture of all conversations and relevant themes are identified. Clinical stock take completed. Co-design, phase 2 of the engagement plan to commence, involving 3 population sessions planned for early October 2023. Resourcing requirement identified and approved, currently advertised.	KSO1 KSO2 KSO3 KSO4 undefined
1291	22/11/2022	Overarching Corporate Risk - Keeping our staff engaged, motivated and supported during a time of great change	Risk of not being able to keep our staff engaged, motivated and supported during a time of great change	Review of staff survey□ Early escalation of issues via exit interviews and "stay" interviews□ Listening and Engagement events with staff□ Partnership working forums with JCNC and JLNC□ EDS Staff Network□ Care First Employee Assistance Programme□ Staff Appraisal system□	Robert Stevens	Clare Pirie	Staff Safety	12	8	27/04/23: Process established for regular review of exit interviews. Feedback from staff ambassadors group, quarterly pulse survey and other sources kept under review.□ 24/01/2023: Better Place to Work Survey results being analysed with key recommendations to be put forward. Project Wingman on site to support staff engagement and recognition w/c 23 Jan for 2 weeks.□ Trust vacancy rates have fallen since June 2022 along with Turnover□ Staff Survey 2022 results due in Feb 2023 under embargo which will give us an understanding of areas of progress and concern□	KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1290	22/11/2022	Possible impact of infection outbreak on maintaining patient and staff safety in a post covid health care setting	Risk to patient and staff safety due to Covid and other possible infection outbreaks.	Rigid IPACT measures in place and management of outbreak guidance reviewed in light of post covid learning.□ □ □	Nicola Reeves	Liz Blackburn	Patient Safety	12	8	June 2023 - Risk reviewed following Corporate risk refresh□ April 2023 - Reduction in Covid screening as per national guidance. Lateral Flow tests in place for specific high risk cases.□ March 2023 - Risk reviewed. Trust moving to a BAU approach regarding management of infection control outbreaks. Risk 1210 closed as actions are incorporated in this risk□ February 2023 - Plans to reduce asymptomatic testing of staff continue. Small numbers of positive staff and patients continue to be seen but not creating operational issues at time of review.□ January 2023 - Reviewed, continue to see small numbers of covid positive patients and staff. Optigene lab will be "mothballed" in April 2023 □ December 2022 - Risk reviewed. Challenges remain in the "post covid" health economy for QVH. Impacts from staff sickness due to covid and positive patients attending have been seen during December.	KSO1 KSO2
1286	28/11/2022	Inability to provide full pharmacy services due to vacancies and sickness	There is a risk that, due to insufficient pharmacy staff and key staff being required to work clinically, key policies are not updated in a timely manner, leading to a risk to new services and out of date policies. Delays to indirect clinical services (e.g. updating policies/ guidelines/ audit/ training/ incident reviews)□ Unable to move forward with non-clinical initiatives e.g EPMA introduction□ Delays in projects e.g. DMS and unable to support new services□ Loss of established staff with organization memory and staff able to undertake certain tasks.□ Increase in incidents	1. Some bank in place to help.□ 2. Regularly chase agencies for any potential candidates.□ 3. Adverts on TRAC.□ 4. Recently vacated band 4 technician post to go on TRAC internally for those in training.□ 5. Staff working as team to ensure immediate work covered.□ 6. Chief Pharmacist working addition bank hours.□ 7. Direct clinical work a priority.□ 8. Have capped number of clinical trials department can take on to 3□	Shane Morrison-McCabe	Judy Busby	Compliance (Targets / Assessments / Standards)	12	8	**31.07.23** - Risk hazard wording reviewed and revised.□ 28/7/23 New band 7 pharmacist started but locum left so still without 2 WTE pharmacist cover. No applicants for either band 7 or band 8a posts. Band 5 technician handed in notice - moving to theatres and band 8a MSO will be handing in notice shortly. Appointed 2 new band 2 assistants - going through HR processes now. 8/6/23 Met with Director of Operations on 30/5/23 to discuss concerns regarding proposed establishment. new band 7 pharmacist started 5/6/23, still awaiting full Oc Health clearance regarding vaccination so dispensary based until fully cleared.□ 25/5/23 Budget proposed by business planning involves loss of 2.85 WTE. If this is implemented then some services will have to be reduced / cut permanently - priority will be given to patients safety. Risk of staff resigning, already stressed, overworked and demoralized as shown by staff survey. Will result in poor skill mix.□ 10/5/23 Band 7 still not cleared by Oc Health, but handed in notice at other hospital and hopefully will start beginning June. Band 3 and 4 posts filled. To go out to advert for band 2 vacant post (2WTE. Progressing with band 8b business plan on an page. Still no applicants	KSO1 KSO2 KSO3 KSO4 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1285	17/10/2022	Climate related risks to infrastructure	The potential risk of climate change on the estate and infrastructure which may impact patient and staff safety and the ability to provide a service which leads to business continuity issues	All building projects need to take climate change in to account to future proof and protect against business continuity incident. In addition reduction in the Trusts carbon footprint with the use of solar panels, electric car charging etc. Review of areas where heat particularly needs to be carried out. Risk assessment of air conditioning units in high risk areas	Nicola Reeves	Hugh Barter	Estates Infrastructure & Environment	12	6	June 2023 - Ongoing roof replacement work to address water ingress linked to increased heavy rain and thunderstorms. Clinical areas are still at risk of overheating during heatwave, risk reviewed and score increased to 12□ March 2023 - Risk reviewed. No changes □ January 2023 - Reviewed no changes	KSO1
1272	12/08/2022	Plastics Administration Team Resources	Challenges in delivering timely/adequate cover of our services such as theatre scheduling, Clinic typing and oncology scheduling and general patient pathway administration.□ □	Interim plans with the appointment of Bank staff; band 2, band 3 to support where needed. □ □ Substantive staff undertaking bank hours to help cover the backlog of work.□ □ Daily huddle to coordinate priority of workload through team□ □ Service Manager assisting at Band 4 level with oncology administrative processes.□ □ Support offered by other surgical services to help with scheduling.□ □ Service going out to agency, in light of shortage in Bank labour.□	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	9	29/06/2023 - the service is presently using Indeed.com, agencies, and conventional recruitment methods to explore possibility of appointing more admin' staff. The service have appointed a Rota Co-Ordinator, Scheduler, and second Cancer Co-Ordinator. The service ware out to advert for a band 5 Scheduling Team Leader, and Medical Secretaries. The service, according to current calculations, will be short 3 Medical Secretaries. The staffing issues, therefore, are easing and the department feels more settled. □ □ 25/01/2023 - the risk remains an ensuring, given that there have been 3 resignations in the department in the last two weeks and, in spite of having gone out to advert, there appears to be a very limited pool of people available to appoint. This has been a persistent problem for a good deal of time. The service may need to go to Bank or agency in the short-term to provide cover, in order to avoid burnout within the admin' team. Exit interviews will be performed with leavers to support retention of staff going forward. Conversations will be had with HR to explore what further can be done to improve upon its current recruitment strategy. □	KSO1 KSO2 KSO3

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1268	19/07/2022	Significantly Increased Referral Numbers to Sleep Service	There is a risk that, due to referral numbers to Sleep Services having doubled in comparison to previous rates and currently over 600 per month for a sustained period, that capacity is insufficient to enable patients to be seen and treated in a timely manner (<6wks).	Recruiting to new posts, although that in itself is a risk. Outsourcing of some overnight diagnostic tests where clinically appropriate. Consultant triages referrals to prioritise most urgent.	Shane Morrison-McCabe	Philip Kennedy	Compliance (Targets / Assessments / Standards)	16	8	**8.8.23** Outsourcing remains underway. New clinicians have commenced. System meetings led by the ICS are underway and an overall strategy / model for triage is being explored.□ 26.07.23 We continue to increase capacity by outsourcing two types of test and we are developing plans for a third to be undertaken in the patients own home rather than in hospital. □ □ 26.06.23 Initial meeting held with NHSE/ICB and awaiting follow up clinical network session. Meeting scheduled with UHSx to discuss their plans for re-opening OPD service □ □ 03.05.23 Still awaiting date for ICB task and finish group. Referrals remain at high level. Another new Consultant recruited.□ □ 30.03.23 No dates for task and finish group received from ICB, chasing e-mail sent. Additional medical staffing recruited and maximizing use of external diagnostic capacity.□ □ 06.03.23 Capacity & demand report completed and shared with Trust. To increase use of external companies to support diagnostic	KSO1 KSO2 KSO3 KSO4
1267	19/07/2022	Recruitment Challenges for Sleep Physiology and Technical team	Physiology/Technical team has had significant difficulties in recruiting to vacant posts. Trust has agreed to increase establishment following external review of service and benchmarking tools. Service may have long-standing vacant posts if cannot fill them all.	Seeking to apply Financial recruitment incentive for new starters. have sourced agency staff to support service. Consultant triages new referrals to ensure most urgent cases are prioritised.	Shane Morrison-McCabe	Philip Kennedy	Compliance (Targets / Assessments / Standards)	12	9	**08.08.23** On-going recruitment programme continues, including new staff from overseas and use of apprenticeship model□ □ 26.06.23 On-going recruitment programme due to leavers but approaching full establishment based on original benchmarking exercise.□ □ 03.05.23 New starters confirmed for May and June but other posts to be advertised due to leavers. Staffing model to be reviewed in light of increased referrals□ □ 30.03.23 New starters confirmed for April and further interviews arranged. □ □ 06.03.23 Significant progress with several new starters expected by end of April. 2 posts out to advert with 2 more to be advertised. If all are filled, this would bring us up to the agreed establishment following external review and benchmarking exercise. □ □ 31.01.23 Recruitment at all bands continues - unfortunately 1 chosen B7 candidate has withdrawn so re-advertised. □ 28.11.22 On-going recruitment process. Adverts placed for all teams and interviews to	KSO1 KSO2 KSO3 KSO4

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1266	24/06/2022	Ophthalmic electronic patient record (EPR) - absence	There is a risk that we have surgeons with higher than average complication rates when performing cataract surgery but will be unable to identify this in real time. This is due to the fact that we are only able to manage the quality assurance of NHS cataract surgery retrospectively due to the absence of a functioning Ophthalmic EPR preventing us from participating in the RCOphth National Ophthalmology Database (NOD) Audit.□ □ QVH participated in the NOD for the first 3 years, but withdrew from year 4 onwards as free use/licensing of Medisoft (one of the principle Ophthamic EPR systems) was withdrawn.	At present, we perform an annual partial retrospective audit, the most recent covering a 5 month period with an aim to audit PCR rate in line with RCOphth requirement in order to assess quality of care. To identify complications, multiple sources need to be utilized - cataract complications book: checking when vitrectomy used, theatre log books were used to check description of surgeries and the Ophthalmic implants book which is used across all theatres at QVH.	Shane Morrison-McCabe	Andre Litwin	Compliance (Targets / Assessments / Standards)	15	9	**08.08.23** - No further update□ 06.06.23 - General manager highlighted continued risk within Digital Strategy workshops and in strategic documents being developed. Any risk mitigation will be dictated by the digital strategy.□ 3.5.23 - Risk reviewed by Director of Operations and remains a risk. EMT and F&P fully aware.□ 17th March 2023: No further update□ 31st January 2023: GM engagement in digital strategy meetings and highlighted the importance of an Ophthalmology electronic solution. Further progress will be dictated by the digital strategy.□ 29th November 2022: How the Ophthalmology EPR sits within the information technology and systems workstreams needs to be decided and funding identified to ascertain when this project can commence.□ 27th October 2022: Due to the development of the QVH Digital strategy, the ophthalmology electronic system has been paused until April 2023. Once the capacity allocation to the Trust has been obtained, this project will be re-started.□ October 22 - Options appraisal being submitted to F&P end f October - prioritization within programme of works required.□	KSO2 KSO5
1255	17/02/2022	Sterile Services provision failures	There is a risk that our off site sterile services provider is unable to provide sterile services in line with the contract due to workforce and key processes. this leads to incomplete kit, absent kit or quarantined items.□ The risk is not being able to deliver timely services relating to theatres and outpatient clinics that require sterilized equipment	The sterile services equipment team leader meets daily with the customer service manager of the sterile service provider to ascertain what is required to deliver the service on a daily basis.□ There are weekly meetings with the decontamination lead, sterile services equipment team leader and general manager from the sterile service provider.	Shane Morrison-McCabe	Claire Ziegler	Compliance (Targets / Assessments / Standards)	12	9	**8.8.23**: Weekly meetings are now attended by the sterile service provider production manager, this ensures issues that are raised have clear action plans to resolve the issue promptly. More assurance is now in place. The DoOps led monthly contract review meetings are effective. Share Business Services - SBS are leading the re-procurement process for QVH sterile services, the existing contract term ends in May 2024.□ 15.6.23 QVH continues to have adverse incidents where there are incomplete kit and expired items that have not been returned. This is being chased through escalation processes. There is a contract review meeting 19.6.23. KPIs and the service specification will be revised to explore a tendering process in the next 8-12 months.□ 27.4.23 Sterile services contract monitoring meetings are now being held monthly, pre-contract reports set out data and performance against contract. Performance has been improving with fewer errors, daily scanning and updating is carried out, weekly operational meeting is held by QVH with Sterile service provider and any issues are being successfully mitigated and resolved there.□ □ 31.10.22 - Remedial action plan requested	KSO2 KSO3 KSO4 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1254	16/02/2022	Speech and Language Therapists Staffing (Inpatients and Outpatient/Community Services)	There is a risk that, due to insufficient S&LT staff, the provision of a consistent service to patients is adversely impacted. QVH SLT team has significant level of vacancies within substantive staffing.□ Resulting impact and risks:□ 1.Will breach local targets for waiting times for non-urgent outpatients □ 2.Inability to provide indirect clinical services-(training/reviews of policy's/audit) □ 3. Heavily reliant on Bank and agency staffing □ 4. High pressure on current SLT staff affecting wellbeing/moral	1. Weekly additional bank hours of substansive staff - 0.1WTE max □ 2. Patients with Urgent triage are prioritised at weekly caseload meeting□ 3. Regular team meetings, triage and debrief sessions for staff□ 4. Resourcing team in collaboration with Therapy manager and Principal SLT looking at boosting advertising □ 5. Clinical staff have delegated roles □ 6. Closely monitoring activity and demand, bi-monthly meetings with Manger and Principle SLT	Shane Morrison-McCabe	Sarah Holdsworth	Compliance (Targets / Assessments / Standards)	12	9	**Aug/2023** Current status of Waiting List- 20 patients total on waiting list for SLT- 2 Urgent referrals breaching by under 7days, 14 Routines breaching local KPI's. Longest waiter 181 days- significant improvement on last month. Restructure of SLT Team agreed, recruitment started. Interview completed and offer to internal SLT - Band 7 Community 0.5, permanently filled. Permanent Band 4 SLT post and band 6 post being advertised, interview TBC.□ Caseload meetings continue weekly and next full caseload review with patient communication scheduled for 31/08/23 to re-Ax prioritization.□ □ 31.07.23 - Risk hazard wording reviewed and revised.□ July/ 23: SIGNIFICANT IMPROVEMENT, Current waiting list status - 1 Urgent (not breaching) 17 routines (15 breaching)- since start of bank 0.4WTE. Restructure of SLT team in process clinical/finance team collaboration. Interview B7 SLT 11/08. JDPS needs completion for B4 post. Trust support with continuation of agency/bank work needs to continue next 6 months till sustainable plan in place with permanent recruitment completed. Improvement shared across	KSO1 KSO2 KSO5
1250	24/01/2022	Additional licence conditions	Breach of additional licence conditions.	Interim Chair in post□ Independent review jointly commissioned by NHSEI and QVH to make recommendations which will help resolve conflict and to build a consensus□ Communication of the change in licence conditions to all relevant stakeholders and discussion about the implications. □ Remedial action will be taken once the results of the review are published. □ Discussion at Board and CoG and development of an action plan that will be monitored by the regulator.□ □ March 2023 updated controls: Board and CoG fully aware of the additional licence conditions, and the requirement to operate in accordance with statutory roles and responsibilities. This is considered in the setting of agendas and the conduct of the meeting.□ □ The objective (target risk) -	Clare Pirie	Leonora May	Compliance (Targets / Assessments / Standards)	12	12	April 2023:□ Discussed at March audit committee and then April Board seminar. Risk score reduced as likelihood of breach reduced.□ □ March 2023: □ Chair and company secretary have had initial conversation with NHSE re process for review of licence conditions. Next step is for Board to consider progress and challenges in context of well led review, at April Board seminar. □ Updated controls - see Controls□ □ December 2022: □ The trust is under two additional licence conditions:□ The first relates to ensuring that the Trust has sufficient and effective Board leadership capacity and capability in place, and effectively functioning Council of Governors. □ The second condition relates to the Council of Governors working effectively with the Board, and operating in accordance with their statutory roles and responsibilities. □ The Trust has made progress on both these issues, including appointing a substantive Chair, there is however more work required.□ □ 26/9/22: Independent Review action plan	KSO3 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1249	17/01/2022	Sentinel Lymph Node Biopsy (SLNB) Wait List: capacity issues	Rise in demand to perform Sentinel Lymph Node Biopsy for skin cancer□ Not enough capacity in theatres & clinics to undertake them all leading to longer waits for patients and potential for clinical harm.□	Weekly SLNB meeting with Clinical Director, Clinical Lead for Skin, General Manager, Service Manager, SLNB Co-ordinator, and Clinical Nurse Specialists.□ □ Weekly tracking of non-admitted and admitted SLNB pathways.□ □ CNS 'safety netting', encouraging SLNB patients to look for recurrences and flag if identify them. CNSs also encouraging patients to maintain follow-up/surveillance cycle - as opposed to suspending because they are in expectation of treatment. Cost pressure as being done as additional hours.□ □ Weekend and in-week clinics and theatre lists being added.□ □ Sussex ICS Task and Finish Meeting in place. Support in validating long waiting patients to ensure we are doing everything we can to keep them safe.□ □	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	6	29.06.2023 - there have been no further new recurrences of metastatic disease reported since the SIs were formerly raised and there is a positive upward trajectory in terms of performance against the 31 day and 90 day standards for SLNB. As assurance, I have attached the action plan from the weekly SLNB Oversight Meeting to reflect the work that has been done, and is still being done, to improve the position.□ 3.5.23. Risk reviewed and remains in place - Director of Operations.□ 03/03/2023 - there are presently 3 patients awaiting TCI dates for SLNB and a further 27 who are scheduled for surgery in March. The service has enough baseline capacity and flexibility to cope with the surgical demand for the service; the issue at this stage is the outpatient dimension of the pathway. Whilst there are lots of actions under way to improve the pathway, the headlines are that the ICB are working with QVH to create a better pathway for SLNB patients and QVH are working in the mean-time to generate additional outpatient capacity, including increasing alignment of CNSs to consultant clinics.□ 30/01/2023 - Additional CNS hours to support pathway will be implemented as a cost	KSO1
1247	10/01/2022	First appointment delays from tertiary referrals: Plastics (skin)	First appointments not generated upon receipt of referral to QVH.□ Triage delays: paper copies	Review and improvement of processes □ Validation of PTL□ □ □	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	9	29/06/2023 - this process is not yet applied to all services in Plastics and therefore there are still some tertiary referrals that are distributed in purely paper form. Will catch-up with Service Manager to agree plan.□ 25/01/2023 - emailed Service Manager to clarify if there are any issues with process. □ 22/11/2022 - Medical Secretaries are printing the list of patients off instead of letting the consultants triage online. Will re-convene a meeting to discuss next steps for ensuring consultants use Evolve.□ 24/08/2022 - Evolve Triage Worklist roll-out initiated W/C 15 August. Need to confirm review date, in order to gauge effectiveness of programme.□ 25/7/22 Delay to roll out of Evolve Triage Worklist due to workload pressures. Updated user guide created and roll out by mid/end August. Incidents still being reported on no first appointments booked for some patients.□ 29/06/2022 - triage worklist trialed and proved to be a success. The ambition now is to roll it out more widely. At present we are still seeing instances of delayed address of first appointments and the intention is to raise these as incidents so that the problem can continue to be represented. □ □	KSO3

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1231	04/10/2021	Late tertiary cancer referrals	There is a risk to cancer performance due to the high volume of late tertiary referrals received by the trust. This impacts our 62 Day Referral to Treatment target and 62 Day Backlog trajectory.	unable to control externals late referrals, however:□ Weekly national/regional reporting. □ Twice weekly cancer PTL meetings which goes through each individual patient ensuring they have a next step booked within time. Escalations are sent out after each meeting. □ PTL is widely distributed across the trust, including admin and clinical staff. □ □ The responsible Committee should be the Cancer Board who meet monthly.	Shane Morrison-McCabe	Victoria Worrell	Compliance (Targets / Assessments / Standards)	15	9	29/06/23 update: Due to the trust's status as a tertiary centre for breast, H&N and skin, late tertiary referrals continues to be a key risk to cancer performance. However through the robust data collection and analysis the trust can accurately understand, and mitigate where possible, the risk to performance. The 24 day target is monitored at the monthly cancer board.□ 09/01/23 update: Late tertiary referrals continues to be a key risk to cancer performance, for the 62 Day Referral to Treatment target (24 Day target) and the 62 Day backlog trajectory. Both are closely monitored by the Cancer Board. Late referrals are a data item on the weekly ICB data pack. □ 16/11 update: Late tertiary referrals continues to be a key risk, receiving late referrals from 10 trusts across Kent, Surrey and Sussex. Continuing to closely monitoring the trusts 24 day performance at Cancer Board and in the weekly ICB submissions. □ 27.10.22 The issue of late tertiary referrals has been raised by the DoOps to ICS & NHSE colleagues at the Quarterly Assurance meeting held on 12th October. In addition, it is raised at the Planned Care Leads meeting to ensure system DGH peers expedite patient	KSO3
1226	13/07/2021	Adult Burns - Delivery of commissioned services whilst not meeting all national standards/criteria	-Lack of key services and support functions onsite (renal replacement facilities, on site labs, other acute medical and surgical specialties when needed urgently)□ □	-Operating at Unit level□ -Adult Burns inpatient peer review has taken place□ -Strict admission criteria in place, any patient not meeting criteria will be referred on to a Burns Centre□ -Low threshold for transferring out inpatients who deteriorate and require treatment not available at QVH □ -SLA in place with UHS for ITU verbal support	Tania Cubison	Mr Paul Drake	Patient Safety	12	8	March 2023 - Satisfactory peer review outcome. Work in progress to define model of care moving forwards in collaboration with commissioners and ODN. Capacity challenged due to critical care staffing issues. Patients reviewed on case by case basis to ensure appropriate admission□ December 2022 - Peer review completed, awaiting formal outcome although favorable feedback was given on the day.□ October 2022 - Peer review of service to be carried out 09/11/2022. Spec comm awaiting this outcome.□ June 2022: Specialised commissioners continue to review prior to creation of options appraisal□ 6/4/22 - no update on options appraisal available□ February 2022 - Specialised Commissioning continuing to work on case for change and options appraisal for provision of a compliant burns service□ 15/12/21: NHSE Specialised Commissioning leading work on Case for Change and Options Appraisal□ 31/03/2022 - we are at risk of being short 1.5 Burns Consultants given lead times for recruiting to these posts. Furthermore, we have had no eligible consultants in the last	KSO1 KSO2 KSO3 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1221	07/06/2021	Antimicrobial prescribing	Audit has shown that there are low levels of compliance with antimicrobial prescribing guidance.□ Antibiotics are being prescribed inappropriately by being prescribed when there is no indication, they are being prescribed for too long, no indication is being given, no duration is being documented, samples are not being sent for Microbiology analysis and when they are there is often no review of the organism and therefore antibiotic prescription is not altered.	Clear antimicrobial prescribing policy□ Micro guide available for all staff to download onto their smart devices□ 24 hours on call Microbiology service□ Audits of antibiotic prescribing. □ Infection control guidance and messaging and education of doctors. Indications for antibiotic prescribing mandated on drug charts.	Tania Cubison	Judy Busby	Patient Safety	15	9	**31/7/23** AMS group continues to meet chaired by Deputy Medical Director. IPACT nurses have re-audited.□ 8/6/23 Stewardship group met 24/5/23 with first meeting of new chair. No other medical representation from QVH. Some work started on reviewing guidelines and gaps□ 10/5/23 CQUIN for 2023-24 regarding IV to oral switch.□ 24/4/23 Antimicrobial Stewardship Game arrived. Plan for limited audit discussed ? head and neck cancer and hand trauma as high use areas. 4/4/23. Microbiologists agreed to twice weekly teams meeting DMD (ML)to take forward. 30/3/23 Deputy Medical Director leading on projects regarding guidelines.Ordered Antimicrobial Stewardship board game which looking to incorporate into junior doctor training and also for other staff. □ 6/3/23 Discussing POAP for combined post tomorrow at BCRG□ 9/2/23 Awaiting updated inpatient chart to be in place. Still unable to recruit into AM pharmacist post. Plan on page for combined theatre/AM pharmacist post submitted as part of business planning. New audit requested after higher profile of antimicrobial issues□ 4/1/23 Inpatient chart sent to printers with	KSO1 KSO2
1189	08/12/2020	Workforce succession planning: radiology	There is a risk that, due to insufficient staff, the consistent provision of imaging across all modalities will be adversely affected. This could impact the following:□ - Diagnostic turnaround times for imaging and report - poor DM01 performance.□ - Poor staff and patient safety metrics□ - Higher instances for errors (datix reportable)□ - Higher attrition rates with poor staff wellbeing metrics□ - Worse financial position if reliant on agency/locum staff□ - Less resilience in the imaging service□ - CDC expectation of 7 day working. Not possible currently within available workforce.	- monitoring staff levels and asking for bank / agency if needed□ - advent of apprentice roles□ - training US post available to assist with shortfall and succession planning□ - team engagement for career conversations/ wellbeing check ins□ - HEE funding for course□ □	Shane Morrison-McCabe	Sarah Solanki	Compliance (Targets / Assessments / Standards)	15	9	**13-08-2023** - 2 radiographers (band 5 and 6, 1 consultant and 1 band 3 RDA have handed their notice in this week). I have 1 sonographer who will need maternity cover in due course and 2 current vacancies in admin team. □ 31.07.23 - Risk title updated.□ 13-07-2023 - Interviewed Locum consultant post and appointed. Workforce planning and STAR workshop both progressing. Paper devised for EMT to be presented to promote the need for trust wide strategic workforce planning. □ □ 13-06-2023 - fixed term 6 month locum to support service during onboarding - TRAC application on system. Deep dive paper into workforce succession risk went to F&P in May. Outcome was that it has been acknowledged that this is a strategic issue and wider than radiology. Workforce planning now coming under strategy exec team and 1st meeting held with multiple professions. □ □ 11-05-2023 - POAP submitted to Exec to take forward for temporary agency cover for medical vacancy. 6PA per week for 3-6months. We may have someone interested in consultant role - visiting next week. 8A - interviewed and 3rd time lucky - role offered.	KSO1 KSO2 KSO3 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1168	20/12/2019	Significantly reduced Consultant Histopathologist cover	There is a Risk, due to insufficient Consultant Histopathologists nationally, of delayed Histopathology reporting and specialist dissection with potential failure to meet national cancer target turn around times as well as impacting on patient pathways and organisational reputation.□	Additional plastics specimen reporting being covered by current substantive consultant.□ Newly qualified reporting Biomedical Scientist reporting some skin work and undertakes some complex dissection.□ Newly employed agency Head and neck specialists to cover some Head and neck cancer reporting and MDTs.□ Outsourcing being investigated for additional head and neck cover/business continuity.□ Consultant head and neck pathologist who is leaving Aug 23 has agreed to remain on the bank.□ Exploring additional national/international recruitment via agencies.	Shane Morrison-McCabe	Fiona Lawson	Compliance (Targets / Assessments / Standards)	12	9	**Aug 23**: Head and neck pathologists recruited via agency (P/T). Outsourcing company being investigated for additional H&N reporting. Other agency CVs being reviewed and recruitment ongoing. outgoing H&N consultant agreed to remain on the bank. Risk description updated to reflect corporate request for change to structure of hazard/causes; current score reduced to reflect update.□ June23: Substantive H&N Pathologist due to leave 10th August - locum cover being sought as interim solution.□ May 2023: resignation of substantive H&N Pathologist, risk rescored to 15 and back onto the CRR□ 20 Feb 23 - Newly qualified advanced practitioner in Dermatopathology currently working on Stage D of reporting portfolio and continuing to help support the department with skin reporting. □ 24th Jan 23: existing staff member completed required reporting exams for skin - now an advanced practitioner in Dermatopathology and able to report most case types independently which alleviates some of this vacancy pressure. □ October 2022: discussed at CPG, awaiting update.□ September 22: exploring potential use of	KSO2 KSO3
1087	03/11/2017	Possible failure to comply with Mental Capacity Act	There is a risk that patients are not being assessed as per Mental Capacity act, caused by a number of challenges. Demographic of the patient cohort, frequently day case procedures, cancer pathway waiting list targets, variability in medical "buy in" and "one stop shop" patients. This leads to incomplete mental capacity assessments and can mean patients are not treated with due regard to their best interest. Documentation of the decision making process is often not complete.□ Unable to demonstrate we are safeguarding our most vulnerable patients (i.e. those without capacity to consent to treatment or surgery)	Awareness has been raised at meetings - a number of schedulers and medical secretaries and Pre assessment have received bespoke training regarding the MCA□ Safeguarding section on Evolve in which to save safeguarding and MCA forms□ Mitigations in place now need to fully embed in Trust. Risk reviewed □ Barrister workshop annually □ 2 hour specialist MCA training	Nicola Reeves	Liz Blackburn	Patient Safety	15	4	June 2023 - Total risk reviewed and in view of ongoing challenges with consistent approach to MCA assessment of appropriate patients, risk score increased.□ March 2023 - Reviewed. MCA policy to be re written. Education roll out for clinical colleagues, MCA update to board in late spring□ January 2023 - Reviewed. New MCA and safeguarding lead has commenced in post. Reviewing MCA policy and will be updating to bring in line with legislation, will be board seminar focusing on MCA in couple of months□ October 2022 - Audit completed awaiting new MCA lead to commence in post□ August 2022 - Data entry for MCA Audit taking place. □ July 2022 - MCA audit in process□ October 2021 MCA workshop facilitated by Barrister and set up to be repeated October 2022□ March 2021 MCA audits underway□ March 2021 Training MCA for consultants under review□ □ December 2020 MCA form updated and ready to launch, MCA audits ready to run□ □	KSO1 KSO3 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1040	13/02/2017	Age of X-ray equipment in radiology	- Poor patient care due to decrease image quality and higher radiation doses. □ - More risk of inaccurate diagnosis if poor image quality□ - Less resiliency in equipment if only a single piece of kit - could lead to service failure for a particular type of imaging. □ - more errors due to dose or quality issues.□ - less maneuverability in older kit meaning increase likelihood of manual handling injury. □ - financially expensive repairs on equipment that keeps failing□ - Lower Staff morale□ - workload and throughput - older kit means slower to process etc. □ - kit being used beyond economic state of repair or beyond recommended age of replacement. □ - potential to harm reputation	All equipment is under a maintenance contract, and is subject to QA checks by the maintenance company and by Medical Physics.□ □ Funding has helped support some replacements such as US/Xray room 2. □ Other kit is now ageing and approaching recommended age of replacement.□ □	Shane Morrison-McCabe	Sarah Solanki	Patient Safety	12	2	**11-08-2023** - EMT supported the exploration of Rowntree for use. proposals expected back from vendors regarding more cost neutral or partnership working. □ 13-07-2023 - Paper going to EMT regarding MES and preferred area for location of MRI. Options appraisal not fully complete as previous vendors were asked to provide more cost effective payment mechanisms to move project forward. Meetings yet to take place. □ 11-05-2023 - no update as MES project has not moved forward. Options appraisal for MES being refreshed at the moment by PM and RSM/GM. □ 3.5.23 - Risk reviewed by the Director of Operations and remains a risk.□ 27-03-2023 MES board held - financial team advised that ICB did not approve any additional capital so finance for MES not secure. EMT had approved the project in December with further approval at F&P in January. With this in mind - new head of financial services has asked for indicative costs for the kit should we have critical failure in the interim period for MES project. Buyers have been contacted regarding approaching supply chain. MES PM appointed and on-boarding finalised last week. MRI new model scanner approved, CCN completed and Req	KSO1 KSO2 KSO3
877	21/10/2015	Financial sustainability	1) Failure to achieve key financial targets would adversely impact the NHSI "Financial Sustainability Risk rating and breach the Trust's continuity of service licence. □ 2)Failure to generate surpluses to fund future operational and strategic investment	1) Annual financial and activity plan□ 2) Standing financial Instructions □ 3) Contract Management framework □ 4) Monthly monitoring of financial performance to Board and Finance and Performance committee 5) Performance Management framework including monthly service Performance review meetings 6) Audit Committee reports on internal controls□ 7) Internal audit plan	Maria Wheeler	Jeremy Satchwell	Finance	12	8	May 2023: 2022/23 Year End results have been finalized and the Trust achieved a breakeven position for Income and Expenditure, Cash in the Bank of £11.7m and invested the available capital of £6.5m. The Trust has also submitted a breakeven plan for 23/24 which achieves 109% of 19/20 activity and delivers 5.5% efficiency. This is pleasing result and provides a firm foundation for further investment and development from the ICB. QVH is now recognized as being a key enabler to the strategic development of the Sussex ICS and as such has demonstrated it has a sustainable future.□ September 2022: Month 6 YTD Breakeven and Breakeven Forecast Outturn for year end. Development of in year and longer term financial improvement projects continuing. Efficiency improvement plans to be further worked up with key stakeholders to support longer term financial sustainability. Additional work to evaluate the underlying financial risks and options for mitigation where these are available.□ August 2022: YTD breakeven position for month 3. Further work is ongoing with regards to forecasting for the year and also review of the planning for 23/25 in line with national guidelines. In addition the Trust has started	KSO4

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
834	09/09/2015	Non compliance with some of the national guidelines for paediatric care.	Unavailability of an onsite Paediatrician to review a sick child causing □ 1. Harm to child□ 2. Damage to reputation□ 3. Litigation	1. Service Level Agreement with UHSx providing some Paediatrician cover and external advice. □ 2. Consultant Anaesthetists, Site practitioners and selected Peanut Ward staff EPLS trained to recognise sick child and deal with immediate emergency resuscitation.□ 3. Policy reviewed to lower threshold to transfer sick children out □ 4. No inpatient burns cases□ 5. Operating on under 3 year olds out of hours ceased unless under exceptional circumstances□ □ With regards to SLA for paediatrician cover, □ 1. Continuous dialogue with consultants and business managers□ 2. Annual review meeting - Spring 2023□ □ Audit of all transfers out carried out on monthly basis and reviewed during Paediatric meeting.□	Tania Cubison	Dr Sarah Bailey	Patient Safety	12	4	March 2023 - Date for SLA review being negotiated.□ December 2022 - SLA being reviewed. Telephone advice and guidance in place when UHSx team are not on site. □ April 2022 - SLA still being reviewed□ February 2022: HoN reviewing SLA - nil other significant update□ June 2021: SLA with Associate Director of Business Development. DoN and QVH Paediatric Lead reviewing 2015 standards with a view to updating or changing GAP analysis□ March 2021: r/v DoN and Head of Patient Safety - SLA under review□ February 2021: r/v DoN and Head of Patient Safety - rescored to CRR□ January 2021: due to C-19 there are currently no paediatricians onsite at QVH - 24/7 cover for advice by telephone is available.□ July 2020: meeting held with BSUH & they continue to support this service□	

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023	**Agenda reference:**	**82-23**		
Report title:	Board sub-committee changes				
Sponsor:	Clare Pirie, director of communication and corporate affairs				
Author:	Leonora May, deputy company secretary				
Appendices:	Appendix one: sub-committee membership Appendix two: Audit and risk committee terms of reference Appendix three: Quality and safety committee terms of reference Appendix four: Finance and performance committee terms of reference				
Executive summary					
Purpose of report:	To present sub-committee changes to the Board for approval				
Summary of key issues	- The remit of sub-committees has been reviewed and changes have been made to terms of reference - Agreed variation from standard practice related to the roles of senior independent director and Chair of audit and risk committee				
Recommendation:	The Board is asked to: - **Approve** the updated terms of reference for the audit and risk committee, the quality and safety committee and the finance and performance committee which reflect the changes to membership, meeting frequency, names and remit as set out within this report - **Approve** the proposed changes to the standing orders and scheme of delegation and reservation of powers				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	Effectiveness of risk management framework to be monitored by the audit and risk committee				
Regulation:	Well-led review recommendations addressed				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	Changes to take effect from 1 October 2023				

Report to:	Board Directors
Agenda item:	82-23
Date of meeting:	7 September 2023
Report from:	Clare Pirie, director of communication and corporate affairs
Report author:	Leonora May, deputy company secretary
Date of report:	18 August 2023
Appendices:	Appendix one: sub-committee membership Appendix two: Audit and risk committee terms of reference Appendix three: Quality and safety committee terms of reference Appendix four: Finance and performance committee terms of reference

Sub-committee changes

Introduction

The Trust has undertaken a review of its sub-committees to address recommendations from its recent well-led review, and changes to the composition of the Board following the recruitment of three new non-executive directors.

Committee membership

Committee membership has been reviewed and the proposed Board member membership for each of the committees from 1 October 2023 is set out within appendix one to this report.

Paul Dillon-Robinson was appointed as senior independent director from 17 July 2023. His roles of senior independent director and Chair of the audit and risk committee will present a variation from good practice as the Code of governance for NHS provider trusts states that 'the Chair of the audit committee, ideally, should not be the deputy or vice Chair or senior independent director', however this is proposed as a pragmatic short term solution given that the Trust has three new non-executive directors. This position will be reviewed in January 2024 and the Trust will explain this deviation from the guidance in its annual report 2023/24.

Frequency of meetings

It is proposed that from 1 October 2023, the finance and performance committee will meet bi-monthly instead of monthly. The nomination and remuneration committee and the audit and risk committee will continue to meet quarterly and the strategic development committee will meet monthly.

Committee names and remits

It is proposed that the quality and governance committee is renamed to the quality and safety committee to increase clarity regarding the committees remit in line with the recommendation from the Trust's well-led review, and that the audit committee is renamed to the audit and risk committee.

The audit and risk committee will provide an increased level of scrutiny and assurance over the Trust's risk management framework. The audit and risk committee is the forum through which the Board seeks assurance on governance, risk management and internal control, including scrutiny of risk management. The terms of reference for this committee have been reviewed to strengthen this function and they are included as appendix two to this report.

The terms of reference for the quality and safety committee and the finance and performance committee have also been reviewed in line with the changes set out

above and to ensure that there is no duplication between the committees, specifically related to workforce as recommended by the well-led review. These terms of reference are included within appendices three and four to this report.

Specific responsibilities related to enabling strategies and investment opportunities within the finance and performance committee terms of reference have been removed to avoid duplication with the strategic development committee, which has responsibility for those areas.

Standing orders and scheme of delegation and reservation of power

In line with the changes described above, the following changes will be made to the Trust's standing orders and scheme of delegation and reservation of power:

Standing orders

- References to 'audit committee' changed to 'audit and risk committee'
- References to 'quality and governance committee' changed to 'quality and safety committee'

Scheme of delegation and reservation of power

- References to 'audit committee' changed to 'audit and risk committee'
- References to 'quality and governance committee' changed to 'quality and safety committee'
- Removal of delegated authority to the finance and performance committee for oversight and scrutiny of the Trust's estates and facilities strategy as this becomes the responsibility of the strategic development committee

Recommendation

The Board is asked to**:**

- **Approve** the updated terms of reference for the audit and risk committee, the quality and safety committee and the finance and performance committee which reflect the changes to membership, meeting frequency, names and remit as set out within this report
- **Approve** the proposed changes to the standing orders and scheme of delegation and reservation of powers as set out above

Committee membership 2023/24 (Board members) – from 1st October

Finance & performance committee	
Voting	**Non-voting**
• Peter O'Donnell, Non-executive director (committee Chair) • Russell Hobby, Non-executive director • Jackie Smith, Trust Chair • James Lowell, Chief executive • Maria Wheeler, Chief finance officer • Shane Morrison-McCabe, Director of operations • Rob Stevens, Interim chief people officer	• Nicky Reeves, Chief nurse • Abigail Jago, Director of strategy and partnerships

Quality & safety committee	
Voting	**Non-voting**
• Karen Norman, Non-executive director (committee Chair) • Paul Dillon-Robinson, Non-executive director • Shaun O'Leary, Non-executive director • James Lowell, Chief executive • Nicky Reeves, Chief nurse • Tania Cubison, Medical director • Maria Wheeler, Chief finance officer • Shane Morrison-McCabe, Director of operations • Rob Stevens, Interim chief people officer	• Abigail Jago, Director of strategy and partnerships

Audit and risk committee	
Voting	**Non-voting**
• Paul Dillon-Robinson, Non-executive director (committee Chair) • Russell Hobby, Non-executive director • Peter O'Donnell, Non-executive director	• James Lowell, Chief executive • Representatives of the Trust's internal auditors • Representatives of the Trust's external auditors • Representative of the Trust's counter fraud specialist

Strategic development committee	
Voting	**Non-voting**
• Jackie Smith, Trust Chair (committee Chair) • Shaun O'Leary, Non-executive director • Karen Norman, Non-executive director • James Lowell, Chief executive • Abigail Jago, Director of strategy & partnerships	

Nomination & remuneration committee	
Voting	**Non-voting**
• Jackie Smith, Trust Chair (committee Chair) • Paul Dillion-Robinson, Non-executive director • Karen Norman, Non-executive director • Shaun O'Leary, Non-executive director • Peter O' Donnell, Non-executive director • Russell Hobby, Non-executive director	• James Lowell, Chief executive • Rob Stevens, Interim chief people officer

Charity committee	
Voting	**Non-voting**
• Karen Norman, Non-executive director (committee Chair) • Shaun O'Leary, Non-executive director • Russell Hobby, Non-executive director	• Clare Pirie, Director of communications & corporate affairs

Terms of reference

Name of governance body

Audit and Risk committee

Constitution

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

Accountability

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

Authority

The Committee is authorised by the Board of Directors to:

- investigate any activity within its terms of reference, and commission appropriate independent reviews and studies (subject to approval of spend in line with ~~financial delegated limits~~scheme of delegation and reservation of powers)
- seek relevant information from within the Trust and from any employee (all departments and employees are required to co-operate with requests from the committee).
- obtain relevant legal or other independent advice and to invite professionals with relevant experience and expertise to attend meetings of the committee (subject to approval of spend in line with scheme of delegation and reservation of powers~~budgets agreed by the Board~~). For legal advice, the director of communications and corporate affairs or deputy company secretary shall be consulted prior to procurement of external advice

Purpose

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

Duties and responsibilities

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

- **Integrated governance, risk management and internal control**

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

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit

opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board of directors.

- The underlying assurance processes, including the board assurance framework, that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements (this may be carried out in conjunction with other board committees ~~who~~which ~~will~~ scrutinise and oversee the management of relevant strategic risks).
- The Board of Directors sub-committees, including terms of reference, workplans and span of reporting on an annual basis.
- The effectiveness of assurance arrangements over the Trust's role within the Integrated Care Board (ICB) and other partnership arrangements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by the NHS Counter Fraud Authority~~Protect~~.

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

As part of its integrated approach, the Committee will have effective relationships with other key governance bodies of the Trust (for example, the Quality and ~~Governance~~ Safety Committee) ~~so that it understands processes and linkages~~to support the ~~committees~~committee's oversight role relating to the effectiveness of clinical systems of internal control.

- **Financial reporting**

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

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

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

- Reviewing the annual governance declaration statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statement in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Adequacy of management response to issues identified by audit activity
- Letters of representation
- Explanations for significant variances

The committee should review schedules of losses and compensations, making recommendations to the Board of Directors.

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

The committee ~~should monitor compliance~~will receive assurance on compliance with the Trust's standing orders and standing financial instructions.

The committee will review the waiver register.

Internal audit
The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2017 and provides appropriate independent assurance to the Committee, Chief Executive (as accounting officer) and Board of Directors. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved, making recommendations to the Board of Directors regarding the appointment of the internal auditors.
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response), ~~and~~ ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.
- Meeting with the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out.

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

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment allow (and making recommendations to the council of governors when appropriate).
- Ensuring that the work of the external auditor meets the requirements of the regulator and other regulatory bodies.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual audit plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation.

- Reviewing all external audit reports and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

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

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

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

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

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

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

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

In reviewing the work of ~~a~~ the Quality and ~~Governance~~ Safety Committee, and issues around clinical risk management, the Committee will wish to ~~satisfy itself on the~~receive assurance relating to the effectiveness of systems and processes of clinical governance ~~that can be gained from the~~including the clinical audit function.

Meetings

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

The Committee will meet at least four (4) times a year. The timing of ~~Audit~~ Committee meetings should be planned to coincide with the important events in the year, thereby

ensuring that the ~~Audit~~ Committee is able to exercise its power to influence events.

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

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

Any member of the Committee can ask for a meeting to be convened in person, by video- conference or by telephone, or for a matter to be considered in correspondence.

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

Notice of each meeting confirming the venue, time and date together with an Agenda shall be circulated by the Secretary to each member of the Committee at least 5 clear days prior to the date of the meeting.

Conflicts of Interest

All members and attendees of the Committee must declare any relevant potential interests at the commencement of any meeting. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

Where the Committee considers an item of its business may give rise to a potential conflict by meeting in common, the Committee may refer that business to the Board.

Chairing

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

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

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

Secretariat

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

- Preparation of the draft agenda for agreement with the Chair
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers

- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the Committee's work programme.

Membership

Members with voting rights

The Committee will comprise at least three non-executive directors who shall each have full voting rights. The Chair of the Trust shall not Chair, be a member of, nor have the right to attend Committee meetings without invitation by the Chair as and when appropriate and necessary.~~, nor regularly attend the Committee.~~

The Committee is authorised to co-opt additional members to provide specialist skills, knowledge and experience. At least one Committee member should have recent and relevant financial experience.

Ex-officio attendees without voting rights

- Chief Executive (as Accounting Officer) who shall discuss with the Committee at least annually the process for assurance that supports the annual governance statement. The Chief Executive should also be in attendance when the Committee considers the draft annual governance statement along with the annual report and accounts.
- Representatives of the Trust's internal auditors.
- Representatives of the Trust's external auditors.
- The Trust's counter fraud specialist who will be entitled to attend any committee meeting and have a right of access to all committee members~~shall attend at least two meetings of the Committee in each financial year.~~

In attendance without voting rights

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

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

Quorum

For any meeting of the Committee to proceed, two non-executive director members of the Committee must be present. ~~.~~A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Attendance
Members and attendees are expected to attend all meetings or to send apologies to the chair and Committee secretary at least five clear days* prior to each meeting. Attendees may, by exception and with the consent of the chair, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act on behalf of the Committee attendee. The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.
Papers
Meeting agendas and papers to be distributed to members and individuals invited to attend at least five clear days* prior to the meeting.
Reporting
~~Minutes of the Committee's meetings shall be recorded formally and ratified by the Committee at its next meeting.~~ The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting. The Committee chair shall prepare a report of each Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues which require disclosure to the Board of Directors including where executive action is continually failing to address significant weaknesses. Issues of concern and/or urgency will be reported to the Board of Directors in between its formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the Trust chair. Instances of this nature will be reported to the Board of Directors at its next formal business meeting. The Committee will also report to the Board of Directors at least annually on its work in support of the annual governance statement, specifically commenting on: • The fitness for purpose of the assurance framework • The completeness and 'embeddedness' of risk management in the organisation • The integration of governance arrangements • The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business • The robustness of the processes behind the quality accounts The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. In addition, the Committee shall make an annual report to the council of governors in relation to the performance of the external auditor to enable the council of governors to consider whether or not to re-appoint them.

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

Review

~~These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency.~~ The committee will review on an annual basis its own performance and terms of reference to ensure that it is operating effectively and in line with best practice. The outcomes of this review will be reported in writing to the Board.

The next scheduled review of these terms of reference will be undertaken by the Committee in December 2023 in anticipation of approval by the Board of Directors at its meeting in March 2024.

* Definitions

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

Terms of Reference

Name of governance body

Quality & ~~Governance~~ Safety (Q&S~~G~~) Committee

Constitution

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

Accountability

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

Authority

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

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

Purpose

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

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

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

- Health and safety
- Clinical Governance
- Information Governance (IG)
- Management of medicines and clinical devices
- Safeguarding
- Patient experience
- Infection control
- Research and development governance
- All associated policies and procedures.
- Medical devices
- Clinical audit
- Emergency preparedness resilience and response
- Appraisal & revalidation of medical staff
- Guardian of Safe Working
- CQuIN's
- Patient safety
- Learning from deaths

To fulfil its purpose, the committee will also:

- Identify the key issues and risks requiring discussion or decision by the Board of Directors and advise on appropriate mitigating actions.

- Make recommendations to the Board about the amendment or modification of the Trust's strategic initiatives in the light of changing circumstances or issues arising from implementation.
- Work closely with the Audit and Risk and Finance & Performance committees as necessary.

Duties and Responsibilities

Duties

- Support the compilation of the Trust's annual quality accounts and recommend to the Board of Directors its submission to the Care Quality Commission.
- Approve quality priorities recommended by the Clinical Governance Group for the Board of Directors.
- Ensure that the audit programme adequately addresses issues of relevance and any significant gaps in assurance.
- Receive a quarterly report on healthcare acquired infections and resultant actions.
- Receive and review bi-monthly integrated reports encompassing complaints, litigation, incidents and other patient experience activity.
- Refer issues related to workforce to the Finance and Performance committee and seek assurance from the committee that workforce issues that impact or could impact quality of care are being effectively monitored and that effective action plans are in place~~Ensure that where workforce issues impact, or have a direct relationship with quality of care, they are discussed and monitored.~~
- Review bi-monthly quality components of the corporate risk register (patient safety risks) and assurance framework and make recommendations on areas requiring audit attention, to assist in ensuring that the Trust's audit plans are properly focused on relevant aspects of the risk profile and on any significant gaps in the assurance.
- Ensure that management processes are in place which provide assurance that the Trust has taken appropriate action in response to relevant independent reports, government guidance, statutory instruments and ad hoc reports from enquiries and independent reviews.
- Ensure there are clear lines of accountability for the overall quality and safety of clinical care and risk management.
- Hold to account business units and directorates on all matters relating to quality, risk and governance.

Responsibilities

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

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

Meetings

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

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

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

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

Notice of each meeting confirming the venue, time and date together with an Agenda shall be circulated by the Secretary to each member of the Committee at least 5 clear days prior to the date of the meeting.

Chairing

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

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

Secretariat

The ~~Executive Assistant to the Chief Nurse~~Governance Officer shall be the secretary to the Committee and shall provide administrative support and advice to the chair and membership. The duties of the secretary shall include but not be limited to:

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

Membership

Members

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

- Three~~X2~~ non-executive directors
- Chief Executive
- Chief Nurse
- Deputy Chief Nurse
- Medical Director
- Chief Finance Officer
- Director of Operations
- ~~Director of Workforce and Organisational Development~~Chief People Officer
- Head of Risk and Patient Safety
- Head of Quality and Compliance
- Clinical Director for Clinical Governance
- Allied health Professional Lead
- Chief Pharmacist

Designated deputies will attend as appropriate

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

- The secretary to the Committee (for the purposes described above)
- Director of communications & corporate affairs
- Clinical director of research & innovation
- Director of strategy and partnerships
- Chair of the Board
- The Trust's internal auditor
- Sussex ICB Quality Representative
- Other invitees as appropriate by prior agreement with the Chair

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

Quorum

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

- Two non-executive directors (incl. chair of committee)
- Either the Chief Nurse or Deputy Director of Nursing
- One other director
- Two other members

A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Attendance

Members are expected to attend all meetings or to send apologies to the chair and Committee secretary at least five clear days* prior to each meeting. A suitable deputy should be sent to cover any absence. Deputies must be appropriately senior and empowered to act and vote on the behalf of the Committee member. Furthermore, members need to advise the chair in advance if they have to leave the meeting early or are planning to arrive late.

The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

Papers

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

Reporting

The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting. ~~Minutes of the committee's meeting shall be recorded formally and ratified by the Committee at its next meeting.~~

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

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

Issues of concern and/or urgency will be reported to the board of directors in between formal business meetings by other means and/or as part of other meeting agendas as necessary and

agreed with the Trust chair. Instances of this nature will be reported to the board of directors at its next formal business meeting.

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

Final and approved minutes of Committee meetings shall be circulated to the clinical cabinet and non-executive directors. The Committee chair shall provide an annual report to the Audit and Risk committee to provide assurance on the governance arrangements.

The Committee chair shall report at quarterly meetings of the Council of Governors.

Review

The committee will review on an annual basis its own performance and terms of reference to ensure that it is operating effectively and in line with best practice. The outcomes of this review will be reported in writing to the Board. ~~These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency.~~

The next scheduled review of these terms of reference will be undertaken by the Committee in ~~February~~ January 2024 in anticipation of approval by the Board of Directors at its meeting in March 2024.

Definitions

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

Terms of reference

Name of governance body

Finance and Performance Committee (F&PC)

Constitution

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

Accountability

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

Authority

The Committee is authorised by the Board of Directors to seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary, subject to approval of spend in line with scheme of delegation and reservation of power.

Purpose

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

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

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

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

To fulfil its purpose, the Committee will also:

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

Duties and responsibilities

Duties

Financial and operational performance

- Review and challenge construction of operational and financial plans for the planning period as defined by the regulators.
- Review, interpret and challenge in-year financial and operational performance.

- Review, interpret and challenge workforce profile metrics including sickness absence, people management, bank and agency usage, statutory and mandatory training compliance and recruitment.
- Oversee the development and delivery of any corrective action plans and advise the Board of Directors accordingly.
- Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the Board of Directors.
- Refer issues of quality or specific aspects of the Quality and ~~Governance~~ Safety Committee's remit, and maintain communication between the two committees to provide joint assurance to the Board of Directors.

Corporate risks

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

Estates and Facilities ~~strategy and~~ maintenance programmes

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

~~*Information management and technology strategy, performance and development*~~
~~Review the delivery of the Trust's IM&T strategy and planned development programmes as agreed by the Board of Directors.~~

Capital and other investment programmes and decisions

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

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

Cost improvement plans

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

~~*Business development opportunities and business cases*~~

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

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

Responsibilities

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

- Monthly financial and operational performance.
- Estates strategy and maintenance programme.

- ~~Information management and technology strategy, performance and development.~~

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

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

Charing

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

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

Meetings

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

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

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

Notice of each meeting confirming the venue, time and date together with an Agenda shall be circulated by the Secretary to each member of the Committee at least 5 working days prior to the date of the meeting.

Secretariat

The Governance Officer shall be the secretary to the Committee and shall provide administrative support and advice to the chair and membership. The duties of the secretary shall include but not be limited to:

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

Membership

Members with voting rights

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

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

Ex-officio members without voting rights

- ~~The~~ Chief Nurse
- Director of Strategy and Partnerships

In attendance without voting rights
The following posts shall be invited to attend meetings of the Committee in full or in part, but shall neither be a member nor have voting rights.

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

Quorum

For any meeting of the Committee to proceed, two non-executive directors and one executive director of the Trust must be present.

A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Attendance

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

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

The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

Papers

Papers to be distributed to members and those in attendance at least three clear days in advance of the meeting.

Reporting

The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting.~~Minutes of the Committee's meetings shall be recorded formally and ratified by the Committee at its next meeting.~~

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

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

The Committee Chair shall report at quarterly meetings of the Council of Governors.

Review
These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency. The next scheduled review of these terms of reference will be undertaken by the Committee in ~~February~~ January 2024 in anticipation of approval by the Board of Directors at its meeting in March 2024.
***Definitions**
In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023		**Agenda reference:**	**83-23**	
Report title:	Nomination and remuneration committee terms of reference				
Sponsor:	Jackie Smith, Trust Chair				
Author:	Leonora May, deputy company secretary				
Appendices:	Appendix one: nomination and remuneration committee terms of reference				
Executive summary					
Purpose of report:	To present the committee terms of reference to the Board for approval				
Summary of key issues	The committee terms of reference have been reviewed by the committee at its meetings in March and July 2023. The committee's comments and suggestions on the terms of reference have been incorporated into this version, as well as any updates required by the Code of governance for NHS provider trusts, which came into effect from 1 April 2023.				
Recommendation:	The Board is asked to **approve** the terms of reference.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	NA				
Corporate risk register:	NA				
Regulation:	Code of governance for NHS provider trusts Constitution Standing Orders				
Legal:	NA				
Resources:	NA				
Assurance route					
Previously considered by:	Nomination and remuneration committee				
	Date:	17/7/2023	Decision:		
Next steps:	New terms of reference to come into effect from 7 September 2023				

Report to:	Board Directors
Agenda item:	83-23
Date of meeting:	7 September 2023
Report from:	Jackie Smith, Trust Chair
Report author:	Leonora May, deputy company secretary
Date of report:	22 August 2023
Appendices:	Appendix one: nomination and remuneration committee terms of reference

Nomination and remuneration committee terms of reference

Introduction

The nomination and remuneration committee terms of reference are presented to the Board for approval following update.

Executive summary

The terms of reference have been updated in line with feedback received from the committee at its meetings on 2 March 2023 and 17 July 2023, and any updates required by the Code of governance for NHS provider trusts, which came into effect from 1 April 2023. Updates to the terms of reference have been change tracked.

Recommendation

The Board is asked to **approve** the nomination and remuneration committee terms of reference.

Terms of reference

Name of governance body

Nomination and Remuneration Committee

Constitution

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

Accountability

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

Authority

The Committee is authorised by the Board of Directors to:

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

Purpose

The purpose of the Committee is to:

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

- ~~Set the overall policy for the~~ Determine remuneration packages and contractual terms of the executive management team in line with benchmarking and national guidance.

Duties and responsibilities

Duties (nominations)

- When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, including diversity of skills, experience and knowledge and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment.
- Use open advertising or the services of external advisers to facilitate candidate searches.
- Give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required to meet them.
- ~~Consider candidates from a wide range of backgrounds on merit against objective criteria.~~
- Ensure that appointments and succession plans are based on merit and objective criteria and, within this context, promote diversity of gender, social and ethnic backgrounds, disability and personal strengths.
- Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.
- Ensure that proposed appointees meet the "fit and proper person test", and confirm their awareness of the circumstances which would prevent them from holding office.
- Consider any matter relating to the continuation in office of any executive director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.
- ~~whilst remaining a fair employer and subject to the provisions of the law~~Ensure that ~~any director level severance payment whether contractual or non-contractual is discussed with the Trust's NHS England regional director at the earliest opportunity.~~

Duties (remuneration)

- Establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully and collaborate effectively with system partners, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust. To do this, the committee will:
    - Follow the national NHSE VSM (very senior manager) pay strategy and associated QVH VSM pay principles in respect of executive board directors and other positions that report to the chief executive.
    - Use market benchmarking analysis in the annual determination of remuneration of executive directors and other positions that report to the chief executive.
    - Be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases.
    - Ensure that increases are not made where Trust or individual performance do not justify them.
    - Ensure that pay arrangements provide equal pay for work of equal value.

- Take into account internal relativities between the executive team and with other senior posts, both Agenda for Change ~~(AfC)~~ and non-~~AfC~~Agenda for Change.
- Ensure transparent processes so that individuals know how their pay might be increased and third parties can be clear that the processes are auditable and compliant.
- Ensure that any performance-related element of executive directors' remuneration is transparent, stretching and designed to promote the long-term sustainability of the Trust. The committee will should take as a baseline for performance any required competencies specified in the job description for the post.
  ~~Decide if a proportion of executive directors' remuneration should be linked to corporate and individual performance. The committee should judge where to position its Trust relative to other NHS FTs and comparable organisations. Such comparisons should be used with caution to avoid any risk of increase in remuneration despite no corresponding improvement in performance.~~
- Monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this as well as continuing professional and personal development plans when reviewing changes to remuneration levels.

- Recommend and monitor the level and structure of remuneration for senior management. The Board defines senior management this purpose as the first layer of management below Board level.

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

Responsibilities

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

- To identify and appoint candidates to fill posts within its remit as and when they arise.
- In doing so, to adhere to relevant laws, regulations, trust policies and the principles and provisions regarding the levels and components of executive directors' remuneration as defined by section E of the Code of governance for NHS provider trusts.

- To be sensitive to other pay and employment conditions in the Trust and elsewhere in the NHS, especially when determining annual salary increases.
- To keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.
- To give full consideration to and make plans for succession planning for the chief executive and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.
- To sponsor the Trust's leadership development and talent management programmes to support succession plans and meet specific recruitment and retention needs.
- To ratify ~~the recommendations of the Employer Based Awards Committee~~the process for medical and dental Clinical Excellence Awards
- To review executive team skillsets, identify any gaps and consider how they should be addressed

Meetings

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

The Committee will usually meet four ~~three~~ times a year.

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

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

Notice of each meeting confirming the venue, time and date together with an Agenda shall be circulated by the Secretary to each member of the Committee at least ~~5~~five clear days prior to the date of the meeting.

Conflicts of interest

All members and attendees of the Committee must declare any relevant potential interests at the commencement of any meeting. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

Chairing

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

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

Secretariat

The Director of corporate affairs and communications, working closely with the ~~Director of Workforce and organisational development~~chief people officer, shall be the secretary

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

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

Membership

Members with voting rights

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

Ex-officio attendees without voting rights

- Chief Executive
- ~~Director of Workforce and Organisational Development~~Chief People Officer

In attendance without voting rights

- The secretary to the Committee (for the purposes described above)
- Any other member of the Board of Directors, senior member of Trust staff or external advisor considered appropriate by the chair of the Committee.

Quorum

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

A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Attendance

Members and attendees are expected to attend all meetings or to send apologies to the Chair and Committee secretary at least five clear days* prior to each meeting.

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

The committee Chair may ask any person in attendance who is not a member of the committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

Papers

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

Reporting
The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting. ~~Minutes of the Committee's meetings shall be recorded formally and ratified by the Committee at its next meeting.~~ The Committee chair shall prepare a report of each Committee meeting for submission to the Board of Directors at its next formal business meeting.
Review
These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency. The next scheduled review of these terms of reference will be undertaken by the Committee before approval by the Board of Directors at its meeting in March 2024.
*** Definitions**
• In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023	**Agenda reference:**	**84-23**		
Report title:	**NHS Sussex Shared Delivery Plan**				
Sponsor:	Abigail Jago, Director of Strategy and Partnerships and Acting Chief Executive Officer				
Author:	Abigail Jago, Director of Strategy and Partnerships and Acting Chief Executive Officer				
Appendices:	Appendix one: Sussex Shared Delivery Plan				
Executive summary					
Purpose of report:	The purpose of the report is to APPROVE the final draft of the Sussex Shared Delivery Plan				
Summary of key issues	*Improving Lives Together* (published in January 2023 following engagement across system partners and the Sussex population) sets out the integrated care ambition across health and care in Sussex over the next five years. The Sussex Shared Delivery Plan (SDP) identifies how this will be delivered and specific priorities. The plan will be reviewed annually in line with planning guidance, partner strategic developments and to reflect local Place priorities as described in Health & Wellbeing Board strategies. The specific ambitions within the SDP that are applicable to QVH have been reviewed pertaining to the QVH priorities and are aligned to QVH plans going forwards.				
Recommendation:	The Board is asked to APPROVE the Sussex Shared Delivery plan.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	The strategy is aligned to all strategic objectives within the BAF framework.				
Corporate risk register:	None				
Regulation:	The strategy delivery plan meets the NHSE statutory requirements to develop and agree a joint forward plan with system partners.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Management Team				
	Date:		Decision:		
Next steps:	To continue inclusion within QVH planning and delivery.				

Report to:	Board Directors
Agenda item:	84-23
Date of meeting:	7 September 2023
Report from:	Abigail Jago, Director of Strategy and Partnerships and Acting Chief Executive Officer
Report author:	Abigail Jago, Director of Strategy and Partnerships and Acting Chief Executive Officer
Date of report:	25 August 2023
Appendices:	Appendix one: Shared Delivery Plan

NHS Sussex Shared Delivery Plan

Introduction

Improving Lives Together (published in January 2023 following engagement across system partners and the Sussex population) sets out the integrated care ambition across health and care in Sussex over the next five years. The Sussex Shared Delivery Plan (SDP) identifies how this will be delivered and specific priorities.

Endorsed by the System Oversight Board and approved in June, the SDP brings together into one place the strategic, operational and partnership work that will take place across our system to improve health and care over the short and long term.

The SDP reflects and responds to national policy and guidance and aims to provide one single vehicle for delivery across four areas:

- ***Long term improvement priorities***: a new joined-up community approach through the development of integrated community teams; growing and developing workforce and improving the use of digital technology and information.
- ***Immediate improvement priorities***: Increasing access to, and reducing variability in, primary Care; improving response times to 999 calls and reducing A&E waiting times; reducing diagnostic and planned care waiting lists and accelerating patient flow through, and discharge from, hospitals.
- ***Continuous improvement areas***: addressing health inequalities; addressing mental health, learning disabilities and autism service improvements; strengthening clinical leadership and getting the best use of available finances.
- ***Health and Wellbeing Strategies (H&WB) and Place-Based Partnerships***: Improving Lives Together was built on the joint H&WB Board strategies across the three Sussex places. These set out the local priority needs in the short, medium and long term.

The SDP highlights the role of system, Place, and local communities as well as a provider collaborative, in delivering the agreed shared outcomes.

Governance to deliver the plan has been put in place, with 11 delivery boards across the four priority areas, each chaired by a provider CEO and containing resources from across partner organisations. Clinical leadership is being aligned to all 11 delivery boards.

Progress on delivery of outcome measures and KPIs will be overseen by the System Oversight Board, with assurance oversight from the Sussex Health and Care Assembly and the NHS Sussex Board.

The plan will be reviewed annually in line with planning guidance, partner strategic developments and to reflect local Place priorities as described in Health & Wellbeing Board strategies.

Governance and system engagement

The Sussex Health and Care system endorsements highlight that the final SDP reflects extensive stakeholder engagement and feedback including, but not limited to the following:

- Feedback from NHSE (received 25 April 2023)
- Joint Health and Wellbeing Boards, (Brighton and Hove City Council 7 March 2023, East Sussex County Council 7 March 2023, and West Sussex County Council 27 April 2023)
- Engagement Planning Oversight Group which includes membership of NHS Sussex, Community Ambassadors, Healthwatch's in Sussex, Voluntary Community Sector Alliance Members and Voluntary and Community Sector representatives of inclusion groups, with a focus on health inequality, and a Young Person Ambassador
- Local Authority Directors of Adult and Childrens' Services on a proactive and ongoing basis
- The Sussex Health and Care Assembly (17 May 2023)
- Sussex Oversight Board, most recently (11 May 2023 and 25 May 2023).

Assessment for QVH

The specific ambitions within the SDP that are applicable to QVH have been reviewed in detail pertaining to the QVH priorities and will continue to be aligned to QVH planning going forwards.

Recommendation
The Board is asked to **APPROVE** the final shared delivery plan**.**

Sussex Health&Care

Improving Lives Together

Ambition to reality: Our Shared Delivery Plan

Contents

1.

Making our ambition a reality

Our ambition

Our ambition is to improve the lives of everyone living across Sussex now and in the future. We want local people to thrive to be the best they can be; to be healthier and feel supported; and have the best possible services available to them when and where they need them.

Our Integrated Care Strategy, *Improving Lives Together*, represents this ambition and sets out the agreed long-term improvement priorities we will be focusing on across health and care in Sussex that will bring the greatest benefits to local people and our workforce.

We know that currently people across Sussex are not always getting the support and care they need to live the healthiest life possible.

Our Case for Change outlines the issues we face as a health and care system and why health and care services are not always able to meet the needs of our population. This includes population factors such as our growing and ageing population that means more people need more care more often; the wider determinants of health, such as the social and economic environment our local communities are living within; and people's lifestyles. There is also the lasting impact the Covid-19 pandemic has had on both services and health, and the current cost of living crisis that is negatively affecting people's health and wellbeing.

We also have long-standing health inequalities, with communities and groups of people having worse health than other people because of who they are or where they live, particularly those who are most disadvantaged.

In addition, individuals, communities and our workforce have told us that people are not always getting what they need, when they need it due to difficulties accessing services, support and information, and the disjointed and confusing way the 'system' works.

A lot of work has already taken place across health and care over recent years to improve the support, care, and treatment available, and the timeliness of how people access services, and progress has been made that has brought benefits to local people. However, we recognise this has not always gone far enough in many areas and a lot of the issues we face can only be resolved through a more ambitious approach.

Improving Lives Together represents that ambition and has four aims:

- **To improve health and health outcomes for local people and communities, especially those who are most disadvantaged.**
- **To tackle the health inequalities we have.**
- **To work better and smarter to get the most value out of the funding we have.**
- **To do more to support our communities to develop socially and economically.**

We will do this through organisations working closer together and differently with and within our communities to support people through each stage of their lives. We want to:

- **Help local people start their lives well by doing more to support and protect children, young people, and their families.**
- **Help local people to live their lives well by doing more to support people to stay well and to look after their own health and wellbeing.**
- **Help local people to age well by doing more to support older people to live independently for longer.**
- **Help local people get the treatment, care, and support they need when they do become ill by doing more to get them to the right service the first time.**
- **Help our staff to do the best job they can in the best possible working environment by doing more to support their own health and wellbeing and to promote opportunities which ensure people want to work in health and care services.**

We want to achieve our ambition over the next five years and beyond and recognise that we will not be able to do everything at once, with some things taking longer than others to get up and running. So we need to be focused on what we can do and when. We also need to do it in a realistic way, using the money, workforce, and facilities we have available as a health and care system.

By working together across all system partners, and with local people and communities, we now have an opportunity to combine our collective energy, resource, and expertise to make our ambition a reality.

This Shared Delivery Plan sets out how we will do this over the next five years.

Our Shared Delivery Plan

Our Shared Delivery Plan brings together into one place the strategic, operational and partnership work that will take place across our system to improve health and care for our population over both the short and long term. It reflects and responds to national policy and guidance and aims to provide one single vehicle for delivery and focus for our system. It incorporates four delivery areas:

Delivery Area 1:
Long-term improvement priorities
(Section 2)

We will be building on work that is already taking place and taking new actions to progress the long-term improvement priorities that have been agreed across our health and care system. These are:

- **A new joined-up community approach, through the development of Integrated Community Teams;**
- **Growing and developing our workforce;**
- **Improving our use of digital technology and information.**

Delivery Area 2:
Immediate improvement priorities
(Section 3)

We recognise there are immediate improvements that need to be made to health and care services. Our health and care system is continually extremely challenged, due to high numbers of people needing support and care from services, and this means not everyone is always getting the right care, at the right time and in the right place for their needs. This has had an impact on some people's experience of services and their outcomes and has put intense pressure on our hard-working workforce.

A lot of work is taking place to give people better access to, and experience of, services and these are set out in our 2023-24 Operational Plan. From this plan, we are giving specific focus to four areas that need the most improvement:

- **Increasing access to, and reducing variability in, Primary Care;**
- **Improving response times to 999 calls and reducing A&E waiting times;**
- **Reducing diagnostic and planned care waiting lists;**
- **Accelerating patient flow through, and discharge from, hospitals.**

Delivery Area 3:
Continuous Improvement Areas
(Section 4)

To bring about the improvements we want to make to achieve our ambition, there are four key areas that need continuous focus and improvement:

- **Addressing health inequalities that exist across our population to achieve greater equity in the experience, access, and outcomes of our population.** This is a 'golden thread' running through the delivery of all the actions we are taking, and we also have a specific system-wide focus to help bring about short and long-term change.
- **Addressing the mental health, learning disabilities and autism service improvements that we need to make across our system.**
- **Strong clinical leadership is crucial to enable us to make improvements to both health and care services and the health outcomes of local people.**
- **Getting the best use of the finances available.** We will need to get the most out of the money we have available to invest in services and make sure we are working in the most effective and efficient way.

Delivery Area 4:
Health and Wellbeing Strategies and Place-based Partnerships
(Section 5)

Improving Lives Together is built on the Health and Wellbeing Strategies across our three 'places' of Brighton and Hove, East Sussex, and West Sussex. These set out the local priority areas of work taking place to best meet the needs of our diverse populations. Health and care organisations are working together to deliver these strategies, as well as the long-term, immediate, and continuous improvements that need to be made to achieve our ambition.

Figure 1

Overview of our Shared Delivery Plan

Alongside the four delivery areas, we have other areas of focus **(Section 6)** that will be part of, and cut across, all the work we do. This includes a focus on prevention, climate change commitments, supporting social and economic development, maternity and neonatal care, safeguarding and quality of services.

To support the delivery of our Shared Delivery Plan, our statutory organisations responsible for health and care will work together in a new way across four different levels – System level, NHS provider level, Place level, and Local Community Level **(Section 7)**.

Each of the Long-term Improvement Priorities **(Delivery Area 1)**, Immediate Improvement Priorities **(Delivery Area 2)** and Continuous Improvement Areas **(Delivery Area 3)** will be led by a Delivery Board, chaired by a system Chief Executive Officer, and they will have a workstream that will be resourced from across system partners. The work of these Boards and workstreams will be overseen by a System Oversight Board chaired by the Chief Executive Officer of NHS Sussex. The Boards will address the needs of the whole population of Sussex. To ensure we deliver the focus we are committed to on the needs of children and young people, the system Children and Young People Board will contribute to and advise the work of each of the Delivery Boards to ensure that those needs are addressed.

How improvements will be made

The four delivery areas are not mutually exclusive; they support and interrelate with each other with the collective aim of making improvements over the next five years.

The actions taken across our Immediate Improvement Priorities **(Delivery Area 2)** aim to address issues that can be resolved in the short-term this year and make changes that give people better access to services and reduce waiting times. These will be supported and built on both this year and over the next five years across the Long-term Improvement Priorities **(Delivery Area 1)**, the Continuous Improvement Areas **(Delivery Area 3)** and the actions in our Health and Wellbeing Strategies **(Delivery Area 4)** to address some of the deep-rooted and long-standing issues we face. Collectively, this will support longer-term improvement, change and transformation to the way services are delivered, the way organisations are organised and run and the health and wellbeing of local people.

Figure 2

Each of our Delivery Areas combine to make improvements for local people.

YEAR 1
Immediate Improvement Priorities

- **Long-term Improvement Priorities**
- **Continuous Improvement Priorities**
- **Health and Wellbeing Strategies**

Improving lives of local people

- **Healthier communities:** Starting well, Living well, Ageing well
- **Better access to services**
- **Reduced waits**
- **Better joined-up care**
- **Better staff opportunities and support**

PROGRESS AND IMPROVEMENT
YEARS 1-5

2.

Delivery Area 1: Long-term Improvement Priorities

Achieving our ambition is centred on three agreed long-term priorities – a new joined-up communities approach through Integrated Community Teams; growing and developing our workforce; and improving our use of digital technology and information.

Integrated Community Teams

Over the next five years we will be integrating health, social care, and health-related services across local communities in a way that best meets the needs of the local population, improves quality, and reduces inequalities. This will involve us working with local people to build on what works best already, and to create a multi-disciplinary workforce, tailored to the health and care needs of the community. We will do this by developing **Integrated Community Teams**, that are made up of professionals working together across different organisations with local communities, individuals, and their carers. This will involve integration across primary care, community, mental health, local authority partners, voluntary, community and social enterprise organisations and other local partners.

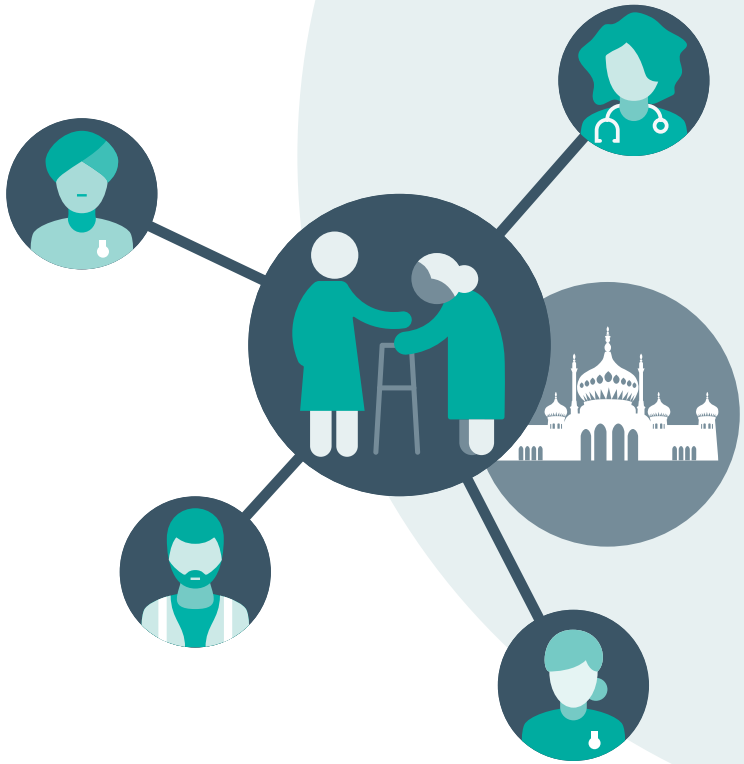
We will develop a '**core offer**' that each Integrated Community Team delivers to everyone, in addition to the individual support and services available to meet the specific needs of different communities. This new service model will be enabled by the delivery of our digital and workforce priorities, meaning our workforce has more time for direct care and to focus on population health management, prevention, and community engagement.

Our Integrated Community Teams will have specific focus on addressing health inequalities, taking preventative and proactive action, and working with local partners that support the wider determinants of health, including housing.

The initial work to progress this priority will build on what is already detailed in our respective Health and Wellbeing Strategies and test new ways of working through innovative programmes in each of our three places – Brighton and Hove, East Sussex, and West Sussex. The learning from these '**Integrated Community Frontrunners**' will be used to shape and inform roll-out of the Integrated Community Team model across our system.

Our Integrated Community Frontrunners

We have selected three programmes at each of our respective Places to be our Integrated Community Frontrunners. These will be tests of change for our new ways of working and our approach to clinical leadership, multi-disciplinary working, the way we use technology and data, and how we will work with local communities to better meet their needs.



Brighton and Hove frontrunner

Across Brighton and Hove, we are working to improve and join-up services to better support people with multiple compound needs and their carers. These are among the most marginalised and vulnerable members of society and face significant health inequalities. There is a 34-year life expectancy gap for people with multiple compound need compared to the general population and they are likely to be living in the most deprived area and specifically Central and East of Brighton.

The aim is for multidisciplinary teams to be working together to better co-ordinate services that are preventative, proactive, responsive, and empowering; enabling individuals to maximise control over their lives. Team members will pool their skills, professional experience, and knowledge to provide a rounded response to the people they are supporting.

The proof of concept started in November 2022 and is benefitting from an independently-led evaluation, monitoring, and learning framework that enables the model to be flexed through an action learning approach. By April 2024, it is planned there will be a reported improvement in the baseline performance metrics for the identified cohort.

East Sussex frontrunner

Hastings has some of the most deprived wards in the country and partners across health and care are currently working with community and voluntary organisations and local people to design and develop services and support in the future. The focus of the initial testing and development phase of the new model is to enhance and integrate our joined-up offer of health, care and wellbeing in communities and neighbourhoods. There are many existing projects and funding streams focussed on reducing the gap in health inequalities, including the gap in life expectancy and the needs of specific groups within this. The programme is intended to build on this to establish a framework for planning and delivering joined-up health, care, and wellbeing services to bring about the most benefit for the local population.

A project called '**Universal Healthcare'** has been underway since June 2022 with a number of community engagement workshops taking place to understand the needs of local people and help shape how they can be better supported in the long-term.

Throughout year one, we will be co-designing a proof of concept and identify early 'quick wins' that can be implemented immediately. By April 2024, we will have an evaluation to support further delivery and improvement and a plan in place to roll-out the approach across other areas of East Sussex.

West Sussex frontrunner

Crawley is one of the most culturally diverse communities in West Sussex and has significant pockets of deprivation where people have poorer health outcomes than other areas of the county.

We have been running a programme of work since 2021 that is an innovative approach to tackling health inequalities and poor outcomes at a borough level. Its aim is to tailor health services and service models to meet the needs of the population with a focus on the most disadvantaged communities.

Phase One of the programme set out to understand what health service developments were required to address health inequalities and improve poor outcomes. We took a local approach to looking at the needs of the population and engaged with local people to understand what barriers they are facing, and what is a priority to help support their health and wellbeing. A range of service developments are being undertaken to ensure they can meet the needs of the local communities.

By April 2024, we will have developed key service business cases and plans and developed the estates strategic outline case.

The actions we are taking this year (2023-24) to progress Integrated Community Teams are:

What we will do	What we will achieve	When
We will define our Integrated Community Teams across Sussex.	We will have a clear footprint for Integrated Community Teams informed by our Joint Strategic Needs Assessments, Health and Wellbeing Strategies, and local population data and insights.	June 2023
We will have data and information in place to support our Integrated Community Teams.	We will be able to measure outcomes that have been agreed at a local level, using a consistent outcomes framework which can be used at a local level and be shared across the Sussex system.	December 2023
We will agree our core offer for communities.	We will define and agree the health and care needs, outcomes and 'core offer' that each Integrated Community Team will deliver to its population.	March 2024
We will test and refine our new ways of working through our three Integrated Community Frontrunners.	We will have learning documented to inform further roll-outs and our approach to clinical leadership, workforce and the use of technology and data.	March 2024

The actions we will take over years 2-5 to deliver Integrated Community Teams are:

What we will do	What we will achieve	When
We will undertake a stocktake and evaluation of year one.	We will understand what is important to local communities, supported by data, and a proposal for the new ways of working.	April 2024
We will further test and refine our new ways of working through our Integrated Community Frontrunners	We will have learning documented to inform further roll-outs and our approach to clinical leadership, workforce and the use of technology and data.	March 2025
Implement a continuous improvement and evaluation approach to improve and refine the way we deliver services within different local footprints.	We will have a continuous learning and improvement approach for Sussex Integrated Community Teams.	March 2027
Rolling out our Integrated Community Team model across Sussex in a series of agreed 'waves'.	We will have a sequential roll-out of Integrated Community teams across Sussex. We will see a steady improvement in patient access, more services delivered locally within different communities, improving patient experience, satisfaction, and outcomes.	March 2027

Difference this will make to local people and how it will be measured

Difference for local people	How it will be measured
Seamless delivery of Proactive Personalised Care.	Reduction in avoidable admissions and increased system capacity and resilience. Patient, carers and stakeholder feedback, qualitative and quantitative datasets, measuring patient journey through the lens of individual patients. Access, waiting time, experience, carer registration and outcome data. Service delivery and efficiency standards.
Tangible reduction in health inequalities, through a focus on prevention and addressing root causes of ill health.	Population Health Management - metrics to be defined to suit local need.
Increased provider resilience with significantly improved collaboration across different organisation boundaries within a patient pathway.	Staff survey results. Workforce evaluation and feedback. Reduced staff turnover. Patient satisfaction surveys.
Increased job satisfaction, career progression and resilience for our workforce.	Workforce evaluation and feedback. Reduced staff turnover.

Growing and developing our workforce

We want to support our staff and volunteers to do the best job they can by growing and developing our workforce. The number of people working in health and care has grown and we need to carry on increasing staff numbers but recruiting more is not the only answer. We need to also get the best out of the staff we already have. There are five objectives we want to achieve:

- **Developing a 'one team' approach across health and care so they can work together and across different areas to help local people get the support and care they need.**
- **We want to support staff to develop new skills and expand the skills they have to allow them to work across different disciplines and areas. We also want to help staff to have more opportunities to progress in their careers.**
- **We want to create a more inclusive working environment that recognises diversity and has a workforce that better represents the population they care for.**
- **We want to encourage, and make it easier for, more young people, students, and people who have never considered a career in health and care, to work with us.**
- **We want to create a culture where people feel valued and supported to develop their skills and expertise. We want to take a 'lifelong learning' approach where people never stop developing their skills throughout their career.**

The actions we are taking this year (2023-24) to better grow and develop our workforce are:

What we will do	What we will achieve	When
We will launch an innovative guaranteed employment scheme, in conjunction with Brighton University and Sussex Partnership NHS Foundation Trust (SPFT).	We will have supported SPFT to achieve an agreed reduction (subject to operational plan) in their registered mental health nurse vacancy rate.	June 2023
We will develop a People Plan with a delivery roadmap for Years 2 to 5. Our approach to ensuring an inclusive culture will be informed by our Workforce Race Equality Standard and Workforce Disability Equality Standard and gender pay gap data.	We will agree one approach to workforce across our system and how this will be implemented.	September 2023
We will agree the model for a single workforce support package across the system.	We will have an agreed single workforce support package in place.	December 2023
We will identify initial communities to test our one workforce approach.	We will begin to roll-out our one workforce approach.	March 2024

The actions we will take over years 2-5 to deliver our workforce aims are:

What we will do	What we will achieve	When
We will develop a digital training programme for Sussex.	Our staff will be better digitally trained.	March 2025
Based on the success of the SPFT and Guaranteed Employment model, we will adapt and adopt this process for an extended number of professions.	Guaranteed employment model will be adapted and adopted to create a pipeline of future workforce.	March 2025
We will review our Equality, Diversity, and Inclusion (EDI) offer across our system to strengthen our consistent approach in tackling inequalities, building on the success of our system Workforce Race Equality Strategy and Statement.	One approach to EDI support in place, taking account of individual organisations or professional context and needs.	March 2025
Build on the work to be undertaken in year one with our pilot Health Care Assistant collaborative bank and our South East regional collaborative with other systems.	Collaborative Bank process established.	March 2025
We will develop a workforce model for Integrated Community Teams.	Integrated Community Teams workforce model agreed.	March 2025
Start transition to new ways of working and provider form.	Colleagues can work in Integrated Community Teams with the same conditions, support inclusive of technology.	March 2026
Review transactional services.	Having a consistent approach to recruitment, payroll and Electronic Staff Record services.	April 2026 – March 2027

Difference this will make to local people and workforce and how it will be measured

Difference for our workforce and local people	How it will be measured
Improved working environment, opportunities, and development.	**For all:** Vacancy rates. Staff survey results. Retention rates. Workforce availability (inclusive of absence rates).
Staff will connect better and form relationships with the community.	Workforce availability (inclusive of absence rates).
Greater opportunities for people to work and have impact in the place they live, with flexible options.	EDI metrics such as WRES, WDES and Gender Pay.
Better use of technology.	Temporary staffing usage.
Inclusive recruitment, with workforce that reflects its community.	Carer registrations among employees.
Opportunities for innovation and research.	

Improving the use of digital technology and information

We need to do much more to harness the potential for the use of digital technology and information. In doing so, we can improve access and join-up our services in a way that will fundamentally transform the experience for our local population and workforce.

We currently have too many disjointed systems, and data that is not shared and available at the point of need and we will be working with our communities and workforce to co-design and deliver long-term improvements.

For our Integrated Community Teams to succeed, we will need to ensure that information can be shared effectively across teams from multiple organisations, in a simple, timely way. We also need to simplify and democratise digital access to services for our population.

To do this, we will Digitise, Connect, and Transform our services.

- **We need to digitise to put the right foundational technology, tools, leadership, and capability in place across our system, and in the hands of our population and workforce. We need to do this in a way that will improve and simplify access for all and reduce the variation we see that leads to inequality and digital exclusion impacting some people and communities more.**
- **We need to connect our population, partners and communities through digital and data services that enable them to play their part in tackling the challenges the system faces and in building trust in the data that informs care, population health management, research, and innovation.**
- **With the right digital and data foundations in place across our system, we need to then transform our services through co-design of more integrated ways of working within our Integrated Community Teams (via our Frontrunners), and across our system; use trusted data and insights to improve, innovate and explore new technologies.**

People and communities will in future be able to choose high quality digital and data services, information, and technologies they have co-designed and can trust; information that supports them to live healthier lives; technologies to help manage their conditions and treatments; and services that communicate and plan with those involved in their treatment and care.

The actions we are taking this year (2023-24) to improve the use of digital technology and information are:

What we will do	What we will achieve	When
We will progress the work to digitise our services by evaluating our baseline position.	A system and provider digital maturity assessment will be completed and nationally benchmarked.	September 2023
We will agree a system-wide digital and data charter, setting out clear design principles and national benchmarking.	We will have 100% of partners formally signed up to the charter.	September 2023
We will establish Digital Centres of Excellence in three providers to lead system improvements and innovation.	We will improve the quality and standard for infrastructure, data intelligence, and innovation across the system.	December 2023
We will map unwarranted variation of inequality of digital access within our population and create a plan to address it. We will establish a People's Panel for digital and data and embed our Digital Inclusion Framework.	We will establish where we have inequality of digital access within our population and better ensure a population-led design approach of digital and data services.	March 2024
We will agree a system-wide data, information, and insight strategy.	A strategy will be in place that will allow us to use data, information, and insight better.	March 2024
We will extend access and enrich services offered through the My Health and Care patient app (integrated with the NHS app).	We will have 65% of patients registered with the NHS App and 33% of patients registered with My Health and Care.	March 2024
We will extend our digital service offering including virtual care technologies, care planning, self-referral, Primary Care accessibility and other capabilities.	We will have an enhanced range of digital service provision and integration across the system.	March 2024

The actions we will take over years 2-5 to deliver improvements to the use of digital technology and information are:

What we will do	What we will achieve	When
Digitise: We will drive improvement across all partners of their digital maturity, cyber security and the commitments agreed in the digital and data charter. We will also work to embed strong digital inclusion practice and reduce unwarranted variation in access and equity of digital services.	Core Electronic Patient Records (EPRs) implemented in all providers.	April 2025
	All Trusts will be consistently good in digital maturity across EPR and cyber security areas of digital maturity.	April 2025
	Quantifiable progress in reducing impacts of digital exclusion and improving design of digital services.	April 2026
Connect: We will co-design, develop and deliver common digital and data platforms and products to enable our population, communities, workforce, researchers, and innovators to have access to the tools and insight they need to improve lives together. Our People's Panel will develop and publish the social rules under which we will operate.	Integrated Community Teams will connect and share data, including with patients, carers and VCSE partners, with 90% of care providers using shared care (Plexus) care record.	April 2026
	NHS App and My Health and Care will be embedded as the "digital front door" in Sussex.	
	Data platform for research and innovation will be fully developed.	
	People's Panel will be publishing a Social Agreement for how we use Digital and Data tools to support their care.	
Transform: We will deliver our digital services through a sustainable model with provider Centres of Excellence; enabling co-design and innovation with our communities; developing our workforce, working in partnership with communities, academia, and industry.	Frontrunner Digital Innovation Lab will be developed.	April 2025
	Digital and Data Science Academy will be launched to tackle long-term. recruitment, development, and retention issues.	April 2026
	Provider Centres of Excellence will be developed in all partner providers across Sussex underpinned by sustainable environmental and financial model.	April 2026
	Digital Innovation Labs will be operating across Sussex.	April 2027

Difference this will make to local people and workforce and how it will be measured

Difference for local people and workforce	How will this be measured
Digitise: We will improve and simplify access to digital technology and services for all and reduce the variation we see that leads to inequality and digital exclusion impacting some people and communities more.	All providers will have consistently good digital maturity across Sussex and across What Good Looks Like domains. Key intervention programmes to tackle digital exclusion and inequity of service have been developed and are having measurable impact. Our population and workforce feel supported to use technology in the best way to suit them and their needs.
Connect: Our population, partners and communities will be connected through digital and data services that informs care, population health management, research, and innovation.	Digital health and care tools and support are established as an everyday service for significant cohorts of patients including those at risk of digital exclusion. People involved with the care and support of an individual (including the individual) share a common view of information and plans and can communicate across the Integrated Community Team.
Transform: Services will be transformed through co-design of more integrated ways of working within our Integrated Community Teams and across our system.	Citizen confidence and trust in digital and data services in Sussex will be improved with strong user experience measures across digital and data services. All providers have achieved core Minimum Digital Foundations safely, through clinically and patient-led implementations with sustainable infrastructure and resourcing in place to continuously improve services.

3.

Delivery Area 2: Immediate Improvement Priorities

Alongside the Long-term Improvement Priorities, there are immediate improvements that need to be made across our health and care services. We have developed and submitted an operational plan for 2023/24 which sets out the key actions that will be taken and how we will ensure best use of finances across our services.

We recognise that all service provision is vital for individuals and communities and work will continue to give people the best possible care and treatment they need in all areas. However, there is a need for us to make greater improvement across four key areas, to improve access to services and reduce the backlog in waiting lists that increased during the pandemic.

Specifically, we need to:

- **Increase access to, and reduce variability in, Primary Care;**
- **Improve response times to 999 calls and reducing A&E waiting times;**
- **Reduce diagnostic and planned care waiting lists;**
- **Accelerate patient flow through, and discharge from, hospitals.**

The actions taken to make improvements in these areas will be carried out this year (2023-24) and will be reviewed, adapted, and built on in the years ahead, according to the effectiveness of the improvements and the needs of local people. The actions will also be supported by the Long-term Improvement Priorities that aim to address many of the issues faced across these areas over time.

Increasing access to, and reducing variability, in Primary Care

GP practices across Sussex work extremely hard to ensure their patients and carers get the timely support, treatment and care they need in the best possible way. In January 2023 alone, there were over 900,000 appointments offered by Sussex practices, which was 97,000 more than the previous month and over 120,000 more than the same time last year.

The growing number of people accessing GP services means it is increasingly becoming difficult for everyone to always get an appointment when the patient wants it. In addition, because each practice works differently, there is variation in how appointments are managed and accessed. This means some people trying to get an appointment can find some systems frustrating and the variation can exacerbate inequalities in access and outcomes.

While general patient satisfaction remains relatively high with GP services, it has declined over recent years and there are some areas where local people find it more difficult than others to access services.

Throughout this year, we will be focusing on increasing capacity across GP services, improving the quality of services and patient outcomes and supporting general practice services to be more sustainable. This includes maximising the benefits of virtual consultations, continuing to improve access to face-to-face appointments and reducing bureaucracy to free-up clinical time. At the end of the year, we expect patient satisfaction and experience to have improved, with patients having increased choice in access to same-day and two weekly appointments via a range of methods.

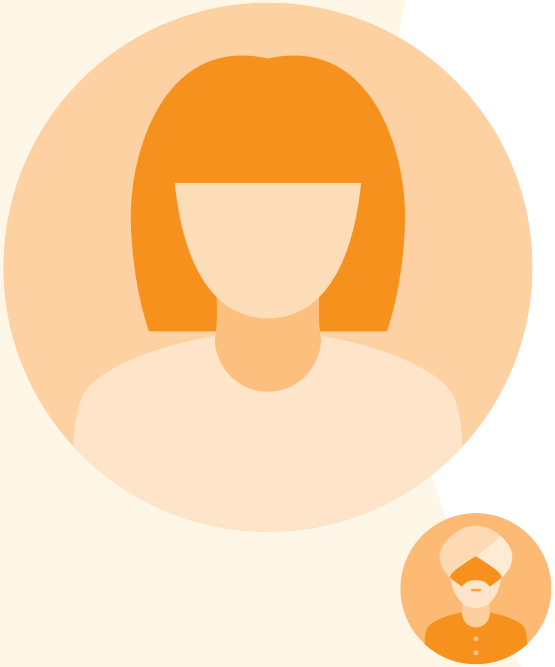
In addition to GP services, we are also focusing on improving access to NHS dentists. Over the last year we have heard significant feedback from local people and Healthwatch around issues with access to dentists across Sussex. This is something that is being experienced across the whole country. Responsibility for dentistry transferred from NHS England to NHS Sussex from April 2022 and we are working locally to make improvements where possible.

This work to improve access will also allow us to deliver continuity of care which is important for people managing multiple long-term conditions. This will be achieved by developing partnerships with the voluntary sector and expanding the roles within the general practice team to include social prescribers, pharmacists, physiotherapists, health and wellbeing coaches and others, to provide people seeking care and support the right contact first time. We will also focus on helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention, building on lessons learnt through the Covid-19 vaccination programme which is an example of how we can develop an Integrated Community Team response to vaccination.

The actions we are taking this year (2023-24) to improve Primary Care access and reduce variability are:

What we will do	What we will achieve	When
Increased coverage of the cloud telephony system to improve service access.	95% of practices will be signed up.	September 2023
Increase people's ability to manage their own health through the NHS App, including booking an appointment.	Target, to be determined once baseline is known (July).	March 2024
Increased practice staff able to provide direct patient care.	245 more staff recruited.	March 2024
Increase referrals to our Community Pharmacist.	We will increase referrals to 17,574.	March 2024
Increased levels of dental activity to improve access. This will include more opportunities for outreach into communities and those living in the most deprived quintiles and making every contact count by aligning the development of dental pathways across the public sector, including early years, health visiting and dental services.	Agree and establish an agreed approach for reporting on all relevant Public Health outcome indicators. Aligned NHS Sussex and Local Authority oral health promotion campaign and commissioning strategy. Improved units of dental activity (UDAs) to 95% of the contract.	September 2023 September 2023 March 2024

Difference this will make to local people and how it will be measured



Difference for local people	How will this be measured
It will be easier for patients to contact practices.	Patient satisfaction scores will improve by 5%.
Patients will be able to access more appointments.	There will be a 2% increase in appointments from the previous year.
Patients will be able to access an appointment within two weeks if they need it.	The number of people obtaining an appointment within two-weeks if they need it will increase by (3.1%) with an additional c.340,188 appointments delivered within two weeks, resulting in an increase from 81.9% during 22/23 to 85% during 23/24.
It will be easier to access a dental appointment.	The number of UDAs delivered compared to pre-pandemic levels (target 100%). UDAs delivered as a proportion of all UDAs contracted (target 95%). This relates to the ambition to improve delivery of contracted activity. Proportion of the Sussex population accessing NHS dental services (provisional target of 47%).

Improving response times to 999 calls and reducing A&E waiting times

Like many systems across the country, we have seen increasing numbers of people using urgent and emergency care services over recent years and this is putting significant strain on our workforce and has impacted on the timeliness for people accessing the care they need.

A lot of work has taken place to continuously look at ways the system can improve responsiveness, quality of care and patient satisfaction. This will be built on, expanded, and taken even further this year and we will be focusing on four key areas to make the biggest improvements:

- **Improving and standardising care to give more of our population access to care which aligns with best practice.**
- **Expanding care outside hospital to ensure people's needs are met sooner and they do not have to end up going to acute hospitals for treatment and care.**
- **Expanding our use of virtual wards to allow more people to be cared for in their own homes when they would otherwise have gone into hospital for care.**

The actions we are taking this year (2023-24) to improve response times to 999 calls and reduce A&E waiting times are:

What we will do	What we will achieve	When
We will undertake a full review of same-day emergency services in Sussex alongside an analysis of the different needs of our population.	We will have a clear understanding of the changes we need to make to ensure all local people have timely access to same-day emergency care.	June 2023
We will increase capacity in our ambulance service, including the roll-out of mental health ambulances, 111 clinical advisory service, virtual wards, non-injured falls service, mental health same- day urgent care services, acute respiratory hubs, urgent community response services and Alternative to Admission Single Point of Access.	A greater number of people will receive rapid assessment and care for physical or mental health conditions in their own home or in the community and therefore avoid a hospital admission.	December 2023
We will support each of our acute hospital sites to undertake improvement work within their emergency departments, including a focus on rapidly streaming patients to the right service.	There will be improved flow of patients and their carers through emergency departments, enabling ambulances to be offloaded and minimising the time that patients spend in departments before being discharged or admitted.	December 2023
We will roll-out clear standardised pathways of care for individuals in Sussex who are at risk of a rapid deterioration in their health, including patients with respiratory illnesses or suffering from frailty.	Vulnerable individuals will spend more of their time in good health and receive rapid, early intervention through joined-up primary, community, and secondary care services when support is required.	March 2024

Difference this will make to local people and how it will be measured

Difference for local people	How will this be measured
More patients will experience shorter waits for treatment in A&E, Urgent Treatment Centres, and Minor Injury Units across Sussex.	We will achieve a minimum of 76% of patients and their carers attending A&E being seen within four hours.
Patients who call 999 with a time critical condition will receive a faster response from the ambulance service.	We will achieve the category 1 response time (90% of calls responded to within 15 minutes) and a better response rate of less than 30 minutes for category 2 (90% of calls responded to within 40 minutes).
More patients will receive medical care closer to home, with admission to an inpatient bed only occurring when absolutely necessary, enabling patients to be cared for in a familiar environment with their carers and the support of friends and family.	We will increase the number of virtual ward beds, reduce the number of ambulance conveyances to hospital (achieving better than the national average), expand 24/7 Mental Health Crisis resolution and home treatment services, increase the number of referrals to urgent community response services and deliver the two-hour urgent community response target of 75%.

Continued on next page...

Difference for local people	How will this be measured
Patients at high risk of hospital admission or who are frequent users of healthcare services will be provided with more proactive care and support to enable them to stay well.	We will see a reduction in the number of high intensity service users and a reduction in the number of admissions and length of stay for patients identified as high risk.
Patients waiting for or undergoing emergency treatment or awaiting admission will be cared for in appropriate clinical settings at all times and will either be admitted or discharged more quickly, spending less time in Emergency Departments.	No patients will be cared for in corridors within Emergency Departments while awaiting treatment or admission. The number of patients and their carers waiting in Emergency Departments for more than 12 hours will reduce to below 2%.

Reducing diagnostic and planned care waiting lists

There are currently large numbers of people waiting too long for diagnostic services and planned care, which can cause a deterioration in their condition, impact on their day-to-day lifestyle, and affect their general health and wellbeing. The lockdown restrictions that were put in place during the pandemic meant waiting times in these areas significantly increased and system partners have been working hard to reduce these as quickly as possible.

We will be maintaining and continuing this work this year and over the longer term will transform the way planned care and cancer services are delivered with the aim that no one waits over a year and we see movement towards achievement of the 18-week standard for elective care and 75% of cancers diagnosed at stage 1 or 2

The actions we are taking this year (2023-24) to reduce diagnostic and planned care waiting lists are:

What we will do	What we will achieve	When
We will enhance patient and carers choice and access to treatment for key specialties including Ear, Nose and Throat and Trauma and Orthopaedic. We will establish clinically led workstreams to develop patient pathways that are productive and standardised across Sussex.	We will have agreed clinical pathways across all acute services for our key specialties to provide greater choice and access to patients and reduce waiting time variation across the system.	September 2023
To support patients and their carers who are referred on a cancer pathway, we will ensure referrals are made in-line with standardised referral protocols and local pathways are optimised, enabled by the Ardens Pro system which is in place across all practices in Sussex. We will continue to increase the number of patients referred with a Faecal Immunochemical Test (FIT) result at point of referral for a suspected colorectal cancer.	We will ensure patients are referred into the most appropriate service based on their referral and clinical information, which will reduce two week wait demand by 30%. With full compliance of colorectal referrals with a FIT test completed, we will reduce the number of colonoscopies required by up to 40%.	September 2023
We will make further use of our Community Diagnostics Centres (CDCs) across Sussex, providing greater access to patients who need a test to support a decision for the care they need	We will prioritise direct access for primary care for computerised tomography (CT), ultrasound and Magnetic Resonance Imaging (MRI). We will have as a minimum six day working across our CDCs providing greater flexibility for patients.	December 2023

Continued on next page...

What we will do	What we will achieve	When
We will continue to realise productivity opportunities to make the best use of our resources, to provide greater access for patients.	We will increase our theatre utilisation rate to a minimum of 85% across all services. We will deliver at least 85% of surgery as a day case procedure. We will reduce the length of stay for key pathways such as hip and knee replacement surgery in-line with best practice rates.	March 2024
We will improve earlier access to hospital services with a focus on reducing the number of patients that do not attend (DNA) their appointment, continuing to provide virtual clinics to reduce the need for patients to attend the hospital, and provide greater flexibility to patients by increasing the number of 'Patient initiated Follow Up' (PIFU) appointments.	We will reduce our DNA rates across Sussex by at least 2% over the course of the year. We will reduce the number of follow up appointments generated by increasing our PIFU rate from 0.5% to 5% across Sussex. We will ensure at least 25% of outpatient activity is undertaken virtually.	March 2024

Difference this will make to local people and how it will be measured

Difference for local people	How will this be measured
We will continue to reduce our waiting times with a commitment to deliver a maximum wait for treatment for patients referred for elective care.	No patient will wait more than 65 weeks for their elective care treatment.
We will continue to reduce the number of patients waiting over 62 days for cancer treatment.	As a maximum, no more than 548 patients will be waiting over 62 days for cancer treatment by March 2024.
We will enhance access to diagnostics for patients across Sussex with our CDC capacity, improved diagnostics pathway, and capital investment in services.	We will ensure at least 75% of patients by March 2024 referred on a cancer pathway will be diagnosed within 28 days. We will continue to reduce our waiting times across 15 diagnostic modalities with no more than 10% of patients waiting more than six weeks.

Accelerating patient flow through, and discharge from, hospitals

There are currently too many patients being cared for in an inpatient hospital bed when there is no longer a health-related need for them to do so. This results in a lack of available beds across the system that can cause risks to both the patient, as they can deteriorate in hospital and be exposed to infection risks, and those waiting for inpatient care.

We have a good track record of system partnership working to improving discharges and we will be building on this and accelerating existing and new initiatives. Sussex is one of six national systems selected as Discharge Frontrunners, which involves health and social care partners locally working together, and with carers and wider partners, to rapidly find innovative solutions and new approaches which have the potential to make a substantial difference. Discharge Frontrunners use tried and tested improvement tools to find what works, how and why and will make recommendations for how their approaches can be adopted across the country. The objective of our programme is to develop, design and test new approaches and service models for discharges across all settings by focusing on integrated workforce models, deploying new technologies, developing shared business intelligence, and developing an economic and financial model to underpin this sustainably.

Our goal will be to bring together a comprehensive model of integrated hospital discharge to support good system patient flow with reduced lengths of hospital stay, admission avoidance, and better long-term outcomes for local people.

The actions we are taking this year (2023-24) to accelerate patient flow through, and discharge from, hospitals are:

What we will do	What we will achieve	When
We will undertake a comprehensive review of discharge pathways to identify, and put in place, improvement plans for the changes which need to be made to reduce delays to patients being discharged from inpatient and community services.	Health and care partners will have a more proactive approach to discharge planning, minimising delays at each part of the pathway (across pathways 0 to 3) and utilising virtual wards for early supported discharge, with a more seamless interface between health and care.	June 2023
We will evaluate and select a small number of digital innovations which will best support improvements in the discharge pathways, alongside the development of a shared data architecture to provide visibility of patient flow and capacity.	We will support more efficient use of our workforce, improved patient experience and seamless working between health and care colleagues.	September 2023 to select innovations; and March 2024 to roll it out.
We will develop an economic model for discharge in Sussex which enables us to make best use of available funding and supports the care market to expand in a sustainable way.	We will have a clear and affordable plan for the future to ensure we understand where best to invest available funds to grow discharge capacity which will meet the needs of our population.	December 2023
We will develop and mobilise a multi-agency workforce plan based on agreed discharge demand and capacity requirements.	We will develop our model for the health and care workforce to enable us to build the right capacity in home care or post-hospital bedded care to meet the needs of our population.	March 2024

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
Patients and their carers will be involved in planning for their discharge from early in their inpatient stay and will be discharged without significant delay as soon as they are declared medically fit to do so into the most appropriate bed for their needs.	There will be a reduction in the number of patients who no longer meet the criteria to reside in hospital who are not discharged.
Patients will be admitted to an inpatient bed (acute, community or mental health) in the most appropriate department for their condition, without significant delay.	We will reduce bed occupancy to 92%.
Patients and their carers will be discharged earlier but receive ongoing clinical oversight where required using digital innovations such as remote monitoring.	There will be a reduction in hospital length of stay (quantified based on experience of exemplars).

4.

Delivery Area 3:

Continuous Improvement Areas

To support the successful delivery of the actions set out across our Long-term and Immediate Improvement Priorities, and our Health and Wellbeing Strategies, there are four key areas that need continuous improvement:

- **Addressing health inequalities**
- **Mental health, learning disabilities and autism**
- **Clinical leadership**
- **Getting the best use of the finances available**

These areas are part of, and are critical success factors in, all the actions and improvements we are making and, therefore, need constant focus across everything we do.

Addressing health inequalities

There are currently avoidable and inequitable differences in health between different groups of people across Sussex. There are many reasons for this, including disability, employment, where someone lives, income, housing, education, their ethnicity, and their personal situation. We know these health inequalities are particularly seen among our most disadvantaged communities, with people living in deprived areas having worse health and outcomes.

Addressing health inequalities is a core aim of Improving Lives Together and is the driving purpose of developing Integrated Community Teams that better meet the needs of our diverse local communities. Health inequalities is a key priority of all our Health and Wellbeing Strategies and is a key element of all the workstreams of our Shared Delivery Plan and will be embedded within many of the actions outlined. This will be done with the following commitments:

- **Co-production** – we will work with those with lived experience to design and delivering change.
- **Interventions** – we will invest in prevention, personalised care, and other activities to drive reductions in heath inequalities.
- **Funding** – we will focus a greater amount of funding based on need.
- **Design of services** – we will undertake Equality and Health Inequalities Impact Assessments for all service changes.
- **Visibility** – we will ensure every decision we make considers the impact of proposals or decisions.
- **Outcomes and performance** – we will always consider the differences across geographical areas, population groups and other factors in how we set and monitor outcomes and performance.
- **Workforce** – we will actively recruit, develop, and support people from our diverse communities.
- **Net Zero and social value** – we will use our resources and assets to help address wider social, economic, or environmental factors.
- **Data quality and reporting** – we will drive work to both improve and increase the recording and reporting of data by key characteristics.

In addition to, and to support, the work across our workstreams and the Health and Wellbeing Strategies, we are taking the following actions to address health inequalities.

The actions we are taking this year (2023-24) to make progress to address health inequalities are:

What we will do	What we will achieve	When
Working with children and young people (CYP), partners, and young carers to develop a defined work programme around the CYP Core20PLUS5 similar to the adults' Core20PLUS5. This will include: • **Address over-reliance on asthma reliever medication and decrease in number of asthma attacks.** • **Increase access to real time continuous glucose monitoring, and insulin pumps, in the most deprived areas, and from ethnic minority backgrounds.** • **Increase access to epilepsy specialist nurses within the first year for those with learning disabilities or autism** • **Address backlog for tooth extractions for under-10's.** Improve Mental Health access rates for 0–17-year-olds from ethnic minorities and children in greatest areas of deprivation.	Develop CYP Core20PLUS5 baseline and improvement trajectory across each of the five clinical areas.	December 2023
Improve position against 2022-23 baseline on hypertension identification and treatment and increase lipid lowering therapy (LLT) prescription.	**Hypertension:** We will improve from the September 2022 position performance of 57% to 77%. **Lipid lowering:** We will increase from September 2022 position of 53% to 60%.	March 2024

Continued on next page...

What we will do	What we will achieve	When
Continue the roll-out of the NHS funded offer of universal smoking tobacco treatment services, across inpatient, maternity, and mental health services and ensure investment at scale and sustainability beyond 2023/24.	Increase proportion of adult inpatient settings offering tobacco dependence services from 0% baseline to 20%. Increase proportion of maternity settings offering tobacco dependence services from 50% to 80%.	March 2024
Address inequalities and improve outcomes in priority clinical pathways for those in deprived geographical areas and with vulnerable or protected characteristics. This includes: • **Reducing waiting times, DNA, and cancellation rates in our most deprived areas and those with protected characteristics.** • **Establishing an inclusion health programme, identify gaps in provision and develop associated commissioning plans.** • **Improve recording of ethnicity recording across all providers.** • **Commissioned baselining of LGBTQ+ and Learning Disability data recording.**	Reduced waiting times, DNA, and cancellation rates for those in deprived geographical areas and protected characteristic groups by 5%. Commissioned dedicated inclusion health network – 60% of providers signed up. Ethnicity recording moved from 65% to 90% data completeness. Data recording baseline achieved for LGBTQ+ and Learning Disability.	March 2024

The actions we will take over years 2-5 to further reduce health inequalities are:

What we will do	What we will achieve	When
Improve position against 2022/23 baseline on hypertension identification and treatment, and lipid lowering therapy prescription.	**Hypertension:** We will continue to improve performance to 80%. **Lipid lowering:** We will continue to improve performance to 70%.	March 2028
Continued support for the roll-out of the NHS funded offer of universal smoking tobacco treatment services, across inpatient, maternity, and mental health services and ensure investment at scale and sustainability beyond 2023/24.	Increase proportion of adult inpatient settings offering tobacco dependence services from 20% to 50% year two and to 80% by year five. Increase proportion of maternity settings offering tobacco dependence services from 80% to 100% by year five.	March 2028
Continue to address inequalities and improve outcomes in priority clinical pathways for those in deprived geographical areas and with vulnerable/protected characteristics.	Build on reducing waiting times, DNA, and cancellation rates in our most deprived areas and those with protected characteristics by reducing further on year one by 5% in years two and three. Dedicated inclusion health network established with 90% of providers signed up by year five. Identified gaps in services commissioned during years two to five. Ethnicity data completeness moving from 90% to 100% data completeness. Data completeness of 50% by year two and 75% by year five for LGBTQ+ and Learning Disability.	March 2028
Dedicated Children and Young Persons (CYP) programme for Core20PLUS5.	5% increase on year one baseline figures by year two and 20% increase on baseline year one figures by year five.	March 2028

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
Improved and equitable access to health care for the population, particularly those in our deprived areas and those with protected characteristics.	Improvement in waiting times and access to treatment times for those from our most deprived areas and with protected characteristics.
Reduced inequalities, and variation in population outcomes.	Reduction in the number of avoidable stroke and cardiac events for adults. Improved access rates to mental health services from areas of deprivation, CYP, males and certain ethnic groups. Improved healthy life expectancy and life expectancy for people with severe mental illness and learning disabilities. Fewer CYP asthma events requiring emergency admissions, improved access to specialist nurse for those with epilepsy, learning disabilities and autism and fewer dental extractions for 0-10 years.
Reduced inequalities in delivery of services, service developments, commissioning, and employment.	Reduction in gaps for health inclusion groups in community service provision, which will reduce requirements for emergency and urgent care and fewer GP appointments.
Inclusive digital pathways.	Focused and reasonable adjustments will be applied to digital pathways to support population groups at risk of digital exclusion.

Mental Health, Learning Disabilities and Autism

Supporting people with mental health, learning disabilities and autism is a key priority across system partners. Although we are working across these areas in one workstream, they are separate areas of focus and will require differing approaches and actions.

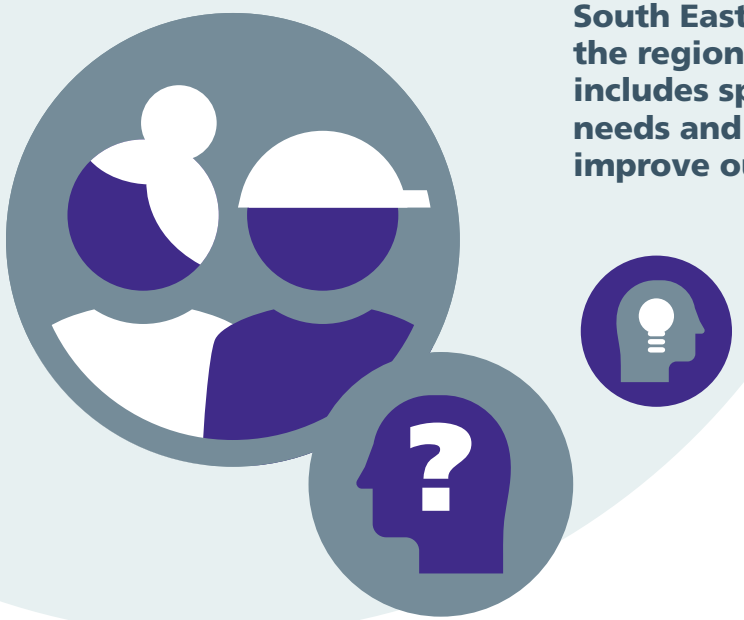
Our aim is to ensure those who are suffering from emotional distress and mental ill health get the support, care, and treatment they need as quickly as possible and can live fulfilled lives within their communities. A lot of work has taken place to improve mental health services, including establishing the specialist perinatal mental health community service, increased physical health checks for those with serious mental illness, and recruitment of additional clinical staff in the eating disorder service. This has been done through consistent delivery of the Mental Health Investment Standard (MHIS) and this will be achieved again in 2023-24 at a level of 7.1%.

Despite funding and staffing levels increasing, the need for mental health services has grown exponentially in recent years, with the pandemic contributing to a rapid rise in emotional distress, depression and anxiety, and many individuals are still facing lengthy waits for assessment and treatment.

We are taking action in response to this growing need through our operational plan this year (2023-24) and over the longer term:

- **We will improve care for those facing mental health crisis through rapid access to crisis services, such as NHS 111 links to the crisis line, Crisis Houses, Safe Havens, and specialist teams that will support the emergency services where an individual with mental health needs is being detained.**
- **We will continue to improve access to support for children and young people, access to talking therapy services for adults and perinatal services.**
- **We will eliminate out of area placements to provide care closer to home.**
- **We will work to increase dementia diagnosis through schemes such as the locally commissioned services in Primary Care.**
- **We will continue to deliver and work towards meeting the commitments detailed within the NHS Mental Health Plan 2019/20-2023/24 across the range of services.**

These key commitments sit within the context of a comprehensive programme of transformation focused on population health and wellbeing and addressing health inequalities.



Alongside our focus on mental health, we are working to improve the care and outcomes for those with learning disabilities and autism. This includes:

- **Working to ensure those with learning disabilities receive an annual health check and action plan.**
- **Reducing reliance on inpatient care, and improving the quality of inpatient care, for those with a learning disability and who are autistic through providing services in the community.**
- **Working with the NHS England South East Regional team on the regional delivery plan which includes special educational needs and disabilities (SEND) to improve outcomes.**

The actions we are taking this year (2023-24) to make progress for those with mental health issues, learning disabilities, and autism are:

What we will do	What we will achieve	When
We will ensure care is offered close to home.	We will eliminate out of area placements.	From June 2023
We will finalise and agree a children and young people's and an adult strategy and approach to neuro developments pathways.	We will have a Sussex-wide agreement and plan to standardise our current assessment and diagnostic services .	From June 2023
Increase the numbers of adults accessing talking therapies (formerly known as IAPT services).	We will increase access by 5%.	March 2024
Increase the number of adults and older people supported by the community mental health team.	We will increase support by 5%.	March 2024
We will develop a locally commissioned service to improve our dementia diagnosis rate.	We will increase the dementia diagnosis rate by 0.3% as a minimum from 22/23.	March 2024
We will improve access to perinatal mental health services.	We will increase access by 1%.	March 2024
We will commence a Child and Adolescent Mental Health Service (CAMHS)/acute pathway programme involving all partners.	We will agree and develop a system approach to children and young people requiring an acute response from CAMHS services as part of the wider support network.	March 2024

Continued on next page...

What we will do	What we will achieve	When
We will maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to support admission avoidance and timely discharge.	30 adult and 15 CYP inpatients per million population,	March 2024
We will increase the number of people on the Learning Disability Register who have received an annual health check and action plan.	We will increase the uptake of annual health checks for those on the Learning Disability Register to 75%.	March 2024

The actions we will take over years 2-5 to further improve the experience of those with mental health issues, learning disabilities and autism are:

What we will do	What we will achieve	When
We will develop a strategy that strengthens commissioning aligned to a collaborative delivery of outcomes; enabling increased lead provider arrangements that deliver whole pathway approaches.	Reduced pathway fragmentation, increased provider sustainability and productivity and improved patient and carer outcomes and experience.	March 2025
Fully implement the community transformation plan within Sussex with an agreed and defined model in each place, including a functional single point of access and developed specialist pathways.	A consistent approach to supporting all people that present with mental health problems at primary care level and more cohesive service offer within Primary Care and secondary care mental health services.	March 2025
Develop closer linking of mental and physical health planning and delivery through the Integrated Community Teams approach.	Increased integrated community-based access to support, reducing reliance on more specialist care and delivering improved health outcomes for local people.	March 2025
We will review the existing successful plans for reducing out of area placements and embed practice as business as usual with continuous review and evaluation.	Continuation of the recent reduction of out of area placements offering better experiences for those that require admission and maintain a 0% tolerance.	March 2025
Agree and formalise a dementia model and strategy for each place that is consistent and meets national best practice with the implementation of locally commissioned Primary Care services to support diagnostic rates.	The memory services will offer a clearer and timelier assessment and diagnostic service that will support the existing pre and post diagnostic support for people with dementia. It will also support wider system strategies.	March 2025

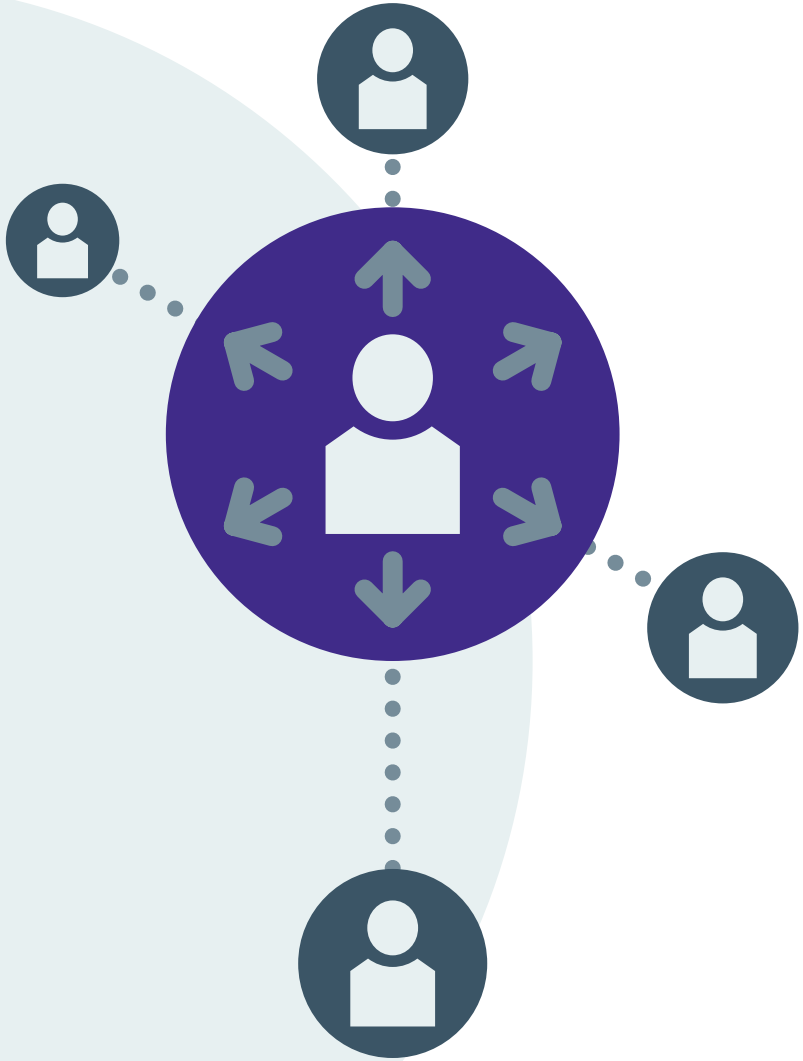
Continued on next page...

What we will do	What we will achieve	When
Develop and fully embed physical health checks for people with severe mental illness outreach and health improvement support in Primary Care as part of Emotional Wellbeing Service and mental health transformation objectives.	We will maintain completed annual comprehensive physical health checks to 75% of GP severe mental illness (SMI) registers	March 2025
Implement the recommendations of the CAMHS review project.	We will improve timeliness of flow through CAMHS services with a consistent offer for children and young people. It will offer improved patient experience and achieve better outcomes for individuals and improve the offer and links to support education and social care processes.	March 2026
We will review the profile of mental health investment to ensure a balanced approach across children and adult services that reflects population demographic and need.	An enhanced focus on early intervention and wellbeing support that reduces reliance on specialist and bed-based services and addresses inequalities in access and provision.	March 2026
We will support the NHS regional plan to offer a cohesive service within our area and engage within the planning process.	This will allow a wider range of interventions across the region to be provided more consistently and will allow us to maximise our resources better on a larger geographical footprint.	October 2026

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
We will undertake a system-wide participation and co-production strategy review, with local authority, experts by experience and VCSE partners, that will be embedded within all work programmes consistently and at all levels of development, review, and evaluation throughout mental health services.	Development of the participation matrix has been agreed with milestones being reported monthly to the Performance and Assurance Group and to the system multi-stakeholder mental health board.
We will have a mental health workforce that is consistent and suitably trained who feel supported and offered opportunities to develop best practice.	Annual staff surveys with a robust audit of issues raised, with associated recommendations and actions that may impact on this commitment led by chief officers.
We will have health and care services working as one team to provide a holistic offer of support to people with mental health and learning disabilities in the community in which they live.	Increase in the uptake of annual physical health checks. Increase in access to preventative and timely access to treatment services, same level as those without mental health or learning disabilities.

Clinical Leadership



There is clear evidence that strong clinical and care professional leadership is associated with higher productivity, better organisational performance, and improved health outcomes for local people. The delivery of our ambition will only be successful with strong clinical leadership, and it is recognised that this is something in Sussex that needs to be developed and strengthened at every level within the system.

We want to create a culture that systematically embraces shared learning, based on outcome data, to support clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.

The aim is for patients to have a better quality of joined-up care, better clinical outcomes, and better experience. This will require close working across system partners, including social care, housing, education, and other Local Authority colleagues, as well as the NHS.

The actions we are taking this year (2023-24) to make progress in clinical leadership are:

What we will do	What we will achieve	When
We will formally appoint a clinical leader for each of the three Integrated Community Team Frontrunner programmes.	We will formally appoint a clinical leader for each of the three Integrated Community Team Frontrunner programmes.	From June 2023
Establish multi-professional Clinical Reference Groups (CRG) for each of our Shared Delivery Plan priority areas.	Governance structure confirmed and implemented for the Clinical Reference Groups.	From June 2023
Set out benchmarks for improvements in clinical outcomes.	Agree reduction plan in unwarranted variation.	September 2023
Agree an organisational development approach to quality improvement and use of data.	Agree Quality Improvement training and data baseline. Progress training plan in identified Clinical Leadership Group.	September 2023
Put in place a multi-professional Leadership Academy to develop our clinical leaders across the system.	100 leaders will have undertaken the programme.	March 2024

The actions we will take over years 2-5 to further develop, improve, and progress clinical leadership are:

What we will do	What we will achieve	When
Agreement on clinical support for delivery workstreams.	Review function of Clinical Reference Group support for year one delivery priorities for effectiveness.	March 2025
Review the 100 leaders who have undertaken the Clinical Leadership Academy programmes and work on lessons learned and ways to improve.	Ensure that clinical leaders selected for each of the Integrated Community Teams areas are well trained and supported for leadership.	March 2025
Embed delivery of clinical outcomes as related to each Delivery Board.	Improve the clinical outcomes of greatest importance for the population of Sussex to deliver measurable impacts.	March 2027
Develop the model of clinical delivery within our ICTs year-on-year and build on the use of digital and data within our pathways.	Clinicians are able to use the opportunities of digital, data and technology.	March 2027
Clinical leadership to ensure clinical interventions and transformation are being delivered using the highest quality evidence, though multi-professional teams using continuous improvement cycles.	Review of outcomes of Integrated Community Teams across Sussex to ensure impact of clinical leadership for delivering high quality care and evidence by using agreed metrics.	March 2028
Clinician leaders demonstrating their proficiency in using digital, data and technology as a means of improving the clinical interventions.	Clinical leaders will be using clinical interventions and research data to demonstrate the effectiveness of interventions in clinical pathways.	March 2028
Clinical ownership of population outcomes.	Clinical leaders will be able to demonstrate improvements in agreed clinical outcomes in the pathway of care for the community.	March 2028

Difference this will make to local people and workforce and how it will be measured

Difference for local people and workforce	How will this be measured
There will be integrated working within Integrated Community Teams and networking across the system partners, with a greater focus on preventing ill health and on evidence-based impacts of personalised care.	Public satisfaction with services survey.
Sussex will be an attractive place to work for clinicians, attracting and retaining talent who are able to see they are making a positive difference to local people.	Staff survey on satisfaction and engagement for Trusts.

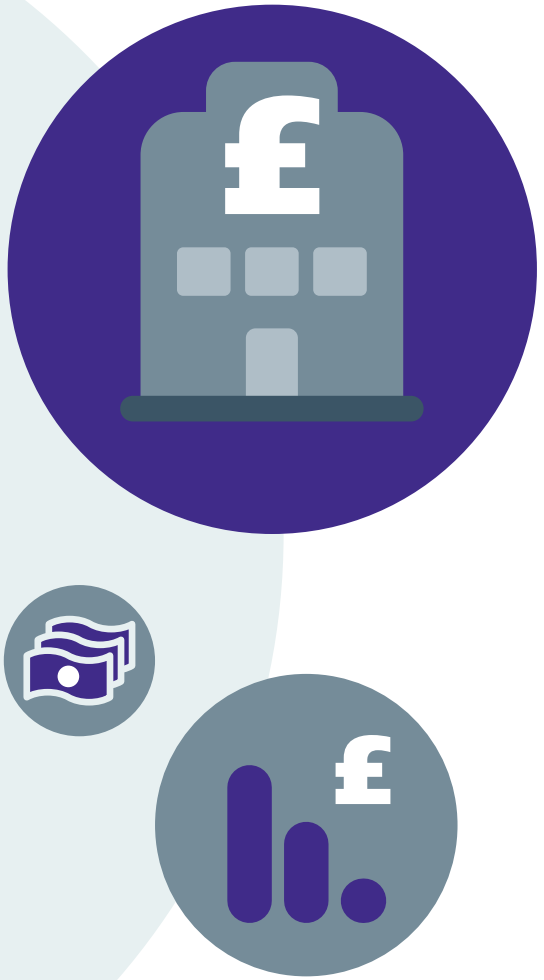
Getting the best from the finances available

Financial sustainability is integral to delivering our ambition as it is a key part of enabling our health and care system to drive improvements to services for local people. We must live within the finances we have available and, to do so, it is crucial that all organisations across our system manages resources effectively, ensuring value for money from every pound spent.

Currently, the NHS across the Sussex system is challenged financially and has a recurrent deficit, which means it is spending more than its allocation. We must therefore work collaboratively across the system to make efficiencies in how we work to get the most out of the money we have available. It also means we must be targeted in our investments, to ensure we are getting most value for local people.

In addition, NHS Sussex is required to make running cost reductions of 20% from 2024/25, with a further 10% reduction from 2025/26.

The Sussex system receives a capital allocation, used to upgrade estates and equipment, and must prioritise all the capital requirements to make sure the funding available is spent in the most effective way. In addition, we receive national capital funding for specific programmes and projects. Over the next five years we will invest in some significant developments which will radically improve patient experience and our productivity. Examples include a new Emergency Department in Brighton, a programme which will eradicate mental health dormitory accommodation, the development of community diagnostic centres and new facilities to deliver elective activity.



A key area of focus for us in improving our finances is productivity, which is the amount of activity we do compared to what it costs. Currently, we are not getting the best use of the money we spend in some areas, such as in our acute hospitals, where current productivity is significantly lower than before the pandemic. To improve our productivity, we have agreed a set of principles and actions across four areas, overseen by a system Productivity Steering Group. These aim to ensure the system is maximising value for money from use of its public funding, expertise, technology, and estates to deliver services. These are:

- **System-led workstreams:** To develop a joined-up Sussex approach and reduce variations across providers across areas such as workforce, procurement, and discharge.
- **Provider-centric workstreams:** To share best practice across providers and identify system opportunities across areas such as theatre productivity, outpatient opportunities and A&E.
- **Integrated approach:** Focusing on productivity opportunities that may impact on both primary and secondary care and potentially areas that impact multiple services/ pathways, including medicine optimisation.
- **Non-pay saving opportunities:** To explore medium-term opportunities in areas like estate optimisation and corporate service.

The actions we are taking this year (2023-24) to get the best from the finances available are:

What we will do	What we will achieve	When
We will create a comprehensive and resourced system productivity plan, with individual workstream targets and milestones and measurable cost reductions demonstrated.	We will have a plan for improving system productivity.	September 2023
We will develop a clinically-led process for optimising some of our clinical models or services, to reduce cost.	Three services or models will be taken forward led by clinicians.	December 2023
We will implement initiatives to improve productivity.	We will see productivity improvement compared to 2019/20 of 10 percentage points, to 7% below 2019/20 for acute Trusts.	March 2024
We will agree a methodology for assessing productivity output for community, mental health, and Primary Care services.	We will have key performance indicators and methodology for productivity across services outside of acute hospitals.	March 2024
We will deliver our 2023/24 system financial plan.	We will meet our financial budget at the end of the year.	March 2024

The actions we will take over years 2-5 to continue to get the best from the finances available are:

What we will do	What we will achieve	When
Model the medium-term financial position of the system including the improvements we would expect as a result of the productivity improvements.	A medium-term financial plan owned by the system.	March 2025
Build a longer-term plan for productivity improvements.	A rolling programme of productivity and efficiency improvements.	March 2025
Review and consider national and international financial frameworks which would support delivery of the Shared Delivery Plan.	A revised financial framework which supports the strategy.	March 2026
Make clinical leadership the natural driver of the productivity improvement programme.	Build enduring clinical leadership into the productivity programme, linking with the Clinical Leadership workstream.	March 2028
Ensure Sussex can live within its financial allocation each year, giving us the freedom to implement our Shared Delivery Plan.	Deliver the annual financial plans.	March 2028
Optimise our capital allocation through prioritising strategic capital requirements.	A prioritised capital plan for 2025/26 onwards (2023/24 and 2024/25 already done).	March 2028
Model and plan the financial impact of all the elements of the five-year plan.	A detailed investment and efficiency plan showing where cost and income will change.	March 2025

Difference this will make to local people and workforce and how it will be measured

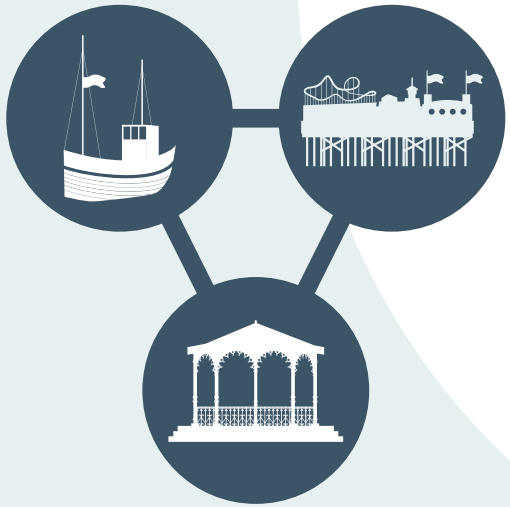
Difference for local people and workforce	How will this be measured
Living within our financial allocation will allow for greater investment in new services and innovation to support and accelerate improvements for local people.	Financial positions across system partners at the end of each financial year.
Greater productivity and efficiency will help people to be seen and treated quicker.	Productivity improvement across the system.
Significant major capital developments which will provide improved facilities and better patient experience.	Capital programmes delivered to time and budget.

5.

Delivery Area 4:
Health and Wellbeing Strategies and developing Place-based Partnerships

Improving Lives Together supports and builds on the three Health and Wellbeing Strategies in place across Sussex.

The Health and Wellbeing Boards in Brighton and Hove, East Sussex and West Sussex have a statutory role to bring together representation from local government; local NHS organisations; Healthwatch; voluntary, community, social enterprise organisations; and other key public services to assess needs and agree plans, focussed on improving health, care and the overall social and economic wellbeing of their populations.

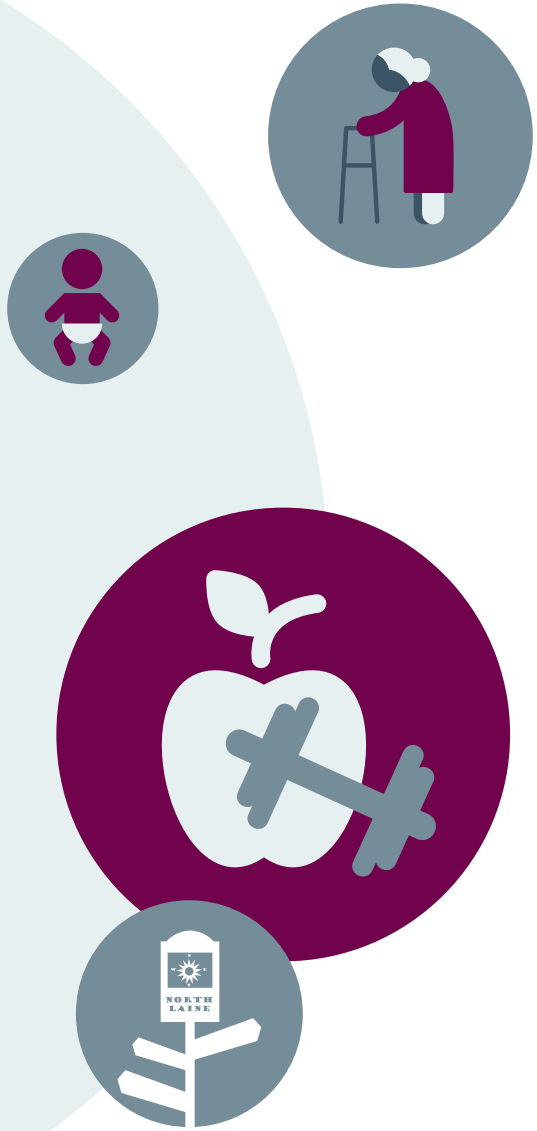


The Health and Wellbeing Strategies use local evidence, data, and insight to set out the priorities for improving health and wellbeing of their populations, responding to the distinct issues and challenges in these places.

Alongside the delivery of the Health and Wellbeing Strategies, one of the key priorities of Improving Lives Together is 'maximising the power of partnerships' and during year one we will be strengthening how partners can work together across our populations in Brighton and Hove, East Sussex, and West Sussex, focussing on the distinct needs and challenges in our local areas. We call this working at 'place', and it is where the local NHS, local government and a wide range of local partners come together to shape and transform health and care and make the most of the collective resources available. We will do this by working in our three Health and Care Partnerships, whose work is overseen by the Health and Wellbeing Boards. Further details of how these partnerships fit into the way of working across our system is in Section 7.

The ways of working and priorities across each of our places are set out below.

Brighton and Hove



Our 2019-30 Health and Wellbeing Strategy focuses on improving health and wellbeing outcomes for the city and across the key life stages of local residents – starting well, living well, ageing well and dying well. Our ambition for Brighton and Hove in 2030 is that:

- **People will live more years in good health (reversing the current falling trend in healthy life expectancy).**
- **The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced.**

Eight principles guide the delivery of our strategy with a focus on health being everyone's business; supporting communities to be more resilient; reducing health inequalities; and making sure that health and care services will provide high quality care, feel more joined-up and will be delivered in the most appropriate place.

The establishment of the Health and Care Partnership Executive Board in January 2020 enables us to build upon the work already started and is now becoming formalised. The firm foundations of the Board enable us to develop and mature service design, delivery, and governance over the coming years.

Our ambitions for improving lives at place

The ambitions set out in our Health and Wellbeing Strategy are:

- Brighton and Hove will be a place which helps people to be healthy.
- The health and wellbeing of young people will be improved. We will have a focus on early years encouraging immunisation; we will address risks to good emotional health and wellbeing; and provide high quality joined-up services which consider the whole family.
- The health and wellbeing of working age adults will be improved. Information, advice, and support will be provided to help people to eat well, move more, drink less and stop smoking to reduce their risk of developing long-term health conditions. There will be easier access to mental health and wellbeing services; sexual health will be improved; and people with disabilities and long-term conditions, and the long-term unemployed, will be supported into work.
- Brighton and Hove will be a place where people can age well. People will be supported to reduce loneliness and social isolation and to reduce their risk of falls and more people will be helped to live independently by services that connect them with their communities.
- The experiences of those at the end of their life, whatever their age, will be improved. We will improve health and wellbeing at the end of life and help communities to develop their own approaches to death, dying, loss and caring. More people will die at home or in the place that they choose and support for families, carers and the bereaved will be enhanced.

How we will deliver our ambition

The Health and Wellbeing Strategy identifies five priority areas for Brighton and Hove:

- **Children and Young People:** We will improve and expand access and existing support to children and young people and their families for mental health, emotional wellbeing, autism, Attention Deficit Hyperactivity Disorder (ADHD), and other neurodevelopmental conditions. We will improve early diagnosis and outcomes for children and young people and increase the identification of, and support for, young carers.

- **Mental Health:** We will implement the key recommendations of our 2022 mental health Joint Strategic Needs Assessment, expanding our support for people with mental health needs and further developing integrated community mental health services, connecting mental health services with community assets. We will do this at local community level and develop integrated systems and increase the provision of supported accommodation and support for people with mental health needs, co-occurring disease, and substance misuse services.
- **Multiple Long-term conditions:** We will improve services to people with long-term conditions to deliver personalised care, tailored to individual needs, strengths, and capabilities. We will aim to better understand the interaction of mental and physical health conditions as a factor to improve outcomes and we will proactively identify and/or support and meet the needs of those at risk of or living with long-term conditions.
- **Cancer:** We will complete the recovery of cancer services affected by the pandemic, improve performance against cancer waiting times standards and deliver the ambitions of the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas and under-served communities where rates of early diagnosis and screening uptake are lower.
- **Multiple Compound Needs:** We will improve and join-up services to better support people with multiple compound needs by delivering an integrated service model, co-produced for and by people with lived experience. We will do this through our Integrated Community Frontrunner programme.

The actions we are taking this year (2023-24) to deliver our Brighton and Hove Placed-based priorities are:

What we will do	What we will achieve	When
Integrated Community Teams frontrunner: Through our multi-disciplinary team pilot we will trial and develop a new integrated model of care and support for people with multiple compound needs and their carers. This will be supported by a clear set of programme objectives, a compact agreement between system partners and an independent evaluation of our pilot project.	We will develop a clear set of programme objectives that supports our aim of increasing life expectancy for people with multiple compound needs. We will establish a compact agreement, across system partners that supports a new integrated model of care and support. We will get an independent evaluation of our pilot project to inform future service design and commissioning.	March 2024
Health inequalities: We will build on the work with Public Health to reduce the spread of blood borne viruses. We will deliver the aims of our current commissioned health inequalities services working with the local population, VCSE and our providers to responds to known areas of health inequalities.	We will build on HIV ED opt- out testing and commence the opt-out blood borne testing. We will improve experience, access, and outcomes for the most disadvantaged communities in Brighton and Hove.	March 2024
Children and young people (CYP): We will implement year one emotional wellbeing action plan priorities for the Foundations for Our Future Place-based Plan. This will include a new emotional wellbeing pathway for CYP and embed training at point of induction for social workers and annual refreshers thereafter.	We will improve the support and interventions for children and young people who are neurodiverse and for children and young people with mental health needs and their carers.	March 2024

Continued on next page...

What we will do	What we will achieve	When
Mental health: We will implement the recommendations of the 2022 Mental Health and Wellbeing JSNA ensuring that progress is made across all seven delivery areas - extend and expand the range of emotional wellbeing services to Primary Care Networks, physical health checks for people with severe mental illness, develop suicide and self-harm prevention action plan.	Increase access to community mental health services. Reduce demand on acute and crisis care. Increase the number of people on severe mental illness registers.	March 2024
Cancer: We will build on the work with Public Health, the local population, VCSE and our providers to help to detect cancer at an early stage through promoting uptake of screening programmes, including expanding the targeted lung health checks programme, Faecal Immunochemical Test (FIT) testing and continuing the fibro scanning outreach service (to check for liver inflammation). The programme will ensure it responds to known areas of health inequalities.	Increased screening rates including in areas of deprivation and communities, including BAME communities, people experiencing homelessness, Trans people, and people with learning disabilities.	March 2024
Multiple long-term conditions: We will develop our cardiovascular disease reduction priorities in Brighton and Hove including hypertension case finding and treatment, and the restoration of the NHS health checks programme with health inequalities lens.	The cardiovascular disease reduction action plan will be developed and monitored at the Brighton and Hove Community Oversight Group.	March 2024

Continued on next page...

What we will do	What we will achieve	When
Hospital discharge: We will develop our integrated model, implement the 2023-24 hospital discharge transformation plan, and deliver the improvements aligned with the discharge frontrunner programme. Our place-based discharge transformation work will happen to ensure efficiency within current processes.	This will enable us to ensure people who no longer need acute inpatient care can go home or to a community setting to continue recovery with appropriate support for any unpaid family/friend carers who help that patient.	March 2024

The actions we will take over years 2-5 to continue to deliver our Brighton and Hove Place-based priorities are:

What we will do	What we will achieve	When
Integrated Community Teams frontrunner: We will evaluate the impact and results of our multi-disciplinary team pilot project, including the independent evaluation report. This will inform our longer-term redesign of services for people with multiple compound needs.	We will develop a long-term integrated model of service, where partner organisations from across the public and community sector will work together as a multidisciplinary team. Service-users and their carers will experience a joined-up service that best meets their multiple health and social care needs.	March 2028
Health inequalities: We will further develop our prevention programmes, in-line with our Health and Wellbeing Strategy priorities, with an increased focus on reducing health inequalities in identified populations and locations across the city.	We will reduce barriers, increase service use, and improve health outcomes for the most disadvantaged communities in the city.	March 2028
Children and young people: We will implement Year 2-5 action plan priorities for Foundations for Our Future Place-based Plan.	We will improve the support and interventions for children and young people who are neurodiverse and for children and young people with mental health needs.	March 2028

Continued on next page...

What we will do	What we will achieve	When
Mental health: We will transform the community mental health system, improving access though provision of holistic care, shifting investment to increasingly focus on CYP as well as prevention. Improve access to stable and secure housing and accommodation-related support for people with serious long term mental health conditions.	We will improve access to community mental health services – both numbers of people accessing and reduction in waiting lists. We will improve access to CYP mental health services – both numbers of people accessing and reduction in waiting lists. We will increase the number of people on the severe mental illness register. We will deliver a reduction in use of avoidable crisis and acute care.	March 2028
Cancer: In-line with the Brighton and Hove wellbeing strategy, we will expand cancer diagnostic and treatment service capacity, enabling earlier diagnosis of cancers through use of community diagnostic centres.	We will achieve the 28 day faster diagnosis standard (75%). We will increase the number of cancers diagnosed at stages 1 and 2. We will reduce under 75 mortality from cancer considered preventable.	March 2028

Continued on next page...

What we will do	What we will achieve	When
Hospital discharge: We will further develop and implement efficient admission avoidance and hospital discharge processes, supported by digital automation and engagement with patients and their carers. We will put in place a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge. We will ensure that more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will ensure discharge pathways allow for greater personalisation to meet the individual need of the patient and their carer.	March 2028
Multiple long-term conditions: We will implement a new integrated intermediate care model for rehabilitation and reablement services including a quality outcomes framework to demonstrate benefits.	We will improve the support for a short time to help more people and their carers to remain in their own home while they recover from a hospital stay.	March 2028

Difference this will make to local people and workforce in Brighton and Hove and how it will be measured

Difference for local people or workforce	How will this be measured
Multiple compound needs: Life expectancy will improve for people with multiple compound needs, reducing the current 34-year gap in life expectancy between this group and the general population. Services for people with multiple compound needs will be integrated and all service-users will have access to a lead professional who coordinates their care and support.	Through a clear outcomes framework, that is consistent across all partner organisations. Through a successful redesign and commissioning of services for people with multiple compound needs.
Health inequalities: Models of health, care and support that focus on prevention, greater independence and choice, self and proactive care including social prescribing through a locality-based integrated neighbourhood team model. This will be tailored to the individual needs within local neighbourhoods and our communities of interest.	Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the gap in life expectancy and healthy life expectancy for communities with health inequalities. Reduction in new cases of HIV, with the aim to achieve zero transmission.
Children and young people: We will see a reduction in waiting times for emotional wellbeing treatment and support, with a greater focus on prevention and early intervention.	Reduced waiting times to access services. Reduction in referrals to specialist CAMHS services.

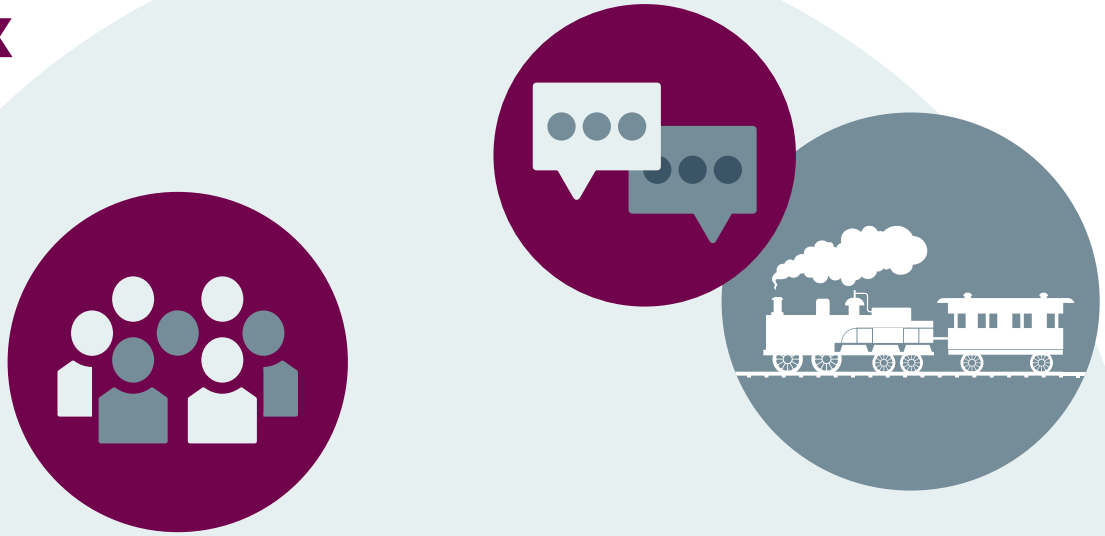
Continued on next page...

Difference for local people or workforce	How will this be measured
Mental Health: Life expectancy will improve for people with serious mental illness. Improved experience of people using services by reducing barriers between services and the need to re-tell their story, reducing the potential for re-traumatisation. Increase in availability of preventative support including suicide prevention. Improve access by making it easier and quicker to get support.	Life expectancy data. Patient Reported Outcome Measures (PROMS). Measurement of suicide rate. Reduction in waiting times. Increase in number of people accessing services.
Cancer: Improved take-up rates of FIT testing, including groups with low participation, particularly men, people from minority ethnic backgrounds and people from deprived areas. Targeted lung health checks will lead to an increase in lung cancers being diagnosed at an earlier stage.	Public Health Screening Data. Cancer Action Group Dashboard. Increase take-up rates of FIT testing by 7%. Increase lung cancer stage 1 diagnosis by 47%.

Continued on next page...

Difference for local people or workforce	How will this be measured
Multiple long-term conditions: Lower levels of mortality and disability due and cardiovascular disease. People will be better supported to remain at home and retain more independence in the community.	Increased levels of independence. 90% of the expected prevalence of Atrial Fibrillation is diagnosed. Reduced time waiting to receive reablement/intermediate care intervention. Reductions in people unnecessarily needing long term care. Reductions in need for care home placements. Increased proportion of care provided at home. Greater personalisation of discharge care and increase in number of personal health budgets and increase in proportion of people living independently at home for longer.
Hospital discharge: Improved discharge process to ensure people return home as appropriately as possible.	Reduction in the length of time between someone being ready to leave hospital and when they do. Maximise the proportion of people who can return home after leaving hospital.

East Sussex



Improving Lives Together and our East Sussex Health and Wellbeing Board Strategy to 2027 align around a shared vision where in the future health and care organisations will work in a more joined-up way with and within communities to better understand and respond to their specific needs. Support and services will be shaped around local people, rather than expect them to fit into the 'system'.

Delivering this requires a collaborative approach across all our organisations to improve health, reduce health inequalities and deliver integrated care for our population. In East Sussex, we have committed to some shared priorities and work based on the needs and assets in our population and the factors that influence people's overall health and ability to stay healthy, in addition to improving outcomes through integrated health and care. The focus of our shared work is aimed at increasing prevention and early intervention and delivering personalised, integrated care.

Our East Sussex Health and Care Partnership brings together the full spectrum of local partners responsible for planning and delivering health and care to our communities. We have comprehensive governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance. The governance arrangements facilitate transparent decision-making and foster the culture and behaviours that enable system working.

Our ambitions for improving lives at place

Aligned to our system ambitions to develop Integrated Community Teams, we will build on our existing work to expand the integrated community model for our population that will better enable health, care and wellbeing for people and families across the whole of life. This will mean designing a model that best enables:

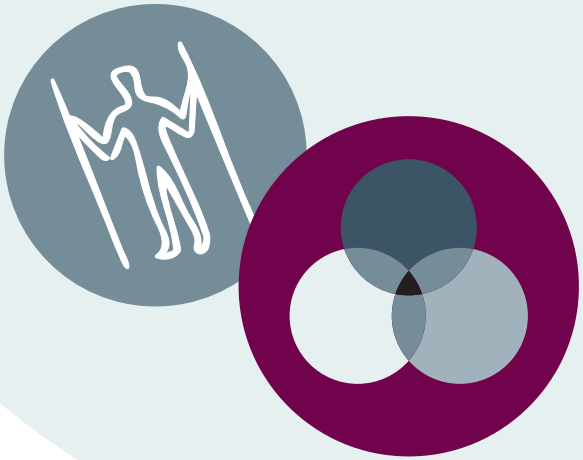
- Working together in our communities across Primary Care, community healthcare, education, social care, mental health, and the full range of local voluntary and community and housing organisations, and using our collective resources driven by a deeper shared understanding of local needs.
- Strengthening our offer of integrated care. For children and young people this will involve working with whole families and linking more closely with early years settings, schools, and colleges. For adults this includes further developing Trusted Assessor roles, rapid crisis response and support with discharges from hospital, as well as exploring ways to build more integrated leadership and roles to deliver better co-ordinated care.
- A clear focus on improving population health overall and therefore the years of life people spend in good health. This includes leisure, housing and environment services provided by borough and district councils and others.

How we will deliver our ambition

Our partnership plans to embed hubs within our integrated communities to help co-ordinate access to local sources of practical support and activities. We also want to develop our plans for using our power as employers and buyers of services to stimulate economic and social wellbeing in our communities. This model will bring:

- Greater capacity in communities to promote mutual support, and deeper levels of joined-up and personalised care, building on the strengths and assets of individuals, families, and communities.
- Greater levels of prevention, early intervention, and ways to proactively respond to prevent situations getting worse.
- New ways to remove the barriers that prevent staff and volunteers working in different teams from working together on the ground.

Accountability through to our Health and Wellbeing Board and strong links into Sussex-wide programmes will enable a clear focus to be retained at Place on our key priority integration programmes across health improvement and reducing health inequalities, and integrated care for children and young people, mental health, and community services.



The actions we are taking this year (2023-24) to deliver our East Sussex Place-based priorities are:

What we will do	What we will achieve	When
Building on the Universal Healthcare initiative and other local programmes, we will have a joined-up approach to planning and delivering health, care, and wellbeing in Hastings, with clear evidence of integrated approaches to improving outcomes for local communities.	A planning and delivery approach agreed by Place leadership board.	March 2024
Service models will be developed and approved for scaling up across the county and an implementation timetable with key milestones agreed.	Service models will be approved by Place leadership board.	March 2024
A comprehensive stakeholder engagement process will take place to help us explore how we can improve health outcomes in cardiovascular disease (CVD) respiratory disease, mental health, and frailty/ageing as significant drivers of poor health and early death in our population.	Improvement plans approved by Place leadership board.	March 2024
Aligned to our discharge workstream, we will develop our integrated hospital discharge model, implement the 2023-24 hospital discharge capacity plan, and deliver the improvements aligned with the discharge frontrunner programme. Our place-based discharge transformation work will happen to ensure efficiency within current processes.	More people will be able to be discharged safely to a community setting.	March 2024

Continued on next page...

What we will do	What we will achieve	When
Deliver our children and young people's programme plan with a key focus on priority workstreams to support getting the best start in life; promoting emotional wellbeing and mental health; physical health, needs of children with SEND, and our most vulnerable young people.	Family hubs with additional support for families with young children; strengthened support for long term conditions (Core20PLUS5 for CYP); clearer and improved pathway for mental health support and support for parent carers.	March 2024
We will deliver initial stages of integrated models of community mental health care within local communities, through Primary Care Network based offers and developing plans to support more people who need housing-based support due to their mental health.	In-year plan delivered.	March 2024
Networks will be developed in communities to help co-ordinate access to local sources of practical support and activities, to boost emotional wellbeing and help with loneliness and isolation.	Consolidation of networks providing access and support to local people.	March 2024
Develop our approach as an "anchor" system in East Sussex, including our plans for using our power as employers and buyers of services to stimulate sustainable economic and social wellbeing in our communities.	Approach approved by Place leadership board.	March 2024

The actions we will take over years 2-5 to continue to deliver our East Sussex Place-based priorities are:

What we will do	What we will achieve	When
Refresh and implement further actions in targeted areas to support population health improvement and integrated care in our four target conditions.	Continuation of measurable plans to improve life expectancy and healthy life expectancy and reduce unplanned use of hospital services.	March 2025
Implement the improvements to cardiology and ophthalmology through reconfigured acute hospital services.	Agreed transformation plans fully implemented improving efficiency and outcomes for local people.	March 2025
Appraise and jointly respond to forthcoming national guidance and tools and system opportunities designed to support a joined-up offer of care at Place across Primary Care, community health, adult social care, mental health, public health, and housing services which relate to health and social care.	An agreed plan to further evolve our provider collaboration at Place to support delegated responsibility for services in scope, to deliver shared population priorities for improved population health and integrated care.	March 2025
Develop a reprofiling of resource application to support a widening of emotional wellbeing services for children and young people.	Improved access to emotional health and wellbeing services that support improved experience for children and young people and reduce the need for more specialist care.	March 2026
Enhance support to families to enable the best start in life including continued development of an integrated pre and post-natal offer.	Improved experience and increased opportunities to support our most vulnerable families.	March 2026

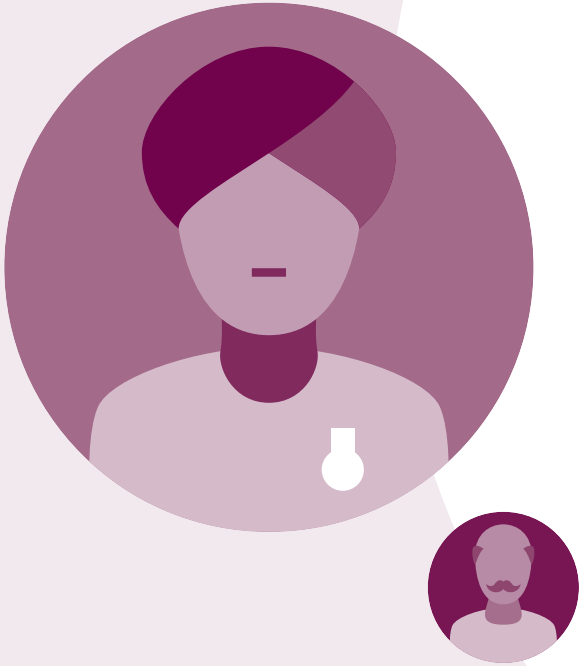
Continued on next page...

What we will do	What we will achieve	When
Implement integrated community-based approaches for mental health and a wider range of early support for mental health, in-line with Sussex- wide approaches.	Reduced reliance on specialist services and improved population health and wellbeing.	March 2026
Continue phased implementation and evolution of locality-based Integrated Community Teams model.	An approach and model supported by comprehensive engagement and fully owned and embedded with communities that delivers integrated support in local communities.	March 2028
Aligned to the discharge workstream, we will further develop and implement efficient hospital discharge processes, supported by digital automation, with a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge, ensuring more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will also ensure discharge pathways allow for greater personalisation to meet the needs of individuals and carers.	March 2028

Difference this will make to local people and workforce in East Sussex and how it will be measured

Difference for local people and workforce	How will this be measured
People will be supported to stay healthy for longer and more proactive preventative care will be available for those who need it, across the full range of organisations that can support this.	Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the gap in life expectancy and healthy life expectancy.
More children and young people will be accessing assessment and treatment more quickly and will be supported to live healthier lives.	Improvements in health outcomes. Increase in the proportion of children and young people with a diagnosable mental health condition who receive treatment from an NHS-funded community mental health service.
More people will be able to access support with their mental health needs more quickly and closer to home and there will be more intensive bespoke housing-based options for people who need it to ensure people can leave hospital more quickly when they are ready. Staff roles will become more manageable and more enjoyable.	Reduction in the number of inappropriate referrals to mental health secondary services, and an increase in appropriate referrals to secondary mental health services improving outcomes, reducing waiting times and preventing issues from worsening.

Continued on next page...



Difference for local people and workforce	How will this be measured
Community care and support will be better co-ordinated to enable people to stay independent for longer, have better onward care after a spell in hospital, and ensure access to local sources of practical support and activities, boost emotional wellbeing, and help with loneliness and isolation.	Increase in the number of people seen within the waiting time target for reablement services. Number of people living at home and accessing support in their communities. Proportion of people with support needs who are in paid employment. Proportion of people who regain independence after using services. Proportion of people and carers who report feeling safe. Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the average length of stay in community beds. Reduction in the average length of stay in Discharge to Assess (D2A) commissioned beds and increased use of D2A bed capacity utilisation.

Continued on next page...

Difference for local people and workforce	How will this be measured
People have access to timely and responsive care, including access to emergency hospital services when they need them.	Reduction in waiting times for GP services, community support and care services. Referral times for health treatment. Reduction in the length of time between somebody being ready to leave hospital and when they do.
Digital services and innovation are used to help make best use of resources.	Proportion of people and staff in all health and care settings able to retrieve relevant information about an individual's care from their local system.

West Sussex

Our West Sussex Health and Wellbeing Board has a Joint Health and Wellbeing Strategy 2019-2024 called ***"Start Well, Live Well, Age Well"***. It sets out the Health and Wellbeing Board's vision, goals, and ways in which we will work to improve health and wellbeing for all residents in West Sussex. It was developed in consultation and collaboration with local residents, service users, multi-disciplinary professionals, and partners. It draws on evidence of West Sussex's health and wellbeing needs from the Joint Strategic Needs Assessment (JSNA).

The strategy adopts a life course approach, identifying our priorities across three themes - Starting Well, Living and Working Well and Ageing well. It consists of a few carefully selected priorities that can significantly contribute towards achieving its vision with a focus on:

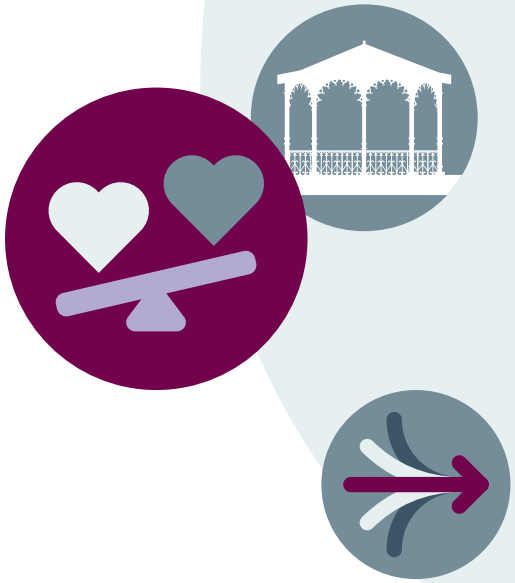
- A whole system approach to prioritise prevention, deliver person-centred care, and tackle health inequalities.
- Harnessing the assets and strengths of local communities to improve health and wellbeing, creating safe, sustainable environments that promote healthy living.

The West Sussex Health and Care Partnership was formed in 2020, bringing together key local health and care partner organisations to work collaboratively to deliver the objectives of the Joint Health and Wellbeing Strategy and the Sussex-wide strategy through a Place-based plan. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board.

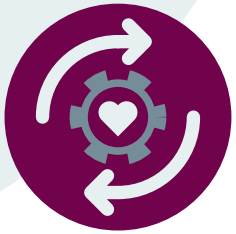
We have developed a model of collaboration that brings changes to people directly within their community, through our Local Community Networks. These are co-located with district and borough footprints and are empowering communities to deliver change through collaborative working between Primary Care, district and borough councils, local Public Health, and voluntary sector enterprises. We will maintain our focus in year one on how Local Community Networks can continue to make the positive changes for people who live in West Sussex, as we develop our Integrated Community Team model across Sussex.

Our ambitions for improving lives at place

Our West Sussex Health and Care Partnership responds to the challenges faced collectively as a group of organisations and the delivery of the priorities set out in *Improving Lives Together*. Our strategic goals are:



- **Address health inequalities:** There are stark inequalities in outcomes, access, and experience of care for maternity and neonatal service users and the opportunities and experience of staff from minority backgrounds and we will tailor our services to target the needs of our local populations and offer a personalised maternity journey that wraps around the individual and their family. We will prioritise the improvement of healthy life expectancy through tackling the key health inequality related conditions and ill health relating to CVD, respiratory and cancer. We will utilise approaches such as tobacco control, cancer screening and health checks and work together with key stakeholders across the area to target our activity and resources where it is needed most based on need and evidence of what works. We will make care more personalised so that people can access health and care services that are more tailored to their needs, make sense to them and focus on what really matters in their lives.
- **Integrate models of care:** We have opportunities to further develop how our services work together to streamline pathways for patients, improve experience and create more integrated approaches. Through integrated services we will remove the unnecessary barriers between our services that are all working to support the same local people and create more sustainable models of care.
- **Transform the way we do things:** We will continue to improve our services where it will have the greatest impact, taking the opportunity to address health inequalities and strengthen our integrated approach. We will continually review our joint transformation priorities year-on-year, systematically improving our services.



How we will deliver our ambition

The West Sussex Health and Care Partnership Place-based Plan uses evidence from the Joint Health and Wellbeing Strategy to determine local priorities and key areas for change agreed across our partners and within the framework of the ambitions outlined on the previous page. To support the delivery of the system-wide priorities and our strategic goals, there are six specific priority areas for change that have been identified from the Health and Wellbeing Strategy for West Sussex:

- **Tackling the wider determinants of health:** We will work together to influence the many determinants of healthy living, such as how services are accessed and how communities can be empowered to support healthy living for their residents.
- **Addressing health inequalities:** We will have a targeted and focused approach for those with most need and who need additional support.
- **Adults Services:** We want to help people 'live the life they want to lead', by remaining independent for as long as possible and maintaining a high quality of life.
- **Children and Young People:** We will improve the existing support to children and young people so they can have the best possible start to life, through our West Sussex Children First programme.
- **Mental Health:** We will expand our support for people with mental health needs to address the growing need, delivering the best standard of physical health checks for people with mental illness, and developing sustainable housing solutions for people living with long-term mental illness.
- **Learning Disabilities and Neurodevelopmental needs:** We will provide greater focus and support for those with a learning disability and neurodevelopmental needs, by reforming our children's and young people's neurodevelopmental diagnosis and care pathway, including social support.

The actions we are taking this year (2023-24) to deliver our West Sussex Place-based priorities are:

What we will do	What we will achieve	When
We will develop and agree a business case and implementation plan for a new Bognor Diagnostics Academic Centre. We will develop education, training and develop courses to support local people in gaining employment in this sector.	We will be able to provide additional capacity for diagnostic tests.	September 2023 March 2024
We will complete a public consultation, produce, and agree a business case and start to mobilise a new model for stroke services in the coastal area of West Sussex subject to the outcomes of the public consultation. We will develop our cardiovascular disease reduction priorities in West Sussex including hypertension case finding and treatment, and the restoration of the NHS health checks programme.	We will be able to become fully compliant with national standards for acute stroke services. The West Sussex Cardiovascular Disease Reduction action plan will be developed and monitored at the West Sussex Cardiovascular Disease Reduction group.	December 2023 March 2024
Aligned to the Integrated Community Frontrunner programme, we will develop new models of care for our priority services in Crawley, produce and agree the business cases (including impact measures) and implementation plans for our four priority service areas and a strategic outline case for improvement to our estates.	We will be able to tailor our services and improve access for the most disadvantaged communities in Crawley. This includes the development of a new Community Diagnostics Centre at Crawley Hospital, and new improved facilities for the Child Development Centre at Crawley Hospital.	March 2024

Continued on next page...

What we will do	What we will achieve	When
Aligned to the discharge workstream, we will develop our integrated hospital discharge model, implement the 2023-24 hospital discharge capacity plan, and deliver the improvements aligned with the discharge frontrunner programme. Our Place-based discharge transformation work will happen to ensure efficiency within current processes.	We will be able to ensure people who no longer need acute inpatient care can go home or to a community setting to continue recovery. We will also ensure Place-based discharge pathways are aligned to national best practice and achieving maximum efficiency.	March 2024
We will develop a new integrated intermediate care model for rehabilitation and reablement services and a business case and implementation plan for the new model.	We will be able to ensure people receive rehabilitation and reablement care in a timely manner, through teams working together in reducing unnecessary duplication and handovers.	March 2024
We will create an emotional wellbeing pathway focused on ensuring that the best outcomes are achieved for children and young people and embed training at point of induction for social workers and annual refreshers thereafter.	We will be able to improve the support and interventions for children and young people with autism and or mental health issues.	March 2024
We will review our joint commissioning arrangements for learning disabilities, mental health, and neurodevelopmental services.	A robust and transparent Section 75 agreement which sets outs the joint and pooled commissioning and provider arrangements between West Sussex Adult Social Care and NHS Sussex West Place to meet the needs of residents. This will enable the introduction of new clinical governance measures on Case Review Process to ensure best practice and compliance to new regulations.	March 2024

The actions we will take over years 2-5 to continue to deliver our West Sussex Place-based priorities are:

What we will do	What we will achieve	When
We will implement tailored health services and service models for our priority service areas in Crawley to meet the needs of the population with a focus on the most disadvantaged communities.	We will increase service use by the most disadvantaged communities in Crawley. We will have improved health outcomes for the most disadvantaged communities. We will have co-ordinated utilisation of estates and assets across health and social care.	March 2028
We will deliver the Bognor Diagnostics Academic Centre.	We will contribute to the West Sussex diagnostic programme to enhance access to diagnostics for patients across Sussex with our CDC capacity, improved diagnostics pathway, and capital investment in services. We will increase in numbers of physiological and imaging workforce being trained or being employed.	March 2028
We will create access to a 24/7 acute stroke centre for the coastal area of West Sussex, subject to the outcome of public consultation. We will further develop and implement seamless rehabilitation pathways to ensure people can return home as soon as their acute episode is resolved. We will implement our cardiovascular disease reduction priorities.	We will have a fully compliant stroke pathway from prevention through to hyper-acute care to rehabilitation in place for the population. We will have better long-term outcomes for patients and their carers and reduced mortality/ disability due to stroke and cardiovascular disease.	March 2028

Continued on next page...

What we will do	What we will achieve	When
We will further develop and implement efficient hospital discharge processes, supported by digital automation. We will put in place a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge. We will ensure more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will ensure discharge pathways allow for greater personalisation to meet the needs of the individual and their carer.	March 2028
We will implement a new integrated intermediate care model for rehabilitation and reablement services including a quality outcomes framework to demonstrate benefits.	We will improve the support for a short time to help more people remain in their own home while they recover from a hospital stay.	March 2028
We will implement a new emotional wellbeing pathway to further support and interventions for children and young people with autism and or mental health issues.	We will ensure that within 24 hours of admittance to a paediatric ward due to autism, learning disabilities or mental health concerns, there is a multi-disciplinary plan to ensure a discharge in-line with their best interest.	March 2028

Continued on next page...

What we will do	What we will achieve	When
We will continue with our Joint Commissioning Review in West Sussex to further enable delivery of the priorities set out in *Improving Lives Together*, the Adult Social Care Strategy, and the Children First Strategy.	We will reform our joint commissioning governance to support the continued development of integrated health and care partnership working at system, place and local community level. We will realign our strategic and financial joint commissioning arrangements to match our local population health priorities, and the priorities set out in our health and care strategic plans.	March 2028

Difference this will make to local people and workforce in West Sussex and how it will be measured

Difference for local people and workforce	How will this be measured
Improved health outcomes for the most disadvantaged communities in Crawley.	Improved health outcomes across a number of areas including maternity, mental health, and long-term conditions. Improved access across a range of services for our most disadvantaged communities. Increase uptake of translation services, with more service available outside 9-5, Monday to Friday.
Improved access and capacity of diagnostics in Bognor Regis.	People will have access to their diagnostics at more convenient times. Reduced waiting times for diagnostics. Local residents in local university diagnostics related courses. Increased workforce supply, skills mix and new roles across imaging workforce.
Lower levels of mortality and disability due to stroke and cardiovascular disease.	More lives saved 90 days post discharge. Increased levels of independence. 90% of the expected prevalence of Atrial Fibrillation is diagnosed in every practice in West Sussex. 90% of people already known to be at high risk of stroke are adequately anticoagulated.

Continued on next page...

Difference for local people and workforce	How will this be measured
Improved discharge process to ensure people return home as appropriately as possible.	Reduction in the length of time between someone being ready to leave hospital and when they do. Reduction in overall number of patients who are ready to leave hospital but cannot. Maximise the proportion of people who can return home after leaving hospital.
People will be better supported to remain at home and retain more independence in the community.	Reduced time waiting to receive reablement/intermediate care intervention. Reductions in people unnecessarily needing long-term care. Reductions in need for care home placements. Increased proportion of care provided at home. Greater personalisation of discharge care and increase in number of personal health budgets. Increase in proportion of people living independently at home for longer.

Continued on next page...

Difference for local people and workforce	How will this be measured
Improved outcomes for children and young people with autism and mental health issues	Within 24 hours of admittance to a paediatric ward due to autism, learning disabilities or mental health concerns there is a multi-disciplinary plan to ensure a discharge in line with their best interest. Mental health, autism and learning disability module for social workers at university.
A shared set of strategic priorities and plans with integrated and streamlined commissioning arrangements and use of resources supporting delivery.	By streamlining and strategically aligning the West Sussex Joint Commissioning activities between local government and the NHS to population health priorities for children and young people, people living with a learning disability or neurodiversity or long-term mental illness, we will aim to deliver: • **Care models that enable greater independence, choice, and self-care.** • **Greater technology enabled care to support more people to live independently at home.** • **Better long-term health outcomes by tacking health inequalities experienced by people with learning disabilities, or mental illness.**

6. Other areas of focus

To support the delivery of our ambition and the four delivery areas, there are other areas that will require continued focus, either within the actions of our improvement priorities or as distinct pieces of work.

Prevention

Prevention is a key principle that underpins the delivery of our ambition. This includes supporting good physical health, supporting people to be socially connected, supporting emotional wellness and positive mental wellbeing, supporting people to feel safe in a clean and sustainable environment. The work being undertaken to deliver our Health and Wellbeing Strategies has prevention as a core focus and this will be taken further with the development of our Integrated Community Teams.

We are committed to the delivery of our Sussex Improving Population Health Strategy and the key priorities in the Sussex Strategic Framework for Health Inequalities. We continue to embed Population Health Management methods to identify target populations for health conditions, prevention programmes, racial health disparities and focussed personalised care interventions. We also have a series of programmes of work to address Core20PLUS5 for children, young people, and adults.

Increasing our focus on addressing the needs of children and young people is also an important element of our commitment to prevention. Using the system Children and Young People's Board to ensure that the work of all our Delivery Boards address the needs of children and young people will help us to identify and take opportunities, where we can, increasingly to shift the profile of our investment into prevention while still continuing to provide the health and care needed across our population.

We will measure the success of our prevention work through:

- **An increase in healthy life expectancy for males and females and a reduction in the inequalities in healthy life expectancy.**
- **A reduction in the prevalence of overweight children in reception and year six of primary school.**
- **An increase in the percentage of children and adults meeting the recommended levels of physical activity.**
- **Meeting national targets for vaccinations and immunisations.**
- **A reduction in rates of emergency admissions and subsequent loss of independence due to falls.**
- **More adult social care users and adult carers have as much social contact as they would like.**
- **More people aged 40-74 are offered and are taking up an NHS Health Check.**

Maternity and Neonatal Care

Maternity service reviews undertaken across England identified the need to proactively identify Trusts that require support before serious issues arise. To safeguard Sussex residents using our perinatal services, we must ensure we can identify adverse outcomes early and act swiftly whilst we embed learning from these national investigation reports. The processes and ways of working we have developed across our local maternity and neonatal system (LMNS) partners will continue to support our response to key national reports, including Ockenden and Reading the Signals.

NHS England published the three-year Maternity and Neonatal Delivery Plan which details the national ambition of ensuring that care is safer, more personalised, and equitable and based around the following themes. NHS Sussex is collaborating with the LNMS to develop provider and system plans to respond to these recommendations.

- **Listening to, and working with, women/people and their families with compassion.**
- **Growing, retaining, and supporting the workforce.**
- **Developing and sustaining a culture of safety, learning and support.**
- **Standards and structures that underpin safer, more personalised, and more equitable care.**

Safeguarding

We want to ensure all children, adults, families, and communities across Sussex are safe and free from all forms of abuse and harm. This involves a whole-system multi-agency approach that crosses all ages, places where people live and work, communities, and systems.

NHS Sussex has an agreed strategic approach to maintain safe and effective safeguarding and Looked After Children services and to strengthen arrangements for safeguarding children and adults at risk from abuse and neglect across Sussex.

We are required to demonstrate how our strategic and assurance arrangements enable us to carry out the duties and functions specified under the Care Act (2014) and the Children and Social Work Act (2017). We have an extensive and wide-reaching approach which includes:

- **Clear systems to train staff to recognise and report safeguarding issues.**
- **A clear line of accountability for safeguarding and Looked After Children, reflected in our governance arrangements and overseen by NHS England.**
- **Arrangements to work with local authorities through our Safeguarding Children Partnerships and Safeguarding Adult Boards.**
- **Arrangements to share information between service providers, agencies, and commissioners.**
- **Designated doctors and nurses who are responsible for safeguarding adults, children and looked after children.**
- **A child death review team, who are responsible for reviewing deaths in childhood, including nurses and a designated doctor.**
- **Child Protection Information Sharing (CP-IS), which will continue to be rolled out across Sussex.**

Quality

NHS Sussex has a statutory duty to ensure quality of care is maintained across services and meets the Care Quality Commission minimum standards for quality and safety, and that our health and care organisations have systems in place to check the quality and safety of care provided. Our quality assurance and improvement frameworks support our workforce in ensuring that our populations experience the best possible care. We will know that we are making a difference because:

- **People that inspect our health services will agree that they are safe and the measures for rating our services, such as those set out by the Care Quality Commission (CQC), will have improved.**
- **Our workforce will tell us that our services are improving in quality. By April 2024 we will have co-produced meaningful measures of quality and safety with our people and communities as well as an improvement target for the subsequent five years.**
- **People will report a better experience of contacting our Primary Care services.**
- **Our staff will be able to talk about and report quality and safety concerns freely without fear of speaking up or being criticised.**
- **There will be evidence that we are working more closely and better together to improve quality, responding to complaints more quickly, and running educational events to teach people how to create better quality and safety in our integrated services.**

Supporting social and economic development

Supporting local social and economic development across Sussex is one of the core aims of achieving our ambition. This will be done through our focus on the wider determinants of health across local people and communities, including access to education and skills, good employment and quality, affordable and sustainable homes – all the things that can help people and communities to thrive and prevent the need for medical intervention and give people the best opportunities for improving their lives.

We want to develop our health and care organisations into 'anchor institutions', where they will use their sizeable assets and ways of working to support the health and wellbeing of local communities and help address health inequalities. NHS Sussex is committed to using its evolving anchor role to explore and develop new networks across the region with the intention of establishing a greater understanding of the cross-sector impacts of health inequalities in Sussex and enabling policymakers from the system and wider sectors to come together to share ideas and develop health focused solutions. A growing socioeconomic challenge in the region and a significant determinant of a healthy and happy life is housing, from quality and accessibility to affordability, NHS Sussex will work with established and new partners to explore strategic options to tackle housing challenges.

This represents a new way of working for our system and it is recognised that it will take time to establish how partners can achieve this ambition most effectively together. To support this, in year one we will establish a baseline understanding of current work happening across the system that we can build on over years two to five. This will include:

- **Procurement activity which promotes local supply chains and local employment opportunities with a living wage.**
- **Employment initiatives that can assist with recruitment and retention of staff, as well as supporting the wider economy of Sussex.**

Climate change commitments

Since 2010, the NHS has reduced its emissions by 30%, exceeding its commitments under the Climate Change Act. In doing so, we have learnt that many of the actions needed to tackle climate change will directly improve patient care and health and wellbeing. This is because many of the drivers of climate change are also the drivers of ill health and health inequalities.

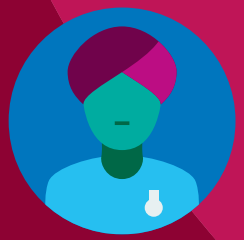
Together to Zero is our plan for a greener NHS in Sussex. The plan sets out how we will work together as partner organisations across our system to reduce carbon emissions and build an NHS more resilient to the effects of climate change. It also sets out a number of key areas for action on climate change that pose the most significant co-benefits for health, and which drive at greater efficiency and productivity. The plan supports the individual organisational plans of our NHS providers and will support the effective delivery of our Integrated Community Teams and Health and Wellbeing Strategies.

Evidence, research, and change methodology

We want to be driven by the best evidence and be at the forefront of improving health and care in our communities. To do this we will generate and use research evidence and create a culture of innovation to bring the best new approaches to Sussex. A new group is being developed called the Innovation and Research Hub, which will aim for the first time to bring together a Sussex-wide approach to Innovation, Research and Evaluation. The Innovation and Research Hub will hold the relationships with academic and research networks, national bodies, universities, local economic groups, and national and local industry groups. The introduction of the Innovation and Research Hub will bring the most progressive approaches in healthcare into Sussex. Having a streamlined approach to evidence finding, impact analysis and implementation will reduce the time lost through the current fragmented approaches but also accelerate the introduction or spread of useful technologies, medicines, or practice.

7.

Developing and delivering our Shared Delivery Plan



Our Shared Delivery Plan meets national guidance and takes account of key national, regional, and local strategies and policies. In-line with guidance, we will review and update the plan before the start of each financial year. We may also revise the plan in-year if considered necessary.

Planning approach and principles

Three principles describing the Shared Delivery Plan's nature and function have been co-developed with systems across the country, Trusts and national organisations representing local authorities and other system partners. These are:

- **Principle 1: Fully aligned with the wider system partnership's ambitions.**
- **Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.**
- **Principle 3: Delivery focused, including specific objectives, trajectories, and milestones as appropriate.**

Maximising the power of partnerships

Improving Lives Together outlines a commitment to maximising the power of partnerships to ensure organisations responsible for health and care work together in the best possible way for local people.

To enable the most effective delivery of our Shared Delivery Plan, it has been agreed that organisations will work together across four different levels:

- **System level – across the whole of Sussex.**
- **NHS provider level – across NHS organisations.**
- **Place level – across the footprints of our three local authorities.**
- **Local community level – to support the development and delivery of the Integrated Community Teams.**

This way of working will enable better integration of services, use of resources, co-ordination, planning, and decision-making that will lead to better joined-up care for local people and better ways of working for our staff. It also supports national policy and guidance. To enable this to happen, we are developing a new operating model across the system that will have a 'golden thread' of all organisations working in the best possible way for local people and patients. In doing so, we will respect the statutory and corporate accountabilities and responsibilities of all organisations.

This will require every statutory organisation to start to work in a new way across the four different levels from April 2024.

System level

We will continue to work at a Sussex-wide system level through the existing statutory architecture that was established with the formal formation of our Integrated Care System.

The Sussex Health and Care Assembly is the Integrated Care Partnership for Sussex, which is a joint committee established by NHS Sussex, Brighton & Hove City Council, East Sussex County Council and West Sussex County Council in accordance with the constitutions of each body. The membership of the Assembly includes wider partners, including our three Universities, further education, the housing sector, the local enterprise sector, Healthwatch, and the Voluntary Community and Social Enterprise sector. The purpose of the Assembly is to bring a broad section of system partners together to approve and facilitate the strategic direction for meeting the broader health, public health, and social care needs of the population. This allows for partnership and collaborative working to take place across wider partners.

NHS Sussex Integrated Care Board (ICB) is the statutory NHS organisation responsible for the oversight of performance, quality, and resource allocation of NHS services across Sussex. This is done by working with NHS providers and a legal obligation to work with Local Authority partners. The NHS Sussex Board is made up of independent Non-executive Directors, partner members from NHS providers, local authorities, and Primary Care, as well as Executives. The future function of NHS Sussex will change to be predominantly focused on the strategy and planning for the system to achieve improved outcomes for the population. A new operating model will be developed during 2023-24 and will be in place from 2024-25.

NHS provider level

A Provider Collaborative will be established, which will involve NHS providers working together in a more formal, effective, and joined-up way for the benefit of patients and staff. The collaborative will design the service transformation models to deliver the strategic priorities, in co-production with partners, at Place and local community level. The provider collaborative will include Primary Care as part of the membership.

Place level

We will strengthen how our organisations work together across our populations in Brighton and Hove, East Sussex and West Sussex through Health and Care Partnerships and delivery of the Place-based Health and Wellbeing Strategies. Place will be the intermediary tier for the NHS and the primary tier for the Local Authority to discharge its statutory responsibilities to meet residents' needs in their council area. It will oversee and provide leadership for the delivery of services at community level and fulfilment of legal duties in respect of Place-based partnerships including with Health and Wellbeing Boards.

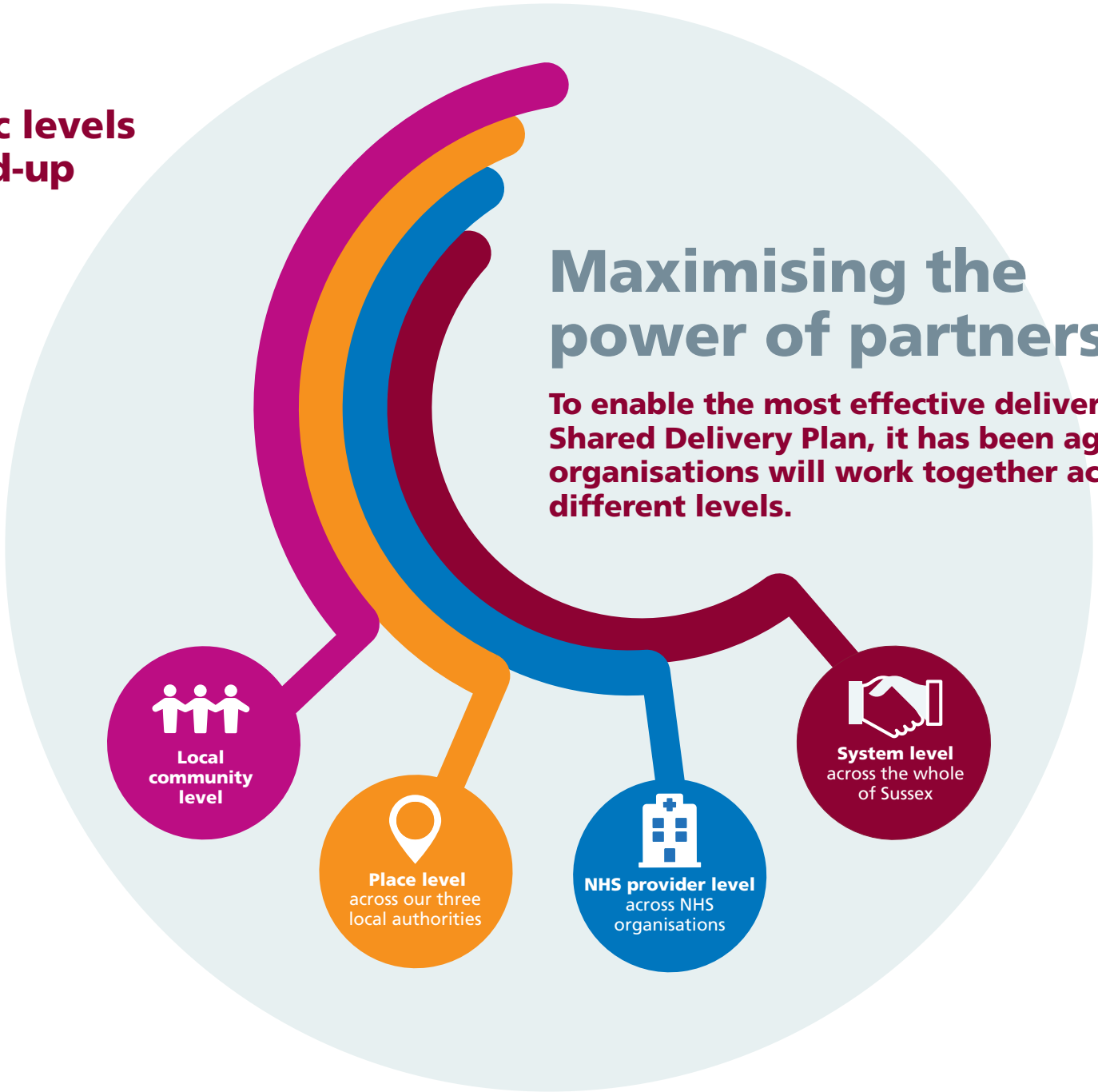
Local community level

We will integrate services and ways of working at a local community level through the formation of Integrated Community Teams. We are consciously using the term 'community', rather than 'neighbourhood' which is also often used to represent integration at a very local level, as we will have a broader focus on people's individual needs that will stretch beyond simply the geographical location they live. By community, we mean both the recognised local area someone lives and communities that people identify with, such as those with the same interest, beliefs or ways of life.

Integrated Community Teams will be the focus for prevention, self-care, and providing support to help people make choices about their care and look after their own health priorities, enabled by strengthened Primary Care and assets-based approaches with communities. They will be supported to develop new approaches across Sussex which will be based on empowering our communities, the promotion of local leadership, equality of partnership between participating organisations, a permission to innovate for local people and for staff, and a different approach to working with people. As our communities across Sussex are all unique, partner organisations will have to work in a pragmatic and flexible way at this level and will be supported to do so. This will involve changes to how partners have worked in the past to ensure they are able to work in an integrated way at a local level.

Figure 3

Strategic levels of joined-up working



Governance and leadership

Governance for delivery

The delivery structure for the Shared Delivery Plan is outlined on page 117. This involves each of our Long-term Improvement Priorities (Delivery Area 1), Immediate Improvement Priorities (Delivery Area 2) and Continuous Improvement Areas (Delivery Area 3) having a Delivery Board to lead the delivery of the agreed actions, chaired by a system Chief Executive Officer. Each will have a workstream that will be resourced from across system partners. The work of these Boards and workstreams will be overseen by a System Oversight Board.

Each workstream across Delivery Area 1 and 2 will give due regard to the continuous improvement areas and ensure they are embedded within the work taking place and all will ensure they are supporting the aims and ambitions of *Improving Lives Together* in:

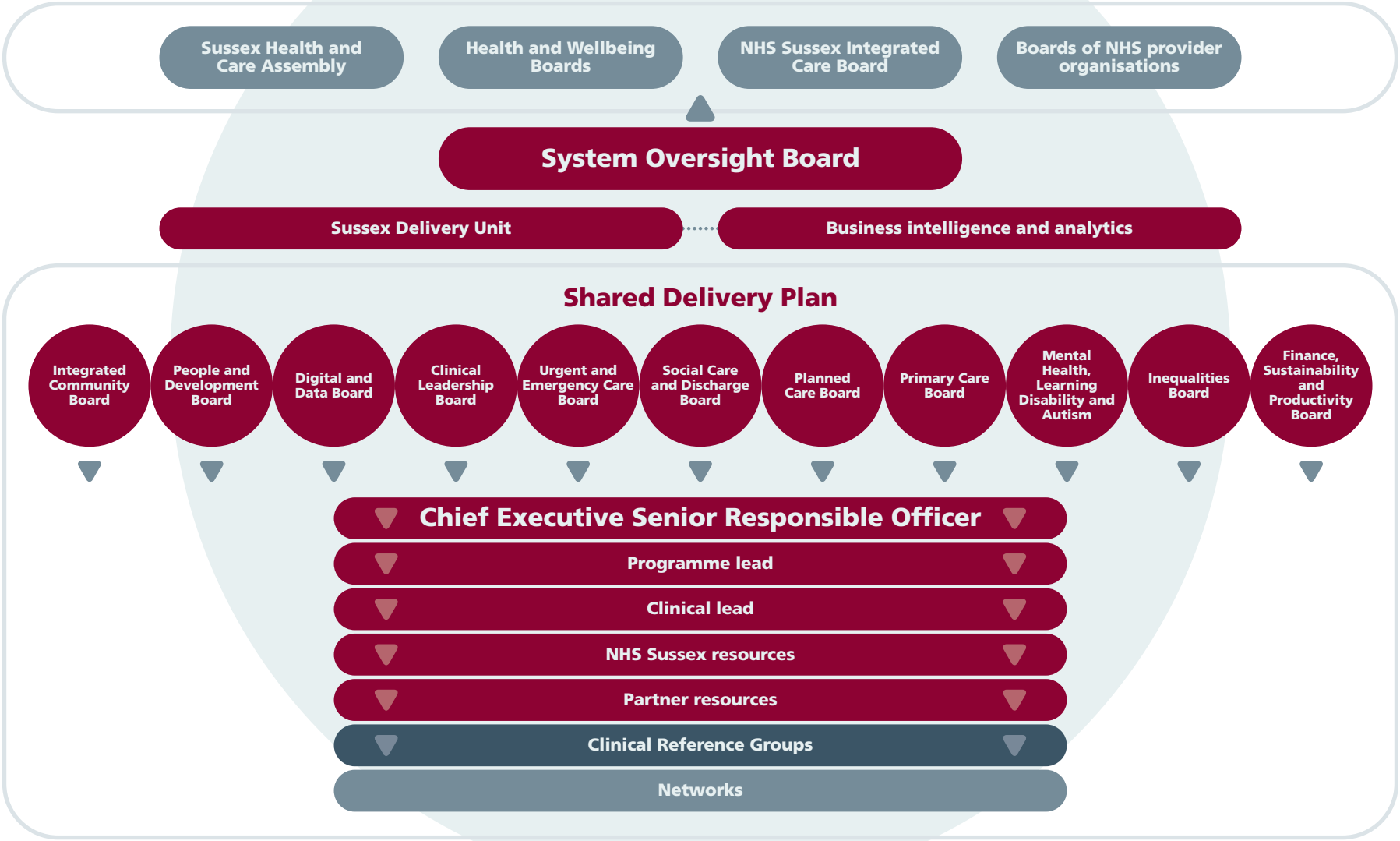
- **Improving health and health outcomes for local people across the life course, with particular focus on children and young people;**
- **Tackling health inequalities;**
- **Working better and smarter;**

  and
- **Supporting communities to develop socially and economically, including sustainability.**

The Delivery Boards will develop detailed workplans and milestones for each workstream and will use insight and data to create outcome frameworks.

Figure 4

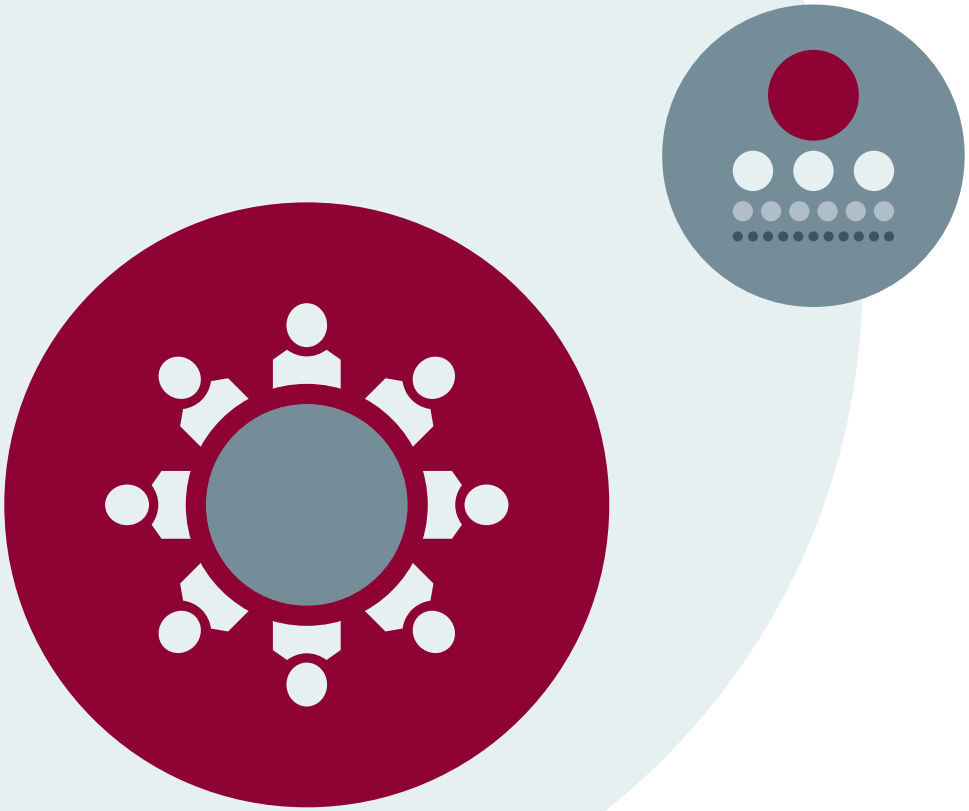
Governance structure for delivery



System Oversight Board

The core functions of the System Oversight Board (SOB) will be to oversee the implementation of the Shared Delivery Plan and to provide leadership with regards to strategy, and resolution of system risk.

SOB will report into the NHS Sussex Executive Committee and onwards to the NHS Sussex Board. Members will be required to report back from SOB through to their respective organisational boards and leadership forums to ensure system alignment. The new SOB replaces the former System Leadership Forum and is made up of Chief Executive Officers from the statutory NHS organisations, GP Federations, and senior representatives from the Local Authorities. This includes the leadership of Surrey and Sussex Healthcare NHS Trust.



Financial strategy and delivery plan

Work has taken place across the system to co-produce a plan to deliver our long-term strategic ambitions. However, it is important to recognise public sector financial constraints over a number of years, which therefore means delivery of this plan is subject to an underpinning financial strategy which will be developed by September 2023. As a result of this there may be further strategic and operational change required to underpin delivery over the next five years, the size and impact of which will need to be captured.

Engagement and partnerships

Our Shared Delivery Plan has been developed across system partners and is informed by national, regional, and local evidence, guidance, and insight. To support the co-development process, we have established an engagement working group, working with:

- **Sussex Health and Care Assembly members**
- **Primary Care providers**
- **Local Authorities and each relevant Health and Wellbeing Boards**
- **Other systems in respect of providers whose operating boundary spans multiple systems**
- **NHS providers**
- **Healthwatch**
- **The voluntary, community, and social enterprise sector**
- **People and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives, in accordance with the requirement to consult.**

Insight from engagement with people and communities across Sussex over a two-year period underpinned the development process of ***Improving Lives Together***, and thematic analysis of this insight has informed the creation of the Shared Delivery Plan. Enhanced engagement opportunities were also offered via online sessions for Foundation Trust Governors and the public, discussions with members of the Sussex VCSE sector, Healthwatch and with other key partners.

Extensive workforce engagement was also undertaken with insight collated from the national NHS staff survey results and from NHS organisation and Local Authority "pulse" surveys.

As we deliver the actions outlined in our Shared Delivery Plan, we are committed to making sure we continue to reach and hear from as many people as possible across Sussex, and ensuring their experiences, views and suggestions shape and influence our work. Each Delivery workstream will set out how the public and patients will be involved and engaged as part of their workplans for the delivery of the agreed actions. Our Working with People and Communities Strategy outlines our approach to public engagement and how we meet the legal duties around involvement.

Sussex
Health&Care

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023		**Agenda reference:**	**85-23**	
Report title:	Strategic development committee assurance				
Sponsor:	Jackie Smith, Trust Chair				
Author:	Leonora May, deputy company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the Board with assurance regarding the development of the Trust strategy and an update on the first meeting of the strategic development committee				
Summary of key issues	- Good progress has been made against the first phase of strategy development - Key risks include securing a sustainable future for the Trust and engagement with stakeholders - An engagement plan is in place and to date 109 engagement sessions have been completed				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	**Information**	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	NA				
Corporate risk register:	The committee reviewed the strategy development risks, issues and opportunities, noting delivering a sustainable future for the organisation and engagement with system and regional stakeholders as the key risks. The committee will continue to monitor controls and mitigations in place to address these risks				
Regulation:	Well led review				
Legal:	NA				
Resources:	NA				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	85-23
Date of meeting:	7 September 2023
Report from:	Jackie Smith, Trust Chair
Report author:	Leonora May, deputy company secretary
Date of report:	18 August 2023
Appendices:	None

Strategic development committee assurance

Introduction

The strategic development committee was established by the Board to provide assurance regarding Trust strategy development and implementation as recommended in the Trust's recent well-led review. The committee held its first meeting on 19 July 2023.

Trust strategy development

The committee received an update on Trust strategy development. Good progress has been made against the first phase and plans are broadly on track. The committee supported the proposed financial model and recognised it as being an important tool for decision making going forward. The committee recognised a need to maintain pace to keep on track in the second phase given the amount of work involved.

An engagement plan related to the development of the Trust strategy is in place and feedback from engagement activities to date is positive, with recognition that this may become more challenging in the next phase as the Trust develops proposals for change. To date, 109 engagement sessions have taken place with approximately 450 stakeholders. The committee agreed that transparency regarding the financial position will remain an important part of engagement.

A stakeholder engagement assurance group has been established to oversee engagement activities with key stakeholders. Members include two governors.

A clear timeline for the development and implementation of enabling strategies is being developed and will be presented to the committee at a future meeting for review.

Other

- The committee reviewed the strategy development risks, issues and opportunities, noting delivering a sustainable future for the organisation and engagement with system and regional stakeholders as the key risks. The committee will continue to monitor controls and mitigations in place to address these risks
- The well led review recommendations and action plan will become a standing agenda item for monitoring by the committee

The next meeting of the committee will be held on 27 September 2023, and I will provide a further committee assurance report for the Board at its meeting on 2 November 2023.

Recommendation

The Board is asked to **note** the contents of the report.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023		**Agenda reference:**	**86-23**	
Report title:	Audit committee assurance				
Sponsor:	Kevin Gould, committee Chair				
Author:	Ellie Simpkin, governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance to the Board in relation to matters discussed at the Audit committee meeting on 03 August 2023				
Summary of key issues	- The committee is satisfied with the overall quality and output of the external audit for 2022/23, despite some last minute challenges - Raising concerns has been added to the 2023/24 internal audit plan during quarter four - The committee would like to see improvement in compliance with tendering processes, reducing the need for single tender waivers and ensuring value for money				
Recommendation:	The Board is asked to **note** the contents of this report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Audit committee				
	Date:	03/08/2023	Decision:		
Next steps:	None				

Report to:	Board Directors
Agenda item:	86-23
Date of meeting:	7 September 2023
Report from:	Kevin Gould, committee Chair
Report author:	Ellie Simpkin, governance officer
Date of report:	22 August 2023
Appendices:	None

Audit committee assurance

Introduction

This purpose of this report is to provide the Board with assurance on matters considered by the Audit committee at its meeting on 3 August 2023.

Assurance on Board Assurance Framework KSO 1 & 2

The committee received assurance of the governance arrangements and committee architecture which support the delivery of KSO 1 and 2. It noted that further assurance is required in the areas of the planned care waiting list and raising concerns which are being prioritised in the internal audit plan for 2023/24. Discussion was had on the assurance received on the clinical audit processes. The role of the Board sub-committees in overseeing the clinical audit programme needs to be considered as part of the quality improvement and strategy development work which the Trust is currently undertaking.

External audit

The committee is satisfied with the overall quality of output and performance of KPMG as the Trust's external auditor for 2022/23, despite challenges completing the audit which led to submission of the accounts at the last minutes. The accounts were submitted on 30 June 2023.

Internal audit

RSM presented an update on the Internal Audit plan. Three reports had been completed since the previous meeting:

- Emergency Planning and Business Planning (Reasonable Assurance, three medium priority actions)
- Financial Assumptions (advisory)
- Data Security and Protection Toolkit (Substantial Assurance)

The committee reviewed the revised Internal Audit plan 2023/24 which was approved with further amendments, including an internal audit on the effectiveness of processes related to raising concerns at QVH has been scheduled for quarter four of 2023/24.

Counter fraud

The Committee received a report on the progress of Counter Fraud activity and the annual reactive benchmarking report.

Financial reporting

The Committee reviewed financial reports demonstrating compliance with the Trust's standing financial instructions and scheme of delegation and reservation of powers which included details of waivers, contracts over £30k and invoices with no purchase order, and received assurance on the use of the Trust's contracts register. The

committee would like to see improvement with compliance with tendering processes, reducing the need for single tender waivers and ensuring value for money

Risk
The corporate risk register was reviewed. The committee noted that improvements to the strategic risk management processes are ongoing and raised concern regarding risks not being update in a timely manner

This was Kevin Gould's last meeting as Audit committee Chair, and the committee thanked him for his valuable contribution. Paul Dillon-Robinson will take over the role of Chair of the newly named Audit risk and assurance committee from 1 September 2023.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07 September 2023		**Agenda reference:**	**87-23**	
Report title:	Workforce performance report				
Sponsor:	Robert Stevens, interim Chief People Officer				
Author:	Robert Stevens, Interim Chief People Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide updates and assurance related to workforce matters.				
Summary of key issues	- Workforce strategy - Equality, diversity and inclusion - Recruitment quality improvement project - Appraisal quality and compliance				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required:	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	**KSO5: *Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	Link to corporate risk related to the service implications of failing to deliver the Trust's workforce strategy				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	None				

Report to:	Board Directors
Agenda item:	87-23
Date of meeting:	7 September 2023
Report from:	Robert Stevens, interim Chief People Officer
Report author:	Robert Stevens, Interim Chief People Officer
Date of report:	11 August 2023
Appendices:	None

Workforce performance report

Workforce Strategy

The workforce and organisation development team will be developing a workforce strategy in coordination with the work underway to develop a new Trust strategy. This will be an enabling strategy that also defines our priorities in relation to Improving Lives Together (January 2023) published by the ICB, the 5 year Sussex Shared Delivery Plan (SDP - July 2023) and Sussex People Plan (*forthcoming*). This work will commence in the autumn.

Equality, Diversity & Inclusion (EDI)

A report on the Staff Survey 2022 was presented to the Board in July 2023. Reports on the Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES) and Gender Pay Gap were presented to the finance and performance committee in July 2023.

Also at the July finance and performance committee meeting we reviewed the findings of the recent WRES and WDES Insight Report (July 2023) undertaken by the HIRO Collective

The reality is that our staff survey and EDI metrics indicate that we need to be bolder and accelerate our efforts to become a more inclusive organisation.

We also need to be more careful in prioritising our actions in line with our capabilities and resources and so we will be developing a joint Staff Survey and EDI improvement plan (incorporating our WRES, WDES and Gender Pay Gap response) with a limited number of priorities, linked to the outputs and outcomes identified in the NHS EDI Improvement Plan for Sussex. This plan will be presented at the next Board following internal discussion and agreement.

Recruitment quality improvement project

There are two main streams of work linked to an ongoing task and finish group:

- **Trac New Starter Portal** – Online forms being added to Trac (our recruitment interface) and plan to go live at end of August 2023, pending training of the resourcing team
- **Digital ID checks** – Proposals being reviewed by relevant corporate teams and on track.

Workforce information

Significant work has been undertaken in August to reconcile ESR (electronic staff record) cost centres and positions with the Finance ledger – this is the first step in improving our workforce KPI reporting.

Organisation Development - Appraisal
The two main streams of work are:

Compliance - As of 1 August, of 142 appraisals that are outstanding, 51 (41 AfC, 10 M&D) are overdue by more than three months. This is an improvement on the previous month and reports have been circulated to executive colleagues.

Quality - A review of the policy and process is ongoing, with the intention to refresh the appraisal form and guidance in the autumn.

- **Apprenticeships** - An annual report has been produced and will go to finance and performance committee in September 2023.

- **Staff Survey -** Picker procured to provide the 2023 survey, which will launch on Monday 2 October and run until Thursday 30 November. A communication plan is currently being developed.

  Quarter 2 National Quarterly Pulse Survey (NQPS) undertaken in July 2023 are being reviewed

- **Work experience programme –** After a pilot event in March 2023 for local schools / relatives of staff, a round is planned for October 2023.

Pay and policy – Disclosure and Barring Service (DBS)
A DBS – criminal record recheck project has commenced to review the scope and frequency of checks. Work is subject to a data cleanse that is 85% complete and the review will be conducted in partnership with the Chief Nurse.

Employee Relations

- **Sickness** - Review of the NHS attendance toolkit against QVH's current Supporting Health in the Workplace Policy has been completed. The Trust's relatively low sickness rates are reflected in already strong alignment with the recommendations in the toolkit. Revisions, subject to review include: the long term sickness absence and ill health retirement processes.

- **Wellbeing** – We are currently developing a Health & Wellbeing plan in line with regional and national teams to implement the "we are safe and healthy" NHS People Promise.

Occupational Health (OH)
The Trust has extended its contract with Cordell Health until the end of March 2024 and has initiated a tender process to procure a long term contract for occupational health services that meet the changing needs of services and our commitment to support the SDP in its vision to develop a single occupational health and wellbeing provider.

Medical Education – GMC Survey
The 2023 results were published in July 2023 with 19 green flags and no red flags in any specialty for the second year in a row.

An action plan is being developed with the director of medical education and specialty tutors to address pink flags in Higher Plastic Surgery and to look at indicators that have not received red or pink flags but where scores have dropped

compared to 2022. Progress will be monitored via the Local Academic Board and Local Faculty Group meetings.

Recommendation
The committee is asked to **note** the contents of the report.

Report cover-page					
References					
Meeting title:	Trust Board				
Meeting date:	07/09/2023		**Agenda reference:**	**88-23**	
Report title:	Financial performance report				
Sponsor:	Maria Wheeler, chief finance officer				
Author:	Jeremy Satchwell, interim deputy chief finance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To presents an overview of the financial position of the Trust at the end of June 2023				
Summary of key issues	Month 3 key financial data. At the close of June, the Trust has achieved a breakeven position and retained cash balances of £13.5m. The forecast outturn is breakeven.				
Recommendation:	The Board is asked to **note** the contents of this report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	24/07/2023	Decision:	NA	
Next steps:	None				

Report to:	Board Directors
Agenda item:	88-23
Date of meeting:	7 September 2023
Report from:	Maria Wheeler, chief finance officer
Report author:	Jeremy Satchwell, interim deputy chief finance officer
Date of report:	25 August 2023
Appendices:	None

Financial performance report

1. Introduction

This report presents an overview of the financial position of the Trust at the end of June 2023 (Month 3). Key financial data are presented in this report.

2. Executive summary

Financial Metric	Period	Result Month 3
Income and Expenditure	YTD	Breakeven
	Year End Forecast	Breakeven
Cash at Bank	YTD	£13.5m
Capital spend	Plan YTD	£1.86m
	Actual YTD	£0.72m
BPPC (Combined NHS & Non NHS)	YTD Volume (%)	95.7%
	YTD Value (%)	95.1%
Efficiencies	Plan YTD	£1.36m
	Actual YTD	£1.36m
	Year End Forecast	£5.5m (5.5%)

Figure 1: Key Financial Performance Metrics

3. Background

The Financial Regime in 2022/23 was based, in the main, on the receipt of Block Allocations of funding from Integrated Care Boards with various performance KPIs and targets agreed alongside these financial envelopes.
In 2023/24, the regime has developed so that in the main, funding allocations are composed of three key elements:

- A Block value for all ICB contracts (Sussex, Kent, Surrey and SE London) and NHSE Specialised Commissioning which are not activity dependent.
- An Elective baseline value for each of the above in terms of elective activity (excluding follow-ups) supported by the Elective Recovery Fund (ERF) to deliver to 109% of 2019/20 levels and which is paid based on elective patient activity delivered
- Block values for all ICBs with activity values below £500k

4. Situation

4.1. Income and Expenditure

The year-end forecast has been updated to reflect the additional income and costs associated with the Agenda for Change pay award which was greater than included in the original plan submitted to NHSE.

The additional income received from the ICB is offset by equivalent costs and there is no impact on the forecast breakeven position.

Income and Expenditure

	In Month £'000				Year to Date £'000				Forecast Outturn £,000		
	22/23	Plan	Actual	Variance	22/23	Plan	Actual	Variance	Plan	Forecast	Variance
Income											
Patient Activity Income	8,313	7,747	7,897	150	22,190	23,240	23,246	6	92,960	94,360	1,400
Other Operating Income	(232)	248	244	(4)	258	743	882	139	2,974	2,974	0
Total Income	**8,081**	**7,994**	**8,141**	**146**	**22,449**	**23,983**	**24,128**	**144**	**95,933**	**97,333**	**1,400**
Pay											
Substantive	(4,379)	(4,900)	(5,046)	(147)	(13,070)	(15,032)	(14,095)	938	(57,630)	(57,483)	147
Bank	(329)	(194)	(358)	(164)	(862)	(582)	(950)	(368)	(2,355)	(3,284)	(930)
Agency	(29)	(41)	(130)	(89)	(214)	(124)	(419)	(295)	(514)	(1,360)	(847)
Total Pay	**(4,737)**	**(5,135)**	**(5,535)**	**(400)**	**(14,146)**	**(15,739)**	**(15,464)**	**275**	**(60,499)**	**(62,128)**	**(1,629)**
Total Non Pay	**(2,621)**	**(2,258)**	**(2,124)**	**134**	**(6,968)**	**(6,773)**	**(7,246)**	**(473)**	**(29,356)**	**(29,290)**	**66**
Total Non Operational Expenditure	**(381)**	**(490)**	**(502)**	**(12)**	**(1,394)**	**(1,471)**	**(1,478)**	**(7)**	**(6,078)**	**(6,155)**	**(77)**
Total Expenditure	**(7,739)**	**(7,883)**	**(8,161)**	**(277)**	**(22,509)**	**(23,983)**	**(24,188)**	**(204)**	**(95,933)**	**(97,573)**	**(1,640)**
	343	**111**	**(20)**	**(131)**	**(60)**	**0**	**(60)**	**(60)**	**0**	**(240)**	**(240)**
Surplus / (Deficit)											
TechnicalAdjustments	(343)	(111)	20	**131**	60		60	**60**		**240**	240
Adjusted Surplus / (Deficit)	**(0)**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**0**	**0**	**0**	**0**

Figure 2: Income and Expenditure Summary Month 3

4.1.1. Patient Activity Income

Impact of industrial action – estimated financial impacts presented in the table below, based on shortfall in plan relating to days of industrial action

Month	Value Weighted Activity (VWA) performance vs relevant month in 2019/20	Impact of Industrial Action-lost income
April	108%	£179k
May	122%	£0k
June	108%	£130k

Figure 3: Activity volumes v 2019/20 and Impact of Industrial action

Activity: current estimate of achievement is 108% for M1 and 122% for M2 and 108% for M3 pre-flex and freeze data being available

Estimated elective contract activity value adjustment vs 12ths of published elective baselines with a Q1 aggregate variance value of £-74k.

4.1.2. Non Patient Care Income

This is various non-patient related income sources e.g. catering, parking and is above plan but expected to be in line with plan at the year end.

4.2. Expenditure

Pay costs are under plan year to date. Vacancies in substantive posts offset by temporary staff costs.

£222k increased Bank and Agency costs incurred as a result of industrial action since April

4.3. Forecast Outturn

At this stage, although there are known risks, the forecast out turn is breakeven.

4.4. Efficiencies

The requirement for delivery of 5.5% efficiency is a national planning assumption.

The budget setting and planning process for 23/24 included a major exercise to re-set the Workforce establishment and related pay budgets by removing historic vacancy factors and un-achieved savings plans. The re-set of the budgets has delivered 3.5% at the start of the year.

The remaining 2% will be delivered by a range of savings, the largest of which is a programme of improvement in theatre efficiency in order that the expenditure on procuring external capacity from the Mcindoe Centre can be curtailed.

The table below provides a high level summary of the plans-(Detailed Plans are available in the Appendices). The theatre improvement is classified as Service re-design. The project to deliver the savings is led by operations.

The savings are monitored through the financial reporting process and currently are being measured through identifying savings in pay costs arising from vacancies in clinical staff in QVH facilities.

Pending the delivery of recurrent savings through the plans, we will continue to measure the savings through favourable pay variances in relevant QVH clinical staff. It is recognised that these savings are non-recurrent and recurrent savings will be measured following the delivery of the theatre productivity improvement plans.

A number of procurement schemes are in the pipeline and some savings have been measured to date. The requirement for operations to identify and deliver savings is a standing item in the regular performance review meetings and the monthly management accounts meetings.

Efficiency Savings 2023/24 YTD

	Actual 30/04/2023 Month 1	Actual 31/05/2023 Month 2	Actual 30/06/2023 Month 3	Plan 31/05/2023 YTD	Actual 31/05/2023 YTD	Variance 31/05/2023 YTD	Plan 31/03/2024 Year ending	Forecast 31/03/2024 Year ending	Variance 31/03/2024 Year ending
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Efficiency Savings - by category									
Pay Efficiencies									
Establishment reviews	288	288	287	863	863	0	3,452	3,452	0
Service re-design - pay	0	0	0	450	0	(450)	1,800	1,350	(450)
Other - pay (Non-recurrent Vacancies)	159	159	163	0	481	481	0	481	481
Total Pay	**447**	**447**	**450**	1,313	**1,344**	**31**	5,252	5,283	31
Non-pay Efficiencies									
Medicines optimisation	0	0	0	0	0		0		0
Procurement (excl drugs) -non-clinical	3	3	4	0	10	10	0		0
Service re-design - Non-pay	0	0	0	47	6	(41)	201	160	(41)
Total Non-Pay	**3**	**3**	**4**	47	**16**	**(31)**	201	170	**(31)**
Total Income	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Efficiencies	**450**	**450**	**454**	**1,360**	**1,360**	**0**	**5,453**	**5,453**	**0**

Figure 4: Efficiency Savings

4.5. Risks and Mitigations

Risk Description	Risk Value £,000	Mitigation
Excess Inflation	-270	Reporting to ICB with a view to secure funding for utilities and premises related inflation
Increased used of Sleep Eqpt above baseine plus 9% levels	-533	Reporting to ICB with a view to secure funding for increased volume of CPAP devices
Lack of activity delivery for ERF/PbR Earnings	-2,611	Manage resource usage levels in line with activity levels
Excess Staff Cost due to strike action	-222	Manage within the staffing vacancies available

Figure 5: Risks and Mitigations

5.0 Treasury Management

The Trust's cash balance remains healthy and is actively generating interest income for the Trust.

We expect cash balances to diminish as the Capital program ramps up for 2023/24 and the Trust transfers £4m cash relating to 2022/23 back to the ICB.

As reported in Month 2 and again for Month 3, there is nothing notable to bring to the Board's attention with regard to the Trust's working capital position, it is expected that creditors will reduce throughout the year when the cash is returned to Sussex ICB and when the fire remediation works are fully on site. Work continues to resolve outstanding debt over 60 days.

The Trust's BPPC (better payment practice code) performance is summarised in the table below. At the end of June, QVH is broadly compliant with the 95% target but continues to work to improve the NHS payment times which are currently under the target for the number of invoices.

Invoices	Total Invoices		Actuals Paid in Time		Performace vs 95%	
	No.	Value	No.	Value	No.	Value
NHS	191	809	174	773	91.1%	95.5%
Non NHS	4,864	14,120	4,665	13,420	95.9%	95.0%
Overall	5,055	14,929	4,839	14,193	95.7%	95.1%

Figure 6: BPPC Performance

5.1 Capital Expenditure

Capital Expenditure is £0.72m at the close of June from a year to date plan (as per original planning assumptions at the start of the year) of £1.86m. It is noted that the EPR and CDC projects are still to start.

5.2 Capital Planning

The table below shows a draft 5 year capital plan. The planning and prioritisation detail below will focus on the capital plan for 2023/24.

Plan	YR1 (000)	YR2 (000)	YR3 (000)	YR4 (000)	YR5 (000)
ESTATES - 6FS	1,562	1,562	1,835	1,842	1,789
ESTATES - ASBESTOS	150	150	150	150	150
ESTATES - OTHER	940	100	100	100	100
IM & T	985	900	900	900	900
MEDICAL DEVICES	600	500	500	500	500
BUSINESS CASES	250	250	250	250	250
IFRS16 - MRI	493	493	0	493	493
Total Plan	**4,980**	**3,955**	**3,735**	**4,235**	**4,182**
Agreed / Estimated CRL	**4,800**	**3,700**	**4,100**	**4,100**	**4,100**
(Over) / Under subscription	**(180)**	**(255)**	**365**	**(135)**	**(82)**

Available capital in 2023/24 is constrained and allocations to projects have been paused whilst major reviews (e.g. 6 Facet Survey) and electrical and fire surveys have been undertaken on the estate.

5.2.1 Estates

The six-facet survey highlighted areas of high risk to the Trust, and these will be addressed in this financial year, and the estimated costs are contained within table above.

An asbestos survey has also been commissioned, a provision has been made in the budget to deal with any emerging risks highlighted in the report. As part of the estate upgrade, the trust's intent is to remove the asbestos risk completely.

5.2.2 IM&T

IM&T is a key operational risk following the Trust's previous "0" digital maturity score. The capital investment in 2023/24 is to complete the next phase of IT infrastructure to facilitate the planned digital transformation programme which includes the replacement of the EPR system.

5.2.3 Medical Devices

Medical devices replacement is a vital part of the programme to ensure the operational equipment remains fit for purpose. The capital investment in this area is partly through direct purchase of equipment and the use of leases or managed equipment service agreement. Under the new IFRS16 financial standard all leases/MES needs to be included as a fixed asset on the balance sheet. As such requires a capital resource.

5.2.4 Prioritisation process

The capital plan above has been through an additional layer of review to ensure the capital programme mitigates the very highest risks for the organisation. The Executive have reviewed the programme at a detailed level of the whole capital plan, and using the information provided, carried out a desk top risk assessment of the programme.

The conclusion of this assessment was to ensure the high risk areas as set out above have been addressed within the capital plan. However there were areas which the Executive felt needed further work, before the capital programme can be finalised. This is set out below;

- *Estates – The Head of Estates will provide a physical risk assessment of the estate to ensure the key areas highlighted are the highest risk. Also to review the areas highlighted in the 6 facet survey as significant risk (rather than high) can be built into the 2024/25 programme and shouldn't be brought forward in this financial year.*

- *IM&T – It was fully accepted this was needed to facilitate the rollout of the digital transformation programme, although the timing of this investment could be flexible depending on the risk based needs of the other areas of the capital programme.*
- *Medical Devices – More detail was requested to obtain a better understanding of the risk posed by the existing equipment. Following this a programme of replacement will be produced to be completed within available resources.*

The capital programme is due to be re-presented to the Executive on 26 September for finalisation. Although the capital programme is in the process of being finalised, urgent works needed to the site will continued to be carried out.

5.3 Sussex System Financial summary

The following tables are provided by the Sussex ICB for Month 3 financial results.

Provider	System YTD Summary - I&E (£000s)		
	YTD Plan	YTD Actual	(Deficit)/ surplus
ESHT	-	(715)	(715)
QVH	4	-	(4)
SCFT	(1,092)	(1,083)	9
SPFT	(2,510)	(4,324)	(1,814)
UHSx	(4,834)	(10,527)	(5,693)
ICB	-	97	97
Total	**(8,432)**	**(16,552)**	**(8,120)**

N.B. 1: The £4k variance is a result of rounding in the plan.

Figure 7: Summary of all Sussex Providers Month 3

Provider	Total YTD Efficiencies (£000s)		
	YTD Plan	YTD Actual	Variance (adverse) / favourable
ESHT	4,003	4,856	853
QVH	1,360	1,360	-
SCFT	3,837	3,217	(620)
SPFT	2,960	3,036	76
UHSx	10,277	10,692	415
ICB	-	-	-
Total	**22,437**	**23,161**	**724**

Figure 8: Summary of all Sussex Providers Efficiency Delivery

6.0 Assessment

At the close of June, the Trust has achieved a breakeven position and retained cash balances of £13.5m. The forecast outturn is breakeven.

The Agenda for Change pay award has been settled and additional income received from the ICB to cover the increased costs above the original planning assumption. This has not resulted in a further cost pressure.

Patient activity levels are broadly in line with plan although elective patient activity was reduced in April and June though industrial action.

Additional pay costs of £222k and loss of income of £309k has been incurred as a result of industrial action in the period from April 2023 to June 2023.

Efficiencies have been delivered through establishment changes and further savings have been noted in Procurement.

The efficiency savings requirement to deliver a break-even plan for 2023/24 (in the wider context of the Sussex system, cost pressures and NHSE requirements) has resulted in an efficiency savings target of £5.4m, which is c. 5.5% of the Trust's cost base (noting this is the requirement for all the providers in Sussex), with £3.4m full year effect already found recurrently and with budgets adjusted, the remainder of the efficiencies requirement profiled into the position.

The 5.5% target overall is significantly higher than previous year's targets, even prior to the Covid-19 pandemic (during which time efficiency requirements were effectively paused). But this Trust has made good progress in achieving the plan.

The theatre productivity improvement scheme is essential in order to deliver recurrent savings in 2023/24.

7.0 Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/23		**Agenda reference:**		**89-23**
Report title:	Operational performance report				
Sponsor:	Shane Morrison-McCabe – Director of Operations				
Author:	Shane Morrison-McCabe – Director of Operations				
Appendices:	Performance data set				
Executive summary					
Purpose of report:	• Set out the July performance for national and local targets and the changes to the number of cancer standards as of October 2023 • Give a summary of the outpatient and theatre transformation programmes performance • Set out the impact of the industrial action and give a RTT waiting list forecast to year end which is based on key assumptions				
Summary of key issues	Cancer: The backlog of patients on a 62 day pathway was above our threshold which puts at risk the achievement of the target. We are above trajectory for patients waiting 104 days+ for cancer treatment. Faster diagnosis was achieved for cancer patients and is forecast to continue to be achieved. DMO1 remains below national target. Sleep service diagnostics is on trajectory for July. Waiting lists have increased and with further increase forecast. A plan is being developed but there are key risks to available capacity including further industrial action. Theatre transformation: 85.0% utilisation for QVH main theatres was achieved for July. Cancellations on the day was 4.1% of elective activity a decrease from June. Ongoing industrial action continues to adversely impact on capacity availability for service provision.				
Recommendation:	The Board is asked to note the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	**KSO3:** ***Operational excellence***	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	89-23
Date of meeting:	7 September 2023
Report from:	Shane Morrison-McCabe – Director of Operations
Report author:	Shane Morrison-McCabe – Director of Operations
Date of report:	21 August 2023
Appendices:	Appendix one: Operational performance data set

Operational performance report

1. Cancer

The backlog of patients on a 62day pathway was above our threshold at 44 patients in July (tolerance threshold is 37). We did not met the 62day performance target (85%) in June, having achieved 83%. Validation of the July data is underway.

The number of patients waiting 104 days plus for definitive cancer treatment is 9 for July against a trajectory of 3 (there were 18 in June).

From 1 October, the standards measuring waiting times for cancer diagnosis and treatment are being modernised and simplified.

The NHS will move from the 10 different standards currently in place to three:

- Faster Diagnosis Standard: a diagnosis or ruling out of cancer within 28 days of referral (set at 75%)
- 31-day treatment standard: commence treatment within 31 days of a decision to treat for all cancer patients (set at 96%)
- 62-day treatment standard: commence treatment within 62 days of being referred or consultant upgrade (set at 85%)

The main changes are:

- Removal of the Two Week Wait standard requiring a first appointment within two weeks
- Combining together the first and subsequent treatment 31-day standards to create one headline performance standard.
- Combining together the Urgent Suspected Cancer GP referral, Urgent Screening and Consultant Upgrade 62-day standards to create one headline performance standard for all patients.

There is no change to the way GPs refer patients onto Urgent Suspected Cancer pathways.

The aim of the refocused standards are to encourage innovations like straight-to-test pathways, remote image review, use of AI and one-stop-shop clinics, and to ensure that patients receive equal focus and priority regardless of their point of entry to the pathway, whether GP referral, screening, or consultant upgrade. They focus on outcomes and incentivising the completion of pathways rather than process measures.

2. Diagnostics

QVH has achieved the cancer faster diagnosis standard (FDS) for June = 86.1% (ICB target = 80%), the national target is 75%. N.B. July data is not available until Mid-September 2023. However, we expect to continue to achieve this target going forward.

Imaging continues to achieve the monthly diagnostic target (DMO1) at 98.92% for July. Sleep DMO1 performance in July was 50**%** which is in line with the revised trajectory. Overall, DMO1 performance was 73.0% for July (which is an increase from the June position of 70.2%. The national target is not met (95%); impacted by demand and capacity challenges within Sleep. Actions are in place and performance is in line with the recovery trajectory.

3. Waiting list and RTT waits

The waiting list total is 17,649 for July (which is an increase of 200 patients from the June total waiting list). This is for patients awaiting inpatient elective procedure, daycases, awaiting a new outpatient appointment or follow-up appointment. The elective waiting list has continued to increase above its trajectory, impacted by lost capacity due to industrial action and bank holidays.

Validation update: We are developing our validation methodology in conjunction with two companies – Source group and MBI (through a well-known LUNA methodology) who will be in a position to do an analysis and artificial intelligence / automated validation approach (Data Quality phase). There will also be workforce based manual validation through Trust staff and MBI. The 'closing of identified pathways' will be carried out by QVH staff.

3.1 Waiting list forecast

The RTT Forecast assumes that the Industrial Action continues as is, this is circa 20%- 25% reduction in capacity each month. The waiting list forecast also assumes that operational treatment capacity remains the same, we still have The McIndoe Centre capacity till the end of the year and staffing levels remain the same. With these assumptions, the waiting list will increase up to a worse case 20,105 at the end of March 2024. Key areas of growth in referrals include Sleep Studies where referrals have significantly increased by 59.2% (956) if you compare the April to July 2023 with the same period in 2022. Plastics had notable increases in referrals between May 2022 And November 2022 – and then came down again. Given how long plastics pathways stay open, this would be feeding into the increased PTL size.

Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
17956	18263	18570	18877	19184	19491	19798	20105

There are Sussex system meetings around the options for addressing this capacity gap attended by the Director of Operations. However, due to forecast reduction in capacity there are risks to the achievement of key targets such as 78wk, 65wk and 52wk reduction trajectories.

78wk target: There are 6 breaches for July all with treatment or clock stop plans in August. There are 7 patients at risk of breaching 78wks in August, they are being worked through on a daily basis to bring forward and treat.

65wk target: There were 55 patients in July who are at 65wk+ awaiting definitive treatment, missing the trajectory (50 patients) by 5. The current forward look for August is 58 patients, (38 Plastics, 18 OMFS and 2 Corneo), which is 8 behind the planned trajectory of 44. The director of Operations is working on options for increasing capacity.

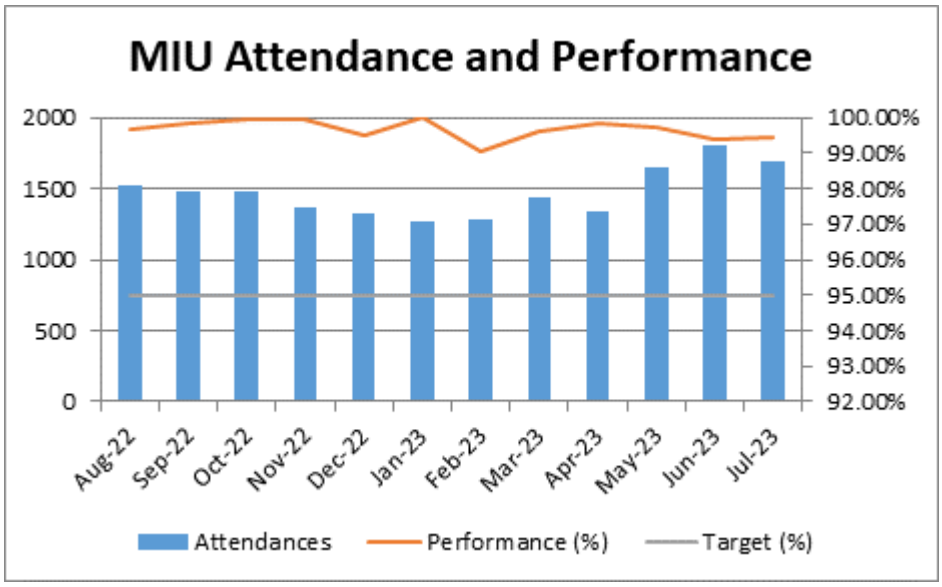
4. Activity

The QVH activity plan target for 2023/24 is to achieve 109% of the 2019/20 activity. We achieved 111.0% for July. The year to date cumulative activity performance is 114%.

5. Minor Injuries Unit

Achieved 99.47% for June against the national 4hr standard of 95%:

Month	Attendances	breaches	Performance (%)	Target (%)
Jul-23	1691	9	**99.47%**	95%



6. Outpatient Transformation

The outpatient transformation programme aims to

- Increase the number of patients placed onto Patient Initiated Follow-Up (PIFU)
- Maintain and increase the number of virtual clinics
- Reduce the number of patients brought into the hospital for follow-up
- Reduce the number of patients who did not attend (DNA)
- Reduce the number of patients who cancel their appointment
- Reduce the time from referral to new patient appointment

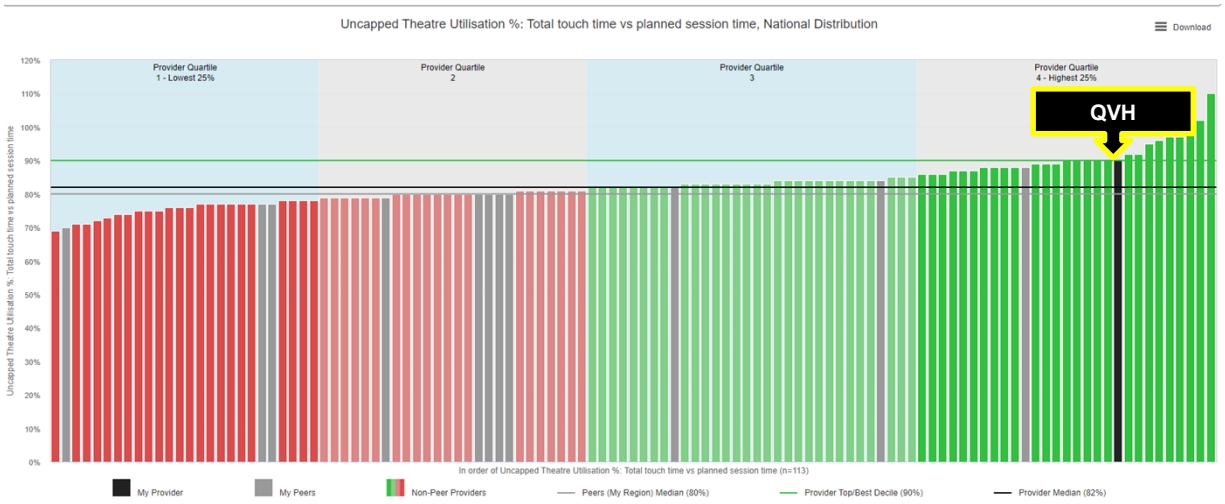
The DNA rate for July is 5.5% against the ICS agreed 2023/3 target of 4% (national target is 6.2%). Targeted improvement action plan is underway to reduce DNAs.
Hospital cancellations on the day was 1.1% for July against the target of 1.0% slightly up on the previous month of 1.0%
Hospital cancellations within 5 days of the appointment achieved 3% against a target of 4% and continues to achieve the target for the fourth month in a row.

7. Theatre transformation

The theatre productivity transformation work programme is moving forward into Phase 2 and is focused on the following key aspects through task and finish groups:

- Reducing cancellations on the day (COTD)
- Increasing the flow of patients through theatre
- Exploring the feasibility of moving local anaesthetic cases out of main theatres and backfilling with general anaesthetic cases
- Reducing 'late starts' and early list finishes to maximise utilisation of the theatre lists during Mon-Fri 08:30 – 17:30.

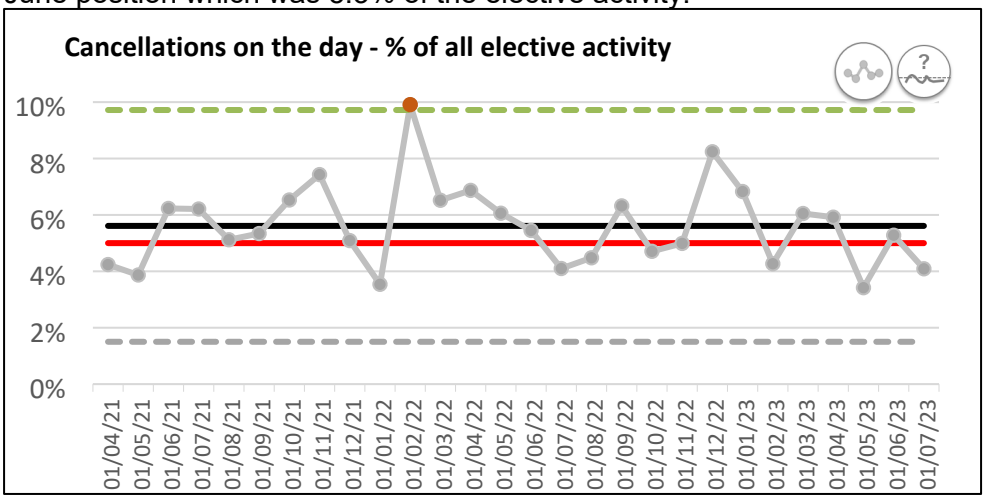
Utilisation for July achieved 85.0% (national target = 85%, local QVH target = 90%) and QVH is in the top quartile nationally:



7.1 The McIndoe centre (TMC) theatre utilisation

Utilisation of TMC for July was 85% (June was 82%)

7.2 Cancellations on the day (COTD) for July was 4.1%, an improvement on the June position which was 5.3% of the elective activity:



Through the cancellations on the day task and finish group the services are focusing on the three most common causes:

1. Operation not needed

2. Pre-existing condition
3. Operation declined

7.3 Key actions to reduce cancellations on the day:

- Cancellations validated weekly by Theatre Manager and Theatre Productivity Manager to ensure accurate data
- Validation to separate cancellations into within our control and not within our control
- Notification form used to ensure all services are alerted to the cancellation in real time
- Developing collaborative working with the services
- Reviewed internal cancellation codes and mapped against national codes
- COTD Task and Finish meet monthly
- Power BI dashboard available for Service Managers and General Manager review their service
- Monthly report circulated to services, including Pre Assessment, for additional narrative, actions taken and any changes to process
- Shared learning across the specialities
- Use of data to focus on repetitive themes
- Policy with actions and roles and responsibilities
    - Includes escalation process for any non-clinical cancellations
    - Includes escalation process for junior clinicians

8. Industrial action - risk to capacity availability

I would like to say a huge thank you to our hard-working, dedicated staff for their response to the NHS strikes. It has been fantastic to see the resilience displayed during these challenging times. The latest Junior Doctors took strike action from Thursday 13th July to Tuesday 18th July, in addition to this, consultants took action on Thursday 20th July to Saturday 22nd of July. As with all strike action our aim was to ensure that emergency care (MIU and Trauma) was still maintained, but planned care has been significantly affected.

There is well governed, cooperative, effective, inclusive planning and on the day management for IA. Clinicians are fully engaged in reviewing patients' clinical priority as part of making decisions on suitability for rescheduling. The scheduling and appointment booking staff take a compassionate approach to contacting patients both to inform them of the cancellation of their existing appointment and to reschedule the appointment. With regards to patient experience, the Director of Operations meets with the Patient Experience Manager to ascertain whether formal patient complaints or PALs enquiries have increased citing IA. There has not been an increase.

The table below sets out the number of cancelled outpatient and operative procedures since January 2023 as well as the number of operating sessions which were unable to be used due to insufficient staff:

	Jan-23	Feb-23	March 23	April 23	May 23	June 23	July – 23	August -23
Outpatients (Junior Dr - IA)	**107**	**120**	**191**	**494**		**133**	**225**	**138**
Operations (Junior Dr - IA)	**31**	**37**	**59**	**43**		**33**	**24**	**42**
Consultant IA							**145 (Out-patient) 50 Operations**	**4 elective cases. 121 outpatient appointments**
Radiographers IA							**9 ultrasound patients rescheduled.**	
Royal College of Nursing IA May 2023								
Capacity lost – (theatre sessions)						**21**	**39 (Junior Dr IA) 50 (Consultant IA)**	**21**

Overall summary:
The table below sets out the total cancelled outpatient appointments and operations due to IA. Using an average daily number of patients seen in outpatients and admitted, the table sets out the worst case total capacity lost. However, some patients were treated during IA, circa 68% of elective capacity was lost (inpatient and day cases). On strike days circa 19% of outpatient capacity was lost. Therefore, on average, 32% of elective patients were seen/treated across the IA days and average 81% of outpatients were seen across the IA days. The average capacity lost was 2,793 outpatient appointments and 514 elective operation slots.

	Total cancellations & rescheduled patient cases January – August 2023	Number of patient appointment and operation capacity lost (worst case) **(based on average seen per day – QVH and spoke sites) 21 working days Junior Dr and Consultant IA (Jan – Aug)**
Outpatients (Junior Dr & Consultant - IA)	**1,674**	**14,700 (of which 11,907 were seen, leaving 2,793 capacity lost)**
Operations (Junior Dr & Consultant - IA)	**323**	**756 (of which 242 were seen, leaving 514 capacity lost)**
Radiographers IA	**9 ultrasound cases**	
Capacity lost since June 2023– (theatre sessions – 1 session is 4hrs)	**131**	

N.B. Outpatient appointment daily average is 700
Inpatient daily average is 36

However, on strike days circa 68% of elective capacity is lost (inpatient and day cases). On strike days circa 19% of outpatient capacity is lost.

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

Operational Performance Report

Shane Morrison-McCabe, Director of Operations

August 2023

Contents

Queen Victoria Hospital NHS Foundation Trust

Performance Summary

Queen Victoria Hospital NHS Foundation Trust

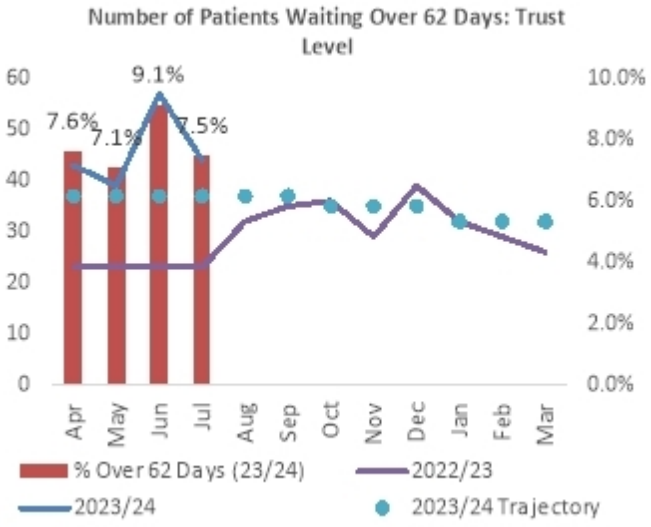
	KPI	TARGET / METRIC	SOURCE	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Change from last month
CANCER	Faster Diagnosis	75% by March '24	National	86.2%	84.4%	81.4%	84.0%	82.9%	82.5%	87.4%	87.2%	83.8%	85.3%	86.1%		↑
	Cancer 62 day+ backlog	Internal trajectory	ICS	32	35	36	29	39	32	29	26	43	39	57	44	↓
	Cancer 62 day performance	85%	National	91.9%	86.3%	84.0%	85.1%	86.3%	80.0%	85.5%	82.5%	83.6%	90.5%	83.3%		↓
DMO1	Diagnostic Activity (excl. Sleep)	Internal plan (% against plan)	Local									89%	87%	85%	81%	↓
	DM01 Diagnostic waits (overall)	95% <6 weeks by March '25	National	71.6%	75.4%	73.9%	70.1%	56.6%	52.8%	62.0%	71.0%	72.4%	73.8%	70.2%	72.9%	↑
	Sleep DM01	Internal trajectory	Local	41.2%	53.0%	57.2%	46.9%	31.8%	23.5%	35.4%	49.5%	47.7%	49.9%	43.0%	49.6%	↑
RTT WAITS	Total Waiting List Size	N/A	N/A	15,706	15,718	15,393	15,222	15,628	15,805	16,040	16,351	16,585	16,844	17105	17649	↑
	RTT78	0	National	5	3	11	9	16	7	14	0	4	5	2	6	↑
	RTT65	0 by March '24 (internal trajectory)	National	52	65	71	77	83	76	85	55	58	61	60	55	↓
	RTT52	Internal trajectory	Local	308	296	312	315	327	315	317	313	313	322	329	338	↑
ACTIVITY	Elective Recovery Increase ADMITTED	23/24 Activity Plan (% against plan)	ICS									88%	97%	93%	85%	↓
	Elective Recovery Increase NON-ADMITTED	23/24 Activity Plan (% against plan)	ICS									107%	100%	100%	104%	↑
OUTPATIENTS	Follow up reduction against 19/20	25% reduction	National	-16%	-14%	-9%	-6%	-15%	-3%	-15%	-10%	-17%	-15%	-12%	-17%	↑
	PIFU	2.8% by March '24	ICS	1.1%	1.5%	1.4%	1.5%	1.0%	1.1%	0.9%	0.9%	1.3%	1.0%	0.8%	0.8%	→
	DNAs	4%	ICS	5.3%	5.1%	4.9%	4.7%	5.8%	4.8%	4.9%	5.2%	5.3%	5.3%	5.4%	5.5%	↑
THEATRE	Theatre Utilisation (uncapped)	90% (85% National)	Local	80.7%	86.5%	81.4%	86.0%	83.0%	83.8%	80.7%	81.9%	80.7%	88.2%	84.0%	85%	↑
MIU	MIU	95% discharged <4hrs	National	99.7%	99.9%	99.9%	99.9%	99.5%	100.0%	99.1%	99.6%	99.9%	99.7%	99.4%	99.5%	↑

RAG	Deteriorating position or plans	Improving position	Delivery of national / local standard

Cancer Performance

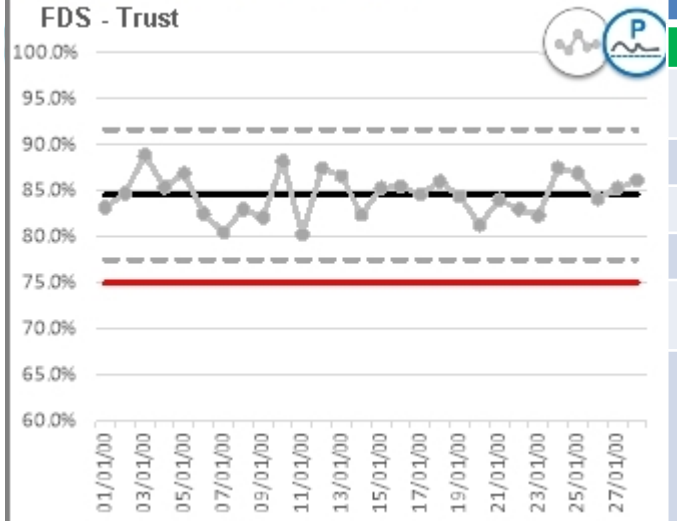
Queen Victoria Hospital NHS Foundation Trust

1. Trend Data – Overs

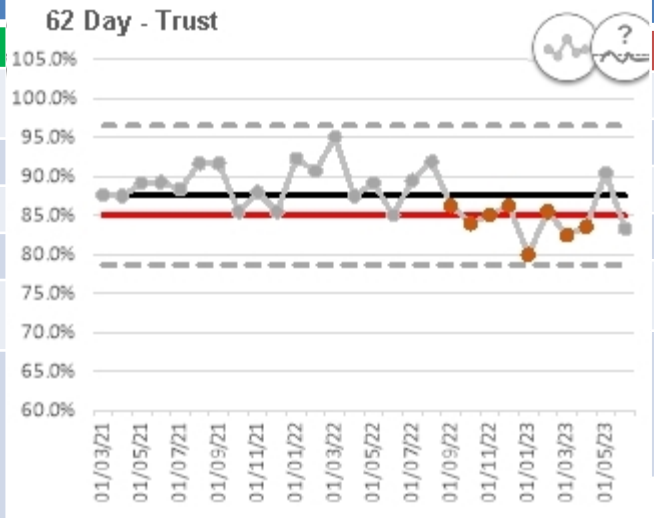


Jul-23
44
Trajectory
37
7.5%
PTL Target
5%
Achievement
Both targets have failed

2. Trend Data - Performance



Jun-23
86.1%
National Target
75%
Target (ICB)
80%
Variance/ Assurance
No significant change. Assurance of consistently meeting the target.



Jun-23
83.3%
National Target
85%
Target (internal)
86%
Variance/ Assurance
No significant change. No assurance of meeting the target regularly.

3. Key Contributors/Forward Look

- ❑ Reported a **reduction in the number of patients waiting over 104 days**, however levels remain above 22/23. The ICB ambition is for all trusts to have a trajectory of 0 patients waiting over 104 days by March 24, and there is a no tolerance for confirmed benign patients (i.e. patient waiting to be told of a non cancer diagnosis).
- ❑ The trust **missed the 62 day backlog trajectory**, however reported a decrease of 13 compared to last month. 30% (13 pts) of the July backlog were late referrals. Numbers are remaining above 22/23.
- ❑ TWW clinic capacity across skin and head & neck (especially ENT) remains a key challenge, with reliance on adhoc capacity becoming standard practice.
- ❑ The trust **achieved the FDS targets in June**.
- ❑ The trust **missed the 62 day referral to treatment target**, reporting a sharp increase in the number of breaches, reporting 8.5 in total (5.5 skin, 2 head & neck, 1 breast), with assurance remaining in the negative.
- ❑ Skin is a key challenge to achieving the 62 day referral to treatment target due to the volume of breaches, with clinic capacity a key factor. Predicting to continue to report high volume of breaches over the coming months.
- ❑ IA will impact Jun and Jul performance, due to the number theatre cancellations.
- ❑ **Forward look:** TWW: failing, FDS: passing, 62 Day: failing, 31 Day: failing.

4. Key Assurance/Action Plans

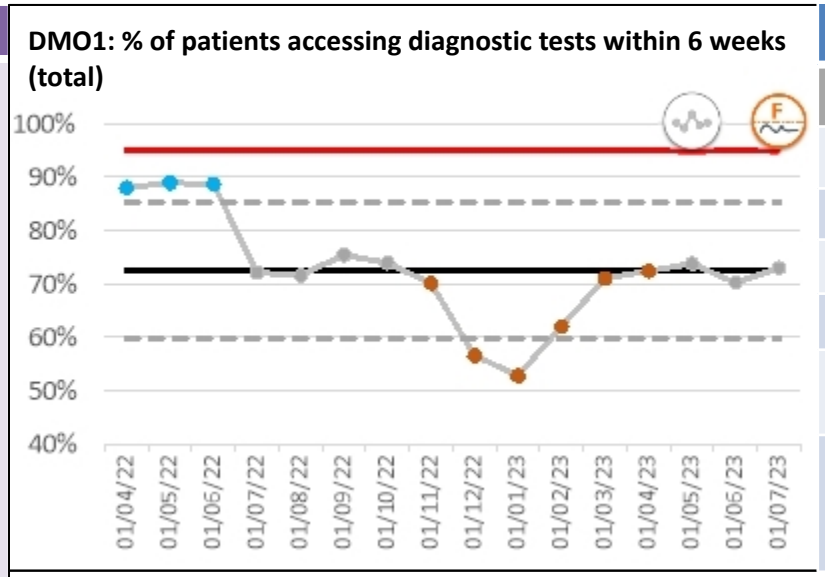
Countermeasures	Actions	Owner	Complete
Teledermatology	Increased teledermatology established capacity in Aug	Plastics GM	Ongoing
Thrive weekly capacity meeting	Mon, Wed and Fri service/access meeting to identify future at risk weeks/underutilisation	Access/GM	Continuing
Cancer PTL	Working with BIU to improve the cancer PTL; to include diagnostics and pathway milestones	Head of Access/CDIPM	Ongoing
Head & neck same day diagnostics	Reviewing current process due to small numbers of same day diagnostic (MOS)	H&N CPN	Ongoing
Breach reporting	RCA – individual monthly meetings	CDIPM	Continuing
Health Inequalities reporting	Expanding analysis of health inequalities data to HNA's	CDIPM	Ongoing
Pre service lead PTL	Focus on confirmed cancers and reducing the overs and potential tip ins	GM/SM	Ongoing

Diagnostic Performance

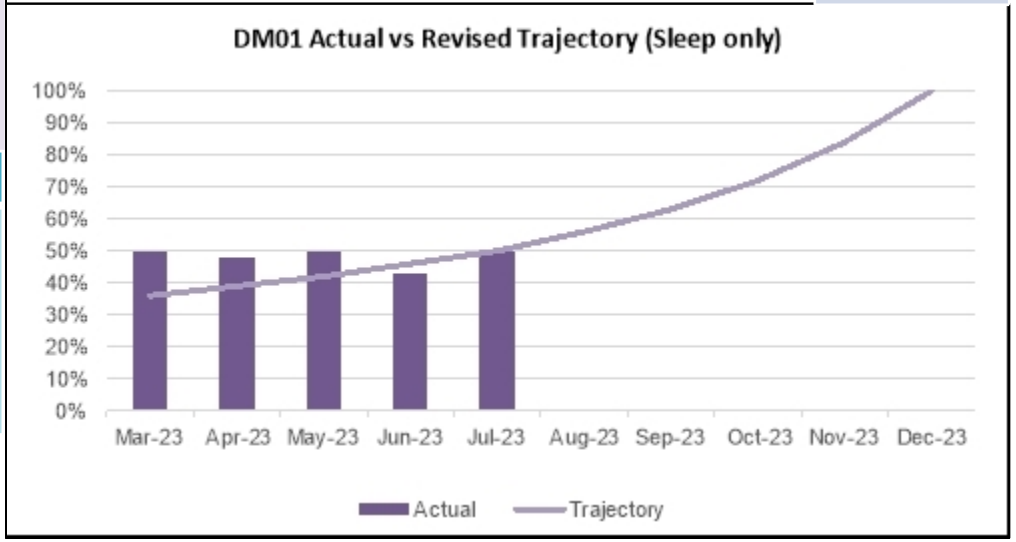
DMO1 NATIONAL POSITION: *(look back – Jun 23)*	
National DMO1: 74.8%	**QVH DMO1:** 70.2%

Performance Commentary	Key Actions & Mitigations	Assurance
There has been normal variation in the overall DMO1 position from previous month, reporting an improved position at 73%, however performance is currently predicted to fail target primarily due to challenges within the Sleep service. Radiology DMO1 performance remains high, reporting 98.9% for June. Sleep DMO1 performance has improved to 50**%,** meeting the revised trajectory for July. Further analysis of referral/activity data underway to support demand and capacity work.	Exploring options to increase outsourced capacity for Sleep diagnostic tests with two further suppliers We are exploring how to increase internal capacity to enable focus on clearing the DMO1 backlog Sleep Staffing: we continue to recruit to admin & clerical vacancies to reliance on bank staffing We have successfully recruited the 3 x band 7 sleep physiology posts; 1 has started in post, the other two are due in post in the coming months. This will reduce the reliance on agency staffing.	We attend the NHS Sussex DM01 & Diagnostics Operational Group We continue to bolster Sleep diagnostic capacity with outsourcing. The new contract for outsourced Polysomnography tests continues to increase capacity and improve our position. Sleep DMO1 is monitored at the QVH weekly Sleep operational meeting Overall DMO1 performance is monitored at the NHS Sussex DMO1 Diagnostics Operational Group.

Forward Look	Risks to Performance
Sleep DMO1 performance through August is improving in line with trajectory.	Variability of referral rates make it challenging to accurately model demand and capacity. Increased pressure on admin team as expectations to deliver additional DMO1 tests cause higher workloads.



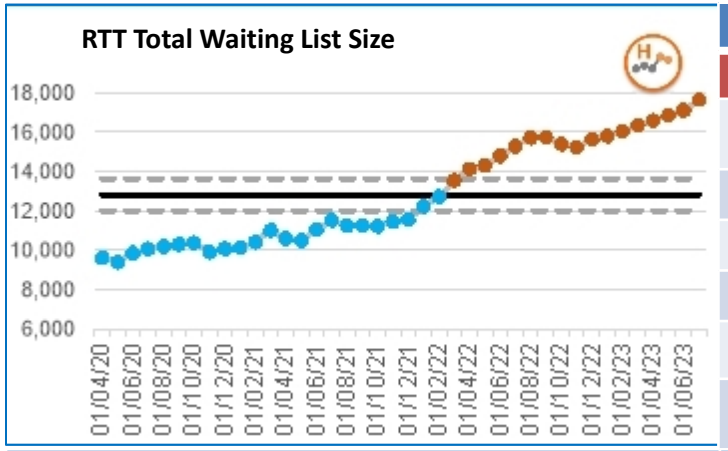
July-23
73%
National Target
95% by Mar-24
Internal Target
95% by Mar-24
Variance/ Assurance
Within normal variance. Consistently failing target.



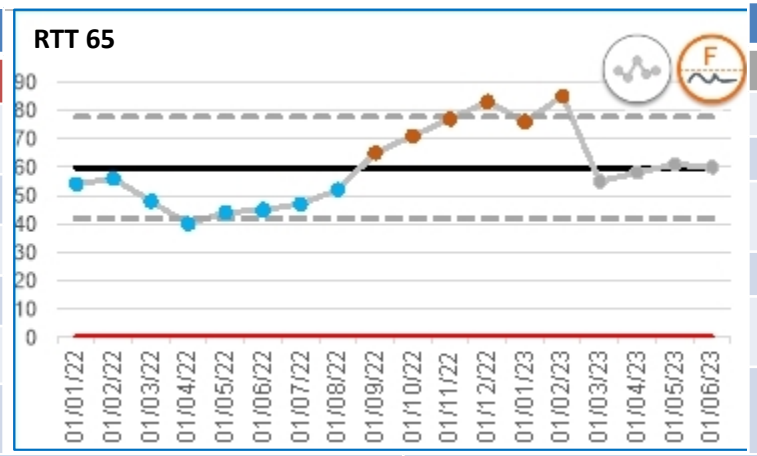
RTT Performance – July 23

RTT NATIONAL POSITION: *(look back – Jun 23)*	
National RTT18: 59.2%	**QVH RTT18:** 63.4%

52WW NATIONAL POSITION: *(look back – Jun 23)*	
National % >52WW: 5.1%	**QVH % >52WW:** 1.9%



July-23
17,649
National Target
n/a
Internal Target
n/a
Variance
Deteriorating variance.



July-23
55
National Target
0 by Mar-24
Internal plan - July
50
Variance/ Assurance
Normal variance. Consistently failing target.

KPI	Latest month	Measure	Target	Variation	Assurance
RTT Total Waiting List Size	Jul 23	17649			
RTT 18	Jul 23	63.1%	92.0%		
RTT 52	Jul 23	338	359		
RTT 65	Jul 23	55	0		
RTT 78	Jul 23	6	0		

Performance Commentary

78WW failed trust trajectory. Performance has an improving variation but is predicted to fail target.

Reported 6 patients in July; of these, 2 have a TCI in Aug, 2 have a TCI pending due to Covid delay and complexity, 1 has an OPA in Aug and the other has since had a clock stop in Aug.

65WW failed trust trajectory by 5 patients: reporting 55 patients in July.

Performance is within normal variation, however we are currently predicted to fail target.

52WW achieved trust trajectory. Showing an improving variation but there is no assurance of reliably hitting target.

All specialties achieved their 52ww trajectories apart from Maxfacs which was challenged by the cumulative effect of IA and theatre and anaesthetic staff shortages, as well as capacity challenges at Medway.

Reported 338 patients; we remain ahead of plan despite ongoing operational challenges of IA and theatre staffing.

Key Actions & Mitigations

Maxfacs and Orthodontics' main mitigating action is waiting list initiative lists on Saturdays to increase capacity, prioritising the longest waiters. Long term plan to increase workforces is being worked up.

Plastics greatest RTT challenges are within breast, hands & Mohs. Mitigations include:

- Weekly scheduling meeting
- Hands patients offered to change care to be under consultants with shorter waiting times.
- Recruitment of 3 consultants (Mohs consultant starting 7 Aug, Skin consultant starting in September & Breast consultant starting in the next few months)
- Exploring additional recovery capacity with both our theatres and TMC
- Progressively devolving further management responsibility of PTLs to admin teams.

Assurance

Long waiters are **monitored at service level**. The weekly PTL meeting is being reviewed to enhance recovery and allow focus on all aspects of the RTT pathway.

New live PTL tool will improve proactive management of long waiters. Go live is slightly delayed due to operational pressures but is expected w/c 21 Aug.

Theatre Improvement programme is ongoing with specific T&F groups for cancellations on the day, patient flow and increasing GA capacity.

Outpatient transformation programme is underway with targeted workstreams to increase utilisation and efficiency.

Validation work: we are engaging with an external company to validate our RTT waiting list.

Forward Look

78WW: predicting 7 in August; failing trajectory.

65WW: predicting 70 in August; failing trajectory.

52WW: predicting 370 in August; failing trajectory.

Risks to Performance

Industrial Action: negatively affecting the length of pathways and available capacity; significant risk of not achieving trajectories for August. **In July we cancelled 370 OPD appointments, 74 Operations, and lost 89 theatre sessions due to IA.**

Theatre Power Issues: power supply issues in August caused periods of Business Continuity and multiple theatre cancellations.

Waiting list (PTL) continues to grow.

Cancellations by patient for medical reasons, including Covid, or for other unavoidable causes.

Staffing: fragility of theatre staffing is causing regular cancellations. Planned consultant absences through the summer period is also having an impact.

RTT Trajectory

52WW & 65WW Performance Vs Plan – Specialty Level

Queen Victoria Hospital NHS Foundation Trust

Trust	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
52wk activity plan	375	377	356	354	336	334	319	346	388	364	361	359
52wk actual	**313**	**322**	**329**	**338**								
65wk activity plan	70	64	58	50	44	38	32	26	20	12	6	0
65wk actual	**58**	**61**	**60**	**55**								

Plastics	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
52wk service plan	225	220	215	210	200	200	190	220	240	240	230	225
52wk actual	**210**	**209**	**200**	**203**								
65wk service plan	35	32	29	25	22	19	16	13	10	6	3	0
65wk actual	**46**	**45**	**41**	**35**								

Sleep & Clinical Support	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
52wk service plan	6	6	5	4	4	4	4	4	5	4	3	3
52wk actual	**1**	**1**	**1**	**2**								
65wk service plan	0	0	0	0	0	0	0	0	0	0	0	0
65wk actual	**0**	**0**	**0**	**0**								

RTT Trajectory

52WW & 65WW Performance Vs Plan – Specialty Level

NHS Queen Victoria Hospital NHS Foundation Trust

Corneo	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
52wk service plan	30	36	36	30	25	19	19	19	22	18	20	16
52wk actual	**19**	**18**	**16**	**18**								
65wk service plan	0	0	0	0	0	0	0	0	0	0	0	0
65wk actual	**2**	**1**	**3**	**3**								

MaxFacs	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
52wk service plan	38	46	36	42	40	41	40	39	44	39	40	42
52wk actual	**40**	**43**	**54**	**56**								
65wk service plan	12	11	10	9	8	7	5	4	3	2	1	0
65wk actual	**10**	**7**	**6**	**6**								

Orthodontics	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
52wk service plan	76	69	64	68	67	70	66	64	77	63	68	73
52wk actual	**43**	**51**	**58**	**59**								
65wk service plan	22	20	18	16	14	12	10	8	6	4	2	0
65wk actual	**5**	**8**	**10**	**11**								

Activity Vs Plan
QVH Site / Independent Sector

Queen Victoria Hospital NHS Foundation Trust

Elective Recovery Group	POD Grouping	M4 Activity Plan	M4 23/24 Activity	% Activity Plan against 23/24 M4 Activity
Elective Recovery Increase	Day Case Total	981	838	85%
	Elective Total	294	237	81%
	First Outpatients Total	3816	3640	95%
	Outpatient Procedures Total	2916	3252	112%
Elective Recovery Increase Total		**8007**	**7967**	**100%**
Elective Recovery Reduction Total	Follow Up Outpatients Total	**10782**	**8926**	**-17%**

PERFORMANCE COMMENTARY

- This data includes activity carried out by QVH at TMC
- Day case activity under plan which is reflected in the value weighted activity. Largely driven by loss of capacity due to Industrial Action. Particular underperformance in Plastics.
- Elective activity under plan with a reduced case complexity compared to 19/20 resulting in a marginally larger underperformance in terms of value weighted activity. Driven by industrial action across Plastics and Max Fax in particular.
- Over performance in First outpatient activity in Max Fax. Underperformance in Burns, Plastics and Sleep. Overall underperformance, again driven by industrial action.
- Over performance in Outpatient procedures driven by Ophthalmology. Underperformance in Max Fax and Orthodontics offset by over performance in Corneo.

FORWARD LOOK / PERFORMANCE RISKS

- Ongoing risk due to fragility of staffing in theatres affecting both day case and elective delivery particularly moving into M5
- Future consultant absences due to retirement, maternity leave, parental leave, special leave a potential risk to delivery across services.
- Industrial action and loss of capacity affecting ability to deliver activity plans and performance targets.
- Theatre power issues in M5 further affecting activity delivery.

Service improvement

Theatre Utilisation July 2023

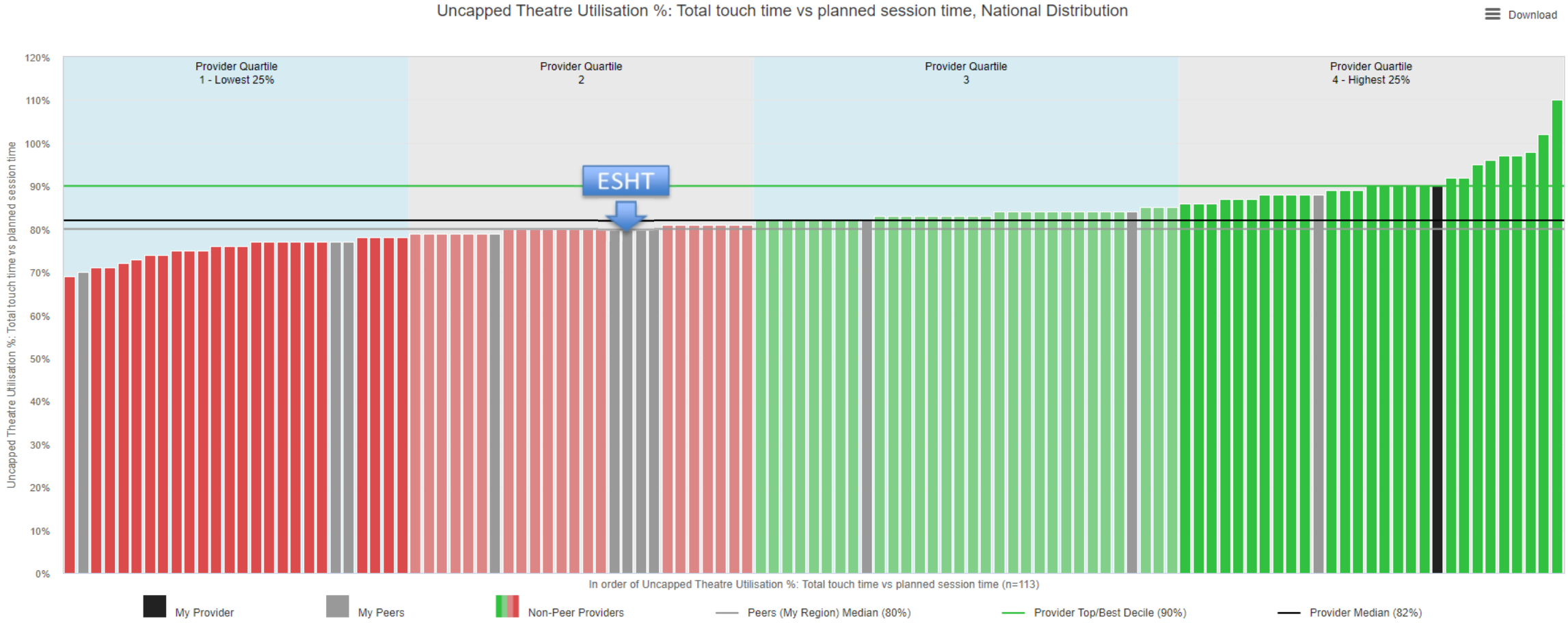
Queen Victoria Hospital NHS Foundation Trust

THEATRE KPIs	Definition	Target	Current Trust position	Model Hospital position 23.07.23 - 30.07.23
LIST BOOKING	• The minutes booked (estimated case length plus the ORSOS turnaround time added) over the number of minutes available (planned session start time to planned session finish time less lunch break minutes)	All specialty pre-lists booked to minimum 95%	Trust wide 101% Maxillofacial 100% Eyes 96% Plastics 103%	
TRUST THEATRE ELECTIVE UTILISATION	• The sum of the actual minutes used (arrival in theatre suite to leave theatre) per case over the available minutes. • Sessions available v sessions delivered in month per specialty	>90% for elective	85%	**Model Hospital target "good" 85%** Provider value 90% Peer median 80% Provider median 82%
LATE STARTS	• Time difference between planned start time and arrival of the first patient in the theatre suite – to include anything more than 15 minutes	Session start 08:30hrs minimum 90% starting on time using the acceptable slippage of 15 minutes - capturing Late starts as 08:45hrs	14 minutes	Provider value 28 Peer median 25 Provider median 27
EARLY FINISHES	• Time difference between last patient leaving and planned end time of theatre session – to include anything more than 30 minutes	5% Early finishes – captured as anything under 30 minutes from session end of 17:30hrs	34 minutes	Provider value 49 Peer median 67 Provider median 68
ON THE DAY CANCELLATIONS	• On the day cancellation that could have been avoided	5% or less - cancellations on the day	30 patients – 4.1% of all elective activity 8 patients 1.1% – within our control 22 patients 3.0%– not within our control	Additional capacity including 5% COTD rate Provider value 5% Peer median 12% Provider median 12%
EXCLUSION CRITERIA				
TRUST THEATRE ELECTIVE UTILISATION – Excludes; External Breast DVH, SASH, WSHT, MTW, ESHT,BSUH, UHSX, BURNS and all Trauma lists				
LATE STARTS – Trauma excluded for reporting purposes				
EARLY FINISHES – Trauma excluded for reporting purposes				

Service improvement (GIRFT)

Theatre Utilisation – Model Hospital Sussex ICB – latest MH data 23.07.23 - 30.07.2023

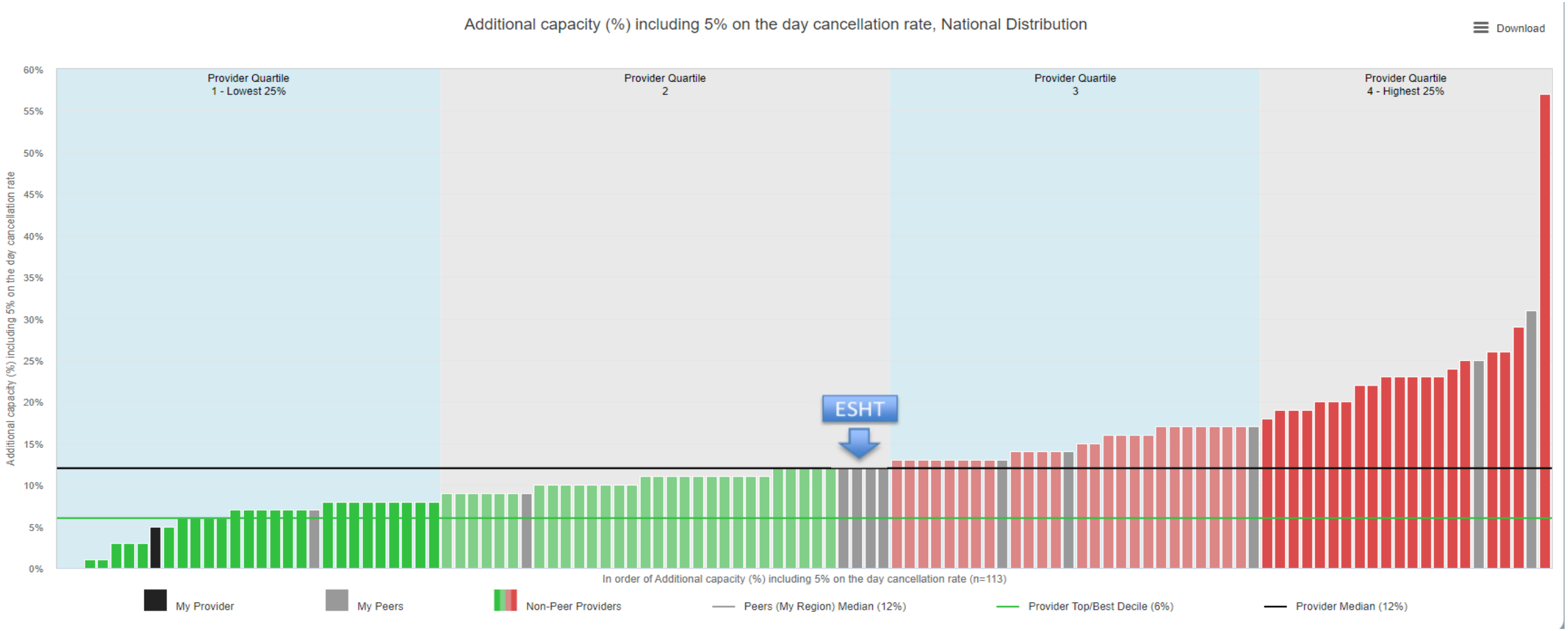
Queen Victoria Hospital NHS Foundation Trust



Service improvement (GIRFT)

Theatre Utilisation – Model Hospital Sussex ICB – latest MH data 23.07.23 - 30.07.2023

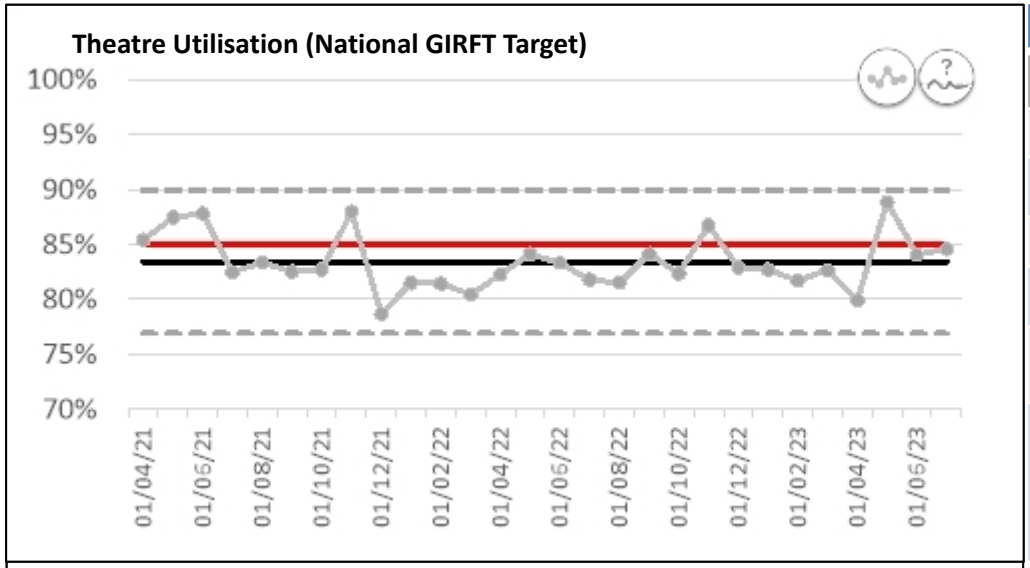
Queen Victoria Hospital NHS Foundation Trust

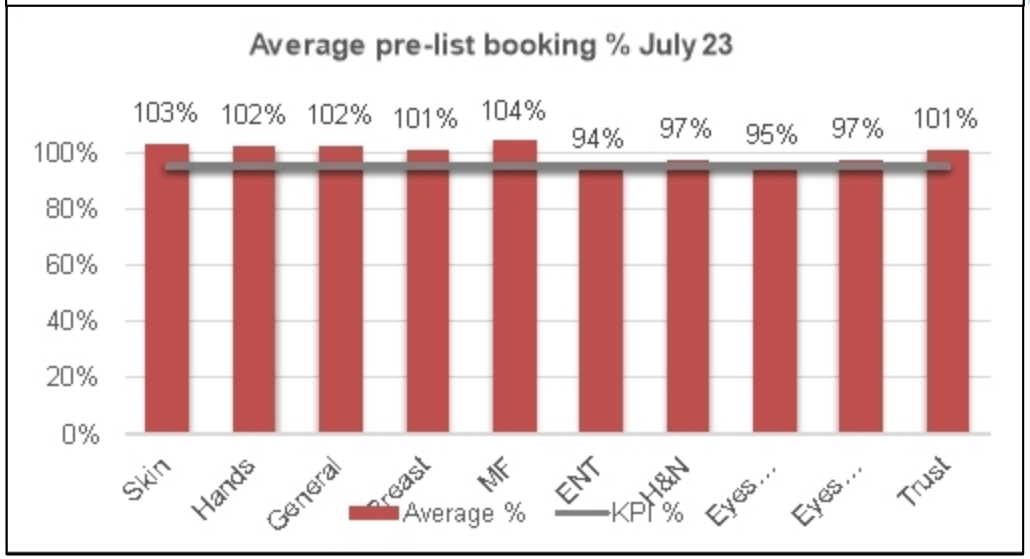


Service improvement

Theatre Utilisation – July 2023

Queen Victoria Hospital NHS Foundation Trust





July-23
85%
National Target
85%
Internal Target
90%
Variance/ Assurance
Within normal variance

Performance Commentary

Total Elective utilisation – Remains consistent and performing well against the GIRFT 85% recommendation.

Actual list utilisation – All services perform well with the exception of Max Facs. Impacted by anaesthetic on the day sickness resulting combining of lists and patient mix.

Pre-list booking - all specialties continue to achieve target at list locking.

Available sessions - Impacted by IA: out of 386 available, we delivered 310 which equates to 80.31%. Or excluding IA loss 97.15%.

Key Actions & Assurance

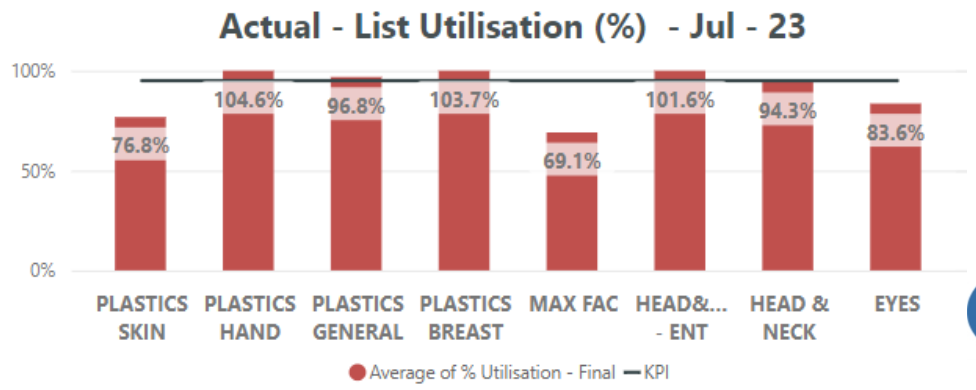
Actual list utilisation – Services continue to engage through 6-4-2 scheduling to ensure optimum use of all available sessions.

Max Facs working with clinicians to review case timings

Theatre Improvement Programme T&F Groups at service level working towards gains within sub specialities through COTD and Patient Flow

Forward Look & Risks

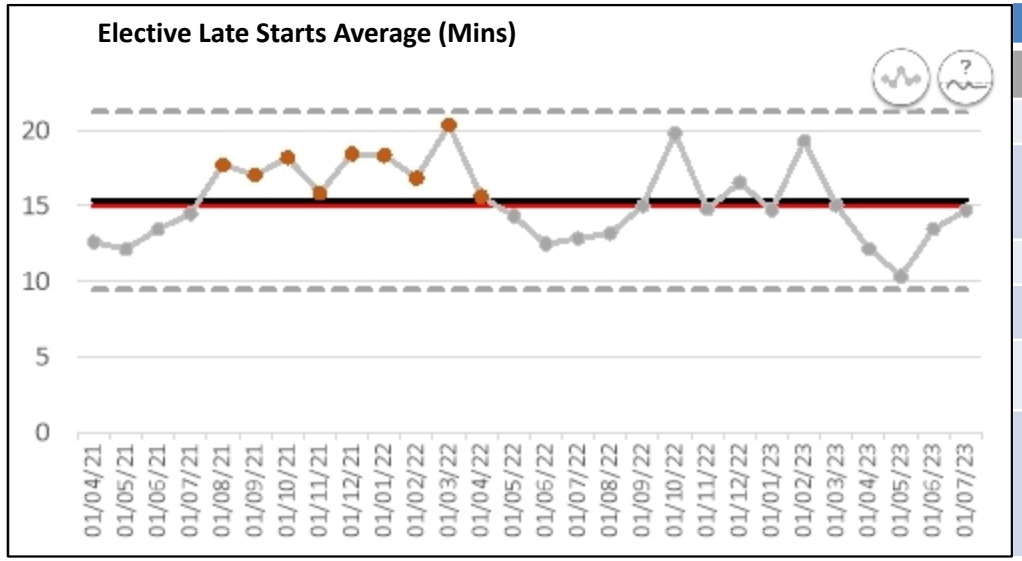
Total Elective utilisation expected to perform below target for August due to the ongoing business continuity incident relating to theatre power issues, as well as Industrial Action, sickness within all rotas and theatre staffing challenges.



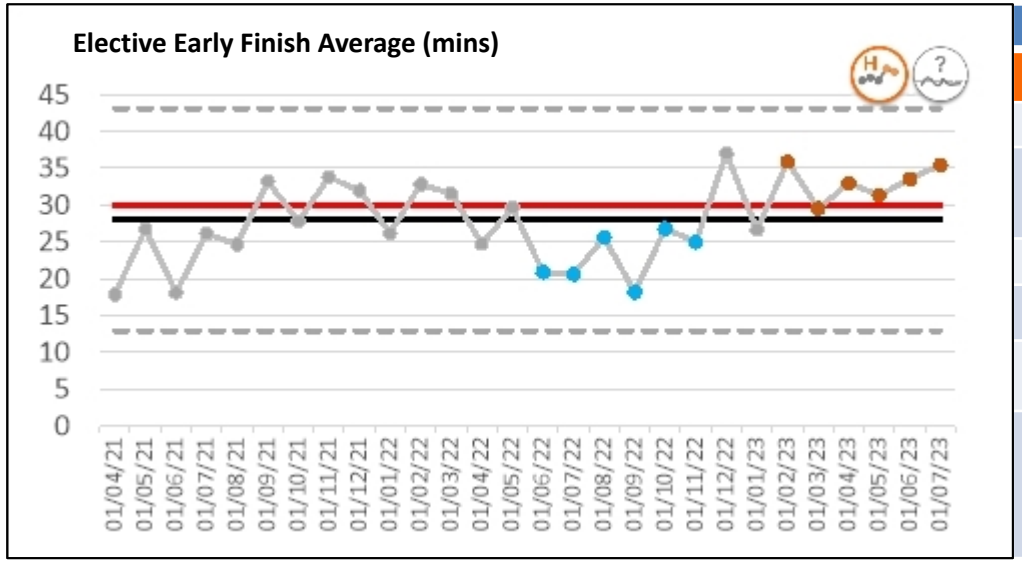
Service improvement

Theatre late starts and early finishes – July 2023

Queen Victoria Hospital NHS Foundation Trust



July-23
14.7 mins
National Target
90% starting on time, up to 15mins late
Internal Target
<15 mins
Variance/ Assurance
Within normal variance Inconsistently meeting target



July-23
35.5 mins
National Target
5% early finishes, under 30mins
Internal Target
<30 mins
Variance/ Assurance
Deteriorating variance Inconsistently meeting target

Performance Commentary

Elective late starts – A slight deterioration in month but still maintaining good performance and target was met. Continue to be challenged with sickness across all staff groups resulting in rota changes and staff/theatre moves. The consistent identified delay theme in month continues to be clinical reasons - surgeon/anaesthetist seeing patients prior to surgery.

Elective early finish – A slight deterioration in month; to be expected due to an increase of COTD. See next slide for COTD commentary and forward look.

Key Actions & Assurance

Elective late starts – Within normal variance, theatres continue to follow current patient flow processes to ensure maximum use of available minutes

Elective early finish – Theatre staff are engaged with Patient Flow transformation work to ensure maximum use of available minutes and flow of the turnaround process. Any consistent themes for lists finishing early are escalated to the services for clinician involvement

Forward Look & Risks

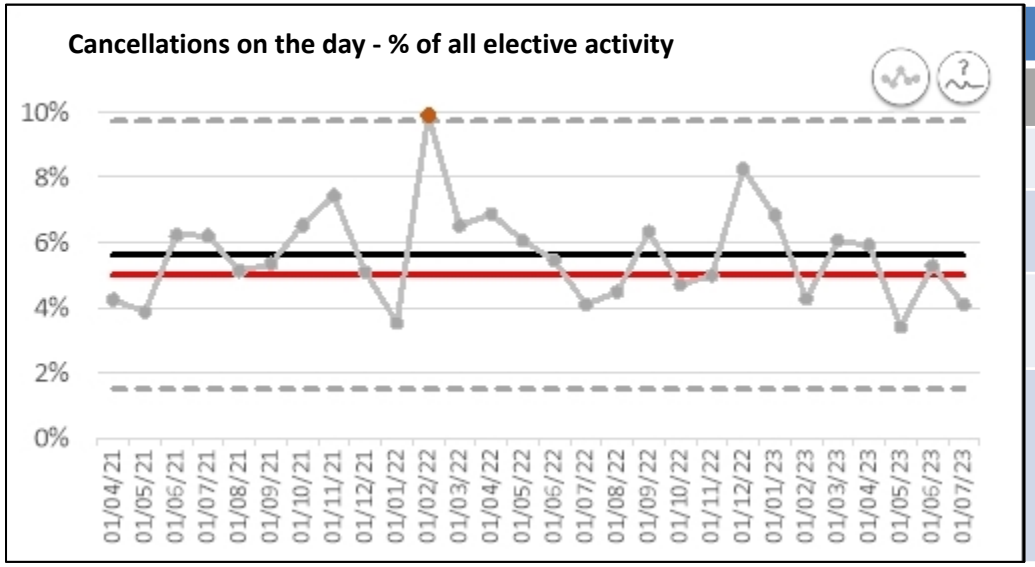
Elective late starts – Risks to performance in August 2023 include theatre staffing challenges and IA and power issues.

Elective early finish – Risks to performance in August 2023 include IA, power issues and annual leave.

Service improvement

COTD as a percentage of elective activity – July 2023

Queen Victoria Hospital NHS Foundation Trust



July-23
4.1%
Target
5%
Variance/ Assurance
Within normal variance Inconsistently meeting target

Performance Commentary

A improvement in month to 4.1%; performance remains within normal variance. We are performing well against the 5% GIRFT guidance but there is no assurance of consistently hitting target.

8 COTD were within our control representing 1.1% of elective activity.

Key Actions & Assurance

Work continues within the COTD T&F Group concentrating on the cancellations within our control, including Operation Declined and Operation not needed.

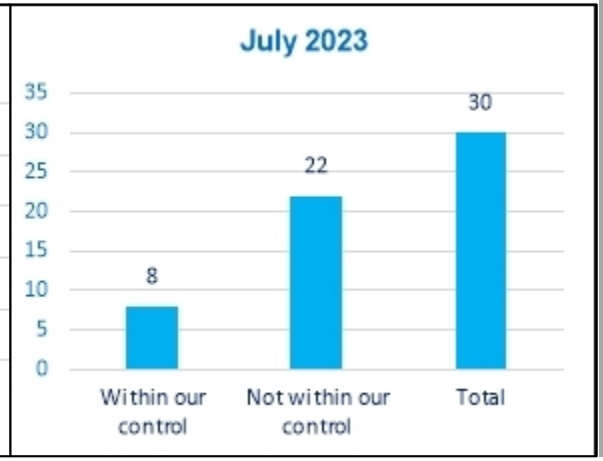
Services are reviewing repetitive themes and implementing action plans to set improvements in place. These will be monitored.

Certain services are challenged by clinical decisions that result in a COTD. A detailed review with clinicians is underway and service action plans are demonstrating an improvement.

Forward Look & Risks

An increase of COTD is expected for August due to theatre power issues. Industrial Action and rota challenges are also expected have a negative impact

Cancellations on the day	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Number per month	42	54	40	42	53	55	33	54	39	29	49	30



DESCRIPTION	Count of CASE_NO
PATIENT - UNWELL	3
PATIENT - OPERATION DECLINED	2
PATIENT - DID NOT ARRIVE	4
HOSPITAL NON CLINICAL - NO STAFF (SURGEON) AVAILABLE	2
HOSPITAL NON CLINICAL - NO STAFF (ANAESTHETIST) AVAILABLE	3
HOSPITAL NON CLINICAL - INSUFFICIENT TIME	3
HOSPITAL NON CLINICAL - EQUIPMENT OR IMPLANT RELATED	2
HOSPITAL CLINICAL-DIFFERENT PROCEDURE REQUIRED	1
HOSPITAL CLINICAL - UNFIT	1
HOSPITAL CLINICAL - PRE-EXISTING CONDITION	1
HOSPITAL CLINICAL - PATIENT UNWELL	3
HOSPITAL CLINICAL - PATIENT NOT PREPARED FOR SURGERY	1
HOSPITAL CLINICAL - OPERATION NOT NEEDED	4

Service improvement (GIRFT)

Outpatients

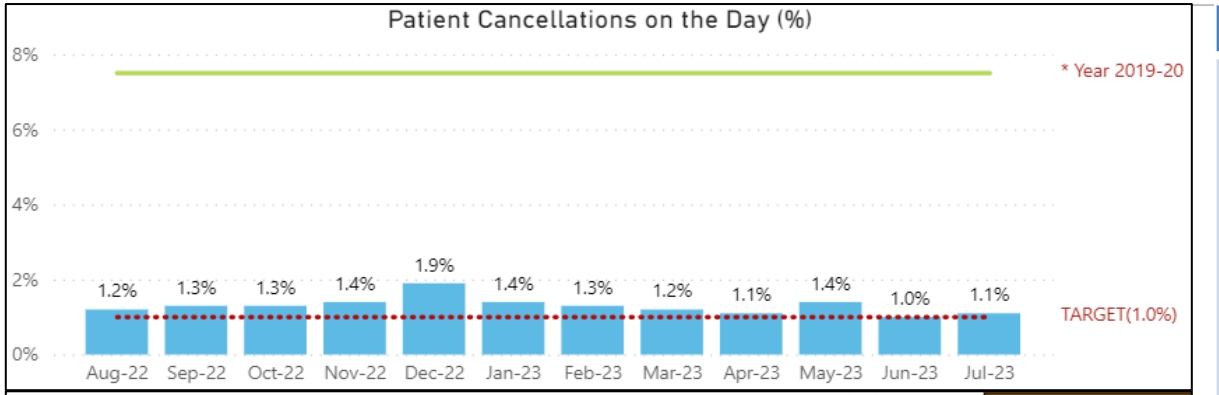
Queen Victoria Hospital NHS Foundation Trust

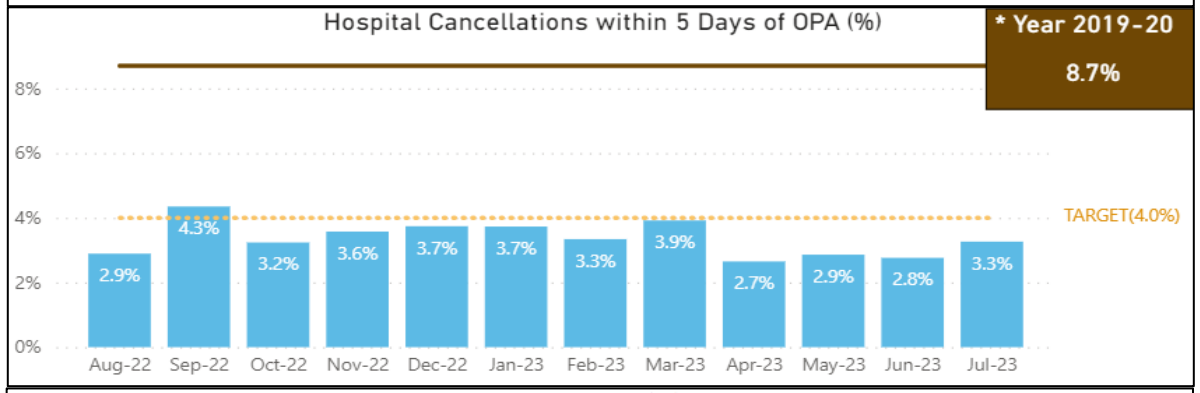
OUTPATIENT KPIs	DEFINITION	TARGET	CURRENT POSITION
HOSPITAL CANCELLATIONS	• Reductions in the number of appointments cancelled by hospital with less than 5 days notice. • Reduction in hospital cancellations on the day. • Excludes: EPS QV, OPSQV, TRAUMO, PAC POST, PAC WI	• Reduction in hospital cancellations to 4% target • National average 8.7% (19/20 data) • https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2020-21	3.3%
PATIENT CANCELLATIONS	• Reduction in patient on the day cancellations • Effectiveness of text messaging service • Excludes: EPS QV, OPSQV, TRAUMO, PAC POST, PAC WI	• Reduction in on day patient cancellations to 1% target • National average 7.5% (19/20 data) • https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2020-21	1.1%
PATIENT DNAs	• Count of DNAs against all outpatient appointments. • Reduction in patient DNA rates. • Excludes: EPS QV, OPSQV, TRAUMO, PAC POST, PAC WI	• Reduction in DNA rate to 4% target • National average 6.2% (19/20 data) • https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2020-21	5.5%
PATIENT INITIATED FOLLOW UPS (PIFU)	• Percentage of outpatient appointments moved onto a PIFU pathway	• Local target 2.8% of all outpatient appointments by March 2024	0.8%
VIRTUAL CONSULTATIONS	• Outpatient appointments delivered by or video or telephone where clinically appropriate	• 25% of all outpatient appointments	21.6%

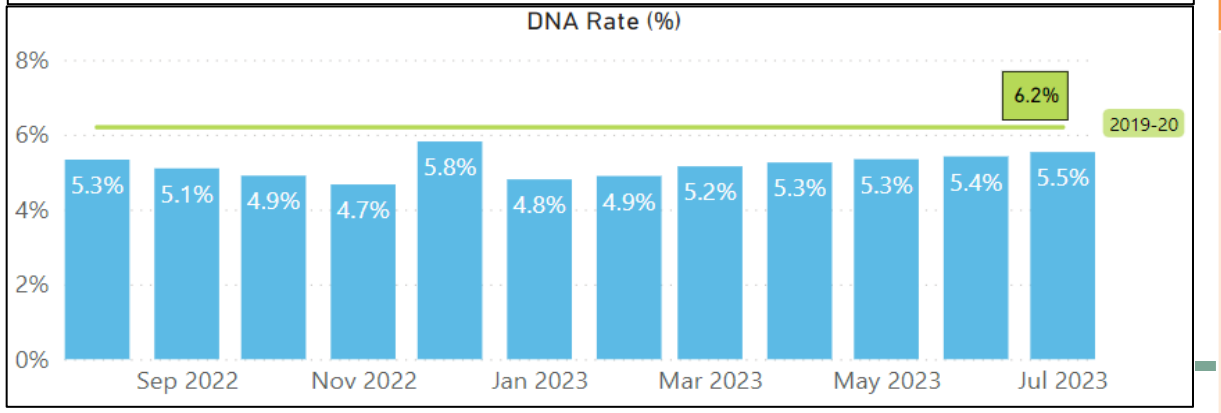
Service Improvement (GIRFT)

Outpatients – COTD & DNAs

Queen Victoria Hospital NHS Foundation Trust







PERFORMANCE COMMENTARY

Benchmarking for our OPD KPIs is based on national performance from 19/20 (pre-Covid NHS data). The most appropriate benchmark for our OPD KPIs is in consideration again and will be reviewed at the next transformation group meeting.

Patient cancellations – performance is stable around the internal target of 1%. This remains well below the national target of 4%.

Hospital cancellations – a slight deterioration in performance compared to previous month, however we continue to achieve target. The deterioration in performance has been affected by Industrial Action.

Patient DNAs – the reported figures have increased due to the correction of an error in the denominator; previous figures had included cancellations by patient, but now show missed appointments only. Performance remains above the 4% target and is gradually deteriorating.

Work is ongoing to review DNA rates by outpatient clinic in order to uncover areas of largest opportunity, as well as considering Health Inequality factors that could be contributing such as age, sex, location and ethnicity.

We are engaged in the NHSE Action on Outpatients reducing DNAs events.

FORWARD LOOK / PERFORMANCE RISKS

DNAs - Work continues within the Sussex Action on Outpatient weekly task and finish group to concentrate on the overall reduction of patient DNAs across the system.

The Outpatient Transformation leads have started to meet with service leads for areas with high DNA rates. We are exploring the possibility of auditing DNA reasons to help direct our actions. The data dashboard is being developed to enable targeted work at clinic level.

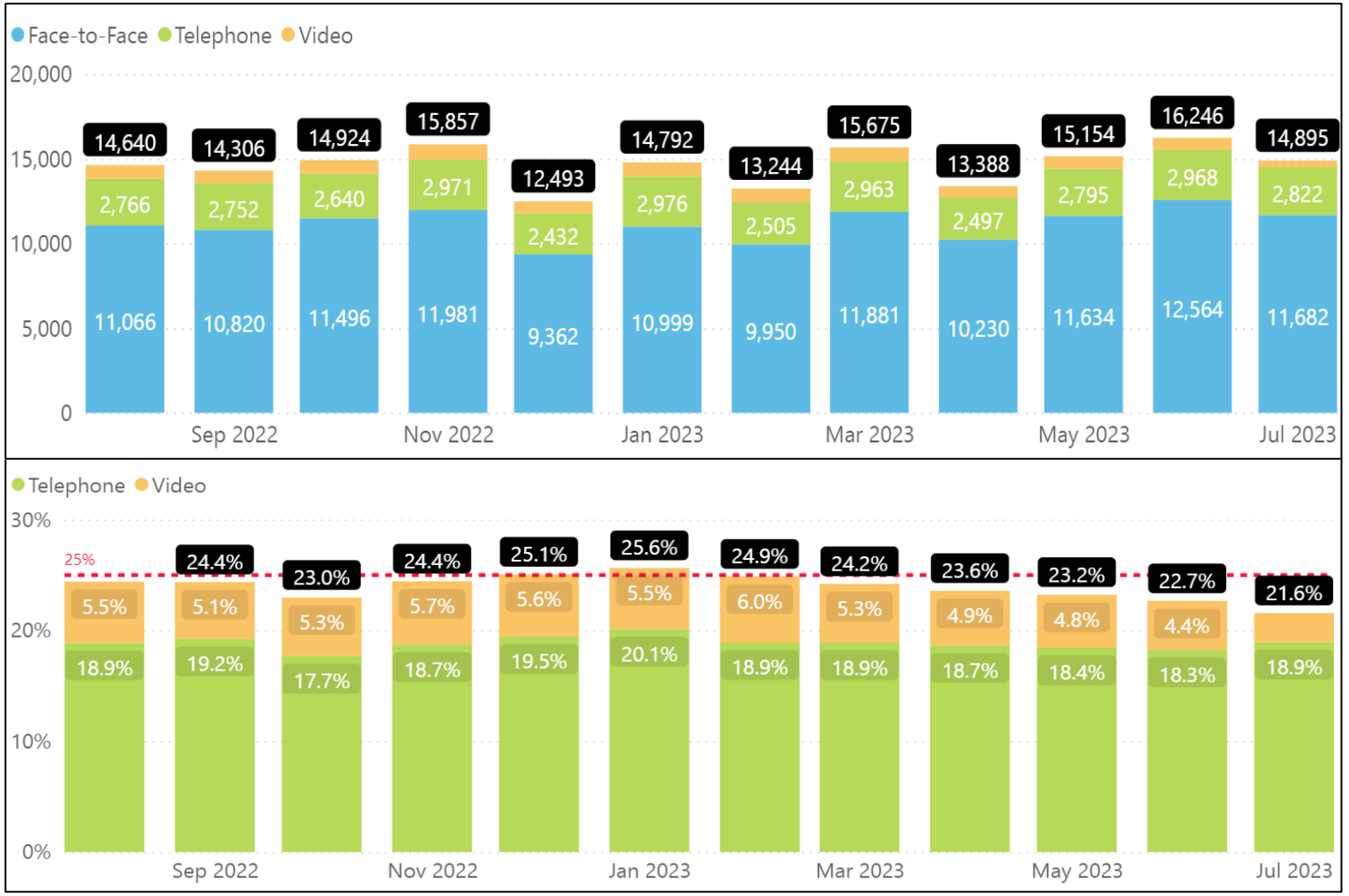
Focused deep dive underway in Therapies to drive improvement. There will be a focused approach to managing areas of opportunity that arise from this.

Hospital cancellations - Industrial Action and theatre power issues in M5 pose a risk to our performance.

Service Improvement (GIRFT)

Outpatients – Virtual

Queen Victoria Hospital NHS Foundation Trust



PERFORMANCE COMMENTARY

21.6% of all outpatient activity in July; a slight reduction for the 6th month in a row

Telephone appointments 18.9%
Video appointment 2.6%

Specialties contributing the highest numbers towards our virtual performance include Plastics, Ophthalmology, Sleep, Maxfacs, Physiotherapy, Orthodontics and Occupational therapy. This is to be expected these are predominantly our larger services.

Some of our smaller specialties see fewer patients but have much higher virtual utilisation rates as a % of their overall activity. For example Dermatology, Psychotherapy, Dietetics, Respiratory services and Speech and Language therapy.

FORWARD LOOK / PERFORMANCE RISKS

There is reduced system focus on delivering virtual activity.

Service Improvement (GIRFT)

Outpatients – PIFU

Queen Victoria Hospital NHS Foundation Trust

PERFORMANCE COMMENTARY

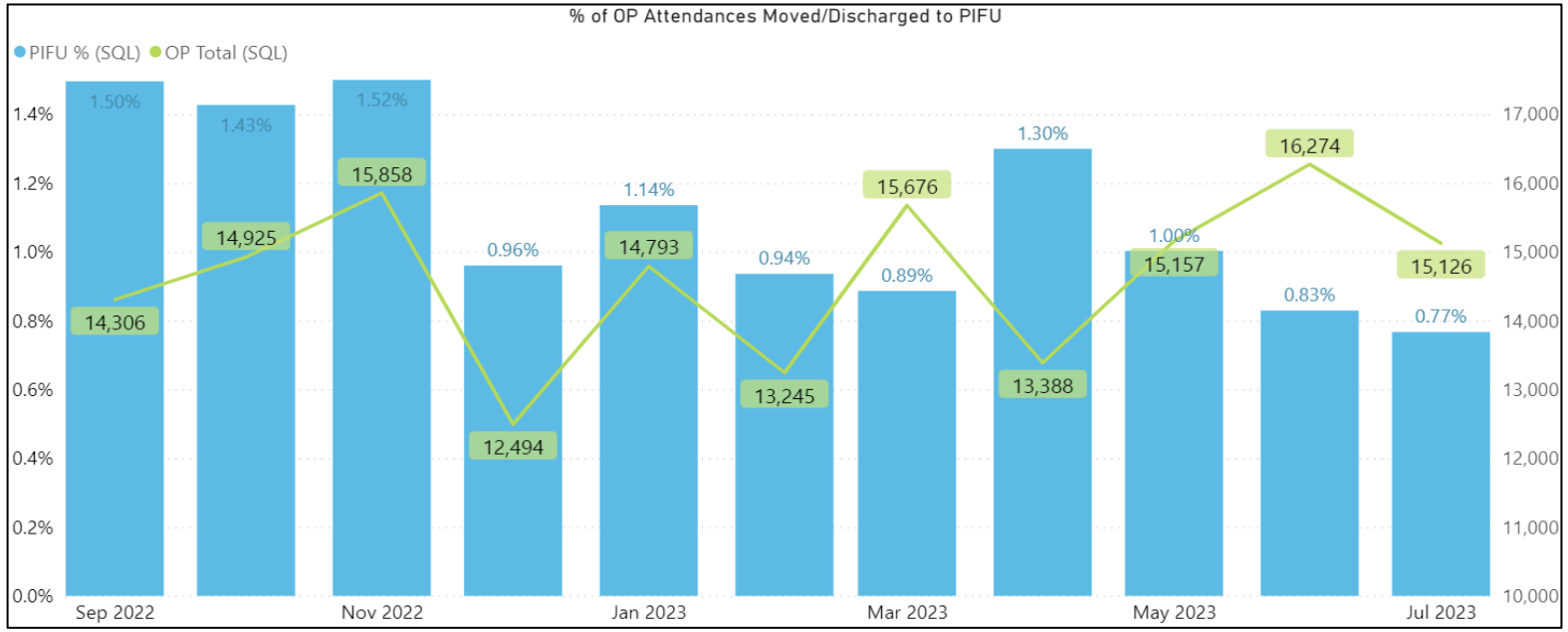
116 patients added to a PIFU pathway in July 2023 out of a total 15,126 outpatient attendances recorded in month = 0.77%.

PIFU is in use in all major specialties. At the end of July a new Facial Palsy PIFU went live and the Skin PIFU pathway was communicated with skin clinicians.

Clinical engagement is encouraged through attending clinical team meetings to emphasise the importance and benefits of PIFU, and by engaging with clinical leads to discuss utilisation and review clinical protocols.

We are offering **admin refresher training** to increase data quality.

National PIFU sprint workshops highlighted the importance of **patient education**; we have developed a PIFU website page which includes a short animated video and links to all PIFU patient leaflets.



FORWARD LOOK / PERFORMANCE RISKS

We are engaging with our regional outpatient transformation leads for support and advice.

Our **greatest risks are clinical engagement and data quality**; we continue to engage with clinicians and retrain admin teams to embed consistent processes.

The BI team is developing the PIFU dashboard so that trust level and specialty data is accessible and accurate to enable targeted work. We are also exploring how best to capture spoke site PIFU figures which are excluded from current reporting.

Ophthalmology has been identified as an area of opportunity; the clinical lead is engaged with this work and there is potential to set up 5 additional PIFU pathways for Ophthalmology sub-specialties. The Community Cardiology PIFU pathway is also in development.

Further patient education resources are in development such as outpatient posters.

Statistical Process Control (SPC) Charts Icon Key

Queen Victoria Hospital NHS Foundation Trust

Variation/Performance Icons			
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	

Assurance Icons			
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Reading/Resources

There are a number of resources to support the use of the Making Data Count methodology, including videos and presentations explaining SPC charts and the approach on the NHS Futures Platform under 'Making Data Count' https://future.nhs.uk/MDC An NHS email address is required to sign up and view.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023		**Agenda reference:**	**90-23**	
Report title:	Financial, operational and workforce performance assurance				
Sponsor:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee				
Author:	Paul Dillon-Robinson, Non-executive director, Chair of Finance & Performance Committee)				
Appendices:	None				
Executive summary					
Purpose of report:	Assurance on financial, operational and workforce performance as discussed at the latest Finance & Performance Committee (24 July 2023)				
Summary of key issues	Operational performance: Cancer standard performance reviewed, as well as productivity through theatre utilisation Workforce: Progress on appraisal completion noted and next focus on quality. Actions to address issues from Gender Pay report, WRES and WDES, discussed Finance: Break-even reported year-to-date and forecast, but need to understand the system financial risk				
Recommendation:	The Board is asked to note the matters discussed and seek further clarification.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services*	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	KSO3, KSO4 and KS05 are relevant to this area. No BAFs were reviewed, given the work being done to revise them				
Corporate risk register:	Corporate risks allocated for oversight by the committee were reported upon and deep dives undertaken on two				
Regulation:	Some KPIs link into the oversight framework of reporting to NHSE and CQC. Issues within Estates have regulatory impacts				
Legal:	No specific legal implications				
Resources:	Resources are fundamental to the delivery of performance				
Assurance route					
Previously considered by:	Finance, operational and workforce reports go through a variety of routes to reach the committee				
	Date:		Decision:		
Next steps:	Review by board				

Report to:	Board of Directors
Agenda item:	90-23
Date of meeting:	7 September 2023
Report from:	Paul Dillon-Robinson, Non-executive Director and Committee Chair
Report author:	Paul Dillon-Robinson, Non-executive Director and Committee Chair
Date of report:	23 August 2023
Appendices:	None

Financial, operational and workforce performance assurance report

Introduction

This report covers the matters discussed at the Finance & Performance Committee meeting on Monday 24 July 2023. The committee does not meet during August, but the current Chair and the future Chair will have met with the three lead executives at the end of August and can provide an update at the Board meeting.

Executive summary

Operational performance: The performance against the current cancer standards was noted, as just below target, and the reasons for them (patient choice, complexity of cases, late referrals) explored. The changes to the standards, subsequently announced, were discussed and will be the subject to review in October, whilst recognising the importance of the patients' experience.

Work is underway on validating the overall waiting lists, to ensure that the (currently 17,000+) list is still a complete and accurate record. Funding for this work, which supplements regular validation, has been received from NHS Sussex.

Theatre utilisation remains a focus for the committee, given the need for productivity to meet activity targets. The committee discussed the impact of industrial action and the need to understand the case mix being referred to the McIndoe Centre, to gain a holistic view of performance.

The committee continued to review the performance of the sleep service and the sterile services contract.

Workforce: The committee were provided with assurance that the issue with overdue annual appraisals had now been addressed, subject to a few areas that are being focused on. Work will now continue on the quality of appraisals, and will return to the committee in December.

The increase in agency usage / spend was reviewed and assurance given that we remain below the agency cap and national target, but industrial action (along with vacancies in substantive posts) has been a factor.

The committee reviewed the Gender Pay Gap Report for 2023, as well as an update on Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) actions. Work on the Gender Pay Gap is focussed on understanding the data (for instance on the gap in the median average hourly rate), as well as improving equality at consultant recruitment. The update on the WRES and WDES followed a report from the Hiro Collective from conversations with staff,

and the committee welcomed the priorities that had been identified and the need for actions.

Finance: The Trust continues to report and forecast a break-even position on revenue, being able to absorb the financial impact of industrial action for the moment, although noting the impact operationally and on patient experience.

The capital programme for this year, and the medium term, was discussed noting the key areas were in estates, information management & technology (IM&T) and medical devices, and that a process for prioritisation had to be in place. Assurance was given that high risk areas would be addressed in this year (especially electrical infrastructure).

Assurance was also provided that the Trust remains in line to deliver the level of efficiencies in 2023/24 and that planning for 2024/25 will commence shortly.

The committee also noted the Sussex system's financial position, both year-to-date and year-end forecast, and the risk to the Trust from the shared duty of NHS organisations for the ICS to break-even. It was agreed that this strategic risk needed to be captured and its management discussed.

Risk deep dives: The committee reviewed two risks; compliance with national cleaning specification and the need for an Eye Bank quality manager. It also noted the wider work on corporate risk management and the importance of separating "risks" from "issues".

Policies: A number of policies, within the schedule for review, were reviewed and agreed.

Recommendation
The Board is asked to **NOTE** the matters above and discuss any issues.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023		**Agenda reference:**	**91-23**	
Report title:	Quality & Safety Board Report				
Sponsor:	Nicky Reeves, Chief Nurse Tania Cubison, Medical Director				
Author:	Nicky Reeves, Chief Nurse, Tania Cubison, Medical Director				
Appendices:	None				
Executive summary					
Purpose of report:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Summary of key issues	The Board's attention should be drawn to the following key areas detailed in the reports: • Q1 CQUINs met • Q1 Quality Priority milestones met • Industrial action continues to impact on services • Update on strengthening patient safety and hearing staff concerns				
Recommendation:	The Board us asked to **note** the contents of the report				
Action required	Approval	**Information**	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	KSO4: *Financial sustainability*	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	The report contributes directly to the delivery of KSO 1 and 2, elements of KSO 3 and 5 also impact on this.				
Corporate risk register:	CRR reviewed as part of the report compilation – and the workforce and RTT18 risk impact the most on quality, safety and patient experience.				
Regulation:	The report contributes and provides evidence of compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's fundamental standards.				
Legal:	As above. The report upholds the principles and values of The NHS Constitution for England and the communities and people it serves – patients and public – and staff.				
Resources:	The report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and governance committee meeting				
	Date:	21/08/23	Decision:	Approved	
Next steps:	None				

Report to:	Board Directors
Agenda item:	91-23
Date of meeting:	7 September 2023
Report from:	Nicky Reeves, chief nurse Tania Cubison, medical director
Report author:	Nicky Reeves, chief nurse Tania Cubison, medical director
Date of report:	25 August 2023
Appendices:	None

Quality and safety report

Board Report

Contents

Executive Summary - Domain – Chief Nurse

Highlights and issues
Q1 CQUIN Target and Submissions have been met

Q1 Quality Priorities have been met

Quality Account has been completed and uploaded within the timeframes

Patient Safety Incident Reporting Framework (PSIRF) lead recruited and in post.

Deep dive in to “learning from patient stories” discussed in Q&G and further assurance to be gained

Strengthening patient safety and hearing staff concerns
Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected. Colleagues across the health service have been shocked and sickened by her actions.

Immediately following the verdict, NHS England wrote to all NHS trusts about doing everything possible to prevent anything like this happening again. The detail of this letter was reviewed in the quality and governance subcommittee of the Board.

We have also had meetings with a range of staff across the organisation to reiterate the importance of listening to the concerns of patients, families and staff, as well as the ways in which staff can raise concerns at QVH, and how we listen to and act on concerns.

We continue to review what else we could do at QVH to ensure that our culture of raising concerns is well understood, easy to use, and that staff know when their concerns have been heard and acted on.

Exception Report

We continue to monitor out of hours operating to ensure that cases are appropriate under CEPOD guidance. There are no current concerns.
This month there were 10 non clinical cancellations, which can adversely impact on patient experience. There were no specific themes.

1 Gram negative bacteraemia – root cause analysis (RCA) being completed

Risk regarding compliance with mental capacity act assessments added to the corporate risk register

Executive Summary - Domain – Medical Director

Highlights and issues

Industrial Action
Industrial action has continued with Junior Doctors, Consultants and Radiographers involved. Safe services were provided by many staff groups working together. We prioritised trauma, urgent care, cancer and longer waiting patients. However, a number of operations and outpatient clinic appointments were rescheduled.

Antimicrobial Stewardship
We continue to work towards the plan to establish a regular teams meeting for microbiology although staffing in University Hospital Sussex has made this a challenge to deliver. The App Microguide that provides an easy access information source for staff has been reviewed by the Deputy Medical Director but microbiology sign off for the changes is still awaited to ensure the microbiology advice available is up to date and tailored to QVH caseload.

Serious Incident
There was an inpatient death in March. Although the Coroner did not request an inquest, our Deputy Medical Director has undertaken an internal investigation with good engagement with the family.

Clinical Services Workstream
The clinical teams are engaging well with the strategy team to develop a clinical baseline position for each service. These baselines will now be discussed with the wider hospital for internal stakeholder input. This has been a good opportunity to review the outcome data from each service against national standards and has been very positive.

Safe Performance Indicators (1)

Metric Description	Target	Q1 2022/3		Q2 2022/3			Q3 2022/3			Q4 2022/3			Q1 2023/4		12 month total/ rolling average
		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23		
Infection Control															
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Clostridium Difficile acquired at QVH post 72 hours after admission	0	**2**	0	**1**	0	0	**1**	0	0	0	0	0	0		4
Gram negative bloodstream infections (including E.coli)	0	0	0	0	0	0	**1**	0	0	0	0	0	**1**		2
MRSA screening - elective	95%	99%	97%	97%	98%	96%	98%	95%	**93%**	97%	97%	97%	95%		97%
MRSA screening - trauma	95%	98%	98%	99%	98%	96%	97%	**90%**	99%	97%	98%	99%	98%		97%
Staff flu vaccine uptake	90%	Reported Oct - Feb	Reported Oct - Feb	**37%**	**53%**	**61%**	**66%**	**68%**	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb		
Offered/ Vacinated/ Vacinated EW	90%	Reported Oct - Feb	Reported Oct - Feb	nc	nc	nc	**84%**	**86%**	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb	Reported Oct - Feb		
Incidents															
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Serious Incidents	0	0	0	0	**1**	0	**2**	0	**1**	0	0	0	0		4
Theatre metrics															
All patients: Number of patients operated on out of hours 22:00 - 08:00	<5	2	1	2	4	3	4	3	2	**8**	2	1	5		37
Paediatrics under 3 years: Induction of anaesthetic was between 18:00 and 08:00	0	0	0	0	0	0	0	0	0	0	0	0	0		0
WHO quantitative compliance		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%		99%
Non-clinical cancellations on the day		8	6	5	6	11	4	6	12	12	5	15	10		123
Needlestick injuries	0	**2**	**2**	**2**	**3**	**1**	**2**	**2**	**2**	0	**3**	**1**	**1**		21
Pressure ulcers (all grades)(Theatre metric)		0	0	0	0	0	0	0	1	0	0	0	0		1
Medication errors															
Total number of incidents involving drug / prescribing errors		**21**	**12**	**18**	**28**	**9**	**12**	**17**	**14**	**19**	**20**	**12**	**14**		**196**
No & Low harm incidents involving drug / prescribing errors		17	8	14	24	8	9	11	11	13	16	10	14		155
Moderate, Severe or Fatal incidents involving drug / prescribing errors		0	0	0	0	0	0	0	0	0	0	0	0		0
Medication administration errors per 1000 spells		2.2	2.2	2.2	2.1	0.7	1.7	3.6	1.6	4.0	2.3	1.1	0.0		2.0
Pressure Ulcers Hospital acquired - category 2 or above		0	1	0	0	0	3	2	0	0	0	0	1		7
VTE initial assessment (Safety Thermometer)	>95%	100%	100%	100%	100%	100%	95%	96%	100%	100%	100%	100%	100%		99%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	>95%	100%	100%	100%	100%	97%	95%	100%	100%	100%	96%	**89%**	100%		98%
Patient Falls resulting in no or low harm (inpatients)		1	2	4	1	1	4	5	5	0	0	2	6		31

Patient Falls resulting in moderate or severe harm or death (inpatients)		0	0	0	0	0	0	0	0	0	0	0	0	0
Patient falls per 1000 bed days		4.6	3.6	2.8	1.9	1.8	3.6	4.7	0.0	5.3	8.4	4.0	3.7	3.7
Transfers Out														
In-Patient Transfers Out - ≥16 years old									3	4	3	0	0	
In-Patient Transfers Out - <16 years old									0	1	1	0	3	
Out-Patient Transfers Out ≥16									0	0	1	0	1	
Paediatric Assessment Unit <16									0	0	0	0	0	
Total Transfer Out									3	5	5	0	4	

Safe Performance Indicators (2)

	Variation/Performance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable.** If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

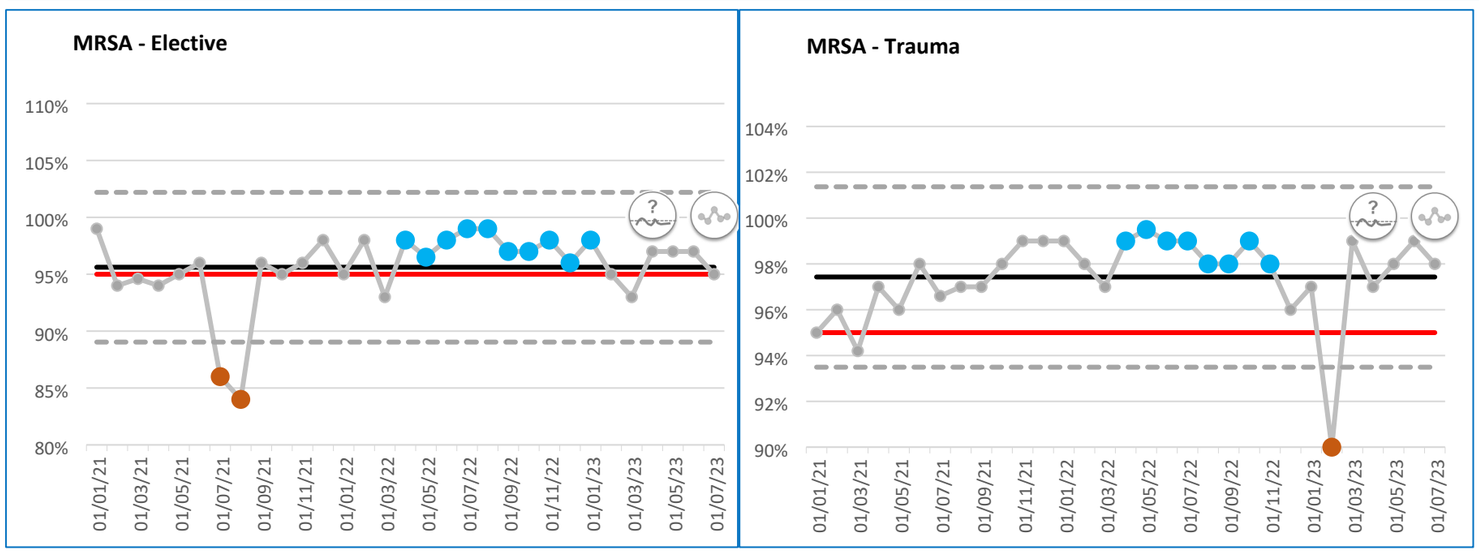
	Assurance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement.** Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

KPI	Date	Measure in month	Target or aspiration	Assurance	Variation	Comments for the latest period shown for each metric
MRSA Screening- Elective	Jul-23	95%	95%			We continue to achieve our target.
MRSA Screening - Trauma	Jul-23	98%	95%			We continue to achieve our target.
Serious Incidents	Jul-23	None in month	Aspire to 0			Within normal limits
Total no of incidents involving drug/prescribing errors	Jul-23	14	Aspire to 0			Reporting of incidents continues to be variable, continues to higher levels of reporting/incidents
Falls per 1000 bed days	Jul-23	7	Aspire to 0			We are just slightly over target, our levels continue to fluctuate, our average remains around 3.5 falls per 1000 bed days.
QVH Acquired PU per 1000 bed days	Jul-23	1	Aspire to 0			Within normal limits, no concerns.
Complaints	Jul-23	3	Not applicable			Within normal limits, no concerns.
Mortalities	Jul-23	2	No preventable deaths			Being reviewed as per process via medical director

Re-admission within 30 days	Jul-23	2%	2%			Within normal limits, no concerns.
Re-admission within 7 days	Jul-23	1%	1%			Within normal limits, no concerns.

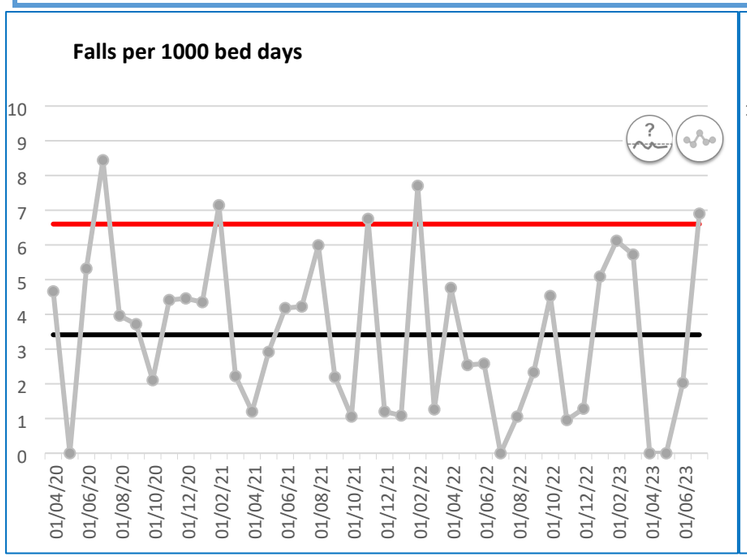
Safe Performance Indicators (3) – MRSA Screening

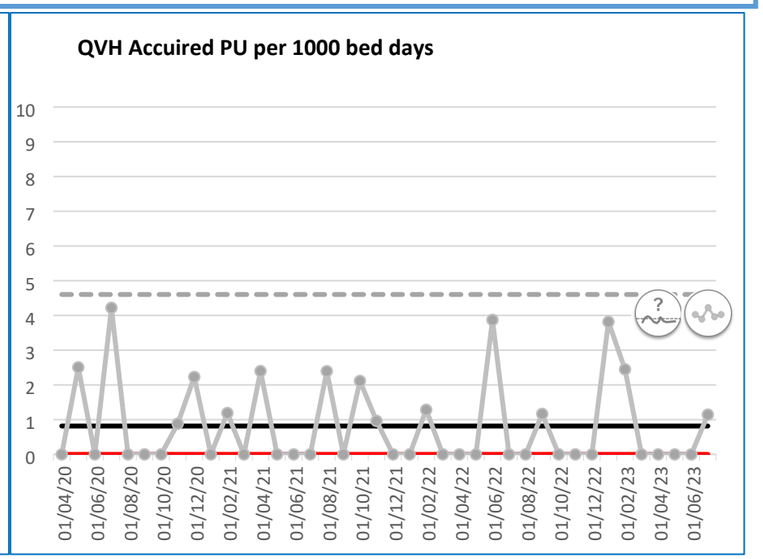
There is evidence our processes have improved however we are not yet completely confident that we will consistently meet our target and continue to monitor closely.



Safe Performance Indicators (4) – Falls & Pressure Ulcers

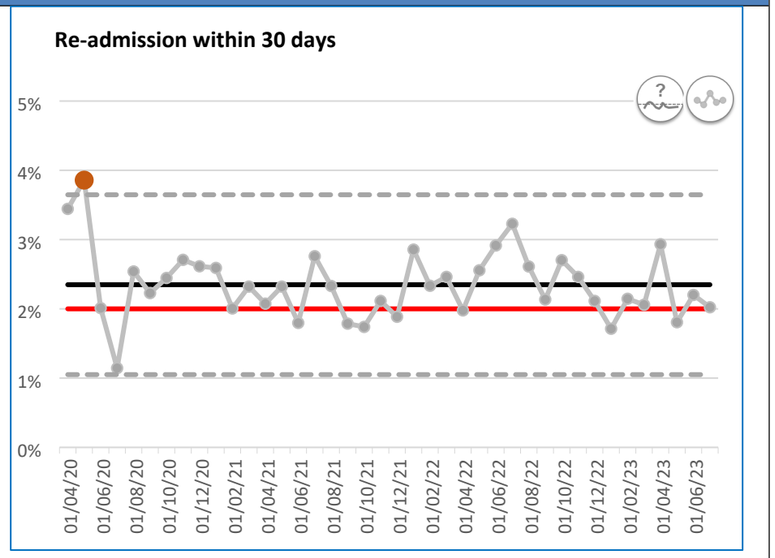
Our fall rate continues to be variable but within expected limits,
QVH acquired pressure ulcers continues within normal variability, with an average of less than 1 per month, per 1000 bed days.

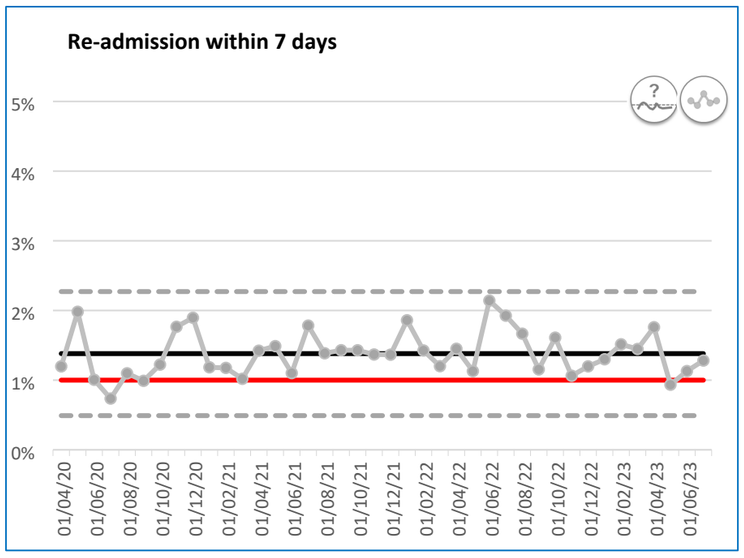




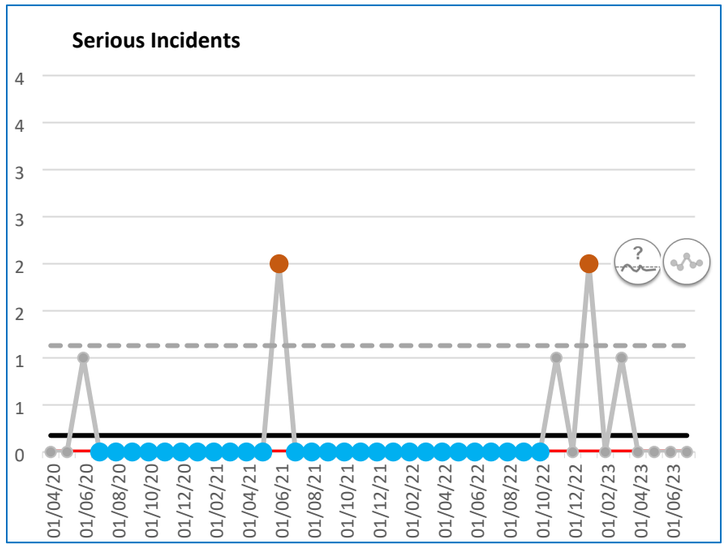
Effective Indicators (1)

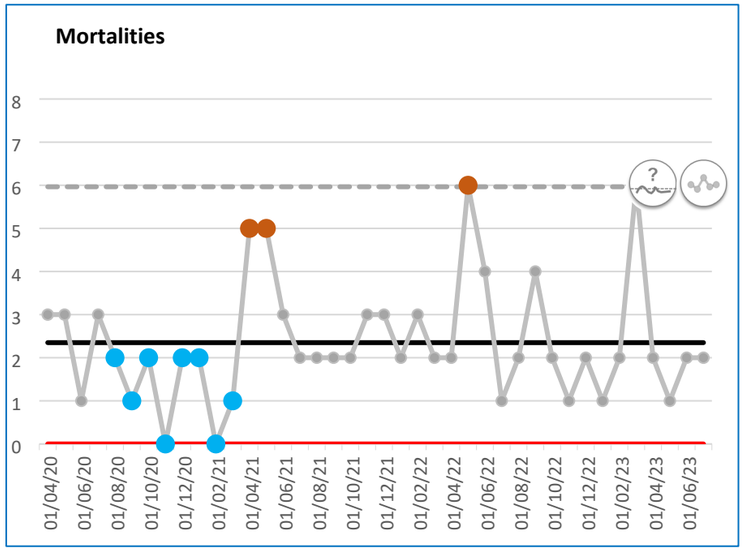
Re-admission levels remain within expected levels. Specialty governance leads review, discuss re-admissions of concern at their local governance meetings, and re-admissions of note are reported to clinical governance group quarterly.



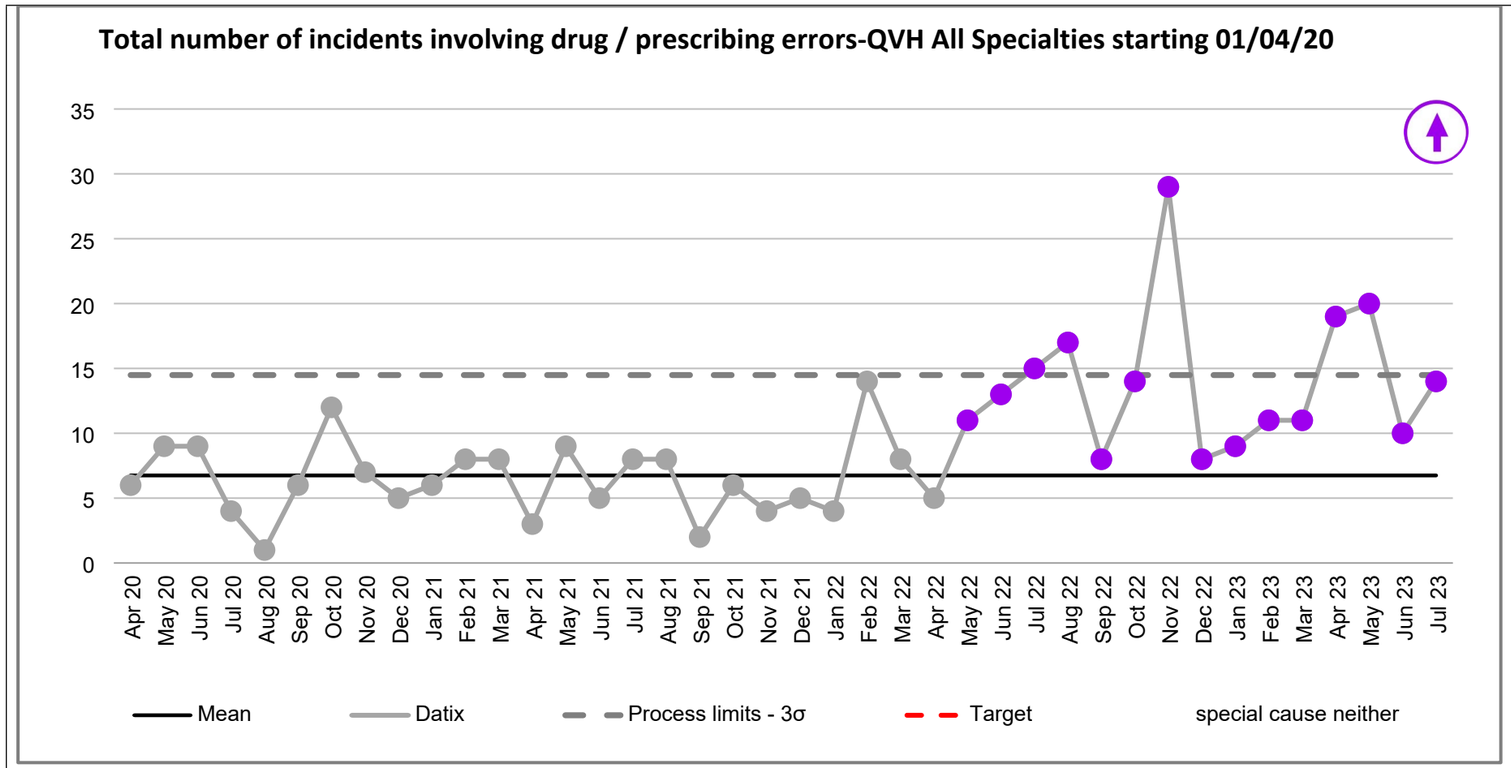


Both serious incidents and mortalities are within expected levels of variation, all mortalities and serious incidents are subject to review by the medical director and chief nurse





The reporting of incidents related to drug and prescribing errors has been variable but mostly within expected limits; we are currently seeing higher levels of errors, these errors are not specialty specific and are a combination wrong site mentioned (left eye instead of right), wrong patient's name, and regular medicine not prescribed or prescribed incorrectly.


Total number of incidents involving drug / prescribing errors-QVH All Specialties starting 01/04/20
35
30
25
20
15
10
5
0
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Mean
Datix
Process limits - 3σ
Target
special cause neither

Nursing Workforce - Performance Indicators

Metrics	Q2 2022/23		Q3 2022/23			Q4 2022/23			Q1 2023/24			Q2 2023/24	12 month average
Nursing Workforce	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	
Establishment WTE Including Bank & Agency	394	394	384	384	384	384	384	384	384	384	384	384	386
Establishment WTE excluding Bank & Agency	344	344	352	352	352	352	352	352	343	343	343	343	348
Staff In Post WTE	328	332	329	331	328	329	330	328	331	333	333	335	331
Agency Total worked in month WTE	4	3	3	3	2	3	3	5	8	6	7	7	4
Bank WTE Total worked in month WTE	37	34	38	35	31	35	39	47	35	33	34	32	36
Staff in Post Vacancy WTE	16	11	23	21	24	22	21	24	12	10	10	9	17
Vacancies % Including Bank & Agency Usage	7%	6%	4%	4%	6%	4%	3%	1%	2%	3%	2%	3%	4%
Staff in Post Vacancies %	5%	3%	7%	6%	7%	6%	6%	7%	4%	3%	3%	3%	5%
Qualified Nurses (NMC) Vacancies WTE	12	7	26	27	27	27	32	35	13	15	17	17	21
Theatre Practitioners (AHP) Vacancies	-2.13	-2.39	1.75	1.75	1.75	1.75	1.75	1.75	2.04	2.04	1.04	1.04	1.0
Band 2 & 3 HCSW Vacancies WTE Clinical support to clinical staff	4	8	-2	-2	-4	-5	-6	-7	0	-3	-3	-6	-2
Band 2 & 3 HCSW Vacancies WTE Non clinical support to clinical staff	4	5	3	3	3	3	3	3	0	0	0	0	2
Other Unqualified Nursing/Support to Nursing/Support to Theatre Practitioners (including TNA's Nursing Associates, Students, Associate Practitioners/Nurses, Dental Nurse and Student ODP's)	0	-2	-4	-6	-2	-5	-8	-8	-2	-4	-5	-4	-4
Trust rolling Annual Turnover % Excluding Trainee Doctors	11%	10%	11%	10%	9%	9%	8%	8%	8%	9%	9%	8%	
Starters WTE In month excluding HEE doctors	4	4	1	4	2	6	1	5	3	4	2	5	3
Leavers WTE In month excluding HEE doctors	1	1	3	2	3	3	0	2	3	4	2	2	2
12 month sickness rate (all sickness)	5.1%	5.1%	5.1%	5.1%	5.4%	5.2%	5.1%	5.0%	5.0%	4.9%	4.8%	TBC	5%
Monthly Sickness Absence % All Sickness	4.9%	4.6%	4.8%	5.4%	8.0%	5.0%	4.9%	5.1%	4.8%	3.2%	3.1%	TBC	5%

		Total Hours Planned & Actual (combined reg & support)														
		RN			NA			HCA			Site Practioner			Total		
		Plan	Actual	%	Plan	Actual	%	Plan	Actual	%	Plan	Actual	%	Plan	Actual	%
Day	Jun-23	5003	5003	100%	127	127	100%	2634	2634	100%	690	661	96%	8453	8424	100%
	Jul-23	5003	4997	100%	127	127	100%	2024	2024	100%	702	702	100%	8522	8504	100%
Night	Jun-23	3611	3611	100%	127	127	100%	1127	1127	100%	690	684	99%	5555	5549	100%
	Jul-23	3864	3864	100%	104	104	100%	1323	1323	100%	713	713	100%	6003	6003	100%

Medical Workforce - Performance Indicators

Metrics	Q2 2022/23		Q3 2022/23			Q4 2022/23			Q1 2023/24			Q2 2023/24	12 month rolling
Medical Workforce	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	
Turnover rate in month, excluding trainees	4%	0%	2%	0%	0%	4%	0%	1%	1%	0%	2%	0%	16%
Turnover in month including trainees 9%	16%	3%	3%	0%	0%	10%	1%	3%	6%	1%	1%	2%	47%
Management cases monthly	0	0	0	2	0	2	1	1	0	0	0	nc	nc
Sickness rate monthly on total medical/dental headcount	2%	2%	2%	3%	3%	1%	1%	2%	1%	1%	1%	nc	nc
Appraisal rate monthly (including deanery trainees)	71%	75%	75%	73%	74%	77%	79%	80%	82%	83%	81%	nc	
Mandatory training monthly	87%	87%	87%	86%	86%	83%	86%	88%	89%	88%	89%	89%	87%
Exception Reporting – Education and Training	5	3	3	0	1	3	1	3	2	0	1	2	24
Exception Reporting – Hours	4	4	2	1	3	2	2	5	0	4	8	1	36

Medical & Dental Staffing	Plans in place for August induction, where we will welcome trainees in Anaesthetics, Plastic Surgery, OMFS, Corneo Plastics and Radiology
Education	Leadership training for all staff - first cohort of 20 delegates have completed LEEP 1 and 2, excellent feedback, and second cohort open to applications for courses running October and November. LEEP 3 will take place in December. QVH GMC survey results excellent – 19 green flags, one light green flag and no red flags in any specialty for the second year in a row. Well attended lecture evening held on 5 July (NHS 75 anniversary)

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023		**Agenda reference:**	**92-23**	
Report title:	Annual reports				
Sponsor:	Nicky Reeves, chief nurse Tania Cubison, medical director				
Author:	Nicky Reeves, chief nurse Tania Cubison, medical director				
Appendices:	Appendix one: Learning from deaths annual report Appendix two: Safeguarding annual report Appendix three: Patient experience annual report				
Executive summary					
Purpose of report:	To present the annual reports to the Board for assurance				
Summary of key issues	Annual reports were reviewed by the quality and governance committee at its annual reports meeting on 15 May 2023. These annual reports are presented to the Board for assurance as the Board has specific oversight responsibilities in these areas. Assurance regarding annual reports was presented to the Board by the quality and governance committee Chair at its last meeting.				
Recommendation:	It is recommended that the Board **notes** the contents of the annual reports				
Action required	Approval	**Information**	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	***World-class clinical services***	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	New BAF strategic risk 01/23				
Corporate risk register:	All patient safety risks				
Regulation:	National guidance on learning from deaths 2017				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	15 May 2023	Decision:		
Next steps:	NA				

Queen Victoria Hospital
NHS Foundation Trust

Learning from Deaths Report

Queen Victoria Hospital NHS Foundation Trust

Annual Report

Report covering the period from

October 2021 – March 2023

Document Control: Quality and Governance Committee Approval
Executive sponsor: Tania Cubison Medical Director

Author: Alison Munday Head of Quality and Compliance, Tania Cubison Medical Director
Date: June 2023
Type: Annual Report
Version: FINAL
Pages: 9
Status:
Circulation: Speciality audit leads. QNet distribution

Background

The Queen Victoria NHS Foundation Trust (QVH) is committed to identifying, reporting and learning from deaths which occur in our care or following interventions and to enhancing the learning in this field through engagement with carers and families and with our clinicians.

For many people, death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. QVH is primarily a surgical hospital which manages complex surgical cases but has very few deaths per year. QVH has a process in place to review all deaths on site, including those patients who are receiving planned care at the end of their life. Care provided to patients at the end of their life is assessed to ensure it is consistent with national guidance

'*National Guidance on learning from Deaths*' (National Quality Board, 2017) outlines the principles that healthcare staff should use when a patient dies whilst in the care of the Trust or within 30 days following discharge or an outpatient procedure. This should include all deaths where families/carers or staff have raised a significant concern about the death, all deaths of those with learning disabilities or severe mental illness and all deaths in areas where people are not expected to die (e.g. elective procedures).

In line with this guidance Queen Victoria Hospital has in place a Responding to and Learning from Deaths policy which details the clinical governance process by which it responds to and learns from deaths of patients in its care. The policy at QVH supports a culture of openness, honesty and transparency. It incorporates Duty of Candour which was made a contractual obligation in April 2013 and reinforces the fundamental obligation to be open and honest in the event of an incident where patient harm has occurred.

This is the fifth annual report on learning from deaths at the QVH and covers the period 1st October 2021 – 31st March 2023. The reports previously covered the time period from 1st of October to 30th September. Therefore, this report covers a longer timeframe so as to bring the reporting period in line with the other QVH annual reports.

Learning Principles

- All deaths are reviewed for internal learning and so that relatives may be informed of what happened to their loved ones
- Data is collated on all deaths occurring within 30 days of treatment or inpatient admission at QVH to ensure care at QVH was appropriate
- Deaths are reported monthly to the appropriate specialty clinical leads for discussion and so that learning can be ascertained and shared
- All deaths are noted and, where necessary, presented and discussed at the bi-monthly joint hospital governance meetings and external peer review meetings where appropriate.

QVH Learning from Deaths Process

The Trust's policy for 'Responding to and Learning from Deaths' stipulates that all patient deaths which occur within thirty days of discharge from QVH inpatient care or following an Outpatient procedure should have an initial preliminary review to estalish whether their deaths were related to QVH treatment/ care. Cases are escalated to a Structured Judgement Review (SJR) or formal investigation as part of the Trust's clinical Governance framework as required.

Investigation through SJR, is recommended in following circumstances:

- Unexpected death, for example in elective surgery
- Any paediatric death
- Any death of a patient with learning difficulties or serious mental health disease
- Patients who are not under the care of QVH at the time of death but where another organisation suggests that the Trust should review the care provided to the patient previously.
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
- All deaths where concerns have been raised internally or externally about the quality of care, or where service improvements are in progress

To provide assurance that the QVH responding to and Learning from Deaths process is robust, over 2022/3 a Trust Mortality Surveillance Panel (TMSP) has been introduced to:

- Oversee, monitor and support the Specialties with the implementation of the Responding and Learning from Deaths policy.
- Monitor compliance/ progress with detailed formal investigations, and escalate to the Clinical Governance Group and Quality & Governance Committee as necessary.
- Ensure that if deaths require to be reported externally, this is completed in a timely way. Ensure that the process for following up the outcome of patients who die within 30 days of emergency transfer out from QVH is robust

The TMSP process was in place for the Maxillo-Facial (MF) unexpected inpatient death which occurred in 2022/3 Q4. It enabled prompt identification that a Serious Incident investigation should be started immediately as at that stage the cause of death had not been determined. The patient's family were contacted and able to give feedback on their loved one's care, they also met with the Medical Director within two weeks of the patient's death.

In addition, an external Consultant colleague has been employed by QVH to be a 'Medical Examiner' (ME) for the Trust. MEs are senior medical doctors who are contracted to provide independent scrutiny of the causes of death. They are trained in the legal and clinical elements of death

Certification processes. QVH's ME will support colleagues to ensure that the Learning from Deaths Policy is consistently embedded into practice by;

- Providing greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- Ensuring the appropriate direction of deaths to the Coroner
- Providing a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improving the quality of death certification
- Improving the quality of mortality data.

During 2022/3 QVH's 'Learning from Deaths Policy' was amended to reflect the introduction of the TMSP and ME service.

Benchmarking QVH's inpatient death rate

		Q3 2021/2	Q4 2021/2	Q1 2022/3	Q2 2022/3	Q3 2022/3	Q4 2022/3
1	**All Inpatient deaths at QVH**		1 (BUR)		1 (BUR)		1 (MF)

QVH Inpatient Mortality	**2016/7**	**2017/8**	**2018/9**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
In-hospital mortality per 100 bed days	0.005%	0.020%	0.026%	0.005%	0.015%	0.022%	0.019%
In-hospital deaths	1	4	5	1	2	4	2

The NHS Standardised Hospital Mortality Index (SHMI) is the ratio between the actual number of patients who die following hospitalisation at a NHS trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there .QVH is on the NHSE exemption list for participating in SHMI as it is not possible to benchmark our unique patient mix against any other providers

QVH monitors mortality data by area, speciality and diagnosis on a monthly basis, in particular for burns and head and neck oncology, both of which are monitored at regional and national level. QVH undertakes detailed reviews of all on-site deaths to identify any potential areas of learning which can be used to improve patient safety and care quality.

All of the inpatient deaths during this time period were Burns (Bur) or Maxillofacial (MF) patients.

QVH's outcomes for our MF patients remain excellent. Our MF patients' survival within 30 days of surgery is 99.1%, which is equivalent to the highest performing units in the country.

The care provided for all inpatient burns patients who die is reviewed by peers at the London South East Burns Network. No 'outlier' burns deaths were identified during this time period.

Classification of Deaths to aid learning

To assist in the identification of patients for more detailed investigation all deaths are now being classified, to reflect the cause of death and if the death was expected. This will focus on QVH core conditions and identify specific issues, while also noting any intervention that might be indicated for other conditions and continue to improve end of life pathways. The groups of patients are:

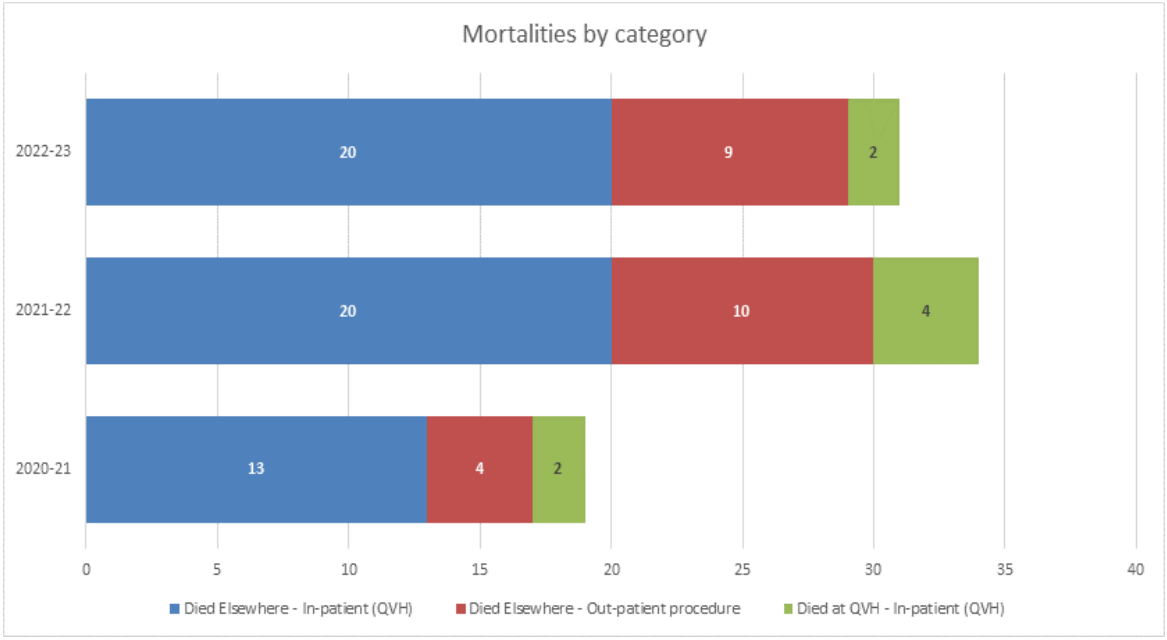
1. **Expected inpatient deaths at QVH.** Some patients have very advanced cancer or severe burns, and although they are not expected to survive for long the QVH

multidisciplinary teams make a significant contribution to their care including end of life care. Many can have good quality of life in the short term although their longer term outcome is not good. If they die at QVH there are often leaning points that can enhance care for other patients. Families also benefit from the reassurance that everything that could have been done was done, and if not then how can we improve the experience for future patients and relatives.

2. **Unexpected inpatient deaths at QVH.** Occasionally a patient dies at QVH with a condition that was not life limiting, their treatment might have been an issue and mistakes can be made. These deaths must be identified and investigated in a timely and effective manner with an inclusive open process, so that leaning can be identified and changes made.
3. **Death within 30 days of inpatient/ outpatient episode from condition unrelated to QVH diagnosis/ care.** This includes unrelated medical conditions and accidents. There is less likely to be learning for QVH from these deaths, but a brief notes review is undertaken to confirm this.
4. **Expected deaths related to conditions treated by QVH within 30 days of QVH inpatient/ outpatient episode.** Patients with significant medical conditions and complications are sometimes transferred to other providers due to lack of specialist staff and facilities at QVH. Although they die at another Trust from an expected cause there will sometimes be learning and actions to undertake
5. **Unexpected death from condition treated by QVH within 30 days of QVH inpatient/ outpatient episode.** This group is very likely to have learning that could be missed. It is now a requirement of the transfer out datix that the outcome of the patient is recorded so that learning /action can be undertaken**.**

Overview of All Mortalities during period 01/10/2021- 31/3/2023

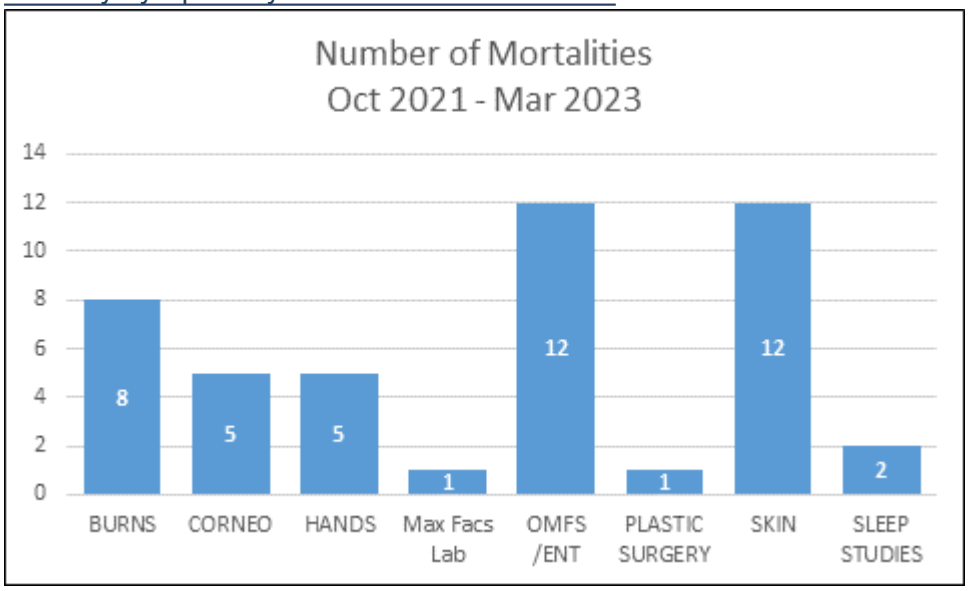
In the period between the 1st October 2021 and the 31th March 2023 there were 46 adult deaths which occurred during inpatient episodes at QVH or within 30 days of an outpatient procedure or inpatient episode at QVH. 3 patients died whilst inpatients during this time period. These 3 categories, with trends over time are illustrated in the chart below.



.

QVH Classification of death		Quarter 3 2021/2	Quarter 4 2021/2	Quarter 1 2022/3	Quarter 2 2022/3	Quarter 3 2022/3	Quarter 4 2022/3
1	Expected inpatient deaths at QVH		1 (BUR)		1 (MF)		
2	Unexpected inpatient deaths at QVH						1 (MF)
3	Death within 30 days of inpatient/ outpatient episode from condition unrelated to QVH diagnosis/ care	7	4	3	3	3	4
4	Expected deaths related to condition treated by QVH within 30 days of QVH inpatient/ outpatient episode	2	2	3	2		2
5	Unexpected death from condition treated by QVH within 30 days of QVH inpatient/ outpatient episode				1		

Mortality by Specialty 01/10/2021 – 31/03/2023



Patients whose cause of death is unknown

At the time of writing this report QVH is awaiting the cause of death for 7 patients who died within 30 days of inpatient/ outpatient treatment at QVH during this time period.

Once the cause of deaths have been established they will be reviewed as per the QVH responding to and learning from deaths governance process. Therefore, in the first instance,

an initial preliminary review will be undertaken for each one so as to determine whether further review of the QVH care is required.

Mortalities by protected characteristics

No statistically significant unwarranted variation was identified in relation to protected characteristics.

Deaths within 30 days of a QVH inpatient or outpatient episode of care.

There was no unwarranted variation in the specialities that patients were treated under prior to dying within 30 days of inpatient tor outpatient treatment at QVH.

Learning from QVH off-site deaths within 30 days of transfer out from QVH. (n=2)

SJRs were completed for 2 patients who died within 30 days of emergency transfer out to another NHS hospital. One of these patients identified died from the condition for which they were being treated at QVH. The other patient died of complications which were unrelated to her burn injury. She had a severe burns injury and would have been an unexpected outlier survivor had she not died. Her care was reviewed at the LSEBN mortality meeting which concluded that she had received excellent care. Neither of the SJRs reviewed identified any potential QVH lapses in care which contributed to their deaths.

Off-site deaths within 30 days of an in-patient episode or outpatient procedure

Fourteen patients died within 30 days of an outpatient procedure in the time period covered by this report.

Preliminary reviews were completed for all these patients; there were no issues with QVH care identified which required further review.

There was no unwarranted variation in the specialities that patients were treated under prior to dying within 30 days of inpatient treatment at QVH.

QVH on site deaths (n=2), (March 2023 death declared as SI)

One of the inpatient deaths was on a palliative care pathway. The SJR identified excellent end of life care, with full involvement of the patient, relatives and the Multi-disciplinary team (MDT).

The unexpected patient death of a complex MF patient which occurred in March has been declared as a Serious Incident.

Learning from Inquests (n=3)

There were 3 inquests held during this time period all of which were for Burns patients. Patient A died at QVH in March 2022, patient B died post transfer out to another Trust in July 2021. Neither of these two Inquests raised any concerns about the care provided by QVH.

Patient C died within 30 days of transfer out from QVH's Critical care Unit in June 2021. Following this inquest the Coroner issued a national prevention of further deaths notice in realation to the management of adjustable flange trachestomies.

A Serious Incident (SI) investigation was completed which identified that, the emergency airway situation prior to patient C's transfer out to another Trust was managed as per best practice guidelines.

There were learning points from the investigation phase after this death. A trustwide action plan was formulated to address the learning from this Inquest and SI investigation. The progress with this is being tracked as per Trust Governance processes.

Learning Disabilities Mortality Review (LeDeR) Programme

None of QVH's on-site mortalities required reporting to the LeDeR programme.

QVH continues to focus on the following actions/recommendations from the LeDeR national report:

- *Providers should clearly identify people requiring the provision of reasonable adjustments, record the adjustments that are required, and regularly audit their provision.*
- *Local services must strengthen their governance in relation to adherence to the Mental Capacity Act, and provide training and audit of compliance 'on the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.*
- *Mandatory learning disability awareness training should be provided to all staff, and be delivered in conjunction with people with learning disabilities and their families.*

End of Life Care

National Audit of Care at the End of Life (NACEL)

QVH is fully committed to identify opportunities to improve the quality of care at the end of life services offered to dying people and those important to them.

As part of this process, QVH participates in NACEL. This is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.

The audit is comprised of the following elements:

- Organisational Level Audit covering two questionnaires specific to the Trust/Health Board and hospital/submission level questions.
- Case Note Review reviewing deaths over a set time period.
- Quality Survey completed online, or by telephone, by the bereaved person. (Optional for acute/community inpatient providers, we chose to participate)
- Staff Reported Measure completed online, by members of staff who are most likely to come into contact with dying patients and those important to them. (Optional for acute/community inpatient providers, we chose to participate).

The NACEL Round 4 QVH specific results were published on the 21st April 2023.

There were not any concerns identified as needing to be formally escalated as part of the NACEL Cause for Concern process. The Deputy Chief Nurse is in the process of reviewing

the results as per the QVH clinical Governance process. A Trust wide action plan will then be implemented to address the learning points identified.

Update on organisational actions identified from round 3 of the NACEL in Learning from Deaths Report

- The End of Life (EoL) Policy has been updated it to meet the current national guidelines and standards of EoL care
- An end of life individualised care plan for use in clinical areas which follows NICE guidance is embedded in practice
- There is a developed Palliative Care Study day
- The Lead Macmillan Head and Neck Clinical Nurse Specialist also supports staff with EoL care as required

QVH Responding to and Learning from Deaths Main themes 2022/3

- There was no unwarranted variation in the number or specialty of deaths during this period
- One inpatient death which occurred in March 2023 has been declared as a SI
- None of the other SJRs during this time period following inpatient deaths raised concerns/ identified any lapses in care which required further formal Trust investigations
- QVH provides good quality, Multi-Disciplinary Team (MDT) led palliative care for patients
- SJRs completed for inpatient deaths which occurred during the time period of this report consistently identified that family involvement in shared decision making and communication between the MDT and family/ loved ones was excellent
- The Learning from deaths policy has been reviewed and amended;
    - A new Trust Mortality Surveillance Panel has been implemented to ensure that all inpatient deaths which occur at QVH or post transfer out are reviewed quickly so as to identify any which require formal investigation.
    - The Trust now has a ME to support its Learning from Deaths process.

Queen Victoria Hospital
NHS Foundation Trust

Safeguarding

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2022 to March 2023

Executive Sponsor: **Nicky Reeves, Chief Nurse**

Authors:
Katy Fowler, Named Nurse for Safeguarding and Looked After Children
Ian Cruickshank, Named Nurse for Safeguarding Adults and MCA lead

April 2023

Executive Summary:

Safeguarding systems at QVH are well established. The current workload, which includes significant time undertaking assurance, is very challenging for a small team to manage albeit within a small Trust.

Current Challenges:

- There have been times where some senior medical staff have not engaged with the safeguarding and Mental Capacity Act (MCA) process in a meaningful way. The safeguarding team have used escalation within the organisation to address this.
- Non-permanent staff compliance with training has been highlighted this year and is reported in the monthly metrics to the board. The medical director is working with the medical education team and clinical directors to ascertain which medical staff remain eligible to work within the Trust.
- Multiple changes to the team in the last 18 months with the retirement of our long serving safeguarding lead Pauline Lambert, and her immediate replacement moving on to another role externally.
- An audit undertaken in the summer of 2022 indicated adherence to the Mental Capacity Act appears poor.
- The safeguarding team is currently under pressure to deliver on all the required work streams. A business case has been put forward to fund additional staffing, this was unsuccessful; other areas of funding are being explored by the chief nurse.
- Audit programme is currently delayed due to workload.
- Managing safeguarding concerns is made more difficult by the lack of electronic patient records. Paper records and several distinct IT systems are an obstacle to sharing information internally, supervision and audit of safeguarding practice

Current Achievements:

- The safeguarding team has been strengthened with the addition of Ian Cruickshank who comes to the Trust with a wealth of knowledge and experience within the fields of safeguarding adults and MCA, both in health and social care settings.
- During this year, the QVH charity was kind enough to fund two domestic abuse sessions run by external provider, Safelives. These sessions were well received and will be followed up with an additional session using QVH case examples and looking at the DASH risk assessment tool.
- This year the safeguarding children Named Nurse worked with two medical students from the Brighton Medical School, alongside Dr Kamal Patel from RACH to review the MDT database. The retrospective review evaluated the patterns and types of injuries in the population of children where there had been identified safeguarding or child protection concerns. The review was presented in several forums externally and won the QVH audit prize.
- The safeguarding team have been working with medical education and learning and development team to make changes in the appraisal system to capture the eight

hours of safeguarding training, over 3 years, that is required by the Intercollegiate documents to be compliant at level 3.

- Following several non-recent abuse disclosures made to staff over recent years the safeguarding team have collaborated with the team at SPFT to provide QVH staff with a guidance document to understand how to manage disclosures of this nature and where to signpost patients to receive support.
- Domestic abuse posters available throughout the Trust with QR codes for patients are staff.
- New and updated training videos have been produced for level 2 training and for new medical staff.

Introduction:

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

Effective safeguarding arrangements must be in place to safeguard children and adults who are at risk of abuse or neglect. These arrangements include:

- safe recruitment
- effective training for staff
- effective supervision arrangements
- working in partnership with other agencies
- Identification of a Named Doctor and Named Nurse for safeguarding children, plus a Named Nurse for adult safeguarding and Mental Capacity Act lead.

The named professionals have a key role in promoting good professional practice within QVH, supporting local safeguarding systems and processes, providing advice and expertise, and ensuring safeguarding training is in place, is delivered and of a suitable quality. They are expected to work closely with QVH Chief Nurse, Sussex Designated Professionals, West Sussex Safeguarding Children Partnership (WSSCP) and West Sussex Safeguarding Adults Board (WSSAB).

Safeguarding Adults:

“All staff within the health service have a responsibility for the safety and well-being of patients and colleagues. Living a life that is free from harm and abuse is a fundamental human right and an essential requirement for health and wellbeing. Safeguarding adult is about the safety and well-being of all patients but providing additional support to those least able to protect themselves from harm and abuse”. NHS England

The Care Act provides the legislative basis for Adult Safeguarding. The local authority, who are the lead agency will, use safeguarding procedures in the following circumstances:

- The patient has care and support needs
- They are less able to protect themselves due to their care and support needs
- They are experiencing or at risk of abuse or neglect

The NHS responsibilities for providing support are wider than this, most obviously for those experiencing domestic abuse; other patients may not meet the threshold for local authority safeguarding procedures but be at significant risk from abuse or neglect.

The Trust sees patients who have suffered domestic abuse. Two very successful half day training sessions by a Specialist provider, Safelives, have been delivered. It is planned to follow this up with shorter practical training to enable staff to manage situations that may involve domestic abuse.

In order to safeguard patients it is necessary for QVH staff to

- Recognise the signs of possible abuse and neglect
- To be professionally curious and provide challenge
- To adhere to making safeguarding personal guidance
- Record and share information appropriately
- Make referrals and liaise with outside agencies
- Agree and action safety/protection plans
- Participate in safeguarding enquiries
- Have systems in place to learn from incidents

In addition to the policies, procedures, training and supervision in these areas immediate guidance, where a possible safeguarding concern is raised, is provided by the Named Nurse for Adult Safeguarding, the Chief Nurse, the Site Practitioners and the Medical Director

QVH adheres to the Sussex Safeguarding Policies and Procedures which provides an over-arching framework to coordinate safeguarding within the Trust.

Safeguarding Children:

'*The welfare of the child is paramount'* is a principal that was enshrined in the Children Act 1989 and remains at the core of safeguarding children practice nationally.

Section 11 of the Children Act 2004 places a statutory duty on all NHS organisations to ensure that services are designed to safeguard and promote the welfare of children. The Section 11 self-assessment audit is completed bi-annually and was completed at the end of 2022. Most actions were assessed as being green except in the new area of the role of fathers and other significant adults, where the safeguarding team assessed QVH as being amber. There is no specific guidance for practitioners to include fathers, partners or significant adults, although the paediatric paperwork asks details of fathers. The children's admission and MIU paperwork is currently in the process of being updated to be more inclusive of differing family structures as well as to encourage staff to capture the voice of the child in their documentation.

QVH has a duty to ensure a culture exists where safeguarding is everybody's business. There are occasions when medical staff have not engaged with the safeguarding process in a robust and meaningful way. Consultants have significant expertise and therefore have a crucial role in identifying concerns and role modelling management of potentially complex safeguarding

situations to junior staff. It is imperative that **all** staff demonstrate professional curiosity, critical thinking and a risk based approach to ensure children are identified when there may be a risk of harm. Once a risk is identified, it is essential colleagues take appropriate steps to safeguard the patient and medical staff are an integral part of this team. To deliver this, medical leadership is being strengthened.

During this year, we have been challenged through the PALS process on the requirement that children who are identified as being electively home educated should have their information shared with the local authority in order to support them in their statutory duty to ensure children have access to a suitable education. At present, it appears that there are not sufficient information sharing agreements in place (outside of West Sussex) to enable the team at QVH to share information about electively home educated children with the local authorities across our region. We will seek consent for this information to be shared from families and will share information where there are safeguarding concerns identified. Follow up work will be undertaken by the safeguarding team with the local authorities over the coming months.

Looked after Children:

Looked after Children or Children in Care are a group of young people who are cared for and accommodated by the Local Authority. This cohort of children may have increased health risks and significant emotional and physical health needs. Although QVH does not have a specially commissioned service for Looked After Children, there is a role in promoting recovery, resilience and well-being for this cohort

There have been several incidents during the year where medical staff have sought consent for significant medical procedures from foster parents. Work has been done with individual staff, in training and by the medical director to ensure that staff are aware that foster carers are not able to provide consent for these procedures and to signpost them to allocated Social Workers who can provide assistance and clarity. There is a 'Who has Parental Responsibility' flow chart available for staff and the consent policy supporting this. Ward staff have been requested to formally record any incidences on Datix to ensure they can be followed up by the medical director.

Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS):

Adherence to the Mental Capacity Act is important to ensure that the provision of health services is provided with shared decision making and lawful consent. An audit undertaken in 2022 indicated poor adherence to the Mental Capacity Act.

The headline statements from the results of this Audit are:

- 28% of patients who meet the requirement for a Capacity Assessment did not receive one
- The previous version of the MCA Orange Form was still in circulation and used for 7 patients in this audit
- Documentation of Capacity Assessment frequently incomplete or partially complete
- Rational behind Best Interests Decisions were often unclear due to poor documentation
- Medical Decision Maker clearly identifiable and appropriately signed in 100% of Best Interests Decisions

- Process around Lasting Power of Attorney (LPOA) is inconsistent, occassions where LPA has signed on Patients behalf but no evidence of LPA within patient record

The reasons this is a particular challenge for QVH relate, in part, to the services provided:

- The Trust provides specialist surgical services across the region, this means that many patients will live some distance from the hospital.
- Day surgery is often undertaken.
- Those with skin cancer, in particular will be an older cohort group more likely to require a mental capacity assessment.
- The aim is for those patients on the Cancer pathway to be initially assessed and treated within the Department of Health and Social Care Targets.

The following actions are being taken to address this:

Practice: The Medical Director has issued directives that the practice of attempting to complete mental capacity assessments and (where necessary) follow the best interest process on the day of surgery should cease (except in exceptional circumstances).

Training: The Level 3 training recently provided focussed on adherence to the Mental Capacity Act within QVH (although it must be noted that it was almost entirely non participative).
It is felt that existing Adult Safeguarding training (refresher and induction) does not allow sufficient time to train staff and ensure their competence and confidence in this area.
In order to address this the MCA Lead is providing additional stand alone training on the MCA for all staff. It is hoped to provide further bespoke sessions to particular groups of staff.
In addition a yearly workshop on the Mental Capacity Act is provided by Alex Ruck Keen, Specialist Barrister. The success of these initiatives will depend on appropriate staff being permitted and encouraged to attend these training sessions.

Policy and Toolkit: The Mental Capacity Act Policy is being rewritten to reflect changes to the law and statutory guidance. The Mental Capacity Act and Best Interest Form is being updated in line with this. In addition a new Toolkit will be developed for practical guidance for the application of the Act. The Restrictive Practices Policy is also being revised.

Procedures: Processes in use in the management of referrals are being reviewed. This will focus on ensuring there is sufficient information being provided by referrers regarding the patient's mental capacity and gathering more information from the patient at the outset regarding involving those who are supporting them.

Audit: It is proposed to complete a further audit of adherence to the MCA within the Trust. This will involve a larger sample than that undertaken in 2022 (previously referred to) and involve significant staffing resources.

Further work is required to ensure where patients are deprived of their liberty that this is completed lawfully with requests for authorisation of DOLs submitted to the local authority.

The implementation of the Liberty Protection Safeguards replacement of Deprivation of Liberty Safeguards have now been delayed until at least the next Parliament.
When enacted this will have important impact throughout the NHS. Specifically the NHS will become the Supervising body for people deprived of their liberty in QVH (rather than the local authority). In addition Children from 16 years will be subject to this legislation. These changes will have important implications for QVH in the resources, training and administrative management of the Act. The Named Nurses for both Children and Adults attend regular meeting with Sussex NHS professionals in preparation for the implementation of the LPS although this is not now imminent.

In addition to the Datix system that records safeguarding concerns the Named Nurse has introduced a spreadsheet to provide improved recording of data for both safeguarding concerns and patients where that are Mental Capacity Act issues.

Prevent

Prevent is part of the governments counter terrorism strategy with its aim to reduce the risk to the UK and its overseas interest from terrorism.

NHS providers are mandated to contribute to the Prevent agenda. Within QVH the Prevent lead role is shared between the Safeguarding Named Nurses. Currently, the level 3 Prevent training is delivered via the national e-learning package and the compliance of permanent staff sits at 95% (76% for non-permanent staff) the national requirement is 85% of staff to be compliant at any time. Prevent basic awareness training and updates are provided as part of the safeguarding training sessions at level 1 and 2.

The prevent delivery plan is due for an update this year, as is the Prevent Benchmarking activity. One of the Safeguarding leads attended the Prevent leads meeting chaired by the ICB.

No Prevent referrals were made during the year 2022/23.

Sussex Safeguarding Standards.

These are 9 standards that enable all parties to identify key benchmarks to ensure an effective auditable approach to safeguarding of all patients.

Standard 1
Strategic leadership:
The Chief Nurse is the executive board lead for safeguarding vulnerable people. The purpose of this role is to oversee and monitor the Trust's compliance with legislation and other safeguarding responsibilities.

QVH has robust safeguarding governance arrangements in place, which is led and supported by a team of specialist safeguarding clinicians.

The Safeguarding team Structure:
Chief Nurse
Named Nurse for Safeguarding Adults and MCA Lead
Named Nurse for Safeguarding Children and Looked After Children
Named Doctor for Safeguarding and Medical Director
Safeguarding Children Specialist Nurse

The strategic safeguarding group is to oversee the development and implementation of adult and children safeguarding, as well as oversight of Looked After Children, Mental Capacity Act practices, Prevent, and Learning Disability and Dementia strategy throughout the organisation. It provides summary updates to the Quality & Governance Committee.

Monthly board metrics are produced to provide the executive board with an overview of safeguarding activity and training as well as additional commentary. The board is due to have a safeguarding seminar in May 2023, postponed from 2022, to enable them to scrutinise the safeguarding arrangements in the Trust and to fully understand their responsibilities within that. Each member must also be up-to-date with the relevant level of safeguarding training to their role.

The safeguarding team links with the ICB Sussex Designated Nurses and wider Sussex network, including the WSSCP and WSSAB via regular meetings to ensure that QVH is updated on the rapidly changing local safeguarding picture and disseminate relevant information to staff in a timely way.

Across QVH there is a network of link champions from service areas who attend a quarterly safeguarding steering group to discuss clinical issues, review learning from Safeguarding Practice Reviews and Safeguarding Adult Reviews as well as case studies from QVH and share practice improvement across the organisation. During this year, the champions have worked with the safeguarding team to roll out domestic abuse poster with QR codes on them for use in all clinical areas.

QVH Named Nurses understand the importance of working together within health and with wider partners to safeguard vulnerable individuals. Over the past year the safeguarding team have endeavoured to attend external meetings, which can be challenging with the workload and the extensive amount of meetings. The list below is not exhaustive and meetings have to be prioritised.

Meetings include:
West Sussex Safeguarding Adults Board
West Sussex Safeguarding Adults NHS Professionals Network
LPS implementation group
West Sussex Safeguarding Children's Partnership
Improvement and Assurance Sub-group of WSSCP
West Sussex Children Health Safeguarding Forum
Child Safeguarding Liaison Group
Sussex Safeguarding Looked After Children Professionals meeting
Safeguarding Supervision for adults and children
Neglect Health Subgroup
West Sussex MASH health group
Prevent Leads meeting

QVH have a 3 year safeguarding strategy that will be reviewed in 2024, Priorities are updated every three year and will align, where appropriate, with WSSAB and WSSCP objectives, they will also take into account PREVENT and Looked after Children priorities.

QVH uses Datix system to report safeguarding incidents as well as any shortfall that may impact on the ability of QVH to meet safeguarding responsibilities. These are highlighted to the board and are discussed during the strategic safeguarding meetings.
Safeguarding open risks:

There are currently no safeguarding corporate risks.

There are three safeguarding departmental risks:

- Not able to demonstrate full compliance with implementation of the MCA, currently data captured on the Datix system covers cases brought to the attention of the safeguarding team (risk rating 9 - LOW) Nursing and Quality department.

- Minor Injuries Unit (MIU) risk (Risk rating 6- LOW) relating to access to previous information held in the Trust about patients re-attending. Staff in MIU do not access the full records of patients when they attend, this poses a risk in terms of safeguarding. Work is underway to mitigate the risks including health records now amalgamating individuals MIU records from January 2021. The Trust has implemented EMIS, an integrated community facing system where primary care information is available for MIU staff to access. However, this system has not provided the information from the GP system that had been hoped for. The longer term aim was for the MIU team to have access to EVOLVE, however this is not now being undertaken; the Trust has identified that an electronic patient record system will be rolled out and MIU will be part of this. This risk is monitored at the Strategic Safeguarding Group. MIU now uses Electronic Discharge Notification (EDN), which ensures that robust discharge information is shared with the GP and Health Visitor (as appropriate) about the episode of care and any concerns raised.

- The introduction of Liberty Protection Safeguards (LPS) to replace DOLS. Corporate risk (Risk rating 9): legislation due to be implemented in 2022, but have been delayed again to the next parliament. QVH safeguarding team are involved in the Sussex-wide LPS steering group. This will be reviewed and downgraded due to the delay of the implementation of LPS to the next parliament.

Standard 2: Lead effectively to reduce the potential of abuse

QVH has policies and procedures in place to support staff to manage safeguarding concerns they may have for patients and others using QVH services, these are available on QNet. Staff have access to safeguarding prompt cards; these cover a variety of safeguarding topics and signpost staff where they can access support.

The Datix system is used as a data collection system and captures 'safeguarding incidents' that are used for case discussion and learning via the steering group. In addition the safeguarding adults lead has begun capturing all incidents on a spread sheet to support case management.

One of the QVH values is quality; as such, the Trust places a great importance on patient experience. The PALS and safeguarding teams work closely together where there are concerns or complaints relating to safeguarding activities.

The safeguarding team have a number of patient information leaflets and posters around the Trust.

Standard 3: Responding Effectively to Allegations of Abuse

QVH currently use an electronic document management system (EVOLVE). There is a safeguarding section available for all patients, as required. This section highlights where there are concerns flagged about a patient in terms of safeguarding or mental capacity. The safeguarding children paperwork has a bar code that automatically scans it into the safeguarding section when uploaded. The safeguarding adult lead is launching the same system for safeguarding adult paperwork. This was launched in the April steering group and provides easier access to any safeguarding concerns that have previously been raised, within the Trust, in relation to a specific patient.

The Electronic Discharge Notification audit of the safeguarding section has been delayed again this year due to lack of resource in the safeguarding team.

The National Child Protection Information systems (CP-IS) is used by Minor Injuries Unit and Peanut Ward to check whether unscheduled children or young people have a child protection plan or are looked after by a local authority continues to be used. The safeguarding team are considering if this should be used in areas across the Trust where older children (16 and 17 year olds) are being cared for, these children will have been previously checked either in the ED department or from the minor injuries team, but the records are not always provided by referring hospitals.

<u>Allegations against staff.</u>
The safeguarding team have been working with the Chief Nurse and HR to ensure that there is a central point where allegations against staff are recorded. Allegations against staff can be varied and not all relate to safeguarding, however it is important that any concerns are recorded in one place so that information can be checked and reports provided as required. The new ICB exception report requests information on allegation against staff in the safeguarding context.

The Safeguarding team worked with the HR team during the year to update the domestic abuse staff policy to enable staff who are survivors and perpetrators of domestic abuse to receive the correct support and keep QVH staff safe.

STANDARD 4: Safeguarding Practice and Procedures

The Safeguarding Team develop a wide range of documents for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets.

Documents are placed on the Website or QNet intranet. All documents are reviewed and updated in collaboration with relevant services and governance groups.

Information is monitored and reviewed regularly and updated on the QNET, including information on who to contact for advice and support. QVH prompt cards are available to staff on the QNet page and are provided to staff via email when they undertake safeguarding training; they are due for update. The safeguarding team plan to review the QNet safeguarding and MCA pages to make them more user friendly, but due to workload this has not yet been undertaken.

Safeguarding referral:

All safeguarding referral forms are provided on line by local authorities, staff are supported to complete these when help is requested.

Restrictive interventions:

When a patient is identified as needing any form of control, restraint or therapeutic holding staff need to follow hospital policy. The policy has been in the process of being updated for some time. Several stakeholders need to be consulted on this policy as well as staff training to be undertaken. The safeguarding adult named nurse and deputy chief nurse are working together to update this policy.

The children's therapeutic holding policy is ready to launch, but has been delayed until the launch of the adult restrictive interventions policy is ready.

Mental Capacity Act

All QVH staff are required to understand their legal responsibilities under the Mental Capacity Act including undertaking mental capacity assessment, best interest decision making processes and when to complete a DOLs application. MCA data is no longer captured on the Datix system as this fails to give an accurate reflection of the total number of mental capacity assessments and best interest's decisions across the Trust. A quarterly audit cycle, will instead, be used to provide assurance of the Trust's compliance with the MCA by focussing on the quality of the completed orange MCA forms. A larger scale audit is planned to look overall at the compliance with the MCA within the Trust. The MCA and Best Interest form is to be updated to reflect changes to the law and guidance and make more user friendly.

Domestic violence and abuse (DVA)

Managing risks, keeping individuals safe and seeking the right specialist advice are all important aspects of patient care when DVA is being considered a possibility or has been confirmed. Raising awareness of and managing DVA situations is included in all levels of safeguarding training.

Domestic Abuse Stalking Honour (DASH) risk assessments have been used by staff to help inform next steps to protect patients. Worth DVA specialist services and the police can provide advice and support to staff at QVH.

Specialist training by an external provider was undertaken in the last year to raise awareness of domestic abuse. Two follow up sessions have been booked to provide staff with practical guidance in managing domestic abuse concerns in the Trust.

Safeguarding Audit

Audit is acknowledged an integral element of the work of the Safeguarding Team, in order to benchmark practice and provide assurance. A three year cycle of audit activity has been developed including core elements such as NICE guidance alongside aspects of clinical practice. This audit programme has been delayed, the safeguarding team have undertaken audits, which had low participation and are having to re-run these as well as challenges with standards against which to benchmark as with the referrals audit. The safeguarding children Named Nurse is working with the Designated Nurses from the ICB to identify relevant standards to audit the quality of QVH referrals against.

A large-scale MCA audit is planned for later on this year following on from the previous audit.

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

The safeguarding team also inputs to the WSSCP and WSSAB multi-agency audits. The Safeguarding Named Nurse for children is a member of the WSSCP improvement and assurance subgroup.

Child Sexual Exploitation and Criminal Exploitation.

Recognition of Child Sexual Exploitation (CSE) or Child Sexual Abuse (CSA) requires careful assessment and consideration when concerns arise. The Safeguarding Children Named Nurse is the CSE lead for QVH and supports staff to access specialist support if required.
Staff within MIU have a 4 question-screening tool available to them when they have a concern about sexual exploitation.

Modern Slavery

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

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

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

The Trust is committed to better understanding its supply chains and collaborating with stakeholders to improve transparency of its arrangements to ensure adequate safeguards in place to prevent incidents of slavery or human trafficking.

The Trust's recruitment and selection procedures include appropriate pre-employment screening of all staff to determine right to work in the UK, and all salaries are above the National Living Wage. All employment agencies that are engaged also meet these standards as a minimum entitlement.

In the event of a patient possibly experiencing slavery or human trafficking staff need to carefully assess the situation using translation services, where required, and seeing the patient alone. Data relating to these aspects of safeguarding are collected by the safeguarding team. There is a Modern Slavery Protocol is available on QNet and is referenced in training and the QVH prompt cards.

Working with QVH communications team:
The safeguarding team have close links with the communications team at QVH where there are strict guidelines for dissemination of information internally for all staff across the organisation, including updates and reviews. The communications team have supported the safeguarding team during the year with information sharing in the form of posters and via Connect, the weekly internal newsletter.

STANDARD 5: Staff Competence

Driving improvement in all aspects of safeguarding practice is a continuous process and as such has to be reviewed, evaluated, developed and adapted over time. There is a safeguarding learning and development strategy for the organisation to steer and facilitate staff competency development in all aspects of safeguarding. Level 1 and 2 safeguarding training incorporates both adult safeguarding, child safeguarding and MCA into a single 'think family' approach to allow staff to be updated on all safeguarding issues as it is important to recognise the complexities and interconnected nature of safeguarding.

QVH safeguarding team continue to offer level 3 Adult and Child Safeguarding sessions separately for consultants and those members of staff who require this additional level of training. These sessions are provided twice yearly. Staff needing to meet the training requirements outlined in the intercollegiate document also have the opportunity to access other level 3 training off site, as part of their personal development, including those run by the local safeguarding Boards, external conferences and workshops. This information will be captured in their training logs and will be self-certified as being completed during their annual appraisal.

This year, the Integrated Care Board (ICB) has continued to provide some excellent level 4 training opportunities in relation to MCA, looked after children and safeguarding adults and children. The most recent topic has been self-neglect and alcoholism and sexual abuse in boys and men, as well as a looked after children away day covering a variety of topics pertinent to this group of children. This level of training is required by the safeguarding team to ensure they are kept up-to-date in such a dynamic environment.

Due to the Covid pandemic all training, levels 1, 2 and 3, were provided virtually via MS Teams, the safeguarding team has reintroduced face-to-face training across levels 1 and 2 to encourage participation and maximise learning. Level 3 training continues to be online via MS Teams, however it is difficult to assess learning and be assured that staff are engaging without cameras on and with little interaction. As a result, there is a plan to undertake the level 3 training face-to-face in the near future – with the support of the senior team in the hospital.

Safeguarding Learning and development Strategy

QVH Safeguarding learning and development strategy was reviewed and updated in 2021. This document is aligned with the core skills framework document and with national guidance from the NHS England regarding roles and competences for health care staff – from 4 intercollegiate documents (Prevent, LAC, Adults and Children). It makes transparent QVH expectations for staff including the Board with regard to safeguarding training and development.

Safeguarding responsibilities remain integral to everyone's job description; this is reiterated during safeguarding training.

STANDARD 6: Safer Recruitment

QVH work to ensure that those working or who are in contact with children, young people and adults are safely recruited and Human Resource processes take account of the need to safeguard and promote the welfare of all. Making sure that QVH do everything we can to prevent appointing people who pose a risk to vulnerable people is an essential part of safeguarding practice and QVH recruit staff and volunteers following safer recruitment procedures.

All staff at the Trust are employed in accordance with the NHS Employers safe recruitment pre-employment check standards.

As part of their induction, new employees, including volunteers are expected to undertake mandatory training in safeguarding at either level 1, 2 or 3 or be able to provide evidence that this has been completed at another trust within the last 3 years.

Building on the changes made last year whereby HR are rolling out enhanced Disclosure and Barring Service (DBS) checks to all clinical staff given that children are seen across the Trust and not just in designated areas. There has been some consideration given to DBS checking other non-clinical members of staff as many have access to areas across the Trust where vulnerable people are being treated; estates staff are an example of this.

STANDARD 7: Learning from incidents

Statutory Safeguarding Reviews:

Safeguarding Adult Reviews (SAR)

Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

QVH were not directly involved in any SAR during 2022-23. Learning from SARS outside of QVH is shared at safeguarding groups if relevant for care delivery.

Local Child Safeguarding Practice Reviews (LCSPR's).

When a child dies or is seriously harmed, including death by suspected suicide, and abuse or neglect is known or suspected to be a factor in the death, West Sussex safeguarding Children Partnership (WSSCP) is required to conduct a Local Safeguarding Practice Review into the involvement of organisations and professionals in the lives of the child and the family.

The purpose of a LCSPR, previously known as Serious Case Reviews (SCR), is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and, consequently, improve multi-agency working to better safeguard and promote the welfare of children.

QVH were not directly involved in any Child Safeguarding Practice Reviews during 2022-23. Although QVH staff members attended court following a previous SCR and resulting criminal prosecution. The Safeguarding Children Named Nurse supported staff who gave evidence.

Child Death Reviews.

The WSSCP is also required to conduct a review of every child death to identify whether there are any lessons to be learned to prevent child deaths in the future.

QVH has not contributed to any child death reviews this year.

Learning from Internal Safeguarding Incidents

All safeguarding children interactions are reported via Datix. Adult incidents are collated on a separate spreadsheet but staff report incidents on Datix to the safeguarding team. This ensures incidents are captured and reported to relevant governance forums for scrutiny and learning. Incident themes & patterns are identified by the safeguarding team which enables policy and procedures to be updated and learning disseminated through training and the Safeguarding Steering Group. These incidents can be used to provide safeguarding supervision and targeted training where there is a need identified. For example the use of case-studies presented to the steering group for discussion and learning.

Clinical Governance Group (CGG).

The CGG is a forum for learning from safeguarding incidents and captures a wide-ranging audience.

Standard 8: Commissioning

The Integrated Care Board (ICB) are the commissioners of local health services, as such they need to be assured that provider organisations from which they commission services have effective safeguarding arrangements in place.

The ICB exception reports are completed and submitted quarterly.

ICB have resumed their Sussex Safeguarding Standards Assurance Return following a pause during the pandemic. This is a contractual obligation that QVH has with the ICB to be part of a system-wide safeguarding assurance approach to keeping our patients safe. This is due to be completed and submitted by 30th June.

A self-assessment tool is completed bi-annually for adult safeguarding for submission to the West Sussex Safeguarding Adults Board (WSSAB) and a similar section 11 (of the Children Act 2004) self-assessment audit, submitted to the West Sussex Safeguarding Children Partnership (WSSCP). During quarter 3 of 2022, the Trust completed the section 11 report. Most areas were assessed as being green. The challenge event has not yet been undertaken. This assessment tool was also shared with the ICB via the designated nurses.

The WSSCP requests that QVH, and all other partner organisations, submit information to be included into their annual report to provide transparency about the safeguarding activities that have been carried out over the previous 12 months and how effective these have been.

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

There have been no safeguarding enquiries raised against QVH in the year 2022-23.

Standard 9: Safeguarding Data Requested by Department of Health

Female Genital Mutilation (FGM).
Understanding the FGM mandatory reporting duty is incorporated into QVH safeguarding training. Staff can access the DH / NHS e-learning package around FGM are available to enhance knowledge and understanding of this subject and their requirements as professionals.

There have been no FGM risk assessments during this year and no patients have been identified as having undergone FGM.

Prevent Returns
QVH submits quarterly reports to the regional co-ordinator. These are shared within the Strategic Safeguarding Group.

QVH has not made any Prevent referrals this year.

Recommendations from last year:

- **Working with the safeguarding medical lead to improve engagement with medical colleagues around training compliance.**
  Overall, the level of training for permanent staff compliance is good, and there have been improvements in recording this. However, there are concerns about the engagement and participation in training and therefore the effectiveness of the learning and its translation into practice.

- **Robust planning and investment for the implementation of LPS.**
  There is a delay in LPS implementation until the next parliament. QVH staff must continue to identify and apply for DOLS where patients require this to enable QVH to fully adhere to the MCA.

- **Evolve – standardisation of patient information systems and documentation methods across the Trust, in order to reduce the risk of duplication and risk of information not being shared between departments.**
  Lack of electronic patient records continues to be an issue across the Trust; this has been highlighted in various forums as a barrier to safeguarding communication, supervision and audit.

- **Investment in external specialist training and release of staff from clinical duties to facilitate attendance.**
  During the year, there has been a focus on domestic abuse; training sessions have been undertaken by a specialist domestic abuse service – kindly funded by the QVH charity. The safeguarding team plan to build on these sessions by offering an in house practical domestic abuse session to build on the great work already done. Broadly speaking, there still appears to be a lack of medical staff signing up for additional training, the safeguarding team are unable to comment on the reasons for this.

<u>Recommendations for this year:</u>

- **Continued work with the medical teams to ensure engagement and collaboration in safeguarding and MCA cases with the support of the Safeguarding Medical Director.**

- **To get the audit programme back on track.**

- **Secure additional safeguarding resource.**

- **Changes to the steering group to make it more learning focused.**

- **Improve compliance with the MCA as measured by audit.**

Queen Victoria Hospital
NHS Foundation Trust

Patient Experience Annual Report

Queen Victoria Hospital NHS Foundation Trust

1 April 2022 to 31 March 2023

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

Contents List

1. **Executive Summary**

We are pleased to publish the combined patient experience complaints and Patient Advice and Liaison Service (PALS) annual report for Queen Victoria Hospital NHS Foundation Trust. This report covers the period from 1 April 2022 to 31 March 2023.

Although not prevalent in everyday life, COVID-19 has continued to be a part of the lives of our patients throughout the period. Measures have adjusted through the period with some, such as mask wearing, a constant feature and others phased out in line with national guidance.

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

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

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

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

This feedback provides us with a holistic view of patient experience and offers insight into what matters to patients. Importantly, it allows us to develop action plans for patient and public engagement and quality improvements.

2. Introduction

This annual report demonstrates how the Trust measures progress towards the ambitions set out in the Trust Key Strategic Objectives (KSO), focusing on KSO1 Outstanding Patient Experience. The report includes a summary of patient and carer feedback and actions and initiatives to improve patient experience between 1 April 2022 and 31 March 2023.

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

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

A key objective of the Trust is to learn, change, improve and innovate in response to the feedback provided by our patients. The lessons learned and trends identified through analysing the data collected through complaints and other Patient Experience feedback plays a key role in improving the quality of care received by patients. Their experience is a priority for the Trust reaching its vision of outstanding care every time.

The efficient and effective handling of complaints by the Trust matters to the people who have taken the time to raise their concerns with us. They deserve an appropriate apology for their experience alongside a recognition where substandard and inadequate care was provided and assurance that we will, or have, put actions in place to ensure other patients are not affected by a reoccurrence of the same concerns.

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

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

The purpose of this report is to provide a review of the Patient Experience data collected through the Friends and Family Test (FFT), the real time survey system, national surveys as well as themes from PALS enquiries and formal complaints received within Queen Victoria Hospital NHS Foundation Trust between 1 April 2022 and 31 March 2023.

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

- delivery of our patient experience strategy
- compliance with the mandatory national FFT

- reporting and demonstrating that we have used patient experience feedback to shape the experience of care

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

The Chief Nurse is the Executive Lead for patient experience, who chairs the Patient Experience Group (PEG) within the Trust. Their role is to be assured that action on improving and responding to patient experience concerns are addressed. Membership of PEG includes representation from: Trust staff, Trust governors, Healthwatch and patient representatives.

This group routinely reviews strategic patient experience actions and progress, to ensure areas of poor patient experience are addressed. We know from existing feedback there are many examples of excellent care and experience being delivered by our staff and the overwhelming majority of patient's comments are very positive. Staff are frequently described as being kind towards patients and towards each other, going beyond the expected level of care.

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

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

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

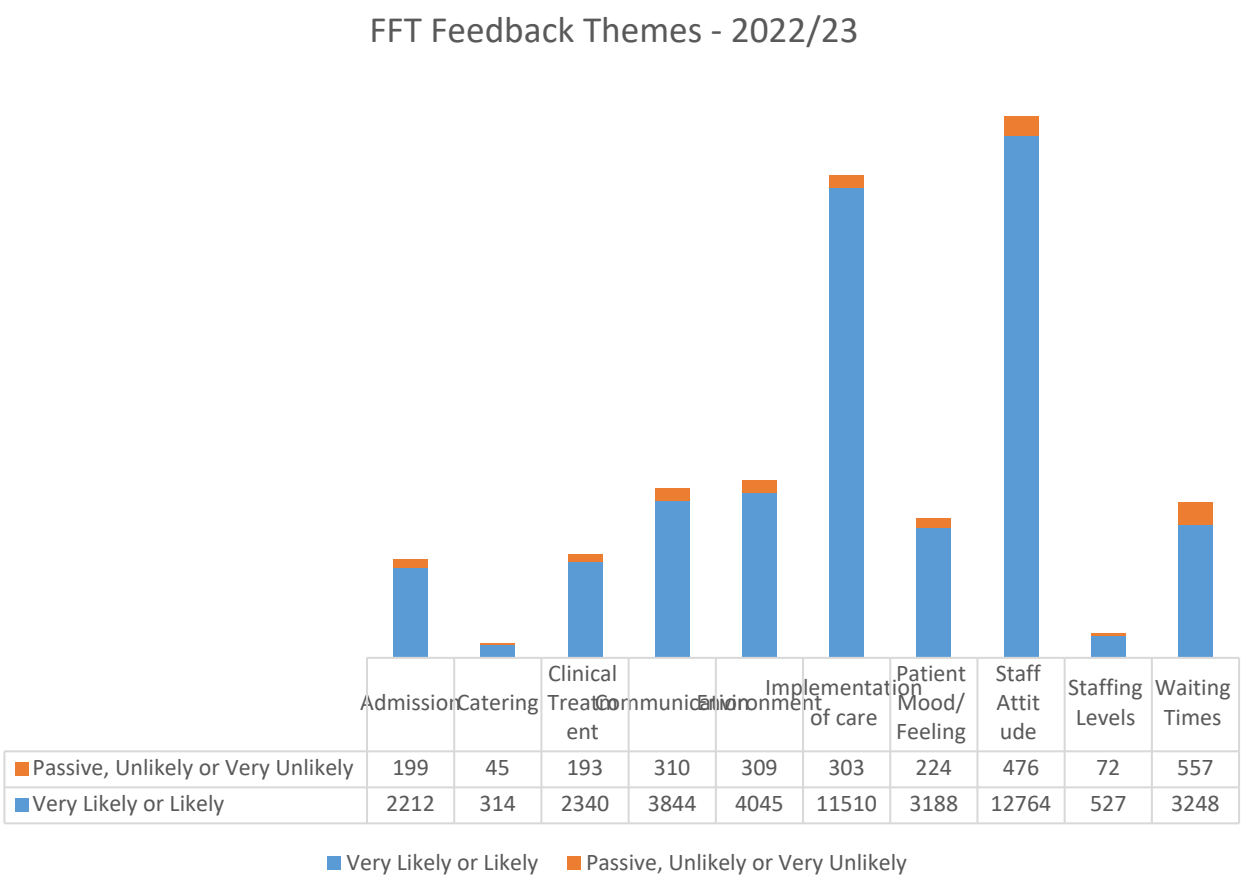
[1] NHS England & Social Care England. The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009)

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

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

Between April 2022 and March 2023, we received **29,442** responses to the FFT, with over **23,000** comments given. This represents an increase of **11%** in the responses we are being given and over 1000 more comments to consider. The overall percentage of inpatients recommending (very likely or likely) was **99%** and all of our results bettered the national average for the period.

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



	Admission	Catering	Clinical Treatment	Communication	Environment	Implementation of care	Patient Mood/ Feeling	Staff Attitude	Staffing Levels	Waiting Times
Passive, Unlikely or Very Unlikely	199	45	193	310	309	303	224	476	72	557
Very Likely or Likely	2212	314	2340	3844	4045	11510	3188	12764	527	3248

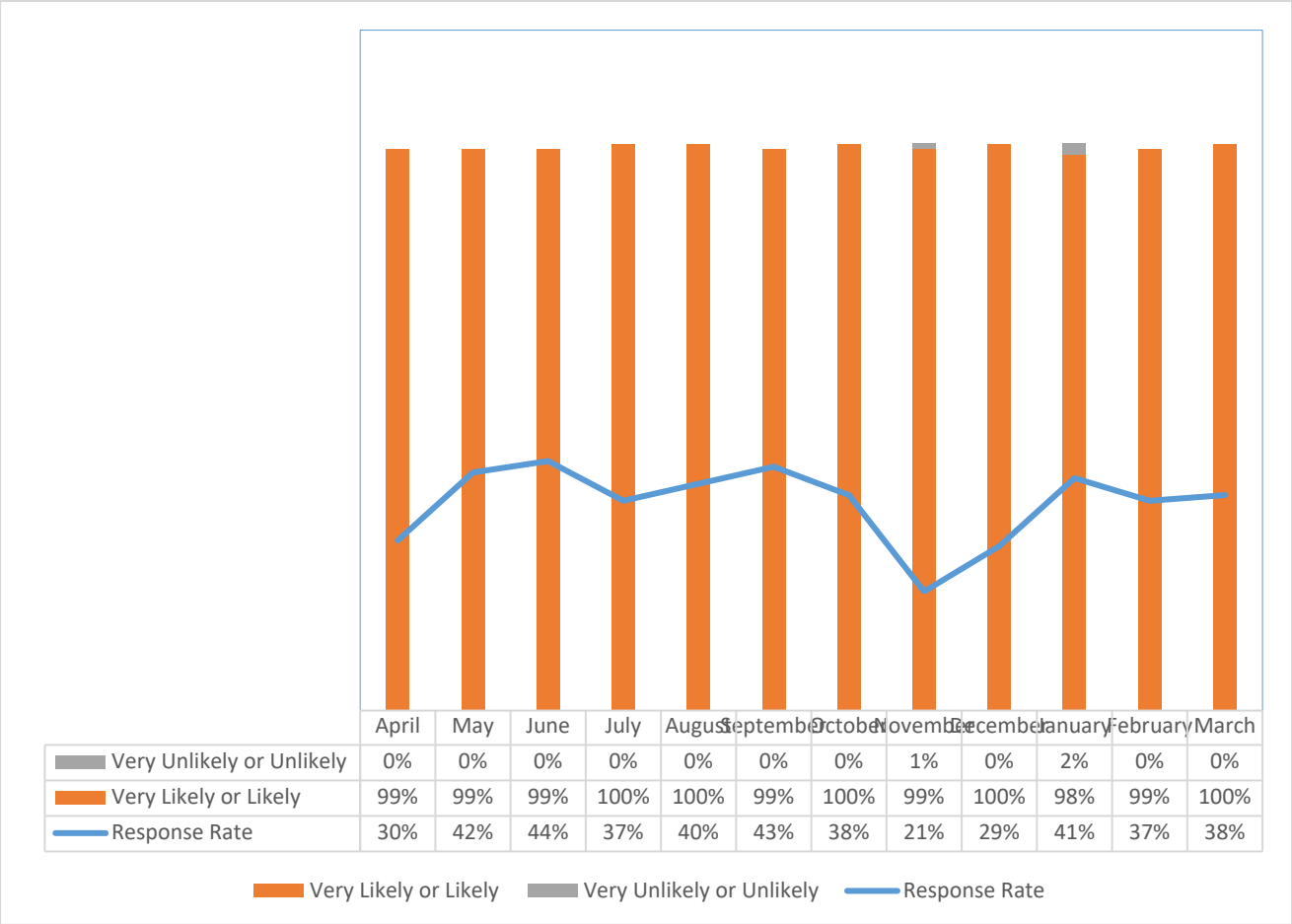
As with previous years, the vast majority of our patients are more than satisfied with the high standards of care they receive, citing the friendliness, helpfulness, excellence, clinical outcomes, professionalism and overall very positive patient experience.

Where patients felt their visit could have been improved were how staff behaved, and how they were communicated with and treated in the context of perceived delays and prolonged waits.

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

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

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



	April	May	June	July	August	September	October	November	December	January	February	March
Very Unlikely or Unlikely	0%	0%	0%	0%	0%	0%	0%	1%	0%	2%	0%	0%
Very Likely or Likely	99%	99%	99%	100%	100%	99%	100%	99%	100%	98%	99%	100%
Response Rate	30%	42%	44%	37%	40%	43%	38%	21%	29%	41%	37%	38%

3.2 How do we report it?
Patient feedback, both from FFT and real time patient experience surveys are routinely provided directly to ward and department managers on a monthly basis which include individual comments. Depending on the sample size, some feedback is provided quarterly. Key metrics are included in the quality scorecard provided to the Trust Board. Each ward displays the FFT score for that ward for patients and staff to see.

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

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

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

5. National inpatient Survey 2022
The survey is well underway and results awaited. They are not available at this time. The latest National Inpatient Survey results can be found on the QVH website and were shared in last years' annual report. This will be updated when new results are made available.

6. Patient Story at Board
Stories can help build a picture of what it is like to be in receipt of our services and how care can be improved or best practice shared. It is a way of ensuring that individual experiences are shared to highlight an area of improvement that will impact on patients.

Bi-monthly a patient, service user or carer attends a Trust Board supported by the Patient Experience Manager to share their story directly with the Board. The Board are keen to hear the lived experience of those sharing their story and by listening to those in receipt of our services, or caring for a loved one in receipt of our services, they gain a real insight into the direct thoughts and feelings of our patients.

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

From April 2022 to March 2023, we had **5** patients attend the Board and present the following stories:

- Improvement opportunities in the skin, maxillofacial and MIU departments from patients, and their relatives, who attended surgery and recognised additional support that could be provided.
- Positive and very personal experiences of attending the skin and maxillofacial departments from patients and their relatives who wanted us to recognise what we had done well.

All Board meetings have had a patient attend to share a story except unfortunately where one patient was unable to join due to a technical error with the virtual meeting room. They attended the next Board meeting in person.

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

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

Hotel Services are an active member of the group in the process of reviewing service criteria in light of cleaning standards and any audits. They highlight the required action impacting

upon the level of current service and to share best practice.

The role of PEG is to:

- Advise the Trust on issues of concern to patients
- Form patient/representative led working groups to help develop priorities for action and ensure regular feedback on outcomes of actions
- Help develop Trust strategies, appraise information for the public developed by the Trust and help determine priorities for patient engagement
- Consider service changes and participate in a range of schemes to gather patient/ carer intelligence on Trust services including surveys, audits and inspections.
- Monitor trends in complaints and feedback
- Ensure the effective implementation of action plans arising from individual local and national surveys
- Share and promote good practice in connection with patient experience

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

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

8. Complaints

This section provides a summary of formal complaints received between 1 April 2022 and 31 March 2023 in accordance with the NHS Complaints Regulations (2009). This includes:

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

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

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

The Trust uses the following definitions:

- Complaints are expressions of displeasure or dissatisfaction where the complainant wishes a formal investigation to be undertaken;
- Concerns are issues that are of interest or importance affecting the person raising them, including displeasure or dissatisfaction and where the complainant is content for the issue to be dealt with via the PALS route;

- Feedback is information/suggestions about care or services that we provide, which may be complimentary or critical;
- Compliments are expressions of thanks and praise.

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

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

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

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

8.1 Standards for complaints management and escalation

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

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

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

8.2 Complaints Received

From April 2022 to 31 March 2023 we received **62** formal complaints, which is an increase of 8 from the previous year (56 complaints) and aligns to local and national trends of increasing complaints being received.

Throughout this period the Trust was focused on picking up services to pre COVID-19 pandemic activity levels and managing backlogs. This activity has seen some services

receive a significant increase in their patient numbers and in turn that increase has undoubtedly led to further feedback, concerns and complaints being received.

The main themes of the complaints are related to perceived delays or prolonged waits for clinical treatment, appointments, surgery and in relation to the Trust's values and behaviours amongst staff.

All complaints are managed individually with the complainant and in a manner best suited to resolve the particular concern raised. Methods of response can include a written response from the Chief Executive, a face to face or virtual face to face resolution meeting with relevant staff and later, potentially if unresolved, an independent review of the care provided.

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

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

All complaints should be acknowledged within 3 working days. In this period, 95% of complaints were acknowledged within 3 working days for the period and a significant improvement on last year. The Trust endeavours to respond to all complaints within 30 working days in an honest, open and timely manner. If it is clear on receipt of the complaint or at any point during the investigation that the investigation cannot be completed on time, for example when a complaint is more complex or requires a joint response from services/organisations a new timeframe will be agreed with the complainant.

During this period the Trust managed 89% of complaints within timescales (30 working days) which is a significant improvement on last year but remains far below the target of 95% that the Trust strives to achieve.

The main reasons for a late response are specialty or clinical delays with the investigation. This is similar to findings of previous years and may have been affected by workloads and conflicting priorities. This is being monitored by the Patient Experience Manager.

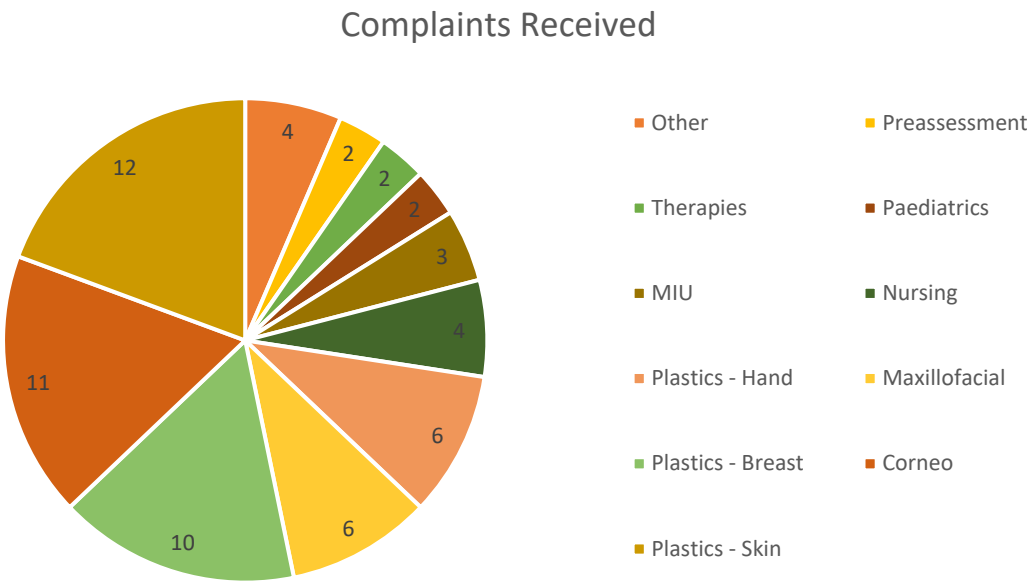
The Trust is committed to learning from any complaint received and considerable focus is placed on this aspect of the complaints process. We try to ensure that all complaints are robustly investigated and that, where action is needed to improve the care or service a patient receives, this is reflected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

The services have systems in place to ensure they learn from complaints and additionally they identify actions in a timely way to improve the experience of future patients. Every

reasonable effort is made to resolve complaint at a local level; this involves prompt correspondence and meetings with complainants.

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

All new staff have received a condensed session about customer care and handling concerns at the Trust induction programme and a training leaflet was enhanced to accompany this training.

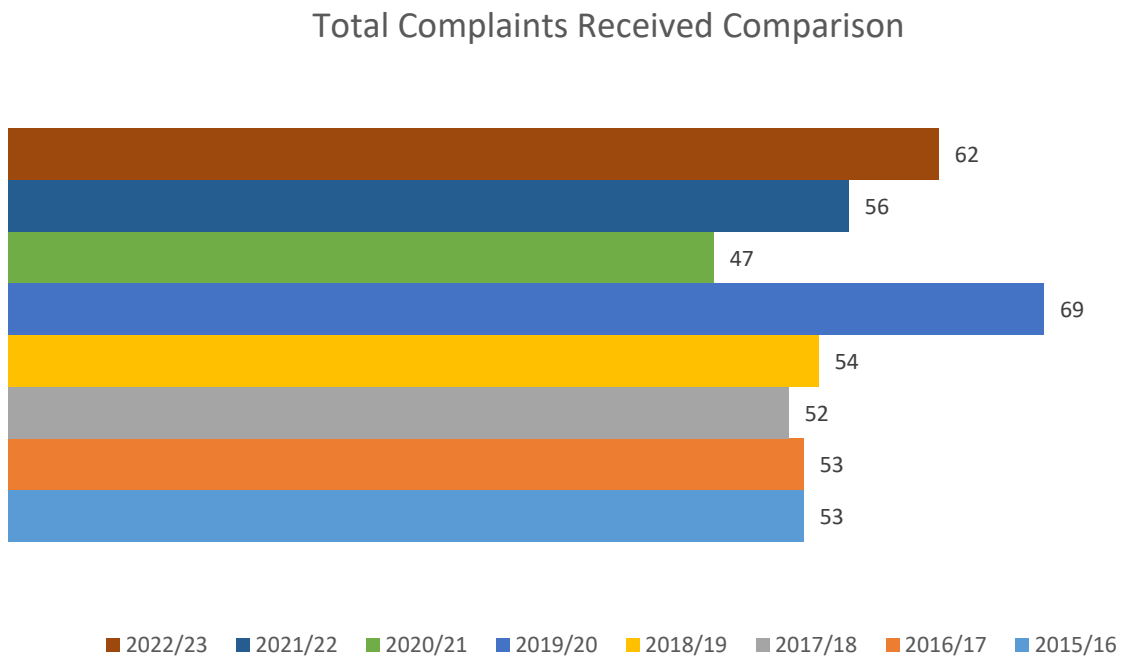


The chart above shows a breakdown of the complaints received this period by specialism. Only those areas where more than one complaint was received are noted. All other areas are captured in another category.
During this period our plastic surgery specialism has been broken down further into subcategories.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

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

Specific business unit meetings have also been arranged this period on a quarterly basis with key service areas. This is to ensure that learning from complaints and other patient experience information is part of a continuous improvement approach to our services. Other service areas are met with on an ad hoc basis when the information generates discussion topics.

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

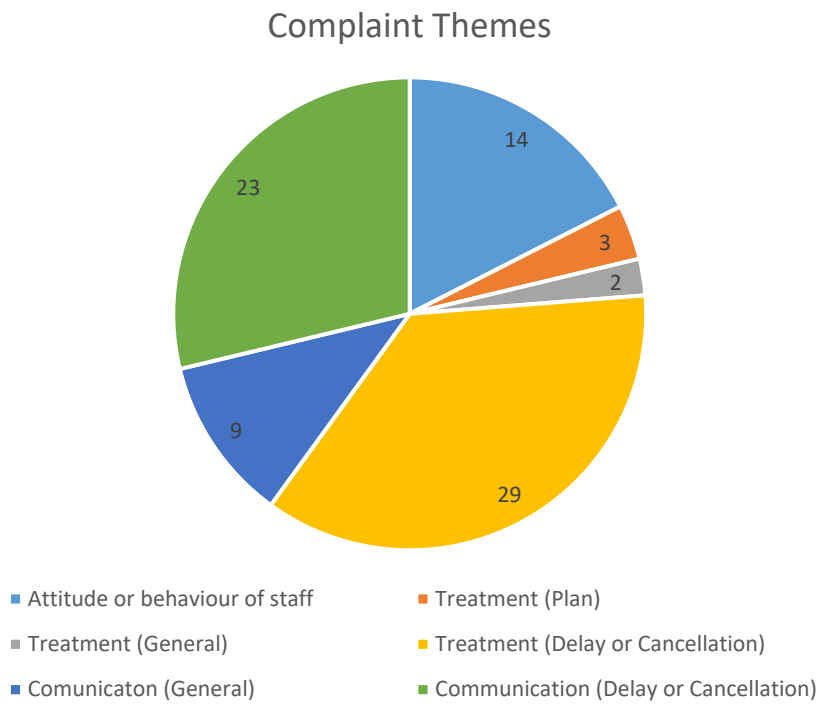


8.3 Investigation outcomes

The following information is displayed without specialism or distinction between different teams such as nursing and medical. Additionally, treatment has been broken down into general, cancelled and plan (i.e. concern raised about the treatment plan offered/not offered and options considered) subcategories. For the purposes of the categorisation, surgery and appointments have been considered treatment.

Presentation of this information is to align to the changes made last year to make the information easier to understand at a glance and show commonality of themes that have been identified within investigations over this period.

Please note that one complaint can have multiple aspects to it (for example, a communication and treatment concern).



On completion of a complaint investigation, we state whether a complaint has immediate actions, incidental learnings or both within our reporting suite. Establishing the lessons from a complaint removes the stigma sometimes associated with a complaint and focuses on the learning it provides. Identifying this information helps us to better understand any training needs and the demand for any changes identified throughout the complaint investigation.

Complaints received during this period included the following themes and whether the complaints provided an immediate action or incidental learning:

- The **sixteen** complaints that identified immediate actions included concerns relating to service failure. This is categorised for example as behaviour complaints that left patients unhappy.
- The **nine** complaints identified as some immediate actions and some incidental learnings were categorised as such due to clear concerns about a patient's experience being poor. This included poor communication, when aspects of the service were performed correctly and accurately but expectations not being met.
- The **twenty six** complaints that identified incidental learnings were concerns that were objective with examples like the offer, or not, of treatment. Incidental learnings were identified through the complaint investigation to improve services in conjunction with the feedback presented.
- There were **three** complaints received that were withdrawn.

There were 54 complaints closed in this period.

8.4 Learning from complaints, concerns or feedback

There is an organisational emphasis on both quality and timeliness of complaint handling which is re-enforced by the Board.

All complaints, together with their respective responses, are quality/accuracy checked and challenged by the Chief Executive and Head of Risk, Clinical Quality and Patient Safety.

As complaints reflect a personal experience, and the number received is relatively small, it is difficult to be precise about any common themes. Most complaints are communication issues and the negative impact this has had. This may be recognised as a communication point but sometimes this is fed back with regards to perception of treatment. Poor attitude and behaviour is a trigger for a complaint when staff do not display empathy and compassion or are abrupt and do not appear to be willing to give the patient the voice to speak. Complaints of this type are more apparent in the outpatient setting. Cancelled elective admissions and the rescheduling of outpatient appointments escalate to a formal complaint when patients cannot be given an early resolution or dates are not considered appropriate.

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

Below are examples of actions and learning identified from complaints:

- Those with learning disabilities have been identified as a patient group we can assist further. A working group has been formed to consider this and improve our service offer.
- Appointment letters are being enhanced to provide greater access to all our patients and provide a standardised approach across the hospital.
- Additional support and guidance is available to members of staff. The pandemic and backlogs has increased demands on us and we recognise that supporting our staff to help them in their lives leads to them providing a better service to our patients.

8.5 Further analysis of formal complaints

- None of the **62** patients who had raised a formal complaint, approached advocacy services to support them through the complaints process.
- The Trust received no requests for a complaint response in large print or braille.
- As in previous years, all formal complaints were received in the English language with no requests made by a complainant (or enquirer) for the assistance of the Trust's Interpreting Service.
- The Trust did not receive any formal complaints where the complainant stated that they had further support needs.
- In line with the Duty of Candour (November 2014) the trust investigation responses have been scrutinised to ensure they are open and transparent. Where it has been established that errors occurred, this was shared with the complainants and an apology given and lessons identified to enhance learning for the Trust.

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

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

8.7 Parliamentary and Health Service Ombudsman (PHSO)
A complainant may refer their complaint to the PHSO if they do not feel that the Trust has responded to all of their concerns or they are unhappy with the way in which we have dealt with their complaint.
The PHSO gives the Trust the opportunity to ensure that all local resolution has taken place to try and resolve the issues and will give an independent view on the complaint.

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

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

They might partly uphold a complaint if:

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

If not upheld this could meant that they found:

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

There were **three** case referred to the PHSO in this period, **one** was found to be not upheld and **two** are ongoing.

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

The PALS lead (Patient Experience Manager) works closely with the service leads to resolve problems and concerns quickly and effectively. If it becomes clear that the patient wishes to raise the issue as a complaint, the concern is addressed through the complaints process. It is made clear that concerns received from, or on behalf of patients does not affect how they are treated, and are seen as valuable information to help improve services for all patients and carers.

During the period of 1 April 2022 to 31 March 2023, there were **202** PALS enquiries which is an increase of **120%** from last year, and may be attributable, in part, to record keeping improvements made by the new Patient Experience Manager:

- **121** of these were dealt with as issues to be resolved (five of these were referred as a formal complaint or an accompanying concern to a formal complaint).
- **81** of these were for advice and information

The majority of these enquiries were related to appointments and operations being cancelled and rescheduled. Themes were mixed, like complaints themes, where patients recognised their issues as communication, treatment and behavioural concerns.

We continue to build relationships with external partners, other NHS Trusts and local Integrated Care Boards. PALS has also continued to ensure that learning is passed on to members of staff and general managers.

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

10. Website feedback

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

The Patient Experience Manager responds to patients leaving feedback on online forums such as Care Opinion and the NHS website. Over the course of the financial year, 20 comments have been posted.

11. Future Development for the year ahead

- Roll out and embed a patient engagement strategy and standardised patient co-design approach to help shape our services;

- Consistently achieve 90% of complaints managed within agreed timescales;

- Embed the new Patient Experience service changes that have been introduced in this period to enhance and develop the benefits it offers the trust.

We will achieve this as follows:

- Launch a patient engagement strategy
- Roll out the use of a patient centred quality improvement methodology for a consistent recognised approach across the Trust
- Improve the monitoring of complaint action plans post-investigation
- Improve the response timescales by adjusting timeframes to build contingency into 30 working day turnaround, including the necessary quality checks
- Continuing to be open and transparent in complaint responses
- Develop ownership with operational and clinical leads that learns lessons from complaints to embed service improvement

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2023		**Agenda reference:**	**93-23**	
Report title:	Quality and safety assurance				
Sponsor:	Karen Norman, non-executive director and committee Chair				
Author:	Karen Norman, non-executive director and committee Chair Ellie Simpkin, governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of the report is to provide assurance on matters considered and discussed by the quality and governance committee at its meeting on 21 August.				
Summary of key issues	• The committee has reviewed the letter sent by NHS England regarding the verdict in the trial of Lucy Letby, noting actions and further assurance where required • The committee received the antimicrobial annual report 2022/23, taking assurance on progress made. Further assurance was sought on poor compliance with antimicrobial prescribing guidelines, noting the impact of staff vacancies • Deep dive into patient complaints received, noting lessons learned and further actions required • The committee received a verbal update on preparation for Trust's next Care Quality Commission visit, took assurance on progress made and noted risks, where identified				
Recommendation:	The Board is asked to **note** the contents of the report, the assurance where given and risks identified.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	KSO3- outstanding patient experience- quality and supply issues with providers, ongoing workforce challenges KSO2- World class clinical services- restricted facilities to manage more complex patients				
Corporate risk register:	The committee continues to review the patient safety risks.				
Regulation:	Health and Social Care Act 2008 CQC standards of quality and safety				
Legal:	As above				
Resources:	None				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	21/08/23	Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	93-23
Date of meeting:	07 September 2023
Report from:	Karen Norman, non-executive director and committee Chair
Report author:	Karen Norman, non-executive director and committee Chair Ellie Simpkin, governance officer
Date of report:	23 August 2023
Appendices:	None

Quality and governance committee assurance

Introduction
This purpose of this report is to provide the Board with assurance on matters considered by the quality and governance committee at its meeting on 21 August 2023.

Raising concerns
The committee reviewed the letter sent by NHS England regarding the verdict in the trial of Lucy Letby. Noting the work already being undertaken by the Trust in relation to the implementation of the new Patient Safety Incident Response Framework, there is confidence in the mechanisms and processes which are in place for staff to raise concerns. Discussion was had on the need to create a culture in which QVH staff at all levels feel able to raise concerns, even if they are based on 'a feeling'. Staff should not be afraid of their concerns turning out to be unfounded. It is important that feedback is provided to staff who raise concerns to create confidence that they are taken seriously and listened to. The committee recognises its role in seeking assurance in this area on behalf of the Board and will be giving further consideration to the actions which QVH is taking to ensure a culture of openness and accountability.

Patient experience
The Trust received twenty three formal complaints during quarter one 2023/24. The main themes are treatment, perceived delays and staff behaviour. No cases were reopened or referred by the Parliamentary and Health Service Ombudsman (PHSO) for consideration during this period. The Trust has an overall inpatient Friends and Family Test (FFT) recommendation rate of 99%.

The committee considered a deep dive into the patient complaints which had been shared at Board in May and July 2023. The report summarised the learning and improvements to processes identified, acknowledged that there is further work to do on the culture within the organisation and noted the development of the patient engagement strategy. The importance of ensuring that the policy for having 'conversations of concern' with staff is being followed was raised. The committee has asked that relevant policies are reviewed to ensure that the framework for addressing staff behaviour can be applied equally to all clinical and medical staff. Further assurance was sought on the triangulation of information and that processes are being applied consistently.

Antimicrobial annual report 2022/23
The committee received partial assurance that antimicrobial stewardship activities are embedded at QVH. The use of restricted antimicrobials is monitored and national antibiotic shortages have been managed without compromising patient care. There is ongoing work to reduce the total usage of antibiotics and improve clinician engagement with antimicrobial stewardship. The lack of an antimicrobial pharmacist has impacted on the ability to progress these improvements. There is concern that

further audits of compliance with drug chart documentation are not being completed due to a lack of staff resources. Consideration needs to be given to how the antimicrobial steering group can be further supported to progress improvements to compliance with antibiotic prescribing. Further assurance was sought on the provision and monitoring of the microbiology services contract.

Clinical quality and patient safety
There have been no new serious incidents declared. Following investigation, a request to downgrade an incident declared has been agreed and two incidents have been approved and closed by the Integrated Care Board scrutiny committee.

The committee received an update on clinical harm reviews. The 2021 clinical harm reviews are 99.5% complete and 89% of the 2022 patient cohort has now been reviewed with one case identified as severe harm which was investigated and confirmed as unavoidable. 43% of the 2023 cohort (from 1 January to 31 July 2023) have been reviewed with no cases of severe harm identified. The medical director advised that further work with NHS Sussex on the harm review tool is underway to improve its effectiveness.

Care Quality Commission (CQC) preparation
Preparation has commenced with work streams on evidence and information, staff engagement, and awareness and preparedness. The committee will consider how to ensure the Board is prepared ahead of the next CQC visit.

Risk
Recognising that improvements to corporate risk process are ongoing, the committee emphasised the importance of ensuring that risks are regularly reviewed and updated.

Other
- The committee has undertaken its annual effectiveness review and will consider the feedback and action at its seminar in November 2023.
- Positive progress is being made against the Trust's quality priorities for 2023/24.
- All Commissioning for Quality and Innovation (CQUIN) indicators were achieved in quarter one 2023/24.
- The committee received the infection prevention and control report for quarter one 2023/24, noting that no updates have been received on progress made on the risk relating to antimicrobial prescribing.
- The committee is not yet fully assured on the concerns in respect to surgical patients who do not fall under the referral to treatment waiting time targets. Further information on this will be provided to the committee at its next meeting.
- Further assurance on the prosthetic waiting list was also sought.

Recommendation
The Board is asked to **note** the contents and recommendations of the report, the assurance where given and the risks identified.