Bundle Public Board 11 January 2024

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143.24 Quality and safety report

Nicky Reeves, Chief Nursing Officer
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144.24 Any other business (by application to the Chair)

Jackie Smith, Trust Chair
Discussion

145.24 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

Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 11 January 2024

Session in PUBLIC
10.00-12.00
Education centre (location 40), QVH

MEMBERSHIP
BOARD OF DIRECTORS
January 2024

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
Chief Executive Officer	-	James Lowell
Medical Director	-	Tania Cubison
Chief Nurse	-	Nicky Reeves
Chief Finance Officer	-	Maria Wheeler

In full attendance (non-voting):

Chief Strategy Officer	-	Abigail Jago
Director of Communications and Corporate Affairs	-	Clare Pirie
Interim Chief People Officer	-	Rob Stevens
Interim Director of Operations	-	Kathy Brasier
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
James Lowell Chief Executive Officer	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)								

Abigail Jago Chief strategy officer	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
Kathy Brasier Interim Director of Operations	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
James Lowell Chief Executive Officer	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)							
Abigail Jago Chief Strategy Officer	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
Kathy Brasier Interim Director of Operations	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 11 January 2024
10.00-12.00

Agenda: session held in public		
WELCOME		
127-24	**Welcome, apologies and declarations of interest** *Jackie Smith, Trust Chair*	
STANDING ITEMS		**Purpose**
128-24	**Patient story**	*Assurance*
129-24	**Draft minutes of the public meeting held on 2 November 2023** *Jackie Smith, Trust Chair*	*Approval*
130-24	**Matters arising and actions pending from previous meetings** *Jackie Smith, Trust Chair*	*Review*
131-24	**Chair's report** *Jackie Smith, Trust Chair*	*Assurance*
132-24	**Chief Executive's report** *James Lowell, Chief Executive Officer*	*Assurance*
GOVERNANCE, STRATEGY AND RISK		
133-24	**Freedom to Speak up Guardian report** *Sheila Perkins, Freedom to Speak Up Guardian*	*Assurance*
134-24	**Strategic case for change and options** *James Lowell, Chief Executive Officer* *Abigail Jago, Chief Strategy Officer*	*Approval*
135-24	**Audit and risk committee assurance** *Paul Dillon-Robinson, Non-Executive Director and committee Chair*	*Assurance*
136-24	**Board assurance framework** *James Lowell, Chief Executive Officer*	*Assurance*
Key strategic objective 4: financial sustainability		
137-24	**Financial, workforce and operational performance assurance** *Peter O'Donnell, Non-Executive Director and committee Chair*	*Assurance*
138-24	**Financial performance** *Maria Wheeler, Chief Finance Officer*	*Assurance*
139-24	**Annual business planning update 2024/25** *Maria Wheeler, Chief Finance Officer*	*Review*
Key strategic objective 5: organisational excellence		

140-24	**Workforce performance report** *Rob Stevens, Interim Chief People Officer*	*Assurance*
Key strategic objective 3: operational excellence		
141-24	**Operational performance report** *Kathy Brasier, Interim Chief Operating Officer*	*Assurance*
Key strategic objectives 1 and 2: outstanding patient experience and world class clinical services		
142-24	**Quality and safety committee assurance** *Karen Norman, Non-Executive Director and committee Chair*	*Assurance*
143-24	**Quality and safety report** *Nicky Reeves, Chief Nursing Officer* *Tania Cubison, Chief Medical Officer*	*Assurance*
MEETING CLOSURE		
144-24	**Any other business (by application to the Chair)** *Jackie Smith, Trust Chair*	*Discussion*
MEMBERS OF THE PUBLIC		
145-24	**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 2 November 2023** **Education centre, QVH**	
Present:	Jackie Smith	Trust Chair (voting) (Chair)
	Paul Dillon-Robinson (PDR)	Senior independent director (voting)
	Karen Norman (KN)	Non-executive director (voting) (via MS Teams)
	Shaun O'Leary (SOL)	Non-executive director (voting)
	Russell Hobby (RH)	Non-executive director (voting)
	James Lowell (JL)	Chief executive officer (voting)
	Maria Wheeler (MW)	Chief finance officer (voting)
	Nicky Reeves (NR)	Chief nurse (voting)
	Tania Cubison (TC)	Medical director (voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
	Robert Stevens (RS)	Interim chief people officer (non-voting)
	Abigail Jago (AJ)	Director of strategy and partnerships
In attendance:	Leonora May (LM)	Deputy company secretary (minutes)
Apologies:	Peter O'Donnell (POD)	Non-executive director (voting)
Members of the public:	Two members of public (for the patient story), five governors and three members of staff (one for the staff story)	

Welcome

101-23 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board, including JL to his first Board meeting, and those observing the meeting including five governors and three members of staff.

The Chair reminded those observing the meeting that they were not invited to participate in discussions and that there will be an opportunity for governors to ask questions at the end of the meeting.

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

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

Standing items

102-23 **Patient story**

The Chair welcomed the patient and their spouse who had joined the meeting on MS Teams to give an account of their experience of being a patient at QVH.

The patient described a night he had spent on the trauma ward. Three people were shouting and using what he described as offensive language on the ward late at night and despite asking them to be quiet, the issue continued. The nurses explained that there was nothing that they could do and moved the patient to a separate room. He explained that besides this incident, the treatment he received at QVH was exceptional.

The patient suggested that learning from the incident might include some training for the nurses so that they are able to respond to future incidents of this nature in an appropriate and timely way.

NR apologised to the patient and described work completed to date to address the issues that the incident has raised and ensure that it does not happen to another patient. She acknowledged that there is a need to provide de-escalation training to nursing staff and reported that there is now more robust security measures in place, although there is a need

	to understand why security were not called that night. MW agreed to take away an action to ensure that all staff know how to and when to contact security for support. **Action MW.** The Board apologised to the patient on behalf of the Trust, explaining that this is not the standard of care that the Trust would expect a patient to receive at QVH. The Board extended thanks to the patient for sharing their story as lessons can be learnt to improve patient care. [the patient and their spouse left the meeting]
103-23	**Staff story** The Board welcomed the Trust's finance business partner who had joined the meeting in person to give an account of his experience as a member of staff at QVH. The finance business partner explained that during and since the Covid pandemic, he has worked remotely and comes onto site two days per month. He talked about the advantages of this as a disabled member of staff which included flexibility to attend medical appointments, increased energy, increased morale, a better work life balance and a reduction in absence. He thought that the benefits for the organisation might include reduced absence, additional hours worked and cost savings to the Trust and wider recruitment pools. He recognised that team building is more difficult when remote working, and that some post holders are not able to work remotely due to the nature of their role. He described QVH as a family and commended the Trust's IT department for the excellent support that they are able to provide to remote workers. In response to a question, he confirmed that the Trust's VPN system works well. RS thanked the member of staff for sharing their experience of flexible working, which he hopes will encourage other members of staff to make requests. The Board extended thanks to the member of staff for sharing their experience.
104-23	**Guardian of safe working report** TC presented the report to the Board, highlighting that exception reporting is now in place and that there is further work to do to address some of the issues raised. She confirmed that she has no concerns regarding safe working hours currently, and that the fines are related to the staffing model that the Trust currently uses. Discussion was had regarding the format of the report and TC agreed that for future reporting, the detailed report will be included as an appendix and support by a front cover report providing assurance and highlighting issues to bring to the Board's attention. The Board **noted** the contents of the report.
105-23	**Draft minutes of the public meeting held on 7 September 2023** The Board **agreed** that the minutes of the public Board meeting held on 7 September 2023 are a true and accurate record of that meeting and **approved** them on that basis.
106-23	**Matters arising and actions pending from the public meeting held on 7 September 2023** The Board noted that: - 232-23 (gender pay report and actions) is on the agenda and the action can be closed - 80-23 (performance dashboard) is not yet due and will be presented to the Board at a later meeting

	The Board noted that there is important work ongoing on the development of the board assurance framework and corporate risk register and that JL has been engaged in this work as the new chief executive officer. The audit and risk committee are assuring the process and the Board will receive a formal update at its meeting in January 2024.
107-23	**Chair's report** JS presented her Chair's report to the Board, reporting that the Thirlwall inquiry terms of reference have been announced. The areas that the inquiry will consider include 'the effectiveness of NHS management and governance structures and processes… whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include consideration of NHS culture.' It is thought to be likely that QVH will be asked to provide the inquiry with information related to the recruitment of Tony Chambers as interim chief executive for four months earlier this year. The Trust will fully support the inquiry. Discussion was had regarding culture and the Board agreed that it is important to prioritise work related to organisational culture, cultural change and continuous improvement and be proactive ahead of the inquiry finishing. The Board acknowledged that this is work in progress. A Board member raised concern regarding an anomaly within the workforce race equality standards (WRES) report, where an area of concern is highlighted but with no evidence of complaints being logged. JL confirmed that work to encourage and ensure that staff feel safe to speak up is in progress and is a priority, stating that it will be important for the Trust to clearly set out behaviour that it will and will not tolerate, and to ensure that staff who raise concerns do not face repercussions. The Board **noted** the contents of the report.
108-23	**Chief Executive's report** JL presented the report to the Board, highlighting the following: - QVH has scored top in the country in the national inpatient survey, with nursing care and experience of leaving hospital scoring the highest. Patients reported feeling involved in decisions about their cate and knowing what would happen next. He thanked all staff for their dedicated to providing excellent patient care - Industrial action is continuing to cause disruption nationally, and work continues to understand the cumulative impact for patient and staff. He confirmed that a report detailing the cumulative impact of industrial action will be presented to the Board at its next meeting - National waiting lists have now reached 7.75m. QVH currently has no patients waiting more than 65 weeks by the end of March 2024. There are plans to offer capacity to support systems during the winter - The flu and Covid vaccination programme is ongoing - The monthly staff briefing system has been relaunched and the first meeting was focussed on speaking up, sexual harassment, investment into QVH and QVH as an anchor institution - Shane Morrison-McCabe, director of operations retired on 20 October 2023 after 38 years of working for the NHS. JL extended thanks to her for all of her support to the Trust during the Covid pandemic The Board considered and discussed the updates as follows: - A Board member asked what controls are in place during strike action to support junior clinical staff. TC confirmed that there is a nominated consultant for elective activity who acts as a supervisor, and that theatre sessions are being cancelled where required

	- In response to a question, JL confirmed that feedback regarding the speaking up questions from the team brief is still being collated. Staff are having conversations that they might not have had before, but there is still work to do - The Board recognised the need to protect the Trust's ability to continue to deliver excellent patient care with the development of its strategy including the pride staff feel about the organisation including a willingness to learn and reflect - The Board acknowledged the requirement for QVH to provide capacity and support for the south east during winter and recognised the need to balance ensuring that the Trust can manage its own waiting lists and protect patients from harm. JL confirmed that the Trust is participating in system capacity meetings and can identify capacity that it will offer to support. There is a need to ensure that patients across Sussex have the same waiting times The Board **noted** the contents of the report.
Governance and strategy	
109-23	**Strategic development committee assurance** JS presented the report to the Board, reporting that the committee had met three times and that the meetings have been discursive to support ongoing work which is moving at pace. The Board **noted** the contents of the report.
110-23	**Audit and risk committee assurance** PDR presented the report to the Board, highlighting an error in the summary of key issues, which should have read 'improvements needed in contract management'. He reported that the committee will receive assurance that the fit and proper persons framework and policy has been effectively embedded into the organisation at its March 2024 meeting, that the contract management internal audit had received a limited opinion and that the committee have requested a comprehensive plan to address issues and that Azets has been appointed as the Trust's external auditor. CP provided an update regarding the work completed to date on the risk management transformation. The board assurance framework has been restructured around eight key strategic risks with a focus on providing assurance that the risks are being effectively managed. The executive leadership team spend time each week focussing on the development of the board assurance framework and jointly own the document, which will be presented to the Board sub-committees for detailed review and scrutiny. The Board **noted** the contents of the report.
Key strategic objectives 1&2: outstanding patient experience and world-class clinical services	
111-23	**Quality and safety committee assurance** KN presented the report to the Board, highlighting that the number of complaints reported to the committee has increased, and that this is due to waiting times. Discussion was had regarding work completed to date to review the Trust's speaking up mechanisms and further actions to be taken. KN confirmed that the committee reviewed the self-assessment exercise completed and that it had taken assurance from the rigor by which it has been completed, but there are a number of areas identified for further work to be undertaken. The committee recognise that there are complexities to the work, including cultural issues and power dynamics and this requires a sophisticated approach to addressing the issues. NR confirmed that staff are aware of how to speak up but are reluctant to do so. There is a need to provide support to staff to be able to articulate concerns.

	The Board **noted** the report.
112-23	**Quality and safety report** NR presented the report to the Board and reported that there was two serious incidents declared during September 2023, and that one of those will be downgraded. Safe staffing levels have been maintained and there has been a significant improvement in medical turnover rates. The Board **noted** the contents of the report.
113-23	**National inpatient survey results** NR presented the national inpatient survey results to the Board, giving credit to all staff for contributing to outstanding patient care. The Board noted that the lowest score was in relation to feedback being sought regarding quality of care during a patient's stay. NR thought that this might be due to patients not recognising what they are being asked as there is no formal process in place for collecting feedback during stays but that this will be reviewed. The Board congratulated and thanked all staff, recognising the survey results as a great achievement. The Board **noted** the contents of the report.
Key strategic objective 3: operational excellence	
114-23	**Financial, workforce and operational performance assurance** RH presented the report to the Board, highlighting the following: - Productivity improvements are required to release pressure on services and waiting lists and there is a need to speed up the work to take local anaesthetic procedures out of theatres and into procedure rooms to increase capacity - The Trust has made good progress to ensure a break even position at year end, but the NHS as a whole faces significant financial pressure - There are equality, diversity and inclusion issues as set out within the WRES and workforce disability equality standards (WDES) reports, and there is a need to speed up work to address the gender pay gap. There is a need for the Trust to connect all of this work; it is thought that when a zero tolerance to bullying and harassment is embedded, staff will feel safe to speak up The Board **noted** the contents of the report.
115-23	**Operational performance report** JL reported that Kathy Brasier will be taking up the role of interim director of operations from 9 November 2023, and that interviews were scheduled for early December to recruit into the post substantively. JL presented the report to the Board, highlighting the minor injuries unit delivering 99.7% performance against the four hour standard as a success given the increased activity from local primary care services. The Trust is investing in additional staff to increase capacity. The Board noted complex pathways as an ongoing issue and queried whether this can be resolved. JL explained that the pathways are complex due to the nature of the organisation, and that there are some parts which are within the Trust's control. The Trust is reaching out to partners to understand where improvements can be made. The Board **noted** the contents of the report.

Key strategic objective 5: Organisational excellence	
116-23	**Workforce performance report** RS presented the report to the Board. The Board noted that an equality, diversity and inclusion (EDI) group is being set up in order to increase focus on progress against the EDI objectives and action plan. Discussion was had regarding the EDI action plan and requested that focus is given to one or two areas that will have the biggest impact to ensure traction. The Board noted the capability and disciplinary figures as being low in comparison to other organisations. In response to a question, RS explained that giving managers the tools and competence to take forward concerns with staff is important; training is in place but it needs to be supported with cultural competence which the Trust is working on. The Board **noted** the contents of the report.
117-23	**WRES and WDES data and EDI action plan** RS presented the reports to the Board, highlighting areas for concern including reports of bullying and harassment, engagement with work and how staff are appreciated and have confidence that they are treated fairly for career progression opportunities. He acknowledged that there is a lot of work to be done in order to have effectively addressed these issues. He reported that staff are becoming more willing to report disabilities and that the diversity of the workforce is increasing. There is a need to respond to diverse staff needs in order that they feel a sense of belonging and ability to engage. The Board considered and discussed the contents of the reports as follows: - The Board raised concern regarding 30% of black, asian and minority ethnic (BAME) staff saying that they have suffered bullying or harassment, but that there are no records of this being reported. RS reported that the EDI group will support the work to understand the data and drivers to ensure that staff are heard and listened to. The Board agreed that continued focus on ensuring that staff feel safe to speak up is required to drive positive change - The Board noted work completed to date to establish staff networks which will ensure that staff have a safe space to talk - The Board agreed that the EDI action plans should be combined into one to ensure that the Board can effectively monitor progress against actions. The Board agreed with a suggestion that a standing update against the plan is included within the chief executive's report to Board The Board **noted** the contents of the report.
118-23	**Gender pay gap annual report and action plan** RS presented the report to the Board, stating that work has been completed to improve the granularity of information available to enable increased focus on actions. He acknowledged that there has been some improvement in the gender pay gap over time but that more needs to be done. Some of the issues are due to structural challenges within the medical workforce; this requires further analysis and the EDI group will focus on actions that can be taken to address the gap, including flexible working opportunities. The Board raised concern regarding progress made to address the pay gap, and requested benchmarking data from other NHS organisations including specialist trusts in order to understand the scale of the challenge. **Action RS.** In response to a question, RS confirmed that during Covid, clinical excellence awards were applied equally to staff across all trusts. New guidelines are awaited and the Trust will continually review the use of the awards.

	The Board **noted** the contents of the report.
Key strategic objective 4: financial sustainability	
119-23	**Financial performance report** MW presented the report to the Board, stating that the Trust is forecasting a breakeven position for year end. She highlighted industrial action and performance as being key risks to this position. The Trust is meeting its efficiency targets for the current year but this is expected to become more challenging going forward. Capital spend is challenged due to delays related to community diagnostic centre (CDC) and electronic patient records (EPR) projects. The system has a deficit at month six and nationally the NHS is financially challenged. QVH may be asked to provide financial support to the system. In response to a question regarding establishment reviews, MW confirmed that there are vacancies which the Trust is underspending on, and a need to use bank and agency staff to fill them. These vacancies were expected to be filled when the plan was agreed. There are additional pay costs due to industrial action and this is a risk going forwards. The Board sought assurance regarding effective management of the capital programme, noting that there has been challenges to achieving the forecasted plan in previous years. MW explained that the Trust may receive additional income if it can increase its performance. She confirmed that the rest of the capital programme is progressing in line with the forecast and that the Trust had been hopeful that the CDC and EPR programmes would be delivered in line with assumptions within the forecast. MW agreed to provide an update related to the industrial action additional pay cost risk and capital investment at the next meeting. **Action MW.** The Board **noted** the contents of the report.
Meeting closure	
120-23	**Any other business (by application to the Chair)** There was no further business and the meeting closed.
Members of the public	
121-23	**Questions from members of the public and governors** No questions were received from members of public ahead of the meeting. The Chair invited the lead governor to ask questions regarding any of the items discussed during the meeting on behalf of the governors. The following questions were asked and responses given. Question Is there any evidence of repercussions for staff after they have raised a concern? Response There is no evidence that staff have faced repercussions for raising concerns. Conversations with staff have indicated a reluctance to speak up because they think that nothing will change, and a worry that it may have an impact on the future of their career. Question Are the non-executive directors comfortable with the information provided within the guardian of safe working report?

	Response The non-executive directors will be seeking further assurance regarding work schedule reviews and have requested that the format of the report is improved for next time to ensure that it provides assurance and highlights issues. Question Is there an update on work completed to address the issues raised by the patient story at the September 2023 Board meeting? Response An investigation has been completed and there are lessons learnt. New equipment has been purchased and there are other ongoing actions for completion. The Board will receive a report regarding themes emerging from patient stories and action taken to address lessons learnt. The Chair thanked governors for observing the meeting and for their questions. There was no further business and the meeting closed.

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	September 2023	80-23	Performance dashboard	Review performance dashboard and present a revised version to the Board	**JL**	~~**11/01/2024**~~ **April 2024**	October 2023: Ongoing work to review the Trust's performance framework Janaury 2024: The operational performance report has been refreshed and the new reporting dashboard is due to be completed in April 2024	**Pending**
3	November 2023	118-23	Gender pay gap report	Provide gender pay gap benchmarking data from other NHS organisations and specialist trusts to the Board	**RS**	**April 2024**	January 2024: Deep dive being completed into gender pay gap and will be presented to the finance and performance committee	**Not yet due**
4	November 2023	119-23	Financial performance	Provide updates regarding industrial action additional pay cost risk and capital investment (CDC and EPR) within the next financial performance report to the Board	**MW**	**11 January 2024**	January 2024: included within financial performance report	**Complete**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/01/2024		**Agenda reference:**	**131-24**	
Report title:	Chair's report				
Sponsor:	Jackie Smith, Trust Chair				
Author:	Jackie Smith, Trust Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on Chair, non-executive director and governor activities since the last meeting, as well as provide an update regarding the business of the strategic development committee for assurance				
Summary of key issues					
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:	131-24
Date of meeting:	11 January 2024
Report from:	Jackie Smith, Trust Chair
Report author:	Jackie Smith, Trust Chair
Date of report:	3 January 2024
Appendices:	None

Chair's report

Service visits

Since the last Board meeting the non-executive directors have visited orthodontics, peri-operative care and theatres, the information governance team, the cancer team, the corneo clinic and the estates team.

These visits have been completed as part of our ongoing work to connect Board members throughout the organisation, 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.

Other non-executive director activities

The non-executive directors have recently taken part in interviews for the roles of chief people officer and chief operating officer.

I continue to maintain regional and national links. The chief executive officer and I are planning to meet with our counterpart colleagues at NHS Kent and Medway shortly to ensure we maintain this important relationship.

Governors

I continue to meet regularly with our lead governor and deputy lead governor to discuss key issues.

We will now hold bi-monthly informal Council of Governor's meetings in between Board meetings to support governors in discharging their duties, and a governor development day is being arranged to be held during February 2024.

A governor working group for the audit and risk committee is being established.

Strategic development committee

Since the last Board meeting, the strategic development committee has met twice, on 22 November 2023 and 4 January 2024

At both meetings the committee received an update on Trust strategy development. The committee recognises that the timeline is ambitious but that good progress is being made, although there are challenges faced by having a small strategy team.

The committee has commended engagement work completed to date. There have been 345 responses to the online survey, seven workshops, 120 internal meetings and 52 external meetings. In total, 1,857 people have been engaged with the development of the Trust strategy. The committee reviewed independent analysis of feedback received to date at its meeting on 4 January 2024.

The committee noted an impending focus towards communication following the discussion regarding strategic options at the Board meeting on 11 January 2024, and

agree that it is an integral part of embedding the strategy. The committee requested a proposal regarding communication at a future meeting.

The committee is supportive of work completed to date in addressing health inequalities and recognises the need for strong ambition and focus in this area. This will be a development subject for the whole Board at a future seminar.

An update regarding provider collaboratives was presented to the committee in November. The committee supported the proposed direction of travel for integrated working and emphasised the need to be clear about governance and decision making, as well as the need to remain focussed on the Trust's three populations. The governance framework will be considered by the Board.

At its meeting on 4 January 2024, the committee reviewed and approved the strategic case for change. The committee also reviewed the strategic options and agreed to recommend the report to the Board.

The next meeting of the committee will be held on 21 February 2024, and the Chair will provide a further committee assurance report for the Board at its meeting in March 2024.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/01/2024		**Agenda reference:**	**132-24**	
Report title:	Chief Executive's report				
Sponsor:	James Lowell, Chief Executive Officer				
Author:	James Lowell, Chief Executive Officer Michelle Baillie, Communications Manager				
Appendices:	Media update				
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	This report includes: • Delivering Improving Lives Together • Veteran Aware accreditation • Industrial Action • Validating our waiting lists				
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:	132-24
Date of meeting:	11 January 2024
Report from:	James Lowell, chief executive officer
Report author:	James Lowell, chief executive officer Michelle Baillie, communications manager
Date of report:	20 December 2023

Chief Executive's report

Delivering Improving Lives Together

NHS providers are increasingly expected to look beyond their organisational priorities to focus on system-wide objectives, as well as improving outcomes and reducing inequalities for the communities they serve. At the Sussex Integrated Care Board meeting in November, agreement was given to move forward with provider collaboratives, partnerships between two or more NHS Trusts aimed at working together to enhance services for their populations and foster collaboration.

This is an exciting time to be part of a collective system leadership to drive forward these conversations for Sussex and for QVH to help transform our local health system.

Working with primary care colleagues

Along with Abigail Jago, Chief Strategy Officer, we have had positive conversations with our colleagues in primary care around the future development of our neighbourhood strategy. This will bring together our ambitions for our minor injuries unit, community diagnostic centre and primary care with a neighbourhood offering, to benefit our local population.

Specific thanks to our primary care leaders Minesh Patel, Sharon Pruden, Laura Ireland, Alison Lawson, and Layo Osoba who took time out to help us develop the strategy.

Local council meeting

I had the pleasure of attending my first East Grinstead Town Council meeting on the evening of 30 November. There was great support and real interest in our strategic development work. I look forward to sharing more with the council in the future and appreciate the excitement shown by all Council members.

Veteran Aware accreditation

I am delighted that Queen Victoria Hospital NHS Foundation Trust was formally recognised as 'Veteran Aware', just in time for Remembrance Day. The accreditation was given to us by the Veterans Covenant Healthcare Alliance (VCHA), a group of NHS healthcare providers in England committed to providing the best standards of care for the Armed Forces community, based on the principles of the Armed Forces Covenant.

We have a proud military history dating back to WWII so this was a poignant honour for us. Thank you to Tania Cubison, Chief Medical Officer, and colleagues who helped us

gain this important accreditation. The official Veteran Aware plaque is now pride of place next to the Guinea Pig Roll of Honour in our Canadian Wing.

Celebrating our staff
In December I had the honour of presenting NHS long service awards to colleagues from across the organisation who had achieved 10, 15 and 20 year milestones. It is testament to their commitment and dedication that we had a room full of people to recognise, including those who have spent all or the majority of their career so far at QVH. I was also able to present awards to colleagues who had achieved their 25 and 30 year NHS long service. It was humbling to hear how positively they spoke of QVH and their real passion for our organisation.

Thanks to workforce development funding from Health Education England we have been able to offer English support classes for colleagues who have English as a second language.

At the end of December I met with those who have completed the course and presented them with their certificates. The learning opportunity has enabled colleagues to improve their skills and support them developing their careers here at QVH which is a key part of our staff support ambition.

Inspiring the next generation
As an anchor institution, it is important that we forge and maintain strong links with the local community including schools and colleges. I was honoured to accompany Sam Briggs, Principal Speech and Language Therapist, in talking to health and social care students at Oriel High School in Crawley about NHS careers. We shared our own experiences and the different routes you can take, to a receptive audience who described our presentation as “inspiring.” I hope we may see some of the students working at QVH in years to come.

Validating our waiting lists
As part of NHS England's ask to all trusts to validate their referral to treatment (RTT) waiting lists, we have contacted all patients waiting 12+ weeks for treatment to confirm whether they wish to remain on our waiting list. With NHS waiting lists at a record high, it is important that we maximise our elective capacity and make sure we treat patients who still require our intervention in the timeliest way we can. Thank you to everyone involved in this important project.

Industrial Action
Since the last Board meeting there has been two further periods of industrial action taken by junior doctors – three days just before Christmas and six days just into the New Year. Whilst we support colleagues to have the right to take industrial action, we do not underestimate the time and effort staff across our organisation have put in to help plan for this including rescheduling appointments and working to keep our patients safe. Thank you to everyone involved.

To support the system's work encouraging the public to choose services wisely over the periods of industrial action and winter, Nicky Reeves, Chief Nurse, was interviewed for ITV Meridian, which aired on 20 December. It was an opportunity to showcase what our unit can see and also featured one of our patients explaining why they had chosen not to go to an A&E.

Equality, diversity and inclusion (EDI) update
In September, we as a Board recommitted to eliminating racism in our organisation and set our EDI objectives. As part of this we have launched an EDI group which met for the first time this month, and we are in the process of relaunching our staff networks, each with an executive sponsor. We want staff to have a strong personal sense of workplace belonging.

Our NHS Staff Survey response rate hit 58% which included an increase in responses from our nursing and medical workforce. I am also delighted that 52% of our staff have completed the new Oliver McGowan online training as part of our commitment to support people with a learning disability or autism to access effective support and safe, compassionate and informed care. We are also be working towards implementing the NHS Sexual Safety Charter and gaining Disability Confident Leader (Level 3) accreditation.

Flu and Covid vaccinations for staff
So far nearly half of our staff have received their flu vaccination and 32% have had their Covid booster. We are continuing to encourage colleagues to take up the offer as it is an important way to protect themselves, our patients and each other. Our drop-in flu vaccination sessions will continue right through into the New Year, in addition to colleagues across the hospital who have trained as vaccinators. From Monday 27 November to Friday 1 December we also ran an onsite Covid vaccination clinic for staff, volunteers and patients.

Interim changes in the operations directorate
Kathy Brasier has been appointed Interim Director of Operations, following the retirement of Shane Morrison-McCabe. Kathy is on secondment from her role as our Deputy Director of Strategy and Improvement, whilst we have recruited for a substantive Chief Operating Officer. She is joined by Marc Tramontin as Interim Deputy Director of Operations. Marc is on secondment from his role as General Manager Oral, Maxillofacial and Corneo, within the operations team.

Internal Team Brief
The new programme of monthly hybrid staff briefing sessions called Team Brief is well underway. The sessions provide an opportunity for staff to receive information about our hospital in a timely and consistent way. Managers and supervisors are asked to make sure their teams are not only updated but encourage them to have a meaningful discussion about the content, with any questions or concerns fed back for us to follow up or use to shape future sessions.

QVH Charity Christmas challenge
Each year our QVH Charity funds for 24 children and young people who have experienced life changing traumatic injuries to attend an activity weekend. Called CREW (challenging recreational experience weekend), it is centred on building confidence, creating a sense of belonging, and making lasting memories and friendships for the children who attend.

Along with my executive leadership colleagues we committed to running, cycling or swimming 250 miles to raise £250 for CREW, the cost of one child's place. We are delighted to have just hit the £1,000 mark which will fund for four young people to attend. Thank you to everyone who sponsored us as well as colleagues from across our organisation who have been running their own fundraising events to raise as much as we can this Christmas for CREW.

Christmas tree
I am assured it would not be Christmas at QVH without the official lighting of the tree on the front lawn on the 1 December. I was honoured to have the responsibility of pressing the button this year, joined by Bob Marchant, president of the League of Friends. Thank you to all of our colleagues who came out on a very cold Friday afternoon to watch and the wonderful singers from East Grinstead Choral Society who joined us, accompanied by our impromptu QVH staff choir!

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

Report to:	Board Directors
Agenda item:	132-24.1
Date of meeting:	11 January 2024
Report author:	Michelle Baillie, Communications Manager
Date of report:	22 December 2023

QVH media update – October and November 2023

Highlights of the key media coverage QVH received in *October*:

The dangers of hot water bottles

Baljit Dheansa, consultant plastic surgeon, was interviewed for ITV Meridian (featured on the East and West regions) about the dangers of hot water bottles. It comes after reports of injuries from leaking bottles went up nationally by more than a third in the first six months of this year, many caused by bottles over two years old. He explained the types of injuries seen at Queen Victoria Hospital and how to safely use bottles where essential, including checking the manufacturing date printed onto each one.

Final members of the Guinea Pig Club pass away

Tributes were paid in the media to the service and life of the last members of the Guinea Pig Club, Flight Sergeant Sam Gallop and Lieutenant Jan Stangrycuk-Black, who both passed away within a week of each other aged 101.

Queen Victoria Hospital was mentioned as the place where they both received life-changing treatment (and where the club was founded) in a number of national outlets including The BBC, The Times (print and online); The Mirror; The Daily Mail; Forces.net; GB News; and BBC South East Today – which also featured an interview with Bob Marchant, secretary of the club who worked at the hospital alongside Sir Archibald McIndoe. Local radio stations including Meridian FM and Greatest Hits Sussex also carried the news.

Waiting list validation

The Daily Mail featured the news that NHS trusts are taking part in a national waiting list validation exercise, with some of the longest waiting patients being offered the chance to opt to go to another hospital. Queen Victoria Hospital was named in a table of all NHS trusts alongside the number of patients waiting 18 weeks for treatment.

Choosing services wisely

To coincide with the period of industrial action taken by consultants and junior doctors (2-5 October), Queen Victoria Hospital's minor injuries unit was named in proactive media initiated by NHS Sussex, as an alternative to A&E. This was carried by Sussex Express (repeated on Yahoo News) and on the NHS England website.

Imaging arrangement for collaboration

News of an agreement being signed between Surrey and Sussex Healthcare NHS Trust and imaging IT company Sectra, was covered by a number of technical titles including Digital Health and UK Authority. It means the trust will share a common picture archiving and communication systems (PACS) with five others in the region, including Queen Victoria Hospital, which has already deployed the system.

Highlights of the key media coverage QVH received in *November:*

Four hour waiting time
The Argus carried an article highlighting how more than half of NHS trusts in Sussex fell short of their A&E waiting time targets in October. Queen Victoria Hospital's minor injuries unit was mentioned, along with Sussex Community NHS Foundation Trust, for seeing nearly all patients within four hours. The numbers reflect the pressures the local health system is currently facing.

Dangers of fireworks
The Sun spoke to the mum of a Queen Victoria Hospital patient, Tyler Norris-Sayers, about how she hopes that he will one day be able to receive pioneering surgery after losing an eye at a fireworks display. Tyler from Lancashire had several operations at the hospital following the accident seven years ago. The Sun has followed Tyler's progress over the last few years. The article was also featured in The US Sun.

Veteran Aware accreditation
Queen Victoria Hospital gaining Veteran Aware accreditation from the veterans Covenant Healthcare Alliance was featured on the Sussex Express website (repeated on Yahoo News), as well as in NHS Sussex's newsletter. It means the hospital is committed to providing the best standards of care for the Armed Forces community, based on the principles of the Armed Forces Covenant.

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**11 January 2024**		**Agenda reference:**	**133-24**	
Report title:	Freedom to Speak Up Guardian's report				
Sponsor:	Nicky Reeves, Chief Nurse				
Author:	Sheila Perkins, Freedom to Speak Up Guardian				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of this report is to update the Board on the work of the Freedom to Speak Up Guardian.				
Summary of key issues	• The current Speak Up guardian will be standing down during Q4 and plans are in place to address this with no break in the provision of the vital role • The speak up guardian, interim CPO and CN meet on a monthly basis to review cases and triangulate information • Themes from the Barriers to Speaking Up quiz include the "futility factor" and fear of repercussion which have been discussed during December "Team Brief" by the Chief Nurse				
Recommendation:	The board of directors is asked to **NOTE** the contents of this report				
Action required *[highlight **one** only]*	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	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:	NHSE FTSU Board review tool				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:	N/A				

Report to: Board Directors
Agenda item: 133-24
Date of meeting: 11 January 2024
Report from: Sheila Perkins, FTSU guardian
Report author: Sheila Perkins, FTSU guardian
Date of report:
Appendices: None

Freedom to speak up report 01/05/2023 – 30/11/2023

Staff Demographic	
Nursing	5
Allied Health Professionals	0
Medical / Dental	3
Administrative Staff	0
Additional Clinical Services	0

Themes	
Patient experience (no safety issues)	0
Patient experience potential safety issues	1
Staffing levels	0
HR Issues: i.e. compassionate leave / annual leave	2
Bullying/unacceptable behaviour from managers / team leader / colleagues i.*e. not feeling supported when working remotely; feeling unfairly treated; manager unapproachable; colleagues gossiping*	5
Inappropriate treatment from manager / team members	0

At the time of reporting, 2 cases remain open and under investigation (1 individual and 1 team)

Of note, one individual asked not to proceed due to anxieties about repercussions for them however the issues raised are being investigated by the Chief Medical officer and Chief Nurse as part of a datix review and no single individual has been attributed to the review.

The two HR related cases related to pay issues

1 case involved a team, with four individuals speaking with me about an individual manager

1 individual returned, reporting ‘detrimental treatment’ – this is being investigated

Speak up Month October was well promoted and publicised on the intranet and Connect

The Speak Up guardian has visited as many departments and spoken to as many people as possible

During “Speak up Month” a word search puzzle identifying Barriers to Speaking up was distributed and saw the best return rate in 5 years. Following conversations with staff, two main barriers to speaking up were identified: Fear of repercussions for speaking up, and the futility factor, staff believed that nothing would be done.

Reassurance regarding these themes has been addressed during the December “Team Brief” by the Chief Nurse

The Speak Up guardian is always available to attend team meetings

The Chief Nurse, Interim Chief People Officer and Speak Up Guardian meet on a monthly basis to discuss themes and patterns and to ensure there is the opportunity to triangulate the information.

Following completion of the Freedom to Speak Up “Tool Kit”, there is now a designated Non Executive Director lead for Speak Up.

The current Speak Up guardian has been allocated additional hours but will be stepping down from the Speak up role in the early part of Q4. There are plans in place for a new and fresh approach to delivering this vital role.

It is reassuring that staff are able to raise their concerns directly with the most appropriate person, for example a director/manager or via the “tell Nicky” or whistleblowing routes.

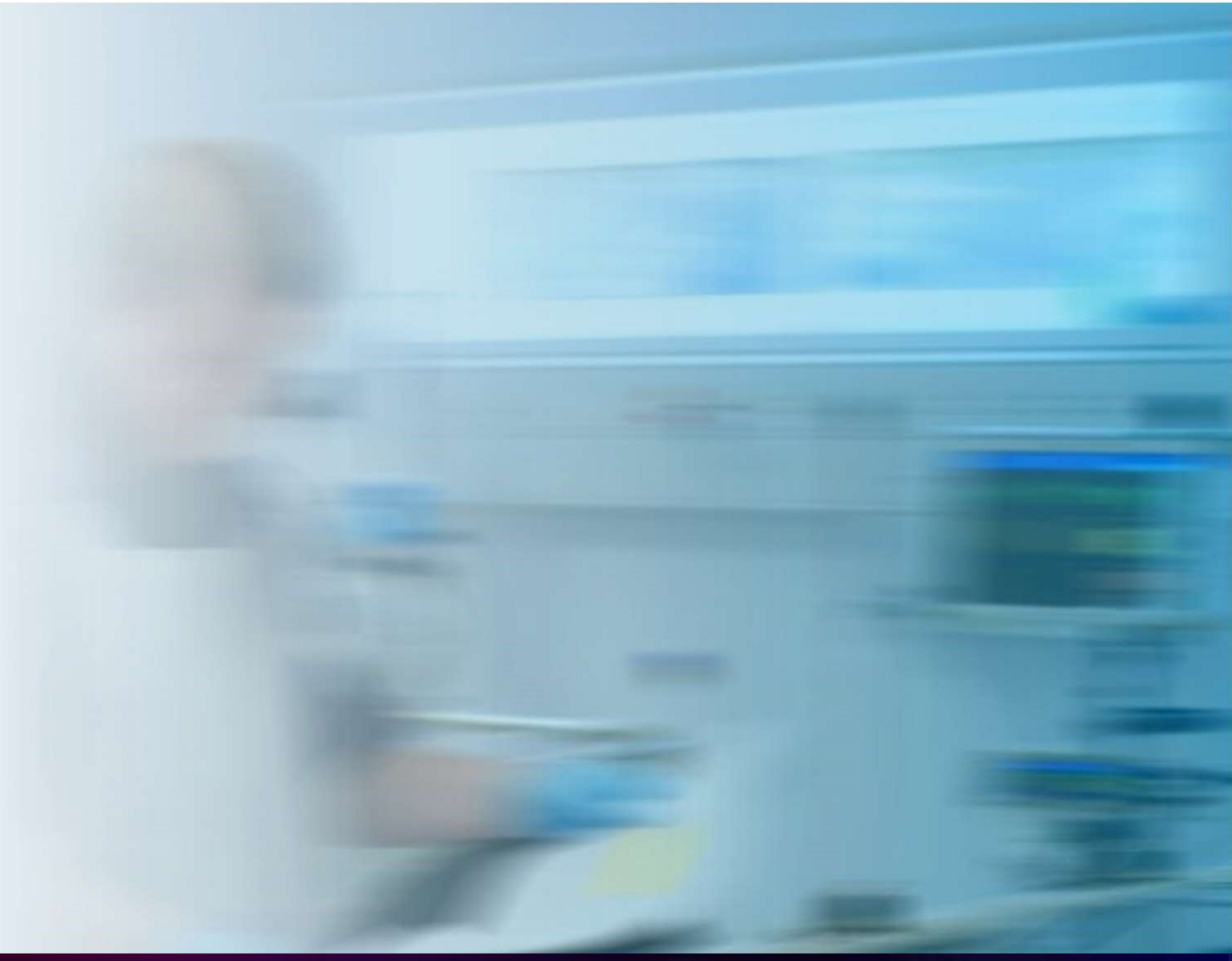
Recommendation
The Board is asked to **note** the contents of the report.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04/01/2024		**Agenda reference:**	134-24.1	
Report title:	Case for change				
Sponsor:	Abigail Jago, Chief Strategy Officer				
Author:	Abigail Jago and executive team				
Appendices:	None				
Executive summary					
Purpose of report:	To present the final version of the strategic case for change for approval.				
Summary of key issues	The case for change is a key document in the strategy development process. The summary sets out why QVH needs to change and drivers for the development of the strategy. The 5 pillars of the case for change include: • Our patients & services • The Landscape • Our People • Our Infrastructure • The Financial Outlook The case for change has been discussed at 2 board seminars, executive leadership team and hospital leadership team as per below.				
Recommendation:	To approve the case for change				
Action required *[embolden **one** only]*	**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:	Implications for BAF 4 and BAF 8 Articulating a clear case for change is key to the development of a sustainable future organisation and associated partnerships.				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	Strategy resourcing for 2023/24 in place				
Assurance route					
Previously considered by:	ELT (7/11/23); HLT (20/11/23); SDC (4/1/2024)				
	Date:	As above	Decision:	Reviewed and agreed.	
Previously considered by:	Board Seminars (November 9th, December 7th 2023)				
	Date:	9/11 7/11	Decision:	Reviewed and agreed subject to minor proposed changes	
Next steps:	NA				

Queen Victoria Hospital
NHS Foundation Trust

A SUMMARY

Why we need to change



Abigail Jago

Final version (10) – 13.12.23

OUR PATIENTS & SERVICES | THE LANDSCAPE | OUR PEOPLE | OUR INFRASTRUCTURE | THE FINANCIAL OUTLOOK

NHS
Queen Victoria Hospital
NHS Foundation Trust

our PATIENTS & SERVICES

QVH achieve **top scores for patient experience**

but there are a number of disjointed pathways

and many patients are waiting too long for their care.

Waiting list has grown significantly with many patients not being treated within optimal timescales; total waiting estimated to reach circa

20,000

by the end of 2023/24

Demand for a number of services including sleep and skin is increasing and we need to

transform how we work to meet need.

Some Trust services **do not meet all national and best practice standards** including paediatric, burns and critical care.

There are **resilience challenges** across a number of clinical and support service areas requiring multiple service level agreements and variable provision

We should have a proactive role in

prevention and prehabilitation

to optimise lifestyle change and support access and waiting well.

Increasing demand for MIU services and substandard accommodation to manage demand.

Research activity within the trust **but** a lack of a formal research & innovation strategy and no formal academic partners.

Queen Victoria Hospital
NHS Foundation Trust

the LANDSCAPE

Growing need for services **nationally**

due to increasing and ageing population, impact of the pandemic and wider determinants of health.

OUR **POPULATIONS**

West Sussex is set to increase **8%** by 2031

with
23% increase in **65+**
28% increase in **85+**
age groups

3% by 2025 **East Sussex** is set to increase

with
8% increase in **65+**
4% increase in **85+**
age groups

Kent is set to increase **8%** by 2028

which is faster than England and the South East region with **28%** increase in **65+**

3% by 2043 **Surrey** is set to increase

By 2030 over **22%** of residents will be aged **65** and over, up 3% from 2018

20 year

gap in healthy **life expectancy** for patients with mental illness or living in deprivation

Life expectancy
> 10 years shorter
for patients living in deprivation, and
30%
of their lives spent unwell with chronic conditions

Changing approach to health and social care delivery (Social Care Act, NHS Long Term plan) - statutory footing of ICBs and shift from competition to collaboration.

QVH must be outward looking, relevant and agile to secure its future and adapt to uncertainty.

Emergent provider collaboratives as the future vehicle for service provision.

Improving Lives Together
Sussex Shared Delivery Plan ambitions.

Fuller (Claire) report and implementation of integrated community teams.

Queen Victoria Hospital
NHS Foundation Trust

our PEOPLE

Exceptional specialist skills and low reported vacancy

But..

Resilience is challenged in some areas.

Strong staff survey results

But..

Need to do more to improve equality, diversity and inclusion, to close the gender pay gap and develop a just and learning culture.

Low staff turnover

But..

We have an ageing workforce and staff tell us we need to improve opportunities for development across all our staff groups.

Innovative workforce plans in some areas

But..

Further work is needed to attract, train and retain our people.

Staff can be supported

But..

We can do more by working in collaboration with others.

Significant education and research opportunities

But..

Lack of supervisory support for some learners and limited research infrastructure.

NHS
Queen Victoria Hospital
NHS Foundation Trust

our
INFRASTRUCTURE

Much of Trust estate is old

- Does not meet patient needs
- In need of constant repair
- Energy inefficient

Many areas of the site have been constructed on a temporary basis and need replacing.

£34m
backlog maintenance required to raise the current estate to the required standard.

The Trust needs to obtain sufficient funding to address this.

£100m
is estimated as investment needed to rebuild the site – annual additional cost implication would be c£4 million per year

In order to attract this level of investment QVH must demonstrate that it is operationally and financially sustainable.

Investment in the region of

£20m
is required to deliver the digital infrastructure – annual additional cost implication of c£3 million per year

This is needed to help transform our services. Revenue funding is needed to support this.

NHS
Queen Victoria Hospital
NHS Foundation Trust

FINANCIAL OUTLOOK

The NHS is struggling financially.

Across Kent, Surrey, and Sussex, integrated care systems are operating at a deficit

Without action the NHS in Sussex will be **£372m** in deficit by 2025/26 and **£645m** by 2028/29.

To avoid this, **every provider needs to** save **5% every year**

For QVH this amounts to

25% or **£25 million**

by 2028/29

NHS in Sussex deficit forecast

40%

of QVH commissioner income comes from non-Sussex ICBs

This will be at risk if we do not work with commissioners to secure ongoing provision of services.

QVH is forecasting **breakeven** this year

but we need to transform how we deliver

so that we do not go into deficit in future years

WE NEED TO CHANGE

Queen Victoria Hospital
NHS Foundation Trust

our PATIENTS & SERVICES

QVH achieve top scores for patient experience but there are a number of disjointed pathways and many patients are waiting too long for their care.

Our waiting list has grown significantly and estimated to reach c. 20,000 by the end of 2023/24.

Demand for a number of services including sleep and skin is increasing and we need to transform how we work to meet need.

Some Trust services do not meet all national standards including paediatric, burns and critical care.

There are resilience challenges across a number of clinical and support service areas e.g. sterile services.

We should have a proactive role in prevention and prehabilitation – to optimise lifestyle change and support access and waiting well.

Increased MIU activity and substandard accommodation to manage demand.

Research activity within the trust but there is a lack of a formal research / innovation and no formal academic partner

the LANDSCAPE

Growing need for services **nationally**, due to increasing and ageing population, impact of the pandemic and wider determinants of health.

Local population (West Sussex) is set to increase by **8%** by **2031** with **23%** increase in **65+** and **28%** increase in **85+** age group.

20 year gap in healthy life expectancy for patients with mental illness or living in deprivation.

Life expectancy **> 10 years** shorter for patients living in deprivation and **30%** of their lives spent unwell with chronic conditions.

Changing approach to health and social care delivery (Social Care Act, NHS Long Term plan) - statutory footing of ICBs and shift from competition to collaboration.

Emergent provider collaboratives as the future vehicle for service provision.

Fuller report and implementation of integrated community teams.

our PEOPLE

Exceptional specialist skills and low reported vacancy but resilience is challenged in some areas.

Strong staff survey results but need to do more to improve equality, diversity and inclusion, to close the gender pay gap and develop a just and learning culture.

Low staff turnover but we have an ageing workforce and staff tell us we need to improve opportunities for development across all our staff groups.

Innovative workforce plans in some areas but further work is needed to attract, train and retain our people.

Staff can be supported but we can do more by working in collaboration with others.

Significant education and research opportunities Lack of supervisory support for some learners and limited research infrastructure

our INFRASTRUCTURE

Much of Trust estate is **old**, does not meet **patient need**, needs constant **repair** & is energy **inefficient**. Many areas of the site have been constructed on a **temporary** basis and need replacing.

£34m backlog maintenance required to raise the current estate to the required standard. The Trust needs to obtain sufficient funding to address this.

£100m is estimated as investment needed to rebuild the site. In order to attract this level of investment QVH must demonstrate that it is operationally and financially sustainable.

Investment in the region of £**20m** is required to deliver the digital infrastructure. This is needed to help transform our services. Revenue funding is needed to support this.

the FINANCIAL OUTLOOK

The NHS is struggling financially. Across Kent, Surrey and Sussex integrated care systems are operating at a **deficit**.

Without action the NHS in Sussex will be **£372m** in deficit by **2025/26** and **£645m** by **2028/29**. To avoid this every provider needs to save **5%** every year.

c40% of QVH commissioner income comes from non Sussex ICBs – this will be at risk if we do not work with commissioners to secure ongoing provision of services.

QVH is forecasting **breakeven** this year but we need to transform how we deliver so that we do not go into deficit in future years.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/01/2024	**Agenda reference:**	134-24.2		
Report title:	Strategic options				
Sponsor:	Abigail Jago, Chief Strategy Officer				
Author:	Abigail Jago, Chief Strategy Officer				
Appendices:	App1 Strategic Engagement Summary / App 2 – Case for Change (see 134-24.1)				
Executive summary					
Purpose of report:	To present the strategic options regarding the high level scope of services for the future Queen Victoria Hospital NHS Foundation Trust and to outline next steps.				
Summary of key issues	Following the decision not to proceed with merger in 2022 QVH needs to develop a clear strategy for its future. This strategy must respond to the national changes to health and care delivery and to local challenges outlined in the proposed case for change. This is critical to ensure long term clinical, operational and financial sustainability. When considering strategic options it is critical to consider the national system within which QVH operates and to be clear regarding the organisational identity and purpose in the future. Following extensive engagement and current state assessment, five options regarding scope of service have been developed for consideration. It is proposed that option 5 – a hybrid model is supported. This option would include the continuation of specialised and regional services (subject to service level review) in addition to developing QVH as a local care provider developing its role in improving the health and wellbeing of the local population and working in collaboration with partners for a defined suite of local services. Following the approval of the proposed option above next steps of the strategy development will include the following: • Review of the impact of the proposed future model for existing services • Consideration of the proposed future model for new services				
Recommendation:	To approve the proposed recommendation and next steps				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	Implications for all BAF risks				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	Strategy resourcing for 2023/24 in place				
Assurance route					
Previously considered by:	Board seminar 7 December 2023, Strategic development committee 4 January				
Next steps:	NA				

Report to:	Board of Directors
Agenda item:	134-24.2
Date of meeting:	4 January 2024
Report from:	Abigail Jago, Chief Strategy Officer
Report author:	Abigail Jago, Chief Strategy Officer
Date of report:	28 December 2023
Appendices:	Appendix 1 Independent engagement summary Appendix 2 Case for change Summary

The Future of QVH - Strategic Options

1 Background and introduction

Queen Victoria Hospital (QVH) is the smallest acute NHS provider in the country. The trust delivers specialist reconstructive, tertiary and secondary care services across Kent, Surrey, Sussex and beyond. QVH also offers a range of services to the local population including a minor injuries unit and a community diagnostics centre. QVH has a history of collaboration with local organisations providing services across a number of 'spoke sites'. The trust is also a key provider in cancer pathways across the health system.

As an organisation QVH has much to be proud of including excellent patient and staff feedback and being held in high regard by many stakeholders. QVH does however have a number of challenges and following the decision not to proceed with merger in 2022 needs to develop a clear strategy to address these to ensure long term clinical, operational and financial sustainability.

2 Strategy development and engagement

In April 2023 QVH commenced work on its future strategy. The work programme includes formation of the clinical services strategy, a suite of enabling strategies (including estates and digital) and also golden thread strategies that set out the trust's ambition in relation to addressing health inequalities, environmental sustainability and its role to support the health and wellbeing of the local population as an anchor institution. The strategy is being developed through a four phase framework and will be launched in September 2024. The phases include understanding the current position, strategy co-design, assessment of options and implementation planning.

Central to the development of the strategy is an ambitious engagement approach. This has been a key focus in order that QVH can draw on a wide breadth of experience, expertise and a full range of perspectives to guide and inform options. To date over 1800 people (internal and external) have been engaged through online surveys, engagement meetings and co-design workshops to gauge 'hopes, fears and ideas' relating to QVH and its future. Over 3000 pieces of feedback have been independently analysed (please see summary set out in Appendix 1).

When considering strategic options it is critical that the purpose of the organisation is well-defined and that it has a clear identity which is recognisable to the NHS, integrated care partnerships (ICPs), populations and the wider community. Furthermore it is essential that QVH as an organisation is relevant to the national and local landscape and that future plans enable QVH to manage the challenges and uncertainty facing the NHS and to deliver the quadruple aim (better health, better patient outcomes, better value and better staff experience).

Following the strategy programme work and engagement to date this paper sets out high level options regarding the proposed scope of services for the organisation. The options will consider the case for change, desirability (the degree to which each option meets the aims and priorities of stakeholders identified through the engagement process), viability (the degree to which each option

is financially viable and sustainable) and feasibility (the degree to which each option can be implemented).

Consideration of individual services will be subsequently considered once the high level scope of provision is determined.

This paper considers 5 options and recommends to the Board the pursual of Option 5.

3 Case for Change

The purpose of the case for change is to set out why change is required and why no change is not an option. It identifies the key drivers for the strategy. The case for change has been developed and agreed with the hospital senior leadership team including clinical directors, general managers and senior nursing leads.

The case for change is based upon five pillars – patients and services, the landscape, people, infrastructure and the financial outlook (please see Appendix 2 for summary version).

3.1 Our patients and services

QVH delivers high quality care which is reflected in the consistent high scores in patient surveys. In 2023 the trust achieved the highest score in the country for the Care Quality Commission inpatient survey. For some patients however pathways are disjointed and waiting times are longer than optimal. Following the pandemic and increases in demand for some services the QVH waiting list is expected to reach c20000 by the end of the financial year. Given the waiting list growth and increases in service demand QVH must look to how patient pathways can be transformed to deliver optimal modern healthcare.

Demand for QVH services is also impacted due to pressures in other parts of the health and care system such as primary care (including GPs and dental services). Transformation of services needs to consider how QVH works with partners to optimally utilise resources to improve both access to services and the health of the population. QVH should also have a proactive role in prevention and supporting the rehabilitation of patients to optimise health outcomes.

There are additionally resilience challenges across a number of key service areas. This is driven in some part by scale, size and operating below critical mass (with some single handed services) but also reflective of the workforce challenges across the NHS. Currently some services are managed through multiple service level agreements which can be disjointed and in some cases not optimal in terms of reliability. For the future, QVH must identity robust arrangements to ensure stability of such services and the strategy development affords an opportunity to rethink how services can be provided.

In considering the provision of services it is important to take into account the organisational contribution to clinical research. Clinical research and innovation is important to ensure ongoing improvements in prevention, treatment and patient outcomes. Although there is research activity within the trust, stakeholders have fed back that more work is needed to ensure that there is a clear research and innovation strategy and a plan to enable the trust to build formal academic partnerships.

3.2 The landscape

Demand for health and care services has grown exponentially in recent years due to an increasing and aging population, impact of the pandemic and wider determinants of health. In the next 20 years the population in the south east is set to increase by 6.1%. By 2043 it is anticipated that there will be an increase of over 36% in the over 65 age range.

There is a similar picture for the local geography. For West Sussex and Kent an 8% population increase is expected by 2031 and 2028 respectively. East Sussex is anticipated to increase 3% by just 2025. Surrey is also expected to see increases, albeit at a slower rate, of 3% by 2043 – however by 2030 more than 20% of the population will be over 65. Demographic changes will have a considerable impact on requirements of health and care services; QVH must have a clear and relevant role in addressing these requirements in the future.

From a national perspective The *NHS Long Term Plan (2019)*, recognises both the ongoing successes of the NHS but also the pressures and challenges. The plan sets out key priorities to tackle three major life stages (start well, live well, and age well) including a focus upon:

- Doing things differently: a new service model for the 21st century
- Preventing illness and tackling health inequalities
- Further progressing care quality and outcomes
- Supporting NHS staff
- Making better use of data and digital technology

Given the challenges there is a changing national approach to the delivery of health and care with a fundamental shift from autonomy and competition to partnership and collaboration. QVH therefore needs to ensure that is operates as an outward looking, collaborative organisation and safeguard its relevance in the new environment. Key to this is the active participation and leadership in the development and delivery of provider collaboratives. In *Working Together at Scale (2021)* NHSE set out how providers should work together in provider collaboratives to improve the health and care of the population. This is different from previous initiatives because collaboration is now a requirement and mandated, rather than encouraged. Provider collaboratives will become a universal part of the health and care landscape across England.

The *2022 Health and Care Act* introduced new legislative measures to support collaboration, including the formalisation of integrated care systems (ICSs), Integrated Care Boards (ICBs) and Integrated Care partnerships (ICPs). The changes in the act mandate all partners across the NHS, local authorities, third sector and local communities to work together meet the needs of the local population. A key premise of the approach is partners working together over smaller geographies including place (e.g. West Sussex) and neighbourhoods (e.g. Mid Sussex or East Grinstead). This is also reflected in the *Fuller (Claire)Stocktake* report which recommends a move to teams of professionals working together to support the health and care of the respective population. Consideration of the 'populations' served by QVH is therefore critical in the development of the future strategy.

The changes at a national scale are reflected within the local health and care systems with a focus on start, live and age well across the geography of all QVH services. From a Sussex Integrated Care System perspective QVH holds a key role in the implementation of the *Improving Lives Together (2022)* shared delivery plan. This has a clear ambition to improve health and health outcomes for local people and communities, to work better and smarter to get best value out of funding, to do more to support communities socially and economically and to tackle health inequalities. The implementation of 16 integrated community teams is a key part of this as is the formation of two provider collaboratives.

The impact of health inequality is significant; patients living in deprivation or those with serious mental illness live on average 10 years less than the general population and live up to one third of their lives spent unwell with chronic conditions. Healthy life expectancy variance is 20 years. These are unacceptable differences and QVH must have a role in the future to work with system partners to close this gap.

In summary given the changes at a national and local level QVH must change to ensure that it is outward looking, relevant, agile and secures its future.

3.3 Our people

QVH benefits from the exceptional specialist skills, commitment and hard work of its staff. Turnover and vacancy is low compared to peers and staff survey results are strong. However the trust has challenges with recruitment in key areas and feedback from staff highlights that there is more to do to improve equality, diversity and inclusion, to close the gender pay gap and develop a just and learning culture.

Despite the outstanding commitment and hard work of staff the continuing deterioration in QVH's ability to recruit to clinical posts in key service areas has resulted in operational challenges. This can in some areas create an over reliance on temporary staffing to address recruitment issues and results in substantial and escalating costs as well as decreasing stability, continuity and consistency.

There are also challenges in regard to an ageing workforce - currently 28.20% of the QVH workforce are aged over 55, an increase from 26% the previous year; 3% of the workforce are over 65. Staff have fed back through the engagement process that further work is needed to ensure that improvements are taken forward to deliver development opportunities across all staff groups to attract and retain staff. As a small organisation career opportunities can be limited and so QVH need to optimise the opportunities of working with system partners to support development and careers to ensure appropriate workforce and skillsets for the future. Staff satisfaction is key to ensure delivery of the very best patient care.

Similarly given national shortages in key workforce areas it is important that QVH is able to be innovative in regard to new roles – there are examples of innovation in this area such as theatres however these tend to be in pockets and small in number and so more needs to be done systematically to develop opportunities. There is particularly an opportunity to recruit locally, train new roles and to offer more though working with partners. Staff have fed back that for some, leaving the organisation is necessary in order to progress. There is both a need and an opportunity to work differently.

As a specialist hospital there are significant opportunities for research, innovation and training however there is a lack of supervisory support for some learners and staff feedback highlights that the trust could have a greater level of ambition and infrastructure to support research output and innovation.

As QVH looks to its future it is critical to build on current successes and deliver a step change in the future workforce planning.

3.4 Our infrastructure

The infrastructure of the hospital estate is incredibly challenged. The site provision has grown organically over the years with the addition of multiple 'temporary buildings'. This has resulted in hospital buildings that are not fit for purpose and that have significant backlog maintenance challenges. A recent estate survey identified that over the next five years there is a £34 million backlog maintenance requirement to bring the estate to a required standard. The trust needs sufficient income to be able to address these challenges.

Given the scale of the estate requirements it is crucial that QVH is developing a future strategy that enables alternative solutions to the infrastructure provision. One ambition would look to optimise the available hospital site for a new fit for purpose hospital building and associated facilities. Estimated costs for this are approximately £100 million. If the organisation were to be successful in achieving this funding additional income of £4 million per annum would be required to manage the revenue cost implications.

Investment in buildings infrastructure would not only provide an improved environment for patient care more generally but would also enable the provision of facilities to meet the requirements of patients with complex needs which is not currently the case in all areas – for example disabled

access and provision. Fit for purpose facilities also offer the opportunity to design efficient and modern patient pathways that enable optimised productivity and access,

There is additionally significant opportunity to improve the digital and data infrastructure within the organisation. This is a key area of national (as set out in the *NHS plan*) and local (as set out in *Improving Lives Together*) priority.

Significant digital infrastructure is required to deliver digital maturity and to ensure optimum patient care and staff experience. Addressing the current digital infrastructure priorities is estimated to require future investment of £20 million. Again to be able to afford the annual implication of the investment additional income of around £3 million would be required.

QVH must have a clear strategic plan to be able to address the challenges and in doing so galvanise the opportunity to materially change the delivery of healthcare improving both patient and staff experience and optimising productivity.

3.5 Our financial outlook

The NHS continues to face rising cost pressures and is struggling financially at both a national and local level. Across Kent Surrey and Sussex all integrated care systems are operating at a deficit. Without intervention and action the NHS in Sussex will be £372 million in deficit by 2025/26 and £645 million in deficit by 2028/29. To address this deficit every provider in the system needs to save 5% every year. For QVH this amounts to 25% or £25 million by 2028/29. Given there will not be additional NHS funding working as a system is critical to organisational sustainability.

QVH has historically had financial challenges however is now in a stronger financial position due to changes in the national financial framework and for 2023/24 is forecasting a break even position. Given the scale of future efficiency and saving however QVH must materially transform services to ensure that the organisation is not in a deficit position in future years.

QVH services has historically been funded by a range of commissioners including NHSE dental and specialist commissioning. 40% of QVH income is through non Sussex ICBs. It is critical that QVH, through the development of the future strategy, work with commissioners and ICBs to ensure the ongoing provision and funding of services. This is particularly important given the uncertainty of changes and devolution of national commissioning including specialist commissioning to Integrated Care Boards

In summary the case for change sets out the key drivers for the strategy and why QVH needs to change. These drivers are considered in review of the high level options for the organisation.

4 Developing our high level strategic options

When considering strategic options as an organisation it is critical to consider the national system within which QVH operates. There are several 'types' of recognisable NHS providers including acute providers, ambulance providers, community providers, integrated providers (providing acute and community services), mental health, combined mental health and specialist providers. Although QVH is a specialist provider its identity has in recent years become inconsistent and unclear to some stakeholders. It is therefore important as a Board to be clear regarding the organisation identity, purpose and to confirm 'who we are' and the organisation QVH seeks to be in the future.

Following extensive engagement with stakeholders internally and externally, an assessment of each service by speciality teams and clinicians and a detailed analysis of our baseline / current position the following options have been developed for consideration.

Options

Table 1

	Option	Option description
1	**Do nothing**	**QVH will continue as is.** Given the challenges set out within the case for change this will not secure sustainability and is likely to result in the need to align with a single partner in the future.
2	**Specialist provider**	**QVH will seek to be the very best in a limited number of specialist & regional services ceasing provision of our local services including the minor injuries unit (MIU) provision** This option would focus on the expansion of existing QVH services and / or the establishment of new specialist services e.g. cancer centre. This option would likely include the continuation of specialist commissioned services such as burns, head and neck cancer, specialist hands and plastic surgery as a regional Kent Surrey and Sussex provider
3	**Generalist provider**	**QVH will seek to be the best local partner providing secondary and community facing services ceasing the provision of specialist work.** This option would look to horizontally diversify QVH secondary services in areas unrelated to its current provision. Examples would include services not provided by QVH e.g. gynaecology, general surgery and urology. The option seeks to develop QVH as a District General Hospital.
4.	**Community provider**	**QVH will seek to be a provider of local services including an innovative neighbourhood hub and ceasing our specialist provision** This option would look to provide local community based services to support our population. This would include an MIU, a community diagnostic centre and services to meet local needs
5.	**Hybrid provider**	**QVH will seek to build on specialist / regional service and be an active local partner providing services and innovative neighbourhood hub** This option would look to be a hybrid model and further develop QVH as an anchor institution. This option would include the continuation of specialised and regional services (subject to service level review) including the respective secondary care element with strategic intention to increase market share or consider diversification with related services in addition to developing QVH as a local care provider working in collaboration with partners with a clear strategy of defined local services.

5 Option appraisal

The table below provides a high level assessment of the proposed options

Option description	Key benefits	Key risks and issues	Desirability	Viability	Feasibility
OPTION 1 **Do nothing**	Key benefits of this option include: • Existing high quality patient services would continue across the existing remit for the foreseeable future; this may be subject to change if a single partner is required to enable resilience and sustainability • Service level agreements can be reviewed within the model to maximise service resilience • There is an opportunity to provide additional capacity to required specialities to support planned care backlog challenges within the ICS • The as-is position would require QVH to build on key relationships to support addressing waiting list backlogs and increasing demand for care • Recruitment and retention opportunities may improve with a larger pool of staff in the event of a single partner.	Key risks / issues of this option include: • The key clinical challenges in regard to patients and services outlined in this case for change could not be addressed and would likely require alignment with a single partner to enable sustainability. • This option materially conflicts with stakeholder feedback to date in regard to opportunities to maintain organisational decision making autonomy. • Challenges with some areas of non-compliance with national standards may continue; if a single partner is progressed QVH may no longer have autonomy to determine future options • Although service level agreements can be reviewed, these are unlikely to fully address the resilience challenges in the future given the wider national picture in relation to workforce limitations • Capital is currently restricted for QVH and without a robust strategic case accessing further capital or revenue funding is unlikely • Investment of infrastructure may be dependent upon collaboration with a single partner and there is a risk that infrastructure solutions will be not being tailored to meet the needs of QVH staff and services • QVH has a strong relationship with local stakeholders however the as-is position does not enable it to be fit for the future. • A do nothing option will not support the shift working as a key system player and collaborator • Recruitment and retention could be adversely affected as an as-is scenario would generate further uncertainty regarding the future of the organisation. • In the likely event of needing to align with a single partner there is a risk that due to the national funding position QVH may not be able to attract required resources	VERY LOW	MEDIUM	MEDIUM

Option description	Key benefits	Key risks and issues	Desirability	Viability	Feasibility
OPTION 2 Specialist provider	Key benefits of this option include: • Opportunity to develop the remit of specialist services and work with partners to optimise service delivery and delivery of best practice standards • Specialist services are held in high regard across stakeholders and this would afford the opportunity to further develop specialist services. • Income for specialist and regional services would continue within this option. • Specialist services may support recruitment and retention of key workforce • Specialist provision would enhance potential opportunities with research and academic partners	Key risks and issues of this option include: • The ceasing of local services including the minor injuries unit is not in line with the feedback of many stakeholders • The ceasing of local services would add pressure to surrounding health and care organisations • The absence of some of the existing local services may create new resilience challenges (for example cardiology, physician support) for the specialist provision • Challenges in meeting all clinical national standards for some current specialist services • This option would limit the ability for QVH to take a leading role as an anchor institution for the local population • Income for specialist and regional services alone would result in a significant reduction in trust income which would impact long term financial sustainability • There is nationally significant uncertainty regarding the impact of devolution of specialist service commissioning which is likely to present a risk to the organisation. This is a particular risk for QVH given services span multiple integrated care systems and boards. • As a purely specialist provider it is unlikely that income would be sufficient to remain a going concern • NHSE are unlikely to support the option • This option does not optimise the opportunity for QVH to be innovative, agile and relevant in the future. • As a purely specialist provider it is unlikely that income would be sufficient to remain a going concern	MEDIUM	LOW	LOW

Option description	Key benefits	Key risks and issues	Desirability	Viability	Feasibility
OPTION 3 Generalist provider	Key benefits of this option include: • Potential opportunities to support system wide recovery • Improve access for some services to the local population • Develop innovative neighbourhood hub	Key risks and issues of this option: • The ceasing of specialist services does not align with the feedback from stakeholders • This option would result in the breakdown of key services with no clear alternative provider across the region • High clinical risk for a number of generalist services & a lack of key services co-location to manage complications • Diversification of services in areas unrelated to current services would pose significant challenges in the provision of expertise, training, support services, facilities and equipment • Although in the short term there is excess demand in a number of general specialities in the longer term this is possible that this may destabilise other organisations • Changes to a wider suite of non- related general services is likely to impact recruitment and retention of key staff; changes could also dilute specialist skills impacting of patient care and staff development • Activity in wider high volume and low complexity general activity is likely to be low value unless specialised • Wider horizontal diversification is likely to have a negative recruitment impact for other providers • Sussex does not need another DGH and this option is highly unlikely to gain commissioner support	LOW	LOW	LOW
OPTION 4 Community provider	Key benefits of this option include: • Opportunity to work with partners to deliver services for the neighbourhood • Opportunities for innovative expansion of the community diagnostic centre and associated services • Meet the needs of the local population • Partially aligned with the stakeholder view regarding the value and continuation of local services	Key risks and issues of the option include: • Loss of specialist services which offer a level of support to existing local services • Community based income (including MIU, CDC, community services) (even with expansion) would not be sufficient to remain as an autonomous NHS provider • Site overheads & infrastructure would be in excess of service need and hence key capacity would be redundant. • QVH is not a viable going concern in the event of this option. • Sussex does not need another community provider/ is highly unlikely to gain ICB support	MEDIUM	VERY LOW	VERY LOW

Option description	Key benefits	Key risks and issues	Desirability	Viability	Feasibility
OPTION 5 Hybrid provider	Key benefits of this option include: • Meet the priorities identified by stakeholders in relation to ongoing delivery of specialist services • Meet the priorities identified by stakeholders in relation to the ongoing provision of local services for the local population • Opportunity to deliver mutually supportive services that provide a local offer and provide resilience to specialist services • Opportunity to develop meaningful partnership with primary care to develop improved services for the local neighbourhood and community • Opportunity to develop a local health offer for the local neighbourhood building upon local confidence of QVH as a local provider of care • Opportunity to work in partnership with multiple health, care and public health colleagues to improve access and opportunities to the local population • Opportunity to expand secondary provision to support system planned care demand and income for areas aligned to trust specialisms • Opportunity to build upon Centre of Excellence for key specialist services • Opportunity to develop the research, innovation and training of specialist service to enhance patient care and outcomes • Opportunity to drive an innovative organisational model that builds upon national and local ambition and fundamentally looks to improve population health • The option would have a beneficial impact upon recruitment and retention • Maintaining core trust income and affording opportunities to deliver high performing and productive services and associated income to support future investment with the hospital • Approach is supported by the ICB and is in line with national policy	Key risks and issues of the option include: • Challenges in meeting all clinical national standards for some current specialist services • This model does not reflect the feedback of some stakeholders that support a specialist only option • Some services may not align with the new model ambition • Hybrid model may be a confusing model if not described clearly to stakeholders	HIGH	HIGH	HIGH

6 Preferred option and recommendation

On assessment of the benefits, risks, issues, desirability, viability and feasibility option 5 is recommended as the preferred option.

This option will retain highly regarded specialist services, provide an innovative health and care offer to the local population and enable delivery of both elements of service to mutual benefit. This option affords the ability to develop innovative collaborative partnerships locally and to build upon QVH as an anchor institution. This option also enables the opportunity to deliver resilient services and to support clinical, operational and financial sustainability in the future.

A hybrid provider model enables to QVH to retain 'what is great' about the patient care delivered by the organisation and provides a bridge to the future in the provision of innovative, collaborative and forward thinking health services.

The option supports the emergent priorities from the stakeholder feedback with a view to progress the following ambition

- We will continue be the centre of excellence for specialist and reconstructive surgery across Kent, Surrey, Sussex and beyond. In our *areas of expertise* we will provide additional planned care capacity to support our Sussex system partners and population

- We will have formal university partnerships that supports training, research and a strengthened academic presence.

- We will, as an anchor institution, collaborate with our partners to provide an integrated neighbourhood hub that supports the health and well- being of our population

- We will work in partnership with other organisations to the benefit of patients aligned to our areas of specialism

7 Next steps

Following the approval of the option for the high level scope of services the next steps of the strategy development will include the following:

- Review of the impact of the proposed future model for existing services and associated recommendations for the clinical services strategy
- Consideration of the proposed future model for new services and associated recommendations for the clinical services strategy
- The development of enabling and golden thread strategies that underpin delivery of the clinical strategy

The Board is asked to:

1. **APPROVE** the case for change
2. **APPROVE** the proposed preferred option and next steps

Strategic engagement: analysis

Independent analysis: interim findings (highlights)

29 NOVEMBER 2023

Better
Decisions
Together

Engagement in numbers

345
responses to the online survey

7
workshops

120
internal/team meetings

52
external meetings

1,857
people

c. 3,000
pieces of feedback analysed

Key Questions

Three key questions:

1. What are your **hopes**? — What do you see as the **main opportunities** for QVH?
2. What are your **fears**? — What do you see as the **biggest challenges** facing QVH?
3. What are your **ideas**? — What would be your **ambition for the future** of QVH?

Two additional questions:

What are we doing now that **we are the best** at?

What would **amazing look like** for patients and staff?

1 Hopes

KEY THEMES

People's hopes for QVH centre on its **unique identity** as an **independent, specialist** organisation that provides **excellent patient care** in a **values-based** environment.

The most common themes are:

- **Services: A Centre of Excellence**
  Building on specialist expertise and reputation; expansion and development of services; local access to local services.
- **People and workforce**
  Delivering excellent patient care in a specialist environment; Professional development and recognition; and a cultural shift and inclusivity.
- **Independence and identity**
  Preserving QVH's unique identity and building on this for the future.

2 Fears

KEY THEMES

People's fears were often centred around the fear of the impact of a **merger**, and the trust **losing its identity** and **independence**. There are also general fears around **closure**.

The most common themes are:

- **Impacts on workforce**
  Fears of losing staff, staff fatigue and low morale, lack of development opportunities, and staff feeling the pressure of a poor working culture.
- **Loss of identity and independence**
  Fears of being vulnerable to a merger and a subsequent loss of identity, independence, and specialist services and staff.
- **Financial risks**
  Fears around being financially viable, not receiving sufficient funding, and the high cost of delivering specialist services in a small trust.
- **Infrastructure and facilities**
  The challenges of delivering care in old buildings with a lack of suitable space and some outdated equipment.
- **Impacts on services and patient experience**
  Fears that services may be reduced or that quality will reduce as services experience increased demand; and that patient experience will decline.

3 Ideas

KEY THEMES

People are keen to see the trust maintain its **excellent patient feedback** and welcoming feel.

Suggestions include **developing services** to better meet current and future population needs while focusing on **positive patient experience**.

The most common themes are:

- **Service suggestions**
  Local service ideas, centring the patient experience, specialised services and expansion of services.
- **Infrastructure ideas**
- **Ideas about workforce**
- **Ideas around identity and independence**
  Including branding and communications
- **Partnerships**
  Including community

What do we do best?

Feedback suggests that people think the hospital's strengths lie in its **patient-centred care**, **specialised services, dedicated staff, place in the community**, and a commitment to **ongoing improvement**.

The most common themes are:

Outstanding patient care

Specialist services

Services for the community

Staff excellence

Better Decisions Together

What do we do best?

Better Decisions Together

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/1/2024		**Agenda reference:**	**135-24**	
Report title:	Audit and risk committee assurance				
Sponsor:	Paul Dillon-Robinson, Non-executive director, Chair of Audit and Risk Committee				
Author:	Paul Dillon-Robinson, Non-executive director, Chair of Audit and Risk Committee				
Appendices:	N/A				
Executive summary					
Purpose of report:	Assurance on matters of governance, risk management and internal control, within the remit of the committee's terms of reference, as discussed at the latest Audit & Risk Committee (13 December 2023)				
Summary of key issues	KSO 5 : assurance taken that workforce objective being broadly met Raising concerns : whilst policy and process in place, less assurance that staff will raise concerns, with further work needed to reinforce the message External audit and annual report : Azets welcomed as the new external auditors and indicative plan agreed, along with timetable. Risk management update : support for the developments being made in this area, along with work on the board assurance framework				
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: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***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:	Progress in developing new corporate risks were discussed				
Regulation:	Regulatory compliance is a factor in a number of areas covered by the committee				
Legal:	No specific legal implications				
Resources:	Resources are fundamental to the delivery of performance				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	Review by Board				

Report to:	Board Directors
Agenda item:	135-24
Date of meeting:	13 December 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:	21 December 2023
Appendices:	None

Audit and Risk Committee assurance report

Introduction
The audit and risk committee met on 13th December.

Executive summary
Assurance on KSO 5: A final review of individual KSOs, ahead of the revised BAFs, looked at the workforce objective, gaining assurance from the many positive indicators, whilst recognising the pressures in some areas and the need to continue work on EDI and behaviours.

Raising concerns: This item reviewed the range of ways that staff can raise concerns, from line management / HR processes through to whistle-blowing, via freedom to speak up. Whilst there is evidence that the policies and systems are in place and known by staff, the committee challenged the effectiveness of the system (i.e. are all concerns being raised) and what obstacles remained for staff that stopped them raising them.

Annual reviews: The committee carried out annual reviews of the approval of policies (noting those that had not been updated, and receiving assurance that none of these were significant) and compliance with the standards of business conduct (a few exceptions were being managed).

Risk management update: The updated approach to the board assurance framework and the process for reporting on the management of corporate and departmental risks was discussed. It was noted that the Audit and Risk Committee will take an oversight role of the system, ensuring that other sub-committees have oversight of individual risks and their management.

External audit and annual report and accounts: The new external auditors, Azets, were welcomed to their first meeting and an indicative plan was agreed for this year's audit, along with a provisional timetable for the production of the annual report and accounts. The committee were keen to explore opportunities to shorten the annual report, noting the management time needed against the set requirements.

Internal audit: Progress against the plan was up to date, although no audits had been completed since the October meeting. The contract for internal audit (and local counter fraud services) will be retendered in 2024 and the details behind this were discussed in a private meeting after the main one.

Local counter fraud specialist: Progress against the plan was noted, including both re-active and pro-active work.

Finance assurance: The committee looks at matters, by exception, to assess the control environment; such as for single tender waivers (less in number, but still felt to be quite high), losses and special payments (low) and payments without purchase orders (small, but consistent, numbers).

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:	11/01/2024		**Agenda reference:**	**136-24**	
Report title:	Board assurance framework (BAF)				
Sponsor:	James Lowell, chief executive officer				
Author:	Leonora May, deputy company secretary				
Appendices:	Appendix one: Board assurance framework summaries Appendix two: Board assurance framework				
Executive summary					
Purpose of report:	This paper provides an update on the development of the risk management framework at the Trust and presents the latest version of the Board Assurance Framework (BAF) to the Board.				
Summary of key issues	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 Trust's strategic risks are being managed. Significant work has been undertaken to refresh the content and the format of the BAF. The new format supports effective capturing of the risk assessments, controls and mitigation strategies, and assurances in place for each strategic risk. Gaps in controls and assurances are also recorded to help inform the ongoing management of risk.				
Recommendation:	To **review** the BAF and: - Confirm that the BAF is appropriately focussed on, and accurately describes, the key risks that may impact on the Trust's ability to deliver its strategic objectives - Advise if there are any specific matters in relation to the strategic risks presented in the BAF that require follow up at a sub-committee (e.g. deep dives into risk assessments or overall assurance levels) - Confirm the role of the Board and its committees in respect of the BAF, as set out at section 4 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:	Whole BAF included				
Corporate risk register:	Corporate risks linked to BAF risks				
Regulation:	CQC				
Legal:	BAF 5 compliance				
Resources:	None				
Assurance route					
Previously considered by:	Board seminar 7 December 2023				
Next steps:	Reporting as business as usual Refresh of corporate risk register Review of risk appetite Updated risk management policy				

Report to:	Board Directors
Agenda item:	136-24
Date of meeting:	11 January 2024
Report from:	James Lowell, chief executive officer
Report author:	Leonora May, deputy company secretary
Date of report:	18 December 2023
Appendices:	Appendix one: Board assurance framework summaries Appendix two: Board assurance framework

Risk management

1. Executive summary

This paper provides an update on the development of the risk management framework at the Trust and presents the latest version of the Board Assurance Framework (BAF) to the Board.

The background to the project is provided at Section 2 followed by an update on progress since the last Board meeting at Section 3.

The revised BAF is introduced at Section 4 with further detail provided at Appendix 1 and 2.

An update on the work for refreshing the corporate risk register is included at Section 5.

An overview of next steps is set out at Section 6.

The ask of the Board, as presented at Section 7, is to review this report and the accompanying Appendices to:

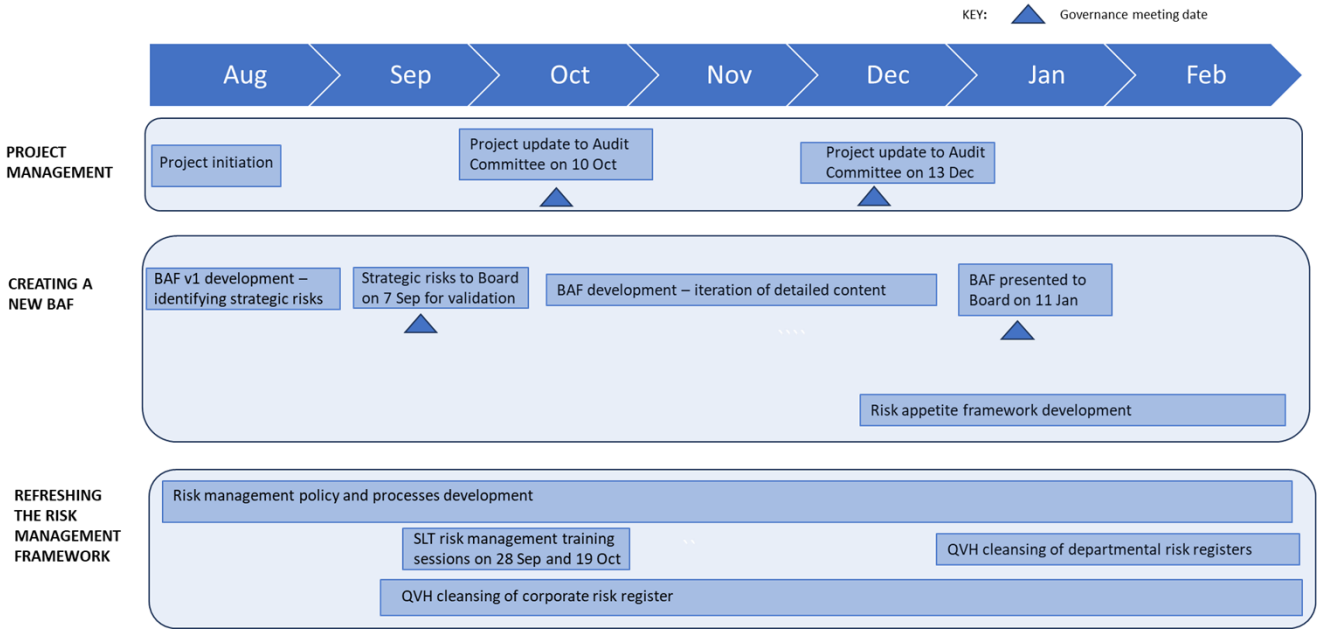
A. Confirm that the BAF is appropriately focussed on, and accurately describes, the key risks that may impact on the Trust's ability to deliver its strategic objectives

B. Advise if there are any specific matters in relation to the strategic risks presented in the BAF that require follow up at a sub-committee (e.g. deep dives into risk assessments or overall assurance levels)

C. Confirm the role of the Board and its committees in respect of the BAF, as set out at section 4 of this report

2. Background

The Trust has been evolving its approach to risk management during the second half of 2023, including revising the scope, content and format of our recording of strategic and corporate risks to give the Board the most up to date view of the key risks facing the Trust, and how these are being effectively managed. External support has been utilised to provide the additional capacity and expertise needed for this transformation. The project is on track as per the agreed project plan set out below.



The transformation is planned to continue into 2024, with key activities including finalisation of the updated corporate risk register, refreshing of departmental risks registers, a Board review of the Trust's risk appetite framework, and the launching of an updated Risk Management Policy.

An update on progress was provided to the Audit and Risk Committee on 13 December 2023, as the key oversight forum for this area.

3. Progress to date

The risk management transformation programme includes revising the overarching Risk Management Policy, developing a revised BAF, refining the content of the CRR and the provision of training to increase internal capabilities.

Activities undertaken since the last Board update include: -

- Finalising the BAF (see Section 4 and Appendix 2)
- Progressing the refresh of the CRR (see Section 5)
- Revision of risk types to facilitate enhanced reporting of risk insight
- Completion of a risk appetite survey by Board members to inform the risk appetite workshop scheduled to be carried out in early 2024

4. The revised Board Assurance Framework

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

Trust's strategic risks are being managed. An effective BAF also helps to drive the forward work plan and agendas for the Board and its Committees.

Significant work has been undertaken by the Board during 2023 in order to refresh both the content and the format of the BAF. This work is now complete, and the updated BAF is presented in full as shown at Appendix 2. This detailed document will continue to be iterated following ongoing ELT reviews and challenge sessions in Board committees.

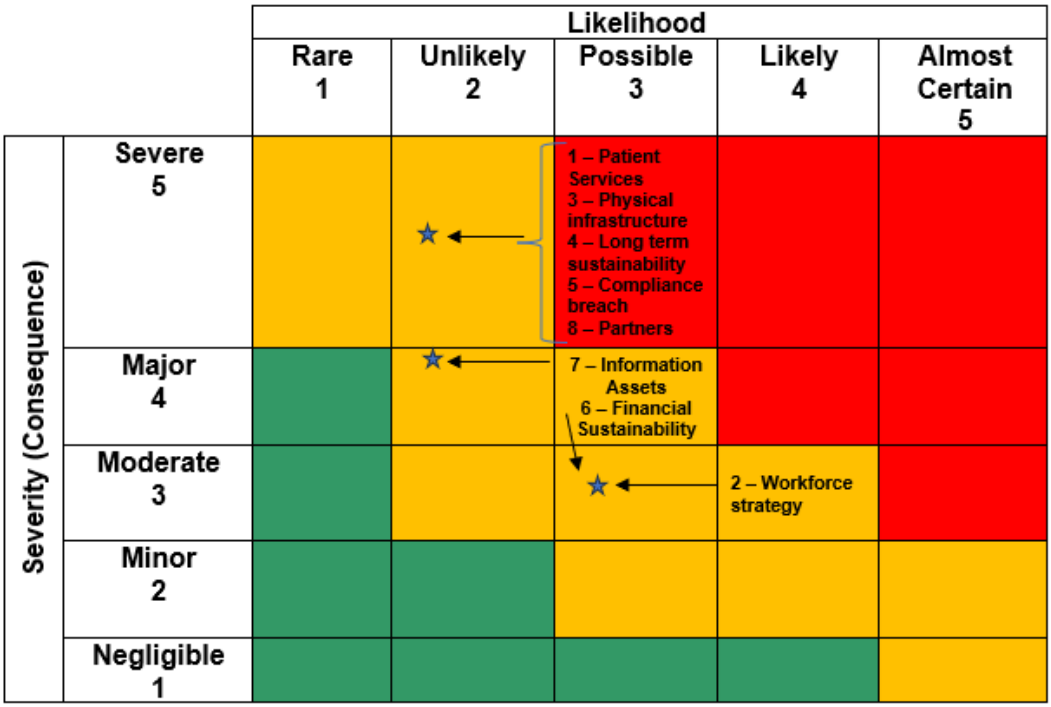
The BAF includes the eight strategic risks identified by the Board during the away day on in July 2023. The new format supports effective capturing of the risk assessments, controls and mitigation strategies, and assurances in place for each strategic risk. Gaps in controls and assurances are also recorded to help inform the ongoing management of risk.

Summaries of the detailed BAF are presented at Appendix 1 in the following four sections:

- Section 1 – Summary of strategic risks
- Section 2 – Mapping of strategic risks to strategic objectives
- Section 3 – Strategic risk exposure
- Section 4 – Summarised risk assessments

This is the first time that the Board has formally received the revised BAF. The current scores (indicated by the text) and target scores (indicated by a star) of the eight strategic risks included in the BAF are shown in the heatmap below. None of the risks have yet achieved their target score.

Diagram 1 – Heat Map for Strategic Risks



The Board will use the BAF to monitor:

- The overall adequacy of assurance on the effectiveness of existing controls for each risk, and whether this is improving or deteriorating over time (overall assurance is presented in the Appendix 1, Section 1 – Summary of strategic risks)

- How the risks might impact delivery of the strategic objectives (refer to Appendix 1, Section 2 – Mapping of strategic risks to strategic objectives)

- How effectively risks are being managed; through considering the gap between current risk score and the target risk score, and whether this gap is closing over time (refer to Appendix 1, Section 3 – Strategic risk exposure)

During 2024, the Board will see trend analysis incorporated in the report accompanying the BAF to help with the above.

Where deemed appropriate, the Board may direct a committee of the Board to undertake further, more detailed scrutiny of individual risks to seek additional assurances (governance committees for each risk are presented in the dashboard at Appendix Section 1 – Summary of strategic risks).

The Board will also consider how the BAF is being used going forward to help influence Board and committee agenda and focus ensuring that the Trust remains sighted on its strategic risks.

The Board will not routinely consider the detail of the risks in the BAF as recorded in Appendix 2; it is the role of the sub-committees to undertake detailed challenge and provide assurance to the Board, specifically around reasonableness of the risk assessments, and the effectiveness of controls, assurances and actions being taken to manage individual risks to achieve the target scores within the expected timeframes. Updates will be provided in each committees' assurance reports to the Board.

The Audit and Risk Committee (ARC) has a responsibility to consider the overall format and quality of population of the BAF, as opposed to the individual risk detail, unless risks are specifically allocated to it in the future. This responsibility is part of the ARC's role in providing assurance to the Board that the Trust has in place an effective risk management framework.

5. The updated corporate risk register

The content and format of the CRR is being refined to enable the executive leadership team and Board to have sufficient oversight of the key corporate level risks and how effectively these are being managed.

The CRR will comprise of the key risks, as agreed by the executive leadership team, that are wider in scope than a single directorate or function and /or significant in terms of their potential severity to warrant executive leadership team oversight, or score more than 12.

The updated CRR was reviewed by the ELT on 12 December 2023, and actions have been agreed to develop the content further. The CRR will be presented to the

Board committees during 2024 to provide independent challenge as part of the routine reporting cycle.
Future Board reporting on the CRR will include details of how the corporate risks map to the strategic risks recorded on the BAF and a highlights dashboard showing key changes from the previous version with supporting narrative such as:

- Number of risks added
- Number of risks removed
- Changes in risk scores

6. Next steps

The risk management update programme will continue during 2024 with the key next steps being the refresh of departmental risks registers, a review of the Trust's risk appetite framework by the Board, and the launching of an updated Risk Management Policy.

This work will rely on configuration changes being made within the Trust's Risk Management system to ensure that the Trust can effectively capture and report its risk information in line with its refreshed framework.

The Trust also recognises that it will need to invest in ongoing communication and training requirements in 2024 to support the launch of the revised Risk Management Policy and embed the cultural changes needed to ensure the success of the risk management transformation.

7. Ask of the Board

The ask of the Board is to review this report and the accompanying BAF to:

A. Confirm that the BAF is appropriately focussed on, and accurately describes, the key risks that may impact on the Trust's ability to deliver its strategic objectives

B. Advise if there are any specific matters in relation to the strategic risks presented in the BAF that require follow up at a sub-committee (e.g. deep dives into risk assessments or overall assurance levels)

C. Confirm the role of the Board and its committees in respect of the BAF, as set out at section 4 of this report

Queen Victoria Hospital
NHS Foundation Trust

APPENDIX 1 - BOARD ASSURANCE FRAMEWORK SUMMARIES

1. SUMMARY OF STRATEGIC RISKS:

The table below presents a summary of the 8 strategic risk assessments included in the BAF and the anticipated dates for reaching the target score for each risk (note: target scores may need to be revised once the Board has agreed its risk appetite framework in early 2024). Each risk is assigned an overall assurance rating showing level of confidence in the controls.

REF	RISK TITLE	Principal Exec[1]	RISK ASSESSMENT[2]			TRAJECTORY	GOVERNANCE COMMITTEE	ASSURANCE RATING[3]
			Inherent	Current	Target	Date to reach target score		
01	**Patient services**	Chief Nurse	25	15	10	Dec 24	Q&S	**AMBER**
02	**Workforce strategy**	Interim Chief People Officer	20	12	9	Mar 25	F&P	**AMBER**
03	**Physical infrastructure**	Chief Finance Officer	20	15	10	Jun 24	F&P	**AMBER**
04	**Long-term sustainability**	Chief Executive	25	15	10	Sep 24	Strategic development	**AMBER**
05	**Compliance breach (non-clinical)**	Chief Executive	20	15	10	Mar 24	F&P	**AMBER**
06	**Financial sustainability**	Chief Finance Officer	25	12	9	Mar 29	F&P	**AMBER**
07	**Information assets**	Chief Strategy Officer	25	12	8	Jul 24	F&P	**AMBER**
08	**Partner organisations**	Chief Executive	25	15	10	Jul 24	Strategic development	**AMBER**

[1] The role responsible for maintaining the risk assessment and overseeing the management of the risk
[2] Risk assessment definitions: Inherent = pre-controls, current = post controls, target = desired level of risk
[3] Overall assurance rating definitions: Red = low confidence indicating that there are serious issues that need to be addressed immediately for the controls to be effective, Amber = medium confidence indicating that there are some issues that need to be monitored and addressed, Green = high confidence indicating that there are no serious issues and the controls are effective

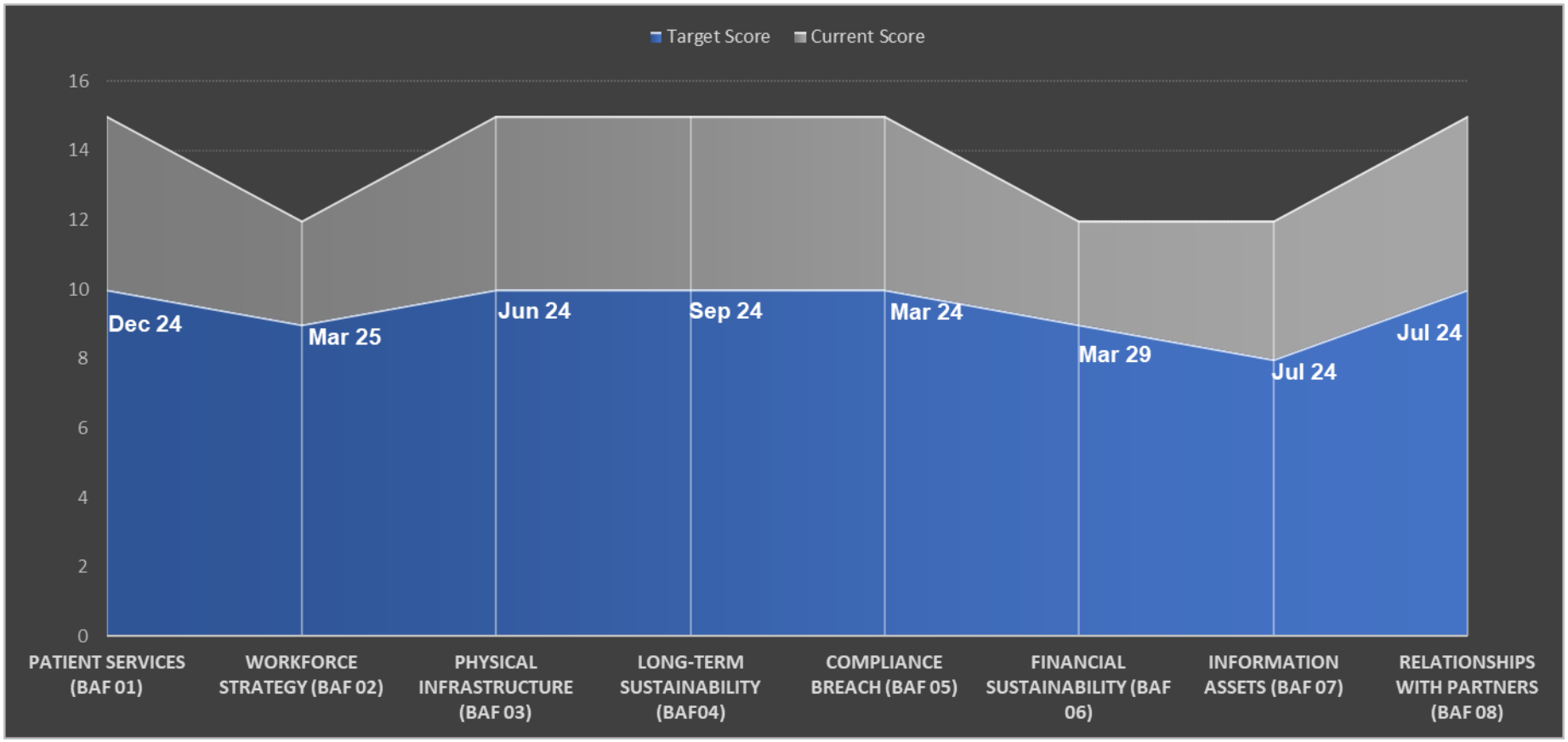
2. MAPPING OF STRATEGIC RISKS TO STRATEGIC OBJECTIVES:

The table below identifies which strategic objectives may be affected by each of the risks recorded on the BAF. The RAG rating of the current risk assessment has been included to give an indication of the current exposure taking existing controls into account. The "maximum risk exposure" for each strategic objective reflects the total of the current scores for all risks that may impact on the objective. The ranking (shown in brackets) indicates that Objectives 2 and 3 jointly have the greatest risk exposure currently.

REF	RISK TITLE	STRATEGIC OBJECTIVES				
		1 Outstanding patient experience	2 World Class Clinical Services	3 Operational excellence	4 Financial Sustainability	5 Organisational Excellence
01	Patient services	15	15	15	n/a	n/a
02	Workforce strategy	12	12	12	12	12
03	Physical infrastructure	15	15	15	15	15
04	Long-term sustainability	15	15	15	15	15
05	Compliance breach	n/a	15	15	15	15
06	Financial sustainability	12	12	12	12	12
07	Information assets	12	12	12	12	12
08	Partner organisations	15	15	15	n/a	n/a
	MAXIMUM RISK EXPOSURE (ranking)	**96 (=2)**	**111 (=1)**	**111 (=1)**	**81 (=3)**	**81 (=3)**

3. STRATEGIC RISK EXPOSURE:

The chart below presents the current vs. target scores for each strategic risk to highlight the size of the gap in addition to the anticipated deadline for achieving the target risk score as recorded in the summary at section 1 of this Appendix.



4. Summarised risk assessments

The pages below present a summarised risk assessments for each strategic risk included in the detailed BAF at Appendix 2.

Risk Ref & Description: 01 – There is a risk that the Trust fails to deliver effective, safe, timely and quality patient services	**Quarter**	**Q1**	**Q2**	**Q3**	**Q4**
	Overall Assurance Rating (RAG)	N/A	N/A	**AMBER**	
Causes: ineffective operational / clinical management (including management of resources and risks / incidents), failure of third-party service providers, ineffective and unpredictable staff behaviours (e.g., communication), physical infrastructure failure	**Number of controls in place**	N/A	N/A	**9**	
Consequences: negative impacts on patient outcomes / experiences, potential harm to people, failing to meet regulatory performance targets, financial implications including losses, regulatory intervention, criminal prosecution, and reputational damage	**Gaps in Controls**	N/A	N/A	**14**	
Strategic Aim: KSO 1, 2 and 3	**Assurances and RAG rating[4]**	N/A	N/A	**20** L1 (8) - 4G,2A,2R L2 (10) - 3G,7A L3 (2) - 1G,1A	
Committee: Quality and Safety Committee	**Gaps in assurance**	N/A	N/A	**9**	
Principal Exec: Chief Nurse	**Current Risk Score**	N/A	N/A	**15**	
Date added: September 2023	**Target Risk Score and Date**	N/A	N/A	**10** (Dec 24)	
Date last discussed: 23 November 2024 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	

[4] L1 – first line, L2 – second line, L3 – third line
R – Red (low confidence), A – Amber (medium confidence), G – Green (high confidence)

Risk Ref & Description: 02 – 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	**Quarter**	**Q1**	**Q2**	**Q3**	**Q4**
	Overall Assurance Rating (RAG)	N/A	N/A	**AMBER**	
Causes: Inadequate leadership and / or resources and a focus on reactive issues mean the workforce team, corporate and clinical services do not address the important workforce challenges and / or fail to keep up to date with national / regional requirements	**Number of controls in place**	N/A	N/A	**6**	
Consequences: Potential reduction in clinical or corporate service capacity or quality with negative impact on care and / or patient and service user experience and outcomes, negative impact on staff health and wellbeing, financial implications including increased temporary staff spend, regulatory intervention, reputational damage, employee grievances / tribunals, higher staff turnover, or potential challenges in recruitment	**Gaps in Controls**	N/A	N/A	**22**	
Strategic Aim: KSO 1-5	**Assurances and RAG rating**	N/A	N/A	**21** L1 (8) - 5G,3A L2 (12) - 5G,7A L3 (1) - 1G	
Committee: Finance and Performance Committee	**Gaps in assurance**	N/A	N/A	**10**	
Principal Exec: Chief People Officer	**Current Risk Score**	N/A	N/A	**12**	
Date added: September 2023	**Target Risk Score and Date**	N/A	N/A	**9** (Mar 25)	

Date last discussed: 23 November 2023 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	
Risk Ref & Description: 03 - There is a risk that the Trust's physical infrastructure (i.e. buildings and services) is not fit for purpose to support an effective, efficient and safe environment for operational delivery	**Quarter**	**Q1**	**Q2**	**Q3**	**Q4**
	Overall Assurance Rating (RAG)	N/A	N/A	**AMBER**	
Causes: Ageing infrastructure, lack of financial investment resulting in back log of maintenance / repairs, ineffective governance, inadequate resources, failure of critical third-party suppliers	**Number of controls in place**	N/A	N/A	**9**	
Consequences: Potential harm to individuals, disruption to / inefficiencies within clinical and support services, damage to physical infrastructure (i.e. the buildings and the services e.g. heating systems, electrical infrastructure, cooling and ventilation systems), financial loss, regulatory intervention, reputational damage, negative impact on staff morale	**Gaps in Controls**	N/A	N/A	**13**	
Strategic Aim: KSO 1-5	**Assurances and RAG rating**	N/A	N/A	**12** L1 (3) - 2G,1R L2 (6) - 3G,3A L3 (3) - 1G,2A	
Committee: Finance and performance committee	**Gaps in assurance**	N/A	N/A	**9**	
Principal Exec: Chief finance officer	**Current Risk Score**	N/A	N/A	**15**	
Date added: 12 October 2023	**Target Risk Score and Date**	N/A	N/A	**10** (Jun 24)	
Date last discussed: 24 October 2023 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	

Risk Ref & Description: 04 – There is a risk that the Trust fails to secure its long-term sustainability leading to closure of services and /or the site	**Quarter**	**Q1**	**Q2**	**Q3**	**Q4**
	Overall Assurance Rating (RAG)	N/A	N/A	**AMBER**	
Causes: Inadequate or ineffective strategic planning / delivery, lack of effective stakeholder engagement (internally and externally) / support, internal governance failures, inadequate leadership capability and capacity, failing to address environmental sustainability matters, emergent change at a trust, system or national level that may impact strategy requirements	**Number of controls in place**	N/A	N/A	**10**	
Consequences: potential for loss of patient services, reduction in staff morale, challenges with recruitment and retention, loss of community employment and local facilities	**Gaps in Controls**	N/A	N/A	**2**	
Strategic Aim: KSO 1-5	**Assurances and RAG rating**	N/A	N/A	**8** L1 (0) L2 (6) - 6G L3 (2) - 2G	
Committee: Strategic Development Committee	**Gaps in assurance**	N/A	N/A	**1**	
Principal Exec: Chief Executive Officer	**Current Risk Score**	N/A	N/A	**15**	
Date added: September 2023	**Target Risk Score and Date**	N/A	N/A	**10** (Sep 24)	
Date last discussed: 17 October 2023 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	

Risk Ref & Description: 05 – There is a risk that the Trust experiences a material legislative or regulatory compliance breach (non-clinical)	**Quarter**	**Q1**	**Q2**	**Q3**	**Q4**
	Overall Assurance Rating (RAG)	N/A	N/A	**AMBER**	
Causes: failure to identify existing and new requirements, unhelpful behaviours (human error / intentional wrongdoing), staff not being adequately trained, failure of third party to deliver, failure of record keeping or IT systems, ineffective policy frameworks and processes	**Number of controls in place**	N/A	N/A	**9**	
Consequences: potential harm to people, regulatory intervention, criminal prosecution, financial losses and reputational damage	**Gaps in Controls**	N/A	N/A	**16**	
Strategic Aim: KSO 2, 3,4 and 5	**Assurances and RAG rating**	N/A	N/A	**12** L1 (0) L2 (8) - 3G,5A L3 (4) - 4G	
Committee: Finance and Performance Committee	**Gaps in assurance**	N/A	N/A	**9**	
Principal Exec: Chief Executive Officer	**Current Risk Score**	N/A	N/A	**15**	
Date added: September 2023	**Target Risk Score Target Risk Score and Date**	N/A	N/A	**10** (Mar 24)	
Date last discussed: 23 November 2023 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	

Risk Ref & Description: 06 – There is a risk that the Trust is unable to deliver medium to long term financial sustainability	**Quarter**	**Q1**	**Q2**	**Q3**	**Q4**
	Overall Assurance Rating (RAG)	N/A	N/A	**AMBER**	
Causes: increasing demand outstrips resources available, impact of investment requirements and inflation, failure to deliver operational efficiencies and /or realise investment programme benefits, potential for unplanned costs (e.g., cyber-attack), lack of available workforce increasing agency spend, Ineffective management of multiple Integrated Care Systems financial transformational risks, impact of political changes and national directives	**Number of controls in place**	N/A	N/A	**10**	
Consequences: possible loss of operational capacity and failure to provide timely treatment to patients, failure to generate funding for investments, potential for workforce restructuring, and /or reputational damage with loss of confidence from stakeholders (e.g., ICB)	**Gaps in Controls**	N/A	N/A	**11**	
Strategic Aim: KSO 1 - 5	**Assurances and RAG rating**	N/A	N/A	**12** L1 (1) - 1A L2 (5) - 2G,3A L3 (6) - 2G,4A	
Committee: Finance and Performance committee	**Gaps in assurance**	N/A	N/A	**5**	
Principal Exec: Chief Finance Officer	**Current Risk Score**	N/A	N/A	**12**	
Date added: September 2023	**Target Risk Score and Date**	N/A	N/A	**9** (Mar 29)	
Date last discussed: 23 November 2023 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	

Risk Ref & Description: 07 - There is a risk that the Trust does not protect and develop its information assets to ensure that they are complete, accurate, accessible, and effectively utilised to support safe and efficient service delivery, fulfilment of strategic objectives, and meet compliance requirements	**Quarter**	**Q1**	**Q2**	**Q3**	**Q4**
	Overall Assurance Rating (RAG)	N/A	N/A	**AMBER**	
Causes: inadequate policies / procedures, staff behaviours, limited funding, insufficient implementation and support resources (capacity and capability), external factors (e.g. cyber-attack, third party performance and management, national and ICS governance relating to funding & process requirements)	**Number of controls in place**	N/A	N/A	**10**	
Consequences: potential for patient harm, inability to deliver services, negative impact on staff, data compromised (confidentiality, integrity and availability) and potentially lost, non-compliance with legislation and best practice standards, poor decision making, reputational damage and financial loss	**Gaps in Controls**	N/A	N/A	**8**	
Strategic Aim: KSO 1 - 5	**Assurances and RAG rating**	N/A	N/A	**13** L1 (1) - 1G L2 (9) - 8G,1A L3 (3) - 2G,1A	
Committee: Finance and Performance Committee	**Gaps in assurance**	N/A	N/A	**4**	
Principal Exec: Chief Strategy Officer	**Current Risk Score**	N/A	N/A	**12**	
Date added: September 2023	**Target Risk Score**	N/A	N/A	**8** (Target date = Jul 24)	
Date last discussed: 13 November (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	

Risk Ref & Description: 08 There is a risk that the Trust does not develop and maintain collaborative relationships with partner organisations built on shared objectives and mutual trust that may impact adversely on the ability to deliver a sustainable future and trust strategy and improve the health of the populations we serve	**Quarter**	**Q1**	**Q2**	**Q3**	**Q4**
	Overall Assurance Rating (RAG)	N/A	N/A	**AMBER**	
Causes: the Trust and /or system partners do not effectively engage with the system framework or direct arrangements, ineffective communication, absence of shared goals	**Number of controls in place**	N/A	N/A	**4**	
Consequences: failure to achieve system and Trust objectives, negative impact on patient outcomes and experience	**Gaps in Controls**	N/A	N/A	**5**	
Strategic Aim: KSO 1, 2 and 3	**Assurances and RAG rating**	N/A	N/A	**9** L1 (3) - 3G L2 (5) - 4G,1A L3 (1) - 1A	
Committee: Strategic Development Committee	**Gaps in assurance**	N/A	N/A	**2**	
Principal Exec: Chief Executive Officer	**Current Risk Score**	N/A	N/A	**15**	
Date added: September 2023	**Target Risk Score**	N/A	N/A	**10** (Target date = Jul 24)	
Date last discussed: 13 November 2023 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	

APPENDIX 2 - BOARD ASSURANCE FRAMEWORK

Version 1.24
18 December 2023

Strategic Aim: KSOs 1, 2 and 3	Overall Assurance Rating (RAG)	Q1	Q2	Q3	Q4
		N/A	N/A	**AMBER**	
Risk Ref & Description: <u>01 – There is a risk that the Trust fails to deliver effective, safe, timely and quality patient services</u> **Causes:** ineffective operational / clinical management (including management of resources and risks / incidents), failure of third-party service providers, ineffective and unpredictable staff behaviours (e.g., communication), physical infrastructure failure **Consequences:** negative impacts on patient outcomes / experiences, potential harm to people, failing to meet regulatory performance targets, financial implications including losses, regulatory intervention, criminal prosecution, and reputational damage				
Committee	Quality and Safety Committee	Date Added:		September 23	
Principal Exec	Chief Nurse	Date Reviewed:		10 November 2023	
Supporting Exec(s)	Medical Director Director of Operations	Last discussed:		23 November 2023 (ELT)	
Risk Assessment	**Consequence**	**Likelihood**		**Score**	
Inherent Risk Rating	5 (Severe)	5 (Almost Certain)		25	
Current Risk Rating	5 (Severe)	3 (Possible)		15	
Target Risk Rating	5 (Severe)	2 (Unlikely)		10 (Target date = Dec 24)	
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**		**Gaps in assurance (what additional assurance is needed)**	
1. Governing documents, policies and procedures including mandatory staff training and staff induction.	Not all staff are aware of governing documents, policies and procedures (refer to action 3) QNet search function and naming process for policies makes location of documents challenging at times (refer to action 14)	<u>2nd line:</u> Mandatory Training reports generated by Learning and Development Centre and shared to department heads (October 2023, Amber) Out of date policy reports are presented to the Q&S Committee (October 2023, Amber)		Lack of assurance that workforce compliance checks and local inductions are completed for all areas and that staff are aware of governing documents, policies and procedures – (refer to longer term actions) Currently no overall MAST reporting to FPC and ELT for scrutiny (refer to action 2) There is a requirement, set by ELT to review the effectiveness of local induction and MAST training – Internal audit review to be scheduled (refer to longer term actions) There is no integrated assurance framework (refer to action 10)	
2. Documented agreement of compliance responsibilities with service providers such as independent sector, Sterile services suppliers and Service level agreement provider	Not managing all third party contracts appropriately which leads to risk of service delivery (refer to action 15)	<u>1st Line:</u> Monthly governance meeting with IS to review, incidents and risks (October 2023, Green) Use of Datix reporting to review issues(October 2023, Green)		None	

		Medical Devices Group meeting reviews new kit (October 2023 Amber) Approval Process of change of practice via Clinical Governance Group well embedded (October 2023 Green)	
3. Regular review of policies and procedures and internal communication of changes in requirements via Connect, internal meetings such as Nursing Quality Forum (NQF) , Clinical Director meetings, Hospital Management Team	Process for staff checking for new policies and procedures and keeping up to date (refer action 3 and longer term actions) Policies are out of date regardless of controls and assurance due to lack of engagement in the review process (refer action 5) Introduction to policy locations at local induction (refer to action 3 and longer term actions	2nd Line: Minutes of meetings seen in Q&S committee for Nursing Quality Forum (October 2023, Green) 2nd line: Out of date policy report seen at Q&S, F&P and Audit and Risk Committee (October 2023, Amber)	Confirmation is required as to route of assurance for information shared via Hospital Management Team Meeting (refer action 4)
4. Horizon scanning for changes to legislation and care standards (through membership of appropriate networks and attendance at quarterly ICB quality review meetings and Sussex EPRR system calls)	Review of which networks we should be aligned with externally (refer to action 11) Not meeting all national standards (refer action 13)	1st line: Governance meetings for all services which do not meet national standards. Minutes available at Clinical Governance Group (October 2023 Amber)	None
5. Clearly defined and documented responsibilities, especially in leadership roles including the use of the appraisal framework. Right people in right roles ensuring we have appropriate clinical engagement and that we follow robust recruitment processes	Not all staff are up to date with appraisals or have up to date job descriptions	2nd Line Appraisal compliance reported by HR team on monthly basis (October 2023, Green) 2rd Line Staff Survey results (October 2023, Amber)	Internal audits to review; number of staff with up to date job descriptions, appraisal quality, and recruitment process (refer to longer term action)
6. CQC preparation utilising benchmarking and self assessment allows us to understand potential gaps and areas for development	There are actions from the previous inspections (2015 and 2019) which have not been carried out and need urgent attention (refer action 6) Self-assessment results need to be used to develop action plan (refer action 8)	1st Line: CQC preparation self-assessment has been completed and is being reviewed to identify gaps (October 2023, Red) 1st line Rolling Quality Review Visits (November 2023 Red) 1st Line CQC preparation updates and feedback at Clinical Governance groups, Quality and Safety Committee and Nursing Quality Forum. (November 2023, Green)	None
7. Learning from incidents and SIs. Patient Safety and Incident Response Framework (PSIRF) policy and plan in place	Patient Safety and Incident Response Framework (PSIRF) roll out is a work in progress; this will enable us to develop learning from local incidents via After Action Reviews and how this learning is disseminated (refer action 7)	2nd Line: Q&S and CGG review serious incidents and Formal internal investigations as required (last tabled October 2023, Green) 3rd Line Minutes of ICB quality review meetings and SI panels – action plans monitored via Q&S	Regular reporting on learning from serious incidents to the quality and safety committee (refer to action 12)

		(October 2023, Green) Internal Audit review risk management on an annual basis (January 2023, Amber)	
8. Clinical Audit programmes to identify risks to patient safety and quality of care.	Sharing learning from clinical audit activity to be robustly rolled out via clinical governance group (refer to action 9)	2nd line: Q&S committee and Audit & Risk Committee (ARC) see the progress against clinical audit plan and output planned for Nov 2023 (October 2023, Amber)	Assurance reporting to ARC re clinical audit learnings being rolled out via clinical governance group (refer to action 9)
9. Freedom to Speak Up (F2SU) Framework in place to support the timely and effective remediation of staff concerns.	Review of F2SU in progress to identify any control gaps (refer to action 1)	2nd line: Board receive quarterly freedom to speak up reports including updates on numbers of "speak ups", whistleblowing and "Tell Nicky (ARC December Amber 2023) ARC receives regular FTSU reporting (October 2023, Amber)	Q&S committee will review F2SU tool kit and action plan until the cultural change is embedded within the organisation (refer action 1)

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Deliver action plan to address gaps identified in the FTSU toolkit review with assurance reporting to Q&S Committee	February 2024	Chief Nurse	On track
2. ELT review of MAST data	February 2024	CPO	TBC
3. Develop policy lists for local inductions, add process for socialisation of new policies to the Policy for policies and explore the use of QPulse to manage organisational policies	February 2024	CPO and Head of Risk	TBC
4. Identify governance routes for HMT and CD Meetings	February 2024	CMO	TBC
5. To reinvigorate process for reviewing out of date policies	February 2024	Head of Risk	TBC
6. To review gaps in CQC actions from previous inspection and take action to address	December 2023	Chief Nurse	TBC
7. Roll out of PSIRF methodology	January 2024	Head of Risk	On track
8. To develop action plan addressing learning from self-assessment	January 2024	Chief Nurse	TBC
9. Clinical audit learnings to be robustly rolled out via clinical governance group with assurance reporting to ARC	TBC	TBC	TBC
10. Development of integrated assurance framework	April 2024	Chief strategy officer	On track
11. Review of which external networks the Trust should be linked to	April 2024	CNO CMO	TBC
12. Regular reporting on learning from serious incidents to the quality and safety committee established	April 2024	CNO CMO	TBC
13. Review national standards and gap analysis (linked to Corporate risk register number 3)	December 2023	CMO, CDs	TBC
14. Review QNet search function and consider renaming some of the frequent accessed policies	April 2024	TBC	TBC
15. Assessment of all Clinical SLAs to identify areas of concern	February 2024	CFO and CMO	TBC

Longer term actions (with indicative timeframe e.g. Q1 2024)	
Policy guide for clinicians with QR code (timeframe TBC) Commission internal audit to review a range of Workforce and OD related processes including recruitment, job description quality, appraisal quality, effectiveness of local induction and MAST training (May 24) – Chief People Officer Commission internal audit to review how the Trust manages staff awareness of governing documents, policies and procedures	
Links to Corporate Risk Register	Risks 1 & 2 Patient Transfers, 3 – National Clinical Standards, 4 - Procurement management, 5 – Compliance with Standards 6 – Major incident, 8 – Speaking Up, and 12 – Mental Capacity Act

Strategic Aim: KSO 1-5	Overall Assurance Rating (RAG)	Q1	Q2	Q3	Q4
		n/a	n/a	AMBER	
Risk Ref & Description: 02 – 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 **Causes:** Inadequate leadership and / or resources and a focus on reactive issues mean the workforce team, corporate and clinical services do not address the important workforce challenges (e.g., capacity and capability, education and training, health and well-being, engagement and morale, culture and behaviours, equality, diversity and inclusion, ineffective third party provider functions, industrial action and key person dependencies) and / or fail to keep up to date with national / regional requirements **Consequences:** Potential reduction in clinical or corporate service capacity or quality with negative impact on care and / or patient and service user experience and outcomes, negative impact on staff health and wellbeing, financial implications including increased temporary staff spend, regulatory intervention, reputational damage, employee grievances / tribunals, higher staff turnover, or potential challenges in recruitment				
Committee	Finance and Performance Committee	Date Added:		September 2023	
Principal Exec	Chief People Officer	Date Reviewed:		8 November 2023	
Supporting Exec(s)	NA	Last discussed:		23 November 2023 (ELT)	
Risk Assessment	**Consequence**	**Likelihood**		**Score**	
Inherent Risk Rating	5 (Severe)	4 (Likely)		20	
Current Risk Rating	3 (Moderate)	4 (Likely)		12	
Target Risk Rating	3 (Moderate)	3 (Possible)		9 (Target date = March 2025)	
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**		**Gaps in assurance (what additional assurance is needed)**	
Recruitment – supporting our current and future workforce needs					
1. Embedding the Trust People and Culture Strategy in order to be **a great place to work** with the right staffing and where individuals and teams are able to do their best work.	Development and implementation of **new People and Culture Strategy** in line with the Sussex People Plan. (Refer to action 1). **Review the end to end recruitment** process, inc: clarity on time to hire, summary recruitment pipeline reporting and review of recruitment / vacancy risks (Refer to action 2). Lack of resource to provide **adequate business partner support** to services in managing their recruitment / retention issues. (Refer to action 3). Absence of a policy or procedure for **managing medical rotation**, inc. regular reporting on training gaps and mitigations. (Refer to action 4). Lack of **EDI lens applied to policy development** and review. (Refer to action 5) Inclusion of **local induction** as part of Trust KPI's (Refer to action 6) and implementation of new **appraisal** framework (Refer to action 7). Ensuring effective **Speak up**, listen up and follow up of staff concerns. (Refer to action 8).	1st Line: Monthly meeting between CPO, CNO and Freedom to Speak up Guardian (Nov 23, Green). JCNC & JLNC (bi-monthly, Amber). Monthly Senior Management Team (SMT) and Service Performance Review (PR) monitoring of operational performance (Oct 23, Amber). Monthly service meetings / Local Faculty Group meetings with medical trainees (Oct 23, Amber). 2nd Line: Bi-monthly exception reporting to F&P and Board on Trust performance (Oct 23, Amber). Monitoring and review of workforce strategy through Strategy Development Group (SDG) October (Oct 23, Amber). Bi-annual reporting of speak up concerns to Audit committee and Board (Dec 24, Green) 3rd line: Annual GMC Survey linked to action 4 (June 23, Green).	New People and Culture Strategy to be reviewed by the Strategic Development Committee and implementation managed though F&P. EDI Group being stood up. Lack of triumvirate working and action planning and escalation of feedback from Local Faculty Groups		

	Legacy **Trust values** require review supported by a **behavioural framework** to enable culture and OD work (Refer to action 9). Management of **temporary staffing** use and spend. (Refer to long term actions)		
Retention – Looking after our people and their sense of belonging			
2. Actively **looking after the wellbeing of all our staff** and ensure a safe and healthy working environment.	Lack of contract for **salary sacrifice** (Vivup) **and Employee Assistance Programme** (Care First) from Feb 24. (Refer to action 10). Lack of timely and effective **review of national staff survey data** and implementation of local and Trust actions, reviewed on an annual cycle. (Refer to action 11). Lack of **health and wellbeing framework** / strategy. (Refer to action 12) Lack of resource to develop and implement more preventative **VPR** initiatives. (Refer to action 13). Lack of resource and budget for health and wellbeing events and publicity. (Refer to action 14).	1st Line: Monthly meeting with OH service providers (Oct 23, Green). 2nd Line: Annual reporting of Staff Survey and Bi-monthly exception reporting for OH and Health and wellbeing through Health and Safety & Quality and Safety and onto Board (Oct 23, Green). Monthly reporting on VPR to ICB (Oct 23, Green)	Lack of monthly review of staff survey actions, health and wellbeing at SMT and PR's. Currently ICB assurance only covers a small number of projects, inc. VRP
3. Implementing our EDI objectives in order to eliminate discrimination and **ensuring everyone feels that they belong**	Absence of **EDI Group and networks** (Refer to action 5) There is a need to develop a longer term EDI implementation plan. (Refer to long term actions)	1st line: Action plan progress tracked within Workforce on a weekly basis (Nov 23, Green). 2nd Line: Bi-monthly reporting in workforce performance report to F&P and Board (Oct 23, Amber). Monthly reporting on EIA 6 HIA to ICB (Starting in Feb 24).	Development of proxy EDI outcome metrics aligned to NHS requirements
4. Inspiring our leaders in a clinically led culture of kindness, compassion and learning through our existing support for leadership and development.	Lack of **leadership and development framework** (refer to action 15) covering talent (refer to action 16) and leadership (including cultural competence), **just culture, civility** and **high performance** team work and improvement. (Refer to longer term actions). Implementation of clinically led directorate and business unit leadership model, supported by integrated assurance framework and new scheme of delegation. (Refer to long term actions).	2nd line: Bi-monthly exception reporting in workforce performance report to Education and Development Group, F&P and Board (Amber).	None
Development and reform – working as one team and developing a multi-skilled workforce			
5. **Supporting all our staff in their education and development** for the workplace today and tomorrow through: • **strategies to mitigate local skill and recruitment challenges** and respond to national shortages • Embedded **education and training programmes**, covering induction, NHSE and non-mandatory training / CPD funding, **work**	Failure to utilise the entire apprenticeship levy each year (tbc) Underperformance of local induction (all staff groups), appraisal (AfC staff only) and MAST compliance (Medical staff only). (Refer to action 18). There is a need to develop long term workforce planning tools to support new roles and ways of organising work. (Refer to action 19).	1st line: Monthly MAST training reports for managers (Nov 23, Green). 2nd line: Bi-monthly exception reporting in workforce performance report to Education and Development Group, F&P and Board (Oct 23, Green). Annual apprenticeship report (Sept 23, Green).	Lack audit of local induction and appraisal completion including objective setting / PDP. Need to review Education and Development Group TOR Audit of local induction and appraisal completion including objective setting / PDP.

experience and **apprenticeship** supported by bi-monthly Education and Development Group (EDG).			
6. **Working with our partners** as part of a systems based workforce model.	There is a need to develop and implement a People Strategy in line with the Sussex People Plan. Sub-strategies need to be finalised in 2024 (Refer to longer term actions) and further development of collaborative programmes of work to follow (refer to longer term actions).	1st Line: SMT monitoring of immediate strategic priorities. (Oct 23 / Green). 2nd Line: Bi-monthly exception reporting to F&P and Board on Trust performance (Oct 23 / Amber). Monitoring and review of workforce strategy through Strategy Development Group (SDG) October (Oct 23 / Amber).Bimonthly summary and exception reporting at ICB sub groups and People Deliver Board (Nov 23 / Amber).	Development and implementation of new People and Culture Strategy to be reviewed by the Strategic Development Group and F&P. (Refer to longer term actions).

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not started)
1. Development of new People and Culture Strategy	Sept 24	CPO	On track
2. End to end recruitment task and finish group established	Sept 24	Head of Resourcing	Not started
3. POAP for new resourcing Business Partner	Dec 23	CPO	Complete
4. Managing medical rotation guidance	Mar 24	Head of Med Ed	Not started
5. Establishment of new EDI Group and re-establish staff networks	Dec 23	CPO	Complete
6. Inclusion of local induction as part of Trust KPI's	March 24	Deputy CPO	Not started
7. Implementation of new appraisal framework	Dec 23	Deputy CPO	On track
8. Implementation of new Speak Up toolkit recommendations	Oct 23	CPO / CNO	Off track
9. Review of Trust values	Dec 23	CSO	On track
10. Tendering of salary sacrifice and employee assistance programme	Mar 24	Deputy CPO	Not started
11. Focus on local staff survey action planning	April 24	Head of OD	Not started
12. Design and implementation of health and wellbeing plan	Mar 24	Head of ER	Not started
13. VPR implementation in line with ICB plans / case for additional support as part of business planning	Mar 24	Deputy CPO	On track
14. Review resource and budget for health and wellbeing initiatives	Nov 23	CPO	On track
15. Design and implementation of Trust leadership and development framework	June 24	CPO / Head of OD	On track
16. Succession planning for Exec team implemented	Dec 23	CPO	On track
17. Mediation training for managers	April 24	Head of ER	Not started
18. Actively manage underperformance of medical MAST training	Feb 24	Head of Med Ed	Not started
19. Development of workforce planning tools and training	Jun 24	CPO / Head of OD	Not started

Longer term actions (with indicative timeframe e.g. Q1 2024)

- New People and Culture Strategy to be reviewed by the Strategic Development Committee (September 2024)
- Development of values and behavioural framework (September 2024)
- Development of sub-strategies within People Strategy, Inc.:
  - Resourcing
  - Wellbeing strategy
  - Systematic process to support staff development, and career progression (Talent Management)
  - Education strategy
- People strategy, linked to medical, nursing, AHP and strategies by staff group
- Implementation of clinically led directorate and business unit leadership model, supported by integrated assurance framework and new scheme of delegation.
- Improved understanding around temporary staffing use / productivity through new Integrated Assurance Process
- Embedded processes for medium and long term workforce planning with links to transformation

Links to Corporate Risk Register	Risk 8 - Speaking up				
Strategic Aim: KSO 1, 2, 3, 4 and 5	**Overall Assurance Rating (RAG)**	**Q1**	**Q2**	**Q3**	**Q4**
		N/A	N/A	**AMBER**	
Risk Ref & Description: 03 - There is a risk that the Trust's physical infrastructure (i.e. buildings and services) is not fit for purpose to support an effective, efficient and safe environment for operational delivery **Causes:** Ageing infrastructure, lack of financial investment resulting in back log of maintenance / repairs, ineffective governance, inadequate resources, failure of critical third-party suppliers **Consequences:** Potential harm to individuals, disruption to / inefficiencies within clinical and support services, damage to physical infrastructure (i.e. the buildings and the services e.g. heating systems, electrical infrastructure, cooling and ventilation systems), financial loss, regulatory intervention, reputational damage, negative impact on staff morale					
Committee	Finance and performance committee	Date Added:		12 October 2023	
Principal Exec	Chief finance officer	Date Reviewed:		09 November 2023	
Supporting Exec(s)	Director of strategy and partnerships	Last discussed:		24 October 2023 (ELT)	
Risk Assessment	**Consequence**	**Likelihood**		**Score**	
Inherent Risk Rating	5 (severe)	4 (likely)		20	
Current Risk Rating	5 (severe)	3 (possible)		15	
Target Risk Rating	5 (severe)	2 (unlikely)		10 (Target date = June 2024)	
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**		**Gaps in assurance (what additional assurance is needed)**	
1. Fully budgeted backlog maintenance schedule for 23/24 agreed in response to six facet survey (undertaken every 5 years by independent surveyor) for example repairs to clock tower	Produce a detailed 5 year backlog maintenance plan informed by the six facet survey (refer to action 2) Review survey results on an annual basis and adjust backlog maintenance plan as needed (refer to action 11)	1st line: Action plan progress tracked within estates team on a monthly basis (Green) 2nd line: Backlog maintenance schedule for 23/24 reviewed with Finance on a monthly basis to track progress and spend (Green) Summarised backlog maintenance reporting to capital programme group (CPG) on a monthly basis (Amber) Estates and facilities reporting to F&P (quarterly) covers a status update on the backlog maintenance plan progress (Amber) 3rd line: Independent six facet survey which gives a complete assessment of the status risk of entire estate (not due until 2028 per NHS Estates guidance)		Formal report to CPG outlining the detail of the maintenance plan (refer to action 4) Improve quality and detail of report to F&P in January 2024 (refer to action 5)	
2. Contracts in place allowing access to specialist expertise (e.g. external Authorising Engineers, AEs, for medical gases, water, fire, lifts etc) to independently test controls, and provide support in the event of deterioration of the essential services (e.g. advice on remediation)		2nd line: AEs attend and contribute to QVH safety group meetings which are minuted. Contributions include the provision of interim and annual reports; the latter provides assurance on the controls in place. Assurance rating determined as Green based on the		Estates team to create a spreadsheet to show service, name of AE, contract period and reporting arrangements (refer to action 6)	

Findings from third party reviews are sighted by estates team in order to raise / update the departmental risk register		attendance and receipt of reports, not the findings of the reports 3rd line: Annual reports from AEs showing the status of controls in place (e.g. up to date policies, qualifications of staff etc). Assurance rating determined as Amber based on the findings of the reports Annual Asbestos Management Survey to identify high risk areas for removal (June 2023, Amber)	Estates to provide a summary report to F&P to highlight any exceptions arising from the AE annual reports (refer to action 7)
3. Policies and standard operating procedures in place. Mechanism in place for regular review and ratification of policies.	SOPs are not centralised and require a review and possible update to ensure they are fit for purpose (refer to action 3) Training for staff on SOPs (refer to action 3)	2nd line: The monthly estates and facilities steering group (attended by risk function) have oversight of the status of policies and SOPs. Meetings are minuted (Nov 23, Policies = Green, SOPS = Amber)	1st line: Internal review of effectiveness of standard operating procedures (Long term action once the SOPS have been updated)
4. Business continuity plans (BCPs) for dealing with a range of estates issues, for example electricity and water failure.	Review and updating of existing business continuity plans to ensure these are fit for purpose. This should include a review of the full scope of potential scenarios that need planning for (refer to longer term actions) Training for staff regarding business continuity plans for estates (refer to longer term actions) Trust wide testing of business continuity plans (refer to longer term actions)	No formal assurance mechanisms in place; controls are viewed as requiring urgent improvement building in learnings from electricity failure to main theatres incident in August 23	2nd line: Reporting on the status of BCP reviews / tests to the monthly estates and facilities steering group and QVH's Emergency Planning Lead
5. Effective management of critical suppliers including resilience planning (e.g., identification of alternative providers)	Absence of formal Contract Management processes (refer to longer term actions) Lacking comprehensive list of critical suppliers (refer to action 12)	1st line: Monthly or quarterly service reviews with critical suppliers (Nov 23, Red)	Estates team to create schedule for quarterly service review meetings in 2024, with all suppliers to have had initial meeting by 31 March 2024 (refer to longer term action)
6. Planned preventative maintenance (PPM) covering all plant (e.g. regular servicing / inspections) to ensure compliance with statutory legislation / regulations and NHS guidance	No central asset register covering all essential plant (refer to action 1) Opportunity to purchase software SFG20 to schedule out PPM based on updated asset register (refer to longer term actions)	None identified	Estates team to consider assurance mechanisms once asset register and updated PPM are in place (refer to longer term actions)
7. Premises Assurance Model (PAM) annual submission to NHSE in March showing the current status of estate. This is a self- assessment tool across areas including policies / procedures, roles and responsibilities, risk assessment, maintenance, training and development etc. which is used by the estates team to drive a development plan	None identified	None identified	1st line: Summarised PAM results to be routinely reported by the Estates team to F&P (refer to action 9)
8. Roles and responsibilities defined and documented within the estates team	Estates structure, including roles and responsibilities, require review and updating e.g. to ensure all Authorised Person roles are fulfilled (refer action 8)	3rd line:	

		Annual performance management reviews of AP's are carried out by the AE's with findings reporting in the annual report (Nov 23 Green)		
9. Risk management framework in place for the identification, management and reporting of estates risks	Estates risk register requires a review and update (refer action 10)	The monthly estates and facilities steering group (attended by risk function) have oversight of the estates risk register. Meetings are minuted (Nov 23 - Green)		
Immediate Actions		**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. To produce a central Asset list for all essential plant		31 January 2024	Interim associate director of estates and facilities (IADEF)	In progress – completion in Q4 23/24
2. Produce a 5 year back log Maintenance Plan		29 February 2024	IADEF	In progress – completion in Q4 23/24
3. SOP review and development of training programme for 2024		31 January 2024	IADEF	In progress – completion in Q4 23/24
4. Formal report to CPG outlining the detail of the maintenance plan		30 November 2023	IADEF	In progress – completion in Q4 23/24
5. Improve quality and detail of report to F&P in January 2024		31 January 2024	IADEF	In progress – completion in Q4 23/24
6. Estates team to create a spreadsheet to show service, name of AE, contract period and reporting arrangements		31 December 2023	IADEF	In progress –completion December 2023
7. Estates to provide a summary report to F&P to highlight any exceptions arising from the AE annual reports		31 January 2024	IADEF	In progress – completion in January 2024
8. Estates structure, including roles and responsibilities, require review and updating		29 February 2024	IADEF	In progress – completion in Q4 23/24
9. Commence summarised reporting of PAM results to F&P – from Jan 2024		31 January 2024	IADEF	In progress – completion in January 2024
10. Review and update estates risk register		29 February 2024	IADEF	In progress – completion in Q4 23/24
11. Review six facet survey results and adjust backlog maintenance plan as needed with sign off by CFO and F&P (Feb 2024 and annually thereafter)		29 February 2024	IADEF	In progress – completion in Q4 23/24
12. Create comprehensive list of critical suppliers with support from procurement team		31 January 2024	IADEF	In progress – completion in Q4 23/24
13. Recruitment of a substantive Associate Director of Estates and Facilities		31 March 2024	Chief Finance Officer	In progress – completion in Q4 23/24
Longer term actions (with indicative timeframe e.g. Q1 2024)				
- Development of the Estates Strategy - Mar 2024, dependant on the clinical strategy - Rebuild the Hospital Site – New hospital Programme – Timeline to be confirmed - Purchase and launch SFG20 software to support planned preventative maintenance – Mar 2024 - Estates team to consider assurance mechanisms once asset register and updated PPM are in place – Mar 2024 - Establish robust contract management processes and improve compliance with procurement regulations – Mar 2024 - Annual review of six facet survey results and adjust backlog maintenance plan as needed with sign off by CFO and F&P – Mar 2024 - BCP review and development of training / testing programme for 2024 – Mar 2024 - Reporting on the status of BCP reviews / tests to the monthly estates and facilities steering group and Emergency Planning Lead – Mar 2024 - Estates team to create schedule for quarterly service review meetings in 2024, with all suppliers to have had initial meeting by Mar 2024 - Internal review of effectiveness of standard operating procedures – March 2024				
Links to Corporate Risk Register	6 - Major incident			

Strategic Aim: KSOs 1, 2, 3, 4 and 5	Overall Assurance Rating (RAG)	Q1	Q2	Q3	Q4
		N/A	N/A	AMBER	
Risk Ref & Description: <u>04 – There is a risk that the Trust fails to secure its long-term sustainability leading to closure of services and /or the site</u> **Causes:** Inadequate or ineffective strategic planning / delivery, lack of effective stakeholder engagement (internally and externally) / support, internal governance failures, inadequate leadership capability and capacity, failing to address environmental sustainability matters, emergent change at a trust, system or national level that may impact strategy requirements **Consequences:** potential for loss of patient services, reduction in staff morale, challenges with recruitment and retention, loss of community employment and local facilities				
Committee	Strategic Development Committee	Date Added:		September 2023	
Principal Exec	Chief Executive Officer	Date Reviewed:		20 November 2023	
Supporting Exec(s)	Chief Strategy Officer	Last discussed:		ELT 17 October 2023	
Risk Assessment	**Consequence**	**Likelihood**		**Score**	
Inherent Risk Rating	5 (severe)	5 (almost certain)		25	
Current Risk Rating	5 (severe)	3 (possible)		15	
Target Risk Rating	5 (severe)	2 (unlikely)		10 (Target date = September 24)	
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**		**Gaps in assurance (what additional assurance is needed)**	
1. Detailed strategy development framework and milestone roadmap approved by Board in April 2023 Outline strategy structure in place setting out the elements of the strategy including the enabling (e.g. digital) and golden thread strategies (e.g. green plan) Position updated within board seminar / private discussions by Chief Strategy Officer (CSO)	None	<u>2nd line:</u> Strategy updates provided to hospital management team on a monthly basis (Nov 23, Green) Framework specific update provided to Board seminar (Apr 23, Green) <u>3rd line:</u> Framework presented to ICB who reported being supportive of the approach (Sep 23, Green)		None	
2. Detailed strategy development programme plan setting out key milestones and actions. Weekly monitoring of plan within strategy function to ensure delivery and initiate any required actions to variance Milestone roadmap approved by Board in November 2023	None	<u>2nd line:</u> Milestone roadmap updates to ELT meetings on a fortnightly basis (Nov 23, Green) Framework specific update provided to Board seminar for approval of milestone roadmap (Nov 23, Green) Verbal updates provided at SDC meetings by CSO with subsequent written committee assurance report provided by SDC Chair to the Board (September 23, Green)		None	
3. Clear and robust internal governance arrangements for decision making aligned to strategy objectives have been agreed by Chief Executive Officer / Board Chair and documented.	None	<u>2nd line:</u> Annual committee review process provides assurance to the Board that the SDC is delivering in line with its terms of reference (Green).		None	

This includes the initiation of the Strategic Development Committee (SDC) to oversee strategic development / implementation and provide assurance and advice to the Board		3rd Line Governor working group in place to provide additional assurance regarding the committee assurance (Green)	
4. Financial resources budgeted in year to support capacity and capability for strategy development requirements. Resource plan held within strategy team and reviewed by CSO on a monthly basis	Resource for 2024/25 to be identified and budgeted as part of business planning (refer to action 3)	None (assurances in place as part of budgeting process captured within BAF Risk 6 Financial Sustainability)	None
5. Clear and comprehensive stakeholder engagement plans to ensure effective stakeholder engagement with internal and external stakeholders including ICB and system partners across KSS (Kent, Surrey and Sussex). Refer to BAF 8 Partnerships for details.	Refer to BAF 8 Partnerships for details.	Refer to BAF 8 Partnerships for details.	Refer to BAF 8 Partnerships for details.

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Strategy framework and milestone plan to be updated / shared at ELT on a fortnightly basis	1. 19/10/23	CSO	Complete
2. Decision making framework for discussion at board seminar and subsequent development	2. 12/10/23	CSO	Complete
3. Review of resource requirements and updated plan	3. Ongoing	CSO	On track

Longer term actions (with indicative timeframe e.g. Q1 2024/25)

1. Review of strategic options – January 2024 - March 2024 Board
2. Phase 3 engagement plans – January – March 2024

Links to Corporate Risk Register	None

Strategic Aim: KSO 2, 3,4 and 5	Overall Assurance Rating (RAG)	Q1	Q2	Q3	Q4
		N/A	N/A	AMBER	
Risk Ref & Description: <u>05 – There is a risk that the Trust experiences a material legislative or regulatory compliance breach (non-clinical)</u> (This would include financial breaches such as fraud, theft, misuse of NHS funds; breaches of legislation including health and safety; breaches of NHS statutory requirements including licence conditions. This does not include; data breaches which are covered by BAF07 – information assets, or clinical breaches which are covered by BAF01.) **Causes:** failure to identify existing and new requirements, unhelpful behaviours (human error / intentional wrongdoing), staff not being adequately trained, failure of third party to deliver, failure of record keeping or IT systems, ineffective policy frameworks and processes **Consequences:** potential harm to people, regulatory intervention, criminal prosecution, financial losses and reputational damage				
Committee	Finance &Performance Committee	Date Added:		September 2023	
Principal Exec	Chief Executive Officer	Date Reviewed:		28 November 2023	
Supporting Exec(s)	Director of Communication and Corporate Affairs Chief Finance Officer	Last discussed:		ELT 23 November 2023	
Risk Assessment	**Consequence**	**Likelihood**		**Score**	
Inherent Risk Rating	5 (Severe)	4 (Likely)		20	
Current Risk Rating	5 (Severe)	3 (Possible)		15	
Target Risk Rating	5 (Severe)	2 (Unlikely)		10 (Target date = March 24)	
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**		**Gaps in assurance (what additional assurance is needed)**	
1. Governing documents including Trust Constitution, SOs, SFIs, SoD and ToRs for sub-committees which set the parameters for decision making and financial authority	Code of conduct for Governors needs updating (refer to long term action) Examples of staff non-compliance with governing documents as reported to the audit and risk committee (e.g. standing financial instructions (procurement) (refer to action 7) Training for budget holders regarding standing financial instructions and scheme of delegation (Refer to action 7)	<u>2nd Line:</u> Reporting to ARC of compliance with governing documents (e.g at every meeting CFO reports on losses and special payments, contracts over £30k, payments of invoices without a PO, waivers, Amber) Reporting to ARC of compliance with code of governance annually (before end of March 2024, RAG TBC) <u>3rd Line:</u> External audit of compliance with SFIs etc annually which is included in the annual report (June 2023, Green) Internal audit on business standards policy (Nov 2020, Green); Secondary employment audit (Oct 2022, Green).		Review of licence conditions compliance (refer to action 4) Review of code of governance compliance (refer to action 5) Standalone review session on annual governance statement to be scheduled in March 24 ahead of accounts signing in June 24 (refer to action 6)	
2a. Policies and procedures (non-clinical) in place (e.g. fit and proper persons policy in line with legislation and NHS framework, and standards of business conduct policy) 2b. Clearly identified role to support policy framework (e.g. quality filter to check that new policies and procedures are established in line with the policy)	Absence of process for staff checking for new policies and procedures and keeping up to date (refer to action 7) Absence of introduction to policy locations at local induction (refer to action 8)	<u>2nd line:</u> Policy log and review process reported to ARC annually (December 2023, Amber) with Board assurance via the committee assurance report Annual report to Audit & Risk Committee (ARC) on compliance with business standards policy (due		None identified	

2c. Policy expiry dates are monitored and followed up with policy owner to support the regular review of policies and procedures (non-clinical) to ensure they remain up to date and fit for purpose	Absence of core mandatory policies list (e.g. policies for line managers, information governance, business standards) (refer to action 9) Lack of adequate training on policy creation / maintenance ("policy for policies") (refer to action 8) Reliance on policy owners to update policies out of the review cycle when needed – no formal process (refer to action 8) Examples of staff non-compliance with policies as reported to the audit and risk committee (e.g. declarations of interest) (refer to action 8) New fit and proper person record for Board members and self-attestation forms completed (refer to action 12)	December 23, Amber rating anticipated in line with last year) Reporting to ARC of compliance with fit and proper persons policy annually (before end of March 2024, RAG TBC)	
3. Staff induction (corporate and local non-clinical) with mandatory and statutory training (MAST)	ELT and FPC review of MAST data (refer to action 10)	2nd line: Internal reporting of MAST training compliance to executive leadership team, general managers, heads of departments and line managers once per month (31 October 2023, Green)	Reporting of MAST compliance for Trust is done currently for the whole organisation so specific team gaps are not being flagged. ELT and F&P review of MAST data will be included with integrated assurance report (refer to action 10) Assurance that workforce compliance checks and local inductions have been completed and are effective (refer to action 10 and longer term action)
4. Horizon scanning for changes to legislation (through membership of appropriate networks, NHS Providers updates, ongoing contact with external legal advisors, NHSE stakeholder engagement) with internal communication of changes in statutory and regulatory requirements	Lack of standard operating procedure for communicating new statutory and regulatory compliance requirements (refer to action 11)	2nd line: Report to ARC and Board- Review of Annual governance statement annually (June 2023, Green)	None identified
5. CQC preparation action plan for the well-led domain	Gap analysis against CQC well led key lines of inquiry pending completion (refer to action 13)		To agree assurance reporting routes for well-led domain and consolidated assurance for Board Re CQC preparedness including all domains (refer to action 14)
6. External counter fraud support provided by external specialist provider who delivers an annual work programme to meet compliance requirements	None identified	3rd Line: Assurance reporting to ARC from local counter fraud specialist (RSM) quarterly (October 2023, Green)	
7. Review of licence conditions and monitoring of compliance	Code of conduct for Governors needs updating (refer to long term action)	2nd line: Self-certification of compliance with Trust licence conditions reported to the Board (May 2023, Green)	Annual review of compliance with licence conditions by ARC (refer to action 4)
8. Compliance incident framework in place enabling the appropriate investigation, resolution and reporting of incidents tracked through Datix (non-clinical)	Clarity required Re scope of non-clinical incidents currently recorded in Datix and where they are reported (refer to action 10)	None identified	Integrated assurance framework will incorporate non-clinical incidents (refer to action 10)

9. Freedom to Speak Up framework in place	Review of Freedom to Speak Up in progress which may identify control gaps (refer to action 2)	2nd line: Board receive quarterly freedom to speak up reports including updates on numbers of "speak ups", whistleblowing and "Tell Nicky" (Board November 2023, Amber) (ARC December 2023) Audit and Risk Committee receives regular FTSU reporting (October 2023, Amber)	Q&S committee will review F2SU tool kit and action plan until the cultural change is embedded within the organisation (refer action 2)

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Staff awareness raising in preparation for CQC inspection – well led	August 2023-January 2024	Chief Nursing Officer and Director of Corporate Affairs	On track
2. Review of existing Freedom to Speak Up Framework re ability of staff to raise concerns and triangulation of soft intelligence – drafting of recommendations for action	August- November 2023	Chief Nursing Officer and Chief People Officer	On track
3. Delivery and reporting of Trust-wide programme of increased visibility of exec and non-exec colleagues	January 2024	Chief Nursing Officer	On track
4. Schedule annual review of licence conditions by ARC	October 2023	Deputy Company Secretary	Complete
5. Schedule annual review of Code of governance compliance by ARC	October 2023	Deputy Company Secretary	Complete
6. Schedule annual review of annual governance statement by ARC (separate from review of annual report)	October 2023	Deputy Company Secretary	Complete
7. Targeted communication to staff groups to increase awareness of requirements of governing documents and regulatory requirements including training for budget holders regarding standing financial instructions and scheme of delegation	February 2024	Director of Corporate Affairs and Chief Finance Officer	On track
8. Develop policy lists for local inductions, add process for socialisation of new policies to the Policy for policies, develop training for creation and maintenance of policies and explore the use of Pulse to manage organisational policies	February 2024	Chief People Officer and Head of Risk	On track
9. Develop core mandatory policies list (eg policies for line managers- information governance, business standards)	February 2024	Chief People Officer	On track
10. Development of integrated assurance framework	April 2024	Chief Strategy Officer	On track
11. Develop standard operating procedure for communicating new regulatory compliance requirements	April 2024	Deputy Company Secretary	On track
12. Fit and proper person information for each Board member collated and available on ESR, as well as new self-attestation forms completed	March 2024	Deputy Company Secretary	On track
13. Gap analysis against CQC well led key lines of inquiry	December 2023	Director of Corporate Affairs	Off track
14. Establish assurance reporting routes for the CQC well-led domain and a consolidated view on all domains for the Board	December 2023	Director of Corporate Affairs	Off track
Longer term actions (with indicative timeframe e.g. Q1 2024)			
- Implement continuous improvement framework Q4 2023/24			
- Code of conduct for governors to be updated Q1 2024/25			
Links to Corporate Risk Register	Risks 4 - procurement, 6- major incident, 8- speaking up		

Strategic Aim: KSO 1, 2, 3,4 and 5	Overall Assurance Rating (RAG)	Q1	Q2	Q3	Q4
		N/A	N/A	AMBER	

Risk Ref & Description: <u>06 – There is a risk that the Trust is unable to deliver medium to long term financial sustainability</u>
Causes: increasing demand outstrips resources available, impact of investment requirements and inflation, failure to deliver operational efficiencies and /or realise investment programme benefits, potential for unplanned costs (e.g., cyber-attack), lack of available workforce increasing agency spend, Ineffective management of multiple Integrated Care Systems financial transformational risks, impact of political changes and national directives
Consequences: possible loss of operational capacity and failure to provide timely treatment to patients, failure to generate funding for investments, potential for workforce restructuring, and /or reputational damage with loss of confidence from stakeholders (e.g., ICB)

Committee	Finance and performance committee	Date Added:	September 2023
Principal Exec	Chief Finance Officer	Date Reviewed:	October 2023
Supporting Exec(s)	Chief Executive Officer	Last discussed:	ELT 23 November 2023
Risk Assessment	**Consequence**	**Likelihood**	**Score**
Inherent Risk Rating	5 (Severe)	5 (Almost certain)	25
Current Risk Rating	4 (Major)	3 (Possible)	12
Target Risk Rating	3 (Moderate)	3 (Possible)	9 (Target date = March 2029)

Controls (what are we doing about risk)	Gaps in Controls (where are we failing to put systems in place)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
1. Annual business planning process, overseen by steering group, engages the whole organisation to pull together workload for the year and cost of delivery. Included within this is also the efficiency programme to maximise use of resources and identification of risks. The financial plan produced in line with the System Medium term financial plan.	The late publication of National Planning guidance; to mitigate this, key assumptions are made based on existing guidance and early review of planning guidance is scheduled to understand the impact on the plan and ensure timely briefings can be issued to the organisation. No further action required.	<u>2nd line:</u> Progress updates and outputs are reported through the internal governance framework including steering group, ELT, F&P, Board (Green) through Nov to Mar <u>3rd line:</u> Progress updates and outputs are reported to the system (March 2023, Green) Internal audit – review of planning process for 23/24 completed May 23 (3rd line, Green- note this was an advisory review so no audit opinion was issued, but findings support a Green rating).	To link the medium term financial plan with the Trust Strategy when approved.
2. Monthly financial reporting scrutinised by finance team, ELT, F&P and Board	Challenges with triangulating information across finance, workforce and activity / operations – scorecard required (refer to action 5).	<u>3rd line:</u> Internal Audit - Financial Management with reasonable assurance opinion (Q2 2023, Amber)	Financial services audit due to be completed in Q4 (3rd line, RAG rating TBC based on audit opinion)
3. Budget holder meetings with Finance Business Partner are held monthly to discuss financial position and actions to mitigate risks identified	No Formal Budget holder training to budget mangers since Covid19 (refer to action 2)	<u>1st and 2nd line:</u> Monthly directorate performance review meetings provide assurance that budget holder meetings have occurred, and the financial position is understood (Amber)	None identified
4. Directorate performance reviews held monthly to enable the Directorates to raise risks and the Executive to scrutinise the Directorate budgets e.g workforce pressures, agency spend, non pay and Income.	No Formal Budget holder training to budget mangers since Covid19 (refer to action 2). Challenges with triangulating information across finance, workforce and activity / operations – scorecard required (refer to action 5)	<u>1st and 2nd line:</u> Reporting to ELT & F&P committees (Amber)	None identified
5. ICB review of monthly provider finance report provides external scrutiny and CFO peer challenge on financial	The Trust may not be subject to the same level of scrutiny as larger Trusts within the system; mitigation is for the Trust to flag risks upwards to the ICB.	<u>3rd line:</u> System governance in place to evidence review of provider reports via the monthly Financial,	No formal feedback loop to QVH Board to share outcomes of ICS review

risks at a system level which enables the Trust to put in place appropriate mitigations		Productivity and Sustainability board chaired by ICB CEO and attended by system CFOs, CEOs and COOs with minutes prepared (Amber)	
6. Financial policies and procedures in place (including standing orders and financial instructions, scheme of delegation) with an annual review mechanism to ensure that these remain up to date	Financial governance training not in place currently (refer to action 3)	2nd line: Reviewed policies are approved by Audit Committee and Board on an annual basis (Green) Audit Committee receives assurance regarding compliance with policies through items such as waiver reports, PO compliance report, contract renewal report, financial internal audit reports and the annual external audit report (Amber)	None identified
7. Staff training - Training for budget holders on the management of budgets, understanding of financial planning, financial governance.	No Formal Budget holder training (refer to action 2)		Budget holder training not yet started. Reporting of budget holder training completed to ELT, F&P on compliance
8. Risk management processes in place to facilitate the identification and management of finance related risks	Lack of comprehensive Staff Training	2nd line: Audit Committee reporting on design and implementation of risk management framework (Amber) Reporting of financial risks on Corporate Risk Register	None identified
9. Supplier management processes including elements of due diligence	Absence of robust contract management processes including financial due diligence of new suppliers and a degree of non-compliance with procurement regulations (refer to action 1)	Internal audit report on contract management. Only partial assurance	Audit committee Action plan is needed to improvement contract management processes (refer to action 7)
10. System framework: (a) system first principle provides the facility for financial assistance and enables cash drawdowns to support service delivery (b) provider collaboration drives greater levels of productivity and efficiencies to support individual organisations to hit financial targets	System framework is managed by the ICBs which remain in development (refer to action 8)	3rd line System governance in place to evidence review of system efficiency and productivity programmes via the monthly Financial, Productivity and Sustainability board chaired by ICB CEO and attended by system CFOs, CEOs and COOs with minutes prepared (Amber)	No formal feedback loop to QVH Board to share outcomes of ICS review

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Establish robust contract management processes and improve compliance with procurement regulations	March 2024	Chief Finance officer	On track for completion Q4 23/24
2. Rollout of formal Budget holder training	March 2024	Chief Finance officer	On track for completion Q4 23/24
3. Financial governance training for budget holders	March 2024	Chief Finance Officer	On track for completion Q4 23/24
4. Rollout of Risk Management Training	March 2024	DoCE	On track for completion Q4 23/24
5. Develop balance scorecard	April 2024	ELT	Q4 development
6. ICB Finance reports share with ELT, F&P & Board	March 2024	ELT	Q4 Completion
7. Develop an action plan to improve contract management processes	March 2024	Chief Finance Officer	On Track for completion Q4 23/24
8. Work with the system to develop provider collaboratives to drive productivity and efficiency	March 2025	ELT	On Track for completion Q4 23/24
Longer term actions (with indicative timeframe e.g. Q1 2024)			
- Identify opportunities for income growth as part of system collaboration (March 2025)			
Links to Corporate Risk Register	Risks 4 – Procurement, 6 - Major Incident, 10 – Financial Plan		

Strategic Aim: KSOs 1 to 5	Overall Assurance Rating (RAG)	Q1	Q2	Q3	Q4
		N/A	N/A	AMBER	

Risk Ref & Description: 07 - There is a risk that the Trust does not protect and develop its information assets to ensure that they are complete, accurate, accessible, and effectively utilised to support safe and efficient service delivery, fulfilment of strategic objectives, and meet compliance requirements
Causes: inadequate policies / procedures, staff behaviours, limited funding, insufficient implementation and support resources (capacity and capability), external factors (e.g. cyber-attack, third party performance and management, national and ICS governance relating to funding & process requirements)
Consequences: potential for patient harm, inability to deliver services, negative impact on staff, data compromised (confidentiality, integrity and availability) and potentially lost, non-compliance with legislation and best practice standards, poor decision making, reputational damage and financial loss.

Committee	Finance and Performance Committee	Date Added:	September 2023
Principal Exec	Chief Strategy Officer	Date Reviewed:	22 November 2023
Supporting Exec(s)	Director of operations	Last discussed:	13 November (ELT)
Risk Assessment	**Consequence**	**Likelihood**	**Score**
Inherent Risk Rating	5 (Severe)	5 (Almost certain)	25
Current Risk Rating	4 (Major)	3 (Possible)	12
Target Risk Rating	4 (Major)	2 (Unlikely)	8 (Target date = July 2024)
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**	**Gaps in assurance (what additional assurance is needed)**
1. Digital services policies and procedures (Information governance, information technology and security) in place. Policy review period in place for regular review and updates made in line with agreed timescales. 2. A trust wide policy administrator is in place to undertake a weekly review of expired policies	Not all staff adhere to the policies and / or know the details of them (refer to longer term action)	2nd line: Trust wide policy review carried as part of CQC preparation in Sep 2023 (Green) Reporting by the corporate governance team on expired policies / policy refresh at IMT, IGG, performance review meetings and F&P (cyclical and trust wide). Meetings are minuted (Green) An annual report on policy activity including expired policies is also submitted to the Audit & Risk Committee (Green)	None
3. Annual mandatory information governance and data security training in place. Mandatory training reports in place and circulated by OD team for monitoring compliance	There is inconsistent delivery of compliance rates and no systematic formal review (refer to action 1) Need to undertake Board cyber security training (Refer to action 6)	2nd line: Monthly reporting of compliance internally produced by L&D team and issued to service mangers for following up non-compliance L&D produce a snapshot mandatory report as part of the annual DSPT submission to NHSE where the target is 95% compliance (May 23, Green) DSPT submission is presented to the IGG and Audit Committee (May / Jun 23, Green) 3rd line:	None

		Internal audit review a sub-set of the DSPT submission (Apr 23, Green)	
4. Patient administration system induction training on appointment (linked to user access controls - access is not provided until training is delivered). Training and access requests forms are recorded in the Clinical Systems team folders	None	None	Policy principles are clearly defined and upheld therefore it is not considered to be beneficial to put in place any assurance which would need to be a manual and resource intensive process.
5. Ad hoc communications take place trust wide via Connect newsletter regarding password, security, phishing and malware awareness and required action recommendations	Lacking a communications plan to support awareness (refer to action 2)	None	To provide progress report on communications plan to IMT once agreed (refer to action 2)
6. Ongoing security updates, reactive vulnerability scanning and penetration testing – remediation plans monitored through IMT group and SIRO	Lack of available enhanced proactive monitoring tools (refer to action 3).	2nd line Reporting to IMT monthly with associated work plans to address remediation plans (Oct 23, Amber) Monthly reports for vulnerabilities KPIs provided to IMT. Meetings are minuted (Oct 23, Green) Quarterly report to performance review on estate posture vulnerabilities. Meetings are minuted (Green)	None
7. IT system disaster recovery plans in place and regularly reviewed and tested. Annual tabletop business continuity plans	Lack of scheduled complete business continuity IT exercise (refer to longer term action)	3rd Line: External / third party provider leading tabletop digital business continuity exercise with feedback report provided to CIO with IMT having oversight of remediation plans (May 23, Amber). Results of the exercise are reported as part of the DSPT	None
8. Information asset register in place (as an online form) and regularly updated (updates are date stamped). Training provided for information asset owners and administrators to understand the role.	None	3rd Line An extract of the updated asset register is included as part of DSPT evidence (May 23, Green)	None
9. Project resources in place for in project deployments.	Insufficient project management support for some initiatives. Some areas of insufficient governance in relation to digital programme deployment (refer to longer term action)	1st line: Digital led projects will reports RAG status on resourcing through to the digital committee on a monthly basis (Oct 23, Green)	Gaps for some trust wide projects in terms of both programme governance and resourcing (refer to actions 5 and 7)
10. Digital strategy in place	Strategy requires a review (refer to action 4)	2nd LINE: Development of digital strategy is an enabling strategy within overall strategy framework. Timelines and updates on the draft strategy have been presented to SDC (Sep 23, Green)	Draft strategy to be approved at ELT and SDC prior to Board sign off (refer to action 4)
11. Development on an integrated assurance framework to support the effective usage of data aligned to strategic priorities			

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track)

1. IG training to be included within integrated assurance framework deployment	April 2024	CSO	On track
2. Enhancing the communications plan to support data access security awareness with progress report to IMT	January 2024	Head of IT / Comms Manager	In progress
3. Include a SIEM tool into business planning for 24/25	January - March 2023	Head of IT	In progress in terms of business planning process submissions
4. Development of digital strategy with Board approval	December2023	CIO / CSO	Draft strategy complete. Board development arrangements and governance in the process of being confirmed
5. Reconciliation of all digital programmes and reporting to digital steering committee	February 2024	CIO/CSO/DCS	In progress
6. Board development dates for cyber security training	February 2024	CSO / CIO	On track – date confirmed Feb 24
7. Management of programmes and project governance to be considered within trust wide governance review	February 2024	CSO / DCS	In progress

Longer term actions (with indicative timeframe e.g. Q1 2024)

- Project resource assessment and planning exercise – Quarter 1 2024
- Plan a full business continuity exercise - TBD
- Review of trust wide approach regarding policy compliance and understanding – TBD (refer to other BAFs as requires a consolidated approach)
- Mapping of trust wide programme and project governance – TBD
- Review trust wide data usage approach & strategy – Quarter 1 2024

Links to Corporate Risk Register	Risk 6 – Major Incident, Risk 7 – Digital Matuity

Strategic Aim: KSO 1, 2 and 3	Overall Assurance Rating (RAG)	Q1	Q2	Q3	Q4
		N/A	N/A	AMBER	
Risk Ref & Description: 08 There is a risk that the Trust does not develop and maintain collaborative relationships with partner organisations built on shared objectives and mutual trust that may impact adversely on the ability to deliver a sustainable future and trust strategy and improve the health of the populations we serve **Causes:** the Trust and /or system partners do not effectively engage with the system framework or direct arrangements, ineffective communication, absence of shared goals **Consequences:** failure to achieve system and Trust objectives, negative impact on patient outcomes and experience					
Committee	Strategic development committee	Date Added:		September 2023	
Principal Exec	Chief Executive Officer	Date Reviewed:		8 November 2023	
Supporting Exec(s)	Chief Strategy Officer	Last discussed:		13 November 2023 (ELT)	
Risk Assessment	**Consequence**	**Likelihood**		**Score**	
Inherent Risk Rating	5 (Severe)	5 (Almost certain)		25	
Current Risk Rating	5 (Severe)	3 (Possible)		15	
Target Risk Rating	5 (Severe)	2 (Unlikely)		10 (Target date = Jul 24)	
Controls (what are we doing about risk)	**Gaps in Controls (where are we failing to put systems in place)**	**Assurances and RAG rating (how do we know if it's working)**		**Gaps in assurance (what additional assurance is needed)**	
1. Engagement plan in place with key internal and external stakeholders (e.g. staff, system partners, governors, local population, NHSE etc) as a core element of the strategy system development.	None identified System partner engagement outside of strategy	1st line: Engagement tracker in place to report progress against plan; this is reviewed weekly by the strategy team (Green) 2nd line: The final engagement plan was presented to the Strategic Development Committee (SDC) on July 2023 (Green). Verbal engagement updates reported to SDC on a monthly basis. Engagement update reported to Governors (quarterly), JLNC (quarterly), HMT (monthly) and Board (at seminars) with respective meeting minutes evidencing the discussions held on progress reported (Green)		Independent review of stakeholder feedback gathered as part of the engagement plan in progress to provide 3rd line assurance (refer to action 3)	
2. The trust continues to work purposely and proactively to be a trusted system partner in the Sussex ICS to deliver the shared delivery plan and agreed priorities. The trust executive have developed strong working relationships in the ICS and partner organisations. Board level representation at system meetings and where appropriate,	Lack of QVH partnership plan and strategy; this will be developed as an enabling strategy within the overall Trust strategy development programme (refer to action 1) There are potential opportunities for additional QVH Executives to assume system leadership roles (refer to action 4)	1st line: Engagement tracker in place to report progress against plan for engagement pertaining to strategy development; this is reviewed weekly by the strategy team (Green)		None identified	

QVH Executives have taken on leadership roles for ICS programmes within the system oversight board workstreams (these responsibilities are specified within the QVH Exec portfolios which are subject to performance management reviews)		2nd Line: CEO Board update includes high level updates on system relationships (Amber) 3rd Line: Workstreams report updates into the System Oversight Board (monthly) and these meetings are minuted (Amber)	
3. The trust executive is building relationships with the neighbouring ICS (Kent and Medway, Surrey Heartlands) to align opportunities including matters pertaining to the Trust strategy. Senior representation in place at Cancer Alliance meetings and CEO and Director of Strategy connections across providers	Further development of relationships is required where new system leaders are in place (refer to action 1) and a comprehensive engagement plan to be developed	1st line: Engagement tracker in place to report progress against plan for engagement pertaining to strategy; this is reviewed weekly by the strategy team (Green) 2nd line: Verbal engagement updates reported to SDC on a monthly basis with subsequent written committee assurance report provided by SDC Chair to the Board (September 23, Green) Engagement update reported to Governors (quarterly), JLNC (quarterly), HMT (monthly) and Board (at seminars). Respective meeting minutes provide evidence that discussions are held on progress reported in the update (Green)	None identified
4. The well led review in Dec 2022 provided a useful source of partner feedback. The trust is implementing a well led action plan to address recommendations of the review and inform its ongoing engagement plans	Review of external partnership feedback findings in well led review to inform ongoing engagement action plan (refer to action 2)	Action plan reported bi-monthly to ELT	Assurance reporting of the implementation of well led partnership engagement actions to SDC and Board once these have been defined

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Full engagement plan (in addition to strategy development plan)	February 2024	DCCA	Not yet started
2. Review well led plan for specific recommendations to strengthen external partner relationships and build action updates into assurance reporting	December 2023	CEO / DCCA	Complete
3. Independent review of strategy stakeholder feedback	December 2023	CSO	Complete
4. Consider potential opportunities for additional QVH Executives to assume system leadership roles	January 2024	CEO / Executives	In progress

Longer term actions (with indicative timeframe e.g. Q1 2024)

- Develop partnership strategy – Q1 2024
- Engagement and provide leadership support to ICS provider collaborative developments – TBC with system timescales and requirements

Links to Corporate Risk Register	Risk 13 – partnership and commissioner risk

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/01/2024		**Agenda reference:**	**137-24**	
Report title:	Financial, workforce and operational performance assurance				
Sponsor:	Peter O'Donnell, committee Chair				
Author:	Peter O'Donnell, committee Chair Ellie Simpkin, governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance to the Board in relation to matters discussed at the Finance & performance committee meeting on 4 January 2024.				
Summary of key issues:	- Performance against 62 day cancer target is a challenge with late referrals and patients with complex pathways impacting on performance. - The total waiting list has increased by 2.8% from month seven. The committee noted the actions being taken to support the management of the long waiters. - Revisions have been made to the QVH operating plan in response to national reforecasting to manage the financial and performance pressures created by the significant industrial action. - The Trust continues to perform well against workforce key performance indicators. There are challenges; spend on bank and agency remains under review and time to hire remains a concern. - The Trust continues to report and forecast a breakeven position. - The national cost collection submission 2022/23 has been completed in line with the Approved Costing Guidance. - The committee reviewed BAFs 02, 03, 05, 06 and 07. Queries were raised as to whether the BAFs accurately reflect the organisation's health given all ratings are either amber or red and asked the executive to review in the next iteration				
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:					
	Date:		Decision:		
Next steps:	None				

Report to:	Board Directors
Agenda item:	137-24
Date of meeting:	11 January 2024
Report from:	Peter O'Donnell, committee Chair
Report author:	Peter O'Donnell, committee Chair Ellie Simpkin, governance officer
Date of report:	4 January 2024
Appendices:	None

Financial, workforce and operational performance assurance

Introduction
This purpose of this report is to provide the Board with assurance on matters considered by the Finance & performance committee at its meeting on 4 January 2024.

Operational performance
The committee received the operational performance summary for month eight. Performance against 62 day cancer target is a challenge with late referrals and patients with complex pathways impacting on performance. The Trust continues to remain compliant with the Faster Diagnosis Standard. The total waiting list has increased by 2.8% from month seven. The committee noted the actions being taken to support the management of the long waiters including the two 'super Saturday' theatre sessions with further additional theatre sessions planned to continue throughout the remainder of the financial year. Further details on the waiting list fluctuations has been requested. The committee was pleased to note that the DMO1 performance for sleep is continuing to improve, in line with the trajectory.

Plans have been made to protect clinical priority and long waiting patients during the periods of junior doctor industrial action where possible, however, there will be an impact on performance trajectories.

The committee also received details on the revisions which have been made to the QVH operating plan in response to national reforecasting to manage the financial and performance pressures created by the significant industrial action. Plans are underway for QVH to achieve zero 65/78 week waits by March 2024. The committee has asked for further details on the financial implications and the risks of revised plan and also an assessment of the impacts of industrial action.

Workforce
The Trust continues to perform well against workforce key performance indicators. Vacancy rates remain low and work on the implementation of the equality, diversity and inclusion action plan is ongoing. There are challenges; spend on bank and agency remains under review and the committee has asked for confirmation that this is driven by the over-performance against activity plans and inflationary pressures driven by the industrial action. Time to hire remains a concern, partly due to visa issues but there are also avoidable delays in shortlisting. It is hoped that new digital on boarding software will improve delays across both medical and non-medical workforce.

Discussion was had on the continuing work on diversity and inclusion and improving the Trust's culture around psychological safety to raise concerns. The committee remains supportive of management actions in these areas.

An update was given on the actions being taken to improve the appraisal quality assurance process which include a new appraisal form and training package which will focus on equipping managers with the skills to undertake meaningful appraisal conversations and effectively manage performance. Compliance analysis and trends will form part of the monthly workforce data. The committee also received an overview of the Trusts compliance and status of medical appraisals, job plans and revalidation.

Finance
The Trust continues to report and forecast a breakeven position. Additional income has been received from NHS Sussex to cover the cost of pay awards above the original planning assumption. Additional pay costs have been incurred as a result of the industrial action. Efficiency targets have been achieved. Delivery of the capital programme continues and it is anticipated that there will be a significant increase n spend in the next few months. Capital leads have been reminded of the need to progress at pace to spend the capital allocation for 2023/24.

The national cost collection submission 2022/23 has been completed in line with the Approved Costing Guidance. Key observations include a significant increase in overhead costs from the previous year, an increase in depreciation costs by £500k from 2021/22 and an increase in building equipment £1.5m from 2021/22. The finance team will be working with operational management to understand in more detail the drivers of the cost increases to inform financial and performance management.

The committee received an update on the business planning for 2024/25 including the system planning principles and proposed provider funding arrangements. Internal business planning has commenced and a baseline activity plan has been constructed using current activity run-rate. The committee looks forward to receiving further details as planning progresses and discussed ensuring there is appropriate Board sign-offs before submission.

Board Assurance Framework
The committee reviewed BAFs 02, 03, 05, 06 and 07. Queries were raised as to whether the BAFs accurately reflect the organisation's health given all ratings are either amber or red and asked the executive to review in the next iteration. The committee was also concerned about whether the documentation provided will allow the Board to clearly identify, assess and monitor the most critical areas of concern for the Trust, given amount of information being presented.

Integrated Assurance Framework
The committee was introduced to the Integrated Assurance Framework (IAF) which will support the achievement of the Trust's vision and strategy through a defined approach to oversight and assurance of service delivery that links the team/wards through the business units to the directorates and the Trust Board. The aim is to have the IAF in place for 2024/25.

Other
- The Trust has increased its compliance with Violence Prevention and Reduction Standards from 21% in March 2023 to 47% in October 2023. A working group has been established and is developing an action plan to meet the standards and reduce the number of violent and aggressive incidents, while increasing the levels of reporting.
- Good progress is being made to improve the resilience of the estate.

- A summary of requests made under the Freedom of Information Act 2000 during the period May to November 2023 and an update on the work being undertaken by the Trust's Information Governance Group was noted.

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:	11/01/2024	**Agenda reference:**	**138-24**		
Report title:	Financial performance report (month 8)				
Sponsor:	Maria Wheeler, Chief finance officer				
Author:	Jeremy Satchwell, Interim deputy chief finance officer				
Appendices:	Appendix one: Financial performance data				
Executive summary					
Purpose of report:	To present an overview of the Financial position of the Trust at the end of November 2023				
Summary of key issues	Month 8 Key Financial Data. At the close of November, the Trust achieved a breakeven position and the Forecast Outturn is Breakeven. The Trust: • had £12.2m Cash in the Bank • Achieved efficiency targets • Achieve Better Payment Practice Code (BPPC) Targets				
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:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	Board of Directors
Agenda item:	93-24
Date of meeting:	11/01/2024
Report from:	Maria Wheeler, Chief finance officer
Report author:	Jeremy Satchwell, Interim deputy chief finance officer
Date of report:	15/12/2023
Appendices:	Appendix one: Financial performance data

Finance Report-Month 8

1. Introduction

This report presents an overview of the financial position of the Trust at the end of November 2023 (Month 8). Key Financial data are presented in this report and the report is accompanied by an Appendix which provides the detailed financial tables setting out Income and Expenditure, The Statement of Financial Position, Cash Flow, Efficiencies, Capital Expenditure and Better Payment Practice code statistics.

2. Executive summary

Financial Metric	Period	Result Month 8
Income and Expenditure	YTD	Breakeven
	Year End Forecast	Breakeven
Cash at Bank	YTD	£12.23m
Capital spend	Plan YTD	£6.05m
	Actual YTD	£2.402m
BPPC (Combined NHS & Non NHS)	YTD Volume (%)	95.0%
	YTD Value (%)	93.5%
Efficiencies	Plan YTD	£3.63m
	Actual YTD	£3.62m
	Year End Forecast	£5.5m (5.5%)

Figure 1: Key Financial Performance Metrics

- At the close of October, the Trust has achieved a breakeven position and retained cash balances of £12.23m. The Forecast Outturn is Breakeven.
- The approved AfC, VSM & M&D pay awards have been settled and additional income received from the ICB to cover the increased costs above the original planning assumption. These have not resulted in a material cost pressure.
- Patient Activity levels are broadly in line with plan although elective patient activity was reduced in each month in April to October through industrial action.
- Additional pay costs have been incurred as a result of the industrial action.
- Efficiencies of £3.62m have been delivered in line with the plan.
- Capital Expenditure is £2.402m at the close of November from a year to date plan (as per original planning assumptions at the start of the year) of £6.05m.

3. Income and Expenditure

Financial Performance Month 8 2024 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	7,537	7,920	8,218	298	60,016	63,361	63,070	(291)	95,042	94,757	(285)
Other Operating Income	387	246	398	151	2,227	1,972	2,787	815	2,958	4,084	1,126
Total Income	**7,924**	**8,167**	**8,616**	**449**	**62,243**	**65,333**	**65,857**	**524**	**98,000**	**98,841**	**841**
Pay											
Substantive	(4,539)	(5,086)	(5,107)	(21)	(35,640)	(40,687)	(38,911)	1,777	(61,031)	(58,691)	2,340
Bank	(295)	(257)	(330)	(74)	(2,736)	(2,041)	(2,716)	(675)	(3,068)	(4,122)	(1,054)
Agency	(110)	(40)	(138)	(98)	(744)	(321)	(1,047)	(726)	(482)	(1,429)	(947)
Total Pay	**(4,944)**	**(5,383)**	**(5,576)**	**(193)**	**(39,119)**	**(43,050)**	**(42,674)**	**376**	**(64,581)**	**(64,242)**	**339**
Total Non Pay	**(2,492)**	**(2,294)**	**(2,535)**	**(242)**	**(19,356)**	**(18,362)**	**(19,108)**	**(746)**	**(27,536)**	**(28,090)**	**(555)**
Total Non Operational Expenditure	**(508)**	**(490)**	**(528)**	**(38)**	**(3,928)**	**(3,922)**	**(4,259)**	**(337)**	**(5,883)**	**(6,785)**	**(902)**
Total Expenditure	**(7,944)**	**(8,167)**	**(8,639)**	**(472)**	**(62,403)**	**(65,333)**	**(66,041)**	**(707)**	**(98,000)**	**(99,118)**	**(1,118)**
Surplus / (Deficit)	**(20)**	**(0)**	**(24)**	**(24)**	**(160)**	**(0)**	**(184)**	**(184)**	**0**	**(277)**	**(277)**
TechnicalAdjustments	(343)		20	**20**	140		140	**140**		**277**	277
Adjusted Surplus / (Deficit)	**(363)**	**(0)**	**(4)**	**(4)**	**(20)**	**(0)**	**(44)**	**(44)**	**0**	**0**	**0**

Figure 2: Income and Expenditure Summary Month 8

3.1 Patient Activity Income

Impact of industrial action – estimated financial impacts presented in the table below, based on shortfall in average daily income for that month when compared to the days with industrial action

	Value Weighted Activity (VWA) performance vs relevant month in 2019/20	Impact of Industrial Action - lost income
April	111%	£141k
May	116%	£0k
June	107%	£96k
July	109%	£342k
August	102%	£213k
September	108% (Est)	£132k
October	117% (Est)	£226k
November	120% (Est)	£0k
Total	112% (YTD Estimate)	£1,150k

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

- Activity: NHSE published ERF achievement is 110% for M1 to M5. Estimates are provided for the months following this with a pre-flex and freeze figure of 120% for M8.
- The M8 estimated YTD position is 112% VWA.
- Estimated YTD ERF contract value adjustment is an over performance of £900k YTD.

3.2 Non Patient Care Income

- This is various non-patient related income sources e.g. catering, parking, Health Education England funding and is above plan and expected to continue to the year end.

3.3 Expenditure

- Pay costs are under plan year to date and vacancies in substantive posts offset by temporary staff costs. This trend has abated in month variance for the first time this reporting year.
- Increased Substantive staff costs & FTE are due to successful recruitment.
- Increased Bank and Agency costs incurred as a result of industrial action since April

3.4 Efficiencies

- The requirement for delivery of 5.5% efficiency is a national planning assumption.
- The re-set of the budgets at the start of the year has delivered 3.5% efficiency recurrently.
- 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.

Efficiency Savings 2023/24 YTD	Actual 30/06/2023 Month 3	Actual 31/07/2023 Month 4	Actual 31/08/2023 Month 5	Actual 30/09/2023 Month 6	Actual 31/10/2023 Month 7	Actual 30/11/2023 Month 8	Plan 31/07/2023 YTD	Actual 31/07/2023 YTD	Variance 31/07/2023 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	£'000	£'000	£'000
Efficiency Savings - by category												
Pay Efficiencies												
Establishment reviews	288	288	288	288	282	288	2,301	2,298	(3)	3,452	3,452	0
Service re-design - pay	0	0	0	0	0	0	1,200	0	(1,200)	1,800	600	(1,200)
Other - pay (Non-recurrent Vacancies)	163	162	163	168	167	169	0	1,310	1,310	0	1,686	1,686
Total Pay	**451**	**450**	**451**	**456**	**449**	**457**	3,501	**3,608**	**107**	5,252	5,359	107
Non-pay Efficiencies												
Medicines optimisation	0	0	0	0	0	0	0	0		0		0
Procurement (excl drugs) -non-clinical	3	3	3	3	3	3	0	24	24	0	39	39
Service re-design - Non-pay	0	0	0	0	0	0	132		(132)	201	69	(132)
Total Non-Pay	**3**	**3**	**3**	**3**	**3**	**3**	132	**24**	**(108)**	201	93	**(108)**
Total Income	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Efficiencies	**454**	**453**	**454**	**459**	**452**	**460**	**3,633**	**3,632**	**(1)**	**5,453**	**5,452**	**(1)**

Figure 3: Efficiency Savings

3.5 Risks and Mitigations

Risk Description	Risk Value £.000	Mitigation
Consultant Bank Rate increase (Curr RR)	128	Reduction of WLI work
Backlog Radiology Cover	244	Spend reduction through grip & control
Histopathology Insourcing Agreement	80	Spend reduction through grip & control
Increased Premises Cost Inflation	270	Spend reduction through grip & control
	721	

Figure 4: Risks and Mitigations

3.6 Capital Expenditure

- Capital Expenditure is £2.402m at the close of November from a year to date plan (as per original planning assumptions at the start of the year) of £6.05m.
- As context, the original Plan is broken down as follows

- ✓ £3.93m Budget to date for the EPR and CDC projects (funded by PDC)
- ✓ £2.12m Budget to date (funded by internally generated CRL)

- It has been highlighted to Capital leads that they need to progress at pace to spend the capital allocation for 2023/24.
- It is noted that the remaining spend of £1.195m relates to new IFRS16 leases, which were not included in the original plan. We are currently holding tentative conversations with the ICS & NHSE with regard to securing additional funding for these. Funding for the IFRS 16 has been allocated at systems level, this funding is limited and does not cover system's requirement. We are yet to be notified of the next step, If we do not secure any additional funding, we will need to use our internal capital allocation, which will reduce our available capital in this year.

Capital Performance @M8 2023/24		YTD Actuals (000)	YTD Plan (000)	YTD Variance (000)	Annual Plan (000)	Forecast (000)
Externally Funded (by PDC)	EPR - Central Programme	376	2,000	(1,624)	4,500	2,156
	CDC - Central Programme	315	1,930	(1,615)	1,930	1,930
	Estates - CRL Not Agreed by the ICS	0	0	0	1,014	0
	Total Externally Funded Schemes	**691**	**3,930**	**(3,239)**	**7,444**	**4,086**
Internally Funded	Medical Devices	19	350	(331)	600	600
	IM & T	54	575	(521)	985	985
	Estates - Backlog Maintenance	443	1,050	(607)	2,982	2,982
	Business cases	0	147	(147)	250	250
	Total Internally Funded Schemes	**516**	**2,122**	**(1,606)**	**4,817**	**4,817**
Unfunded (Funding stream tbc)	New Lease - MRI Scanner	787	0	787	0	787
	New Lease - Theatre Power Banks	408	0	408	0	408
	Total Unfunded Schemes	**1,195**	**0**	**1,195**	**0**	**1,195**
	Total 2023/24 Capex Programme	**2,402**	**6,052**	**(3,650)**	**12,261**	**10,098**

Figure 6: Capital Performance

4. Sussex System Financial summary

The following tables are provided by the Sussex ICB for Month 7 financial results.

	System YTD Summary - I&E (£000s)			
Provider	**YTD Plan**	**YTD Actual**	**Variance (adverse)/ favourable**	**Variance as % of YTD Planned Income**
ESHT	-	(4,848)	(4,848)	(1.28%)
QVH	5	-	(5)	(0.01%)
SCFT	(1,127)	(1,055)	72	0.04%
SPFT	(3,422)	(7,413)	(3,991)	(1.32%)
UHSx	(5,772)	(29,249)	(23,477)	(2.81%)
ICB	-	(8,701)	(8,701)	-
Total	**(10,316)**	**(51,266)**	**(40,950)**	**(2.34%)**

N.B. 1: The £5k variance is a result of rounding's in the plan.

Figure 5: Summary of all Sussex Providers at month 7

5. Recommendation

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

Financial Performance Report: Appendix

Maria Wheeler, Chief Finance Officer

November 2023
Month 8

Income & Expenditure Month 8

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 8 2024
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	*7,537*	7,920	8,218	298	*60,016*	63,361	63,070	(291)	95,042	94,757	(285)
Other Operating Income	*387*	246	398	151	*2,227*	1,972	2,787	815	2,958	4,084	1,126
Total Income	***7,924***	**8,167**	**8,616**	**449**	***62,243***	**65,333**	**65,857**	**524**	**98,000**	**98,841**	**841**
Pay											
Substantive	*(4,539)*	(5,086)	(5,107)	(21)	*(35,640)*	(40,687)	(38,911)	1,777	(61,031)	(58,691)	2,340
Bank	*(295)*	(257)	(330)	(74)	*(2,736)*	(2,041)	(2,716)	(675)	(3,068)	(4,122)	(1,054)
Agency	*(110)*	(40)	(138)	(98)	*(744)*	(321)	(1,047)	(726)	(482)	(1,429)	(947)
Total Pay	***(4,944)***	**(5,383)**	**(5,576)**	**(193)**	***(39,119)***	**(43,050)**	**(42,674)**	**376**	**(64,581)**	**(64,242)**	**339**
Total Non Pay	***(2,492)***	**(2,294)**	**(2,535)**	**(242)**	***(19,356)***	**(18,362)**	**(19,108)**	**(746)**	**(27,536)**	**(28,090)**	**(555)**
Total Non Operational Expenditure	***(508)***	***(490)***	***(528)***	**(38)**	***(3,928)***	***(3,922)***	***(4,259)***	**(337)**	***(5,883)***	***(6,785)***	**(902)**
Total Expenditure	***(7,944)***	**(8,167)**	**(8,639)**	**(472)**	***(62,403)***	**(65,333)**	**(66,041)**	**(707)**	**(98,000)**	**(99,118)**	**(1,118)**
Surplus / (Deficit)	***(20)***	**(0)**	**(24)**	**(24)**	***(160)***	**(0)**	**(184)**	**(184)**	**0**	**(277)**	**(277)**
TechnicalAdjustments	*(343)*		*20*	***20***	*140*		*140*	***140***		**277**	*277*
Adjusted Surplus / (Deficit)	***(363)***	***(0)***	***(4)***	***(4)***	***(20)***	***(0)***	***(44)***	***(44)***	***0***	**0**	***0***

Run Rate Month 8

Queen Victoria Hospital
NHS Foundation Trust

Financial Performance Month 8 2024

Run Rate £,000

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Income													
Patient Activity Income	7,537	7,301	6,993	6,928	10,236	8,153	7,196	7,897	7,826	7,815	7,825	8,140	8,218
Other Operating Income	387	273	867	572	515	313	324	244	355	340	355	457	398
Total Income	***7,924***	***7,575***	***7,859***	***7,499***	***10,751***	***8,467***	***7,520***	**8,141**	**8,181**	**8,155**	**8,181**	**8,597**	**8,616**
Pay													
Substantive	(4,539)	(4,464)	(4,522)	(4,513)	(5,919)	(4,522)	(4,526)	(5,046)	(4,710)	(5,041)	(5,168)	(4,789)	(5,107)
Bank	(295)	(251)	(382)	(388)	(440)	(392)	(200)	(358)	(380)	(339)	(339)	(377)	(330)
Agency	(110)	(101)	(108)	(43)	(160)	(149)	(140)	(130)	(155)	(130)	(94)	(111)	(138)
Total Pay	***(4,944)***	***(4,816)***	***(5,012)***	***(4,944)***	***(6,520)***	***(5,063)***	***(4,866)***	***(5,535)***	***(5,245)***	***(5,511)***	***(5,601)***	***(5,277)***	***(5,576)***
Total Non Pay	***(2,492)***	***(2,277)***	***(2,342)***	***(2,087)***	***(3,656)***	***(2,939)***	***(2,183)***	***(2,124)***	***(2,495)***	***(2,190)***	***(2,130)***	***(2,511)***	***(2,535)***
Total Expenditure	***(7,944)***	***(7,595)***	***(7,879)***	***(7,519)***	***(10,804)***	***(8,487)***	***(7,540)***	***(8,161)***	***(8,201)***	***(8,175)***	***(8,201)***	***(8,637)***	***(8,639)***
Surplus / (Deficit)	***(20)***	***(20)***	***(20)***	***(20)***	***(53)***	***(20)***	***(20)***	***(20)***	***(20)***	***(20)***	***(20)***	***(40)***	***(24)***

Workforce Financial performance Month 8

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 8 2024
Workforce

	In Month WTE					In Month £'000					Year to Date £'000				
	22/23	Plan	Actual	Variance	Total Pay Variance	*22/23*	Plan	Actual	Variance	Total Pay Variance	*22/23*	Plan	Actual	Variance	Total Pay Variance
Substantive															
Admin & Clerical	277.05	317.62	306.26	11.36	(8.68)	*(942)*	(1,175)	(1,149)	26	(33)	*(7,572)*	(9,398)	(8,590)	808	173
Allied Health Professionals & Healthcare Scientists	168.45	176.50	177.68	-1.18	(4.51)	*(694)*	(775)	(771)	4	(15)	*(5,429)*	(6,196)	(5,894)	302	140
Medical	168.42	172.45	168.73	3.72	(0.27)	*(1,734)*	(1,809)	(1,948)	(138)	(207)	*(13,190)*	(14,473)	(14,516)	(43)	(545)
Nursing & Healthcare Assistant	86.15	99.87	96.16	3.71	1.33	*(200)*	(260)	(243)	17	(2)	*(1,670)*	(2,078)	(1,987)	91	(102)
Qualified Nursing	188.63	202.23	183.76	18.47	14.46	*(820)*	(939)	(838)	101	37	*(6,549)*	(7,513)	(6,662)	852	479
Support Staff	54.04	52.27	60.58	-8.31	(9.44)	*(149)*	(129)	(158)	(30)	27	*(1,229)*	(1,029)	(1,261)	(232)	231
Substantive Total	**942.74**	**1,020.94**	**993.17**	**27.77**	**(7.11)**	***(4,539)***	**(5,086)**	**(5,107)**	**(21)**	**(193)**	***(35,640)***	**(40,687)**	**(38,911)**	**1,777**	**376**
Bank															
Admin & Clerical	27.67	10.89	26.29	-15.40		*(77)*	(31)	(67)	(36)		*(633)*	(252)	(633)	(382)	
Agency															
Admin & Clerical	3.99	1.00	5.64	-4.64		*(99)*	(4)	(26)	(23)		*(309)*	(29)	(282)	(253)	
Qualified Nursing	1.70	6.90	8.64	-1.74		*(8)*	(31)	(56)	(25)		*(131)*	(250)	(389)	(139)	
Support Staff	0.00	0.00	0.00	0.00		*0*	0	0	0		*1*	0	0	0	
Agency Total	**8.27**	**9.80**	**17.72**	**-7.92**		***(110)***	**(40)**	**(138)**	**(98)**		***(744)***	**(321)**	**(1,047)**	**(726)**	
Workforce Total	**1,024.36**	**1,082.98**	**1,090.09**	**-7.11**		***(4,944)***	**(5,383)**	**(5,576)**	**(193)**		***(39,119)***	**(43,050)**	**(42,674)**	**376**	

Please note In Month & YTD Plan £ are still subject to pay uplift resulting in an improved variances.

Efficiencies month 8

Queen Victoria Hospital NHS Foundation Trust

Efficiency Savings 2023/24 YTD	Actual 30/06/2023 Month 3	Actual 31/07/2023 Month 4	Actual 31/08/2023 Month 5	Actual 30/09/2023 Month 6	Actual 31/10/2023 Month 7	Actual 30/11/2023 Month 8	Plan 31/07/2023 YTD	Actual 31/07/2023 YTD	Variance 31/07/2023 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	£'000	£'000	£'000
Efficiency Savings - by category												
Pay Efficiencies												
Establishment reviews	288	288	288	288	282	288	2,301	2,298	(3)	3,452	3,452	0
Service re-design - pay	0	0	0	0	0	0	1,200	0	(1,200)	1,800	600	(1,200)
Other - pay (Non-recurrent Vacancies)	163	162	163	168	167	169	0	1,310	1,310	0	1,686	1,686
Total Pay	**451**	**450**	**451**	**456**	**449**	**457**	3,501	**3,608**	**107**	5,252	5,359	107
Non-pay Efficiencies												
Medicines optimisation	0	0	0	0	0	0	0	0		0		0
Procurement (excl drugs) -non-clinical	3	3	3	3	3	3	0	24	24	0	39	39
Service re-design - Non-pay	0	0	0	0	0	0	132		(132)	201	69	(132)
Total Non-Pay	**3**	**3**	**3**	**3**	**3**	**3**	132	**24**	**(108)**	201	93	**(108)**
Total Income	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Efficiencies	**454**	**453**	**454**	**459**	**452**	**460**	**3,633**	**3,632**	**(1)**	**5,453**	**5,452**	**(1)**

Cashflow Report Month 8

Queen Victoria Hospital
NHS Foundation Trust

Financial Performance Month 08 2023/24

Cashflow Report

	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Actual £'000	Actual £'000
	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23
Opening Balance	**9,158**	**14,834**	**13,930**	**13,207**	**15,350**	**11,719**	**10,880**	**13,372**	**13,465**	**13,890**	**10,153**	**10,765**	**12,232**
Receipts													
NHS Block & System income	12,731	6,698	7,101	8,951	7,267	8,334	9,566	9,634	8,446	7,554	8,806	9,733	7,659
Receipts from other income	553	184	344	424	231	244	647	374	327	859	340	386	463
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Cash Support Received	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Receipts	**13,285**	**6,882**	**7,445**	**9,375**	**7,498**	**8,578**	**10,213**	**10,008**	**8,773**	**8,412**	**9,145**	**10,119**	**8,122**
Payments													
Payments to NHS Bodies	(295)	(402)	(437)	(264)	(241)	(667)	(440)	(292)	(371)	(323)	(153)	(371)	(307)
Payments to non-NHS bodies	(2,170)	(2,587)	(2,664)	(2,170)	(5,055)	(3,817)	(2,460)	(3,022)	(2,184)	(6,708)	(2,235)	(2,783)	(2,123)
Capital Payments	(228)												
Net Payroll Payment	(2,743)	(2,744)	(2,677)	(2,719)	(2,949)	(2,733)	(2,708)	(4,037)	(2,788)	(2,928)	(3,110)	(1,592)	(1,461)
Payroll Taxes	(1,363)	(1,301)	(1,284)	(1,302)	(1,323)	(1,436)	(1,344)	(1,354)	(2,163)	(1,372)	(1,394)	(2,991)	(2,931)
Pensions Payment	(810)	(751)	(673)	(776)	(762)	(763)	(769)	(783)	(843)	(818)	(822)	(916)	(859)
PDC Dividends Payment				-	(799)	-	-				(820)	-	-
Loan Interest & Repayment	-		(433)	-	-	-	-	(427)					
Interim Revenue Loan Interest & Repayment	-			-	-	-	-					-	-
Total Payments	**(7,609)**	**(7,785)**	**(8,169)**	**(7,232)**	**(11,129)**	**(9,416)**	**(7,722)**	**(9,915)**	**(8,349)**	**(12,149)**	**(8,533)**	**(8,652)**	**(7,681)**
Net Cash Movement	**5,676**	**(903)**	**(723)**	**2,143**	**(3,631)**	**(838)**	**2,491**	**93**	**425**	**(3,737)**	**612**	**1,466**	**441**
Closing Balance	**14,834**	**13,930**	**13,207**	**15,350**	**11,719**	**10,880**	**13,372**	**13,465**	**13,890**	**10,153**	**10,765**	**12,232**	**12,673**

Debtors Month 8

Queen Victoria Hospital
NHS Foundation Trust

Financial Performance 2023/24

Trade Creditors @ M8

	Oct 22 £'000	Nov 22 £'000	Dec 22 £'000	Jan 23 £'000	Feb 23 £'000	Mar 23 £'000	Apr 23 £'000	May 23 £'000	Jun 23 £'000	Jul 23 £'000	Aug 23 £'000	Sep 23 £'000	Oct 23 £'000	Nov 23 £'000	In Month Change £'000
NHS Accounts Payable Creditors															
0-30 Days Past Invoice Due Date	490	382	388	334	253	799	385	303	364	726	290	392	223	281	57
31-60 Days Past Invoice Due Date	23	163	187	78	241	56	106	156	79	(305)	475	106	119	96	(22)
61-90 Days Past Invoice Due Date	232	72	96	184	17	196	99	147	128	79	(304)	504	133	119	(14)
Over 90 Days Past Invoice Due Date	185	399	661	734	846	855	978	1,005	1,140	1,241	1,315	1,006	1,486	1,601	115
Total NHS Accounts Payable Creditors	**929**	**1,016**	**1,331**	**1,330**	**1,357**	**1,906**	**1,568**	**1,611**	**1,711**	**1,741**	**1,777**	**2,008**	**1,961**	**2,097**	**136**
Non NHS Accounts Payable Creditors															
0-30 Days Past Invoice Due Date	795	1,038	912	575	789	1,741	929	1,120	969	756	1,014	966	835	1,344	509
31-60 Days Past Invoice Due Date	29	41	85	54	19	86	44	48	91	53	26	317	77	54	(23)
61-90 Days Past Invoice Due Date	12	11	19	70	30	18	43	17	19	40	39	19	2	70	68
Over 90 Days Past Invoice Due Date	10	23	55	64	106	146	85	86	43	55	37	51	38	38	1
Total Non NHS Accounts Payable Creditors	**846**	**1,112**	**1,072**	**763**	**945**	**1,991**	**1,101**	**1,271**	**1,122**	**903**	**1,116**	**1,353**	**952**	**1,506**	**555**
Total Accounts Payable Creditors	**1,775**	**2,128**	**2,403**	**2,093**	**2,302**	**3,897**	**2,669**	**2,882**	**2,833**	**2,644**	**2,893**	**3,360**	**2,912**	**3,603**	**691**
NHS : Non NHS ratio	***1.10***	***0.91***	***1.24***	***1.74***	***1.44***	***0.96***	***1.42***	***1.27***	***1.52***	***1.93***	***1.59***	***1.48***	***2.06***	***1.39***	

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/01/2024		**Agenda reference:**	**139-24**	
Report title:	Business Planning 2024/25				
Sponsor:	Maria Wheeler, Chief Finance Officer				
Author:	Tony Reeves, Associate Director Business Development				
Appendices:	None				
Executive summary					
Purpose of report:	To provide an update on 2024/25 business planning				
Summary of key issues	The paper outlines the system planning principles for 24/25 and provides an update in terms of the Trust's business planning process. A baseline activity plan has been constructed using current activity run-rate excluding impact of Industrial Action and reviewed by clinical directorates in terms of achievability. This generates a baseline ERF activity level of 115% of 19/20 levels. It should be noted that the efficiency ask including system convergence factor for 24/25 will be 5% to achieve a break-even position in 24/25.				
Recommendation:	Trust Board to note business planning approach and update				
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:	Contributes to understanding financial sustainability and operational delivery requirements for 24/25				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	Letter to be submitted to commissioners				

Report to:	Board Directors
Agenda item:	Business Planning Update
Date of meeting:	11 January 2024
Report from:	Maria Wheeler, Chief Finance Officer
Report author:	Tony Reeves, Associate Director Business Development
Date of report:	22nd December 2023
Appendices:	None

Business Planning Update

Introduction

This paper provides an update in terms of the system planning approach for 24/25 and internal business planning progress.

Executive summary

The financial position for 2024/25 will be more challenging than 2023/24 with the government confirming a flat cash position for 24/25 and with further pressure for systems to achieve a recurrent break-even position by 2025/26.

A high-level income and expenditure plan has been produced which is currently indicating the Trust will need to deliver a 5% efficiency to break even in 2024/25 and further work is being carried out to develop budget proposals for next year.

A baseline activity plan has been developed which indicates delivery of a current activity run-rate of 115% of 2019/20 activity levels excluding any impact for Industrial Action. It is further expected that an increase in productivity levels will be required to deliver the efficiency ask.

Situation

The system has set out the agreed planning principles for 2024/25 in terms of driving forward plans to accelerate system-wide collaborative transformation particularly including system resource allocation for 24/25 and how investments and dis-investments will be agreed during the planning cycle.

Providers have been given guidance around the non-recurrent elements of funding in terms of growth allocations and pay uplifts, along with a requirement for further grip and control measures and efficiency ask.

The planning has therefore taken these principles on board and developed an outline income and expenditure plan for next year which will require a 5% efficiency programme to achieve breakeven.

Background

The Trust set out an outline programme back in October in terms of the internal planning process and an update is provided below in terms of progress to date and next steps.

Assessment

The following sets out an update and next steps in terms of the Trust's planning process:

Activity Plan - Work has been undertaken with directorates to develop an activity baseline using current run-rate in M7 (adjusting for Industrial Action impact). This has been annualised to give a monthly view in terms of working days and seasonality and is proposed as the activity baseline start point for 24/25. This indicates a delivery level of 115% of VWA.

Budget Reviews - Baseline budget positions have been shared with directorates (including the M7 annualised run-rate) to help identify any cost pressures against current budgets in terms of current activity delivery. Further reviews will then take place in January to produce proposed budgets for next year.

Service Developments - Services have identified their proposed service developments for 24/25 and these are currently being reviewed to understand benefits and delivery impact for further POAP development as per system requirement.

Capital Plans - Services have identified their proposed capital requirements for 24/25 and these are currently being reviewed in terms of any estates implications. Further review of medical equipment requirements will be taken through CPG to understand benefits/requirement.

Efficiencies/Productivity - A small number of efficiencies have been identified to date by directorates and will require further work up to understand benefits. Development of a case for the new Local Anaesthetic Unit should be a key contributor to the efficiency/productivity ask.

Contracting and Operational Standards - Planning and contracting guidance is yet to be issued nationally, but a high level income plan has been worked up based on assumptions in the Medium Term Financial Plan and system finance principles. Further work will be needed once the operational standards have been set out to determine how these will be met.

Recommendation

The Board is asked to note current position in terms of business planning of 2024/25 in advance of the Trust's planning submission due by end of February 2024.

NHS
Queen Victoria Hospital
NHS Foundation Trust

Workforce and Organisational Development Report

December 2023 (November 2023 Data)

Rob Stevens – Interim Chief People Officer

Contents

Queen Victoria Hospital
NHS Foundation Trust

Workforce KPI Summary

Queen Victoria Hospital NHS Foundation Trust

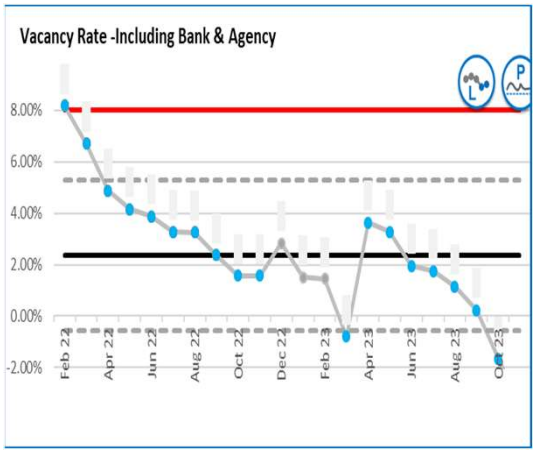
	KPI	Nov-22	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Establishment WTE Including Bank & Agency		1057.16	1082.00	1082.00	1082.00	1082.00	1082.98	1082.98	**1082.98**
Establishment WTE excluding Bank & Agency		1026.97	1021.61	1021.61	1021.61	1021.61	1045.04	1045.04	**1045.04**
Staff In Post WTE		954.75	961.58	966.30	970.70	971.90	985.73	1008.62	**1021.56**
Agency Total worked in month WTE		8.96	11.35	14.97	13.21	15.17	13.31	11.98	**18.73**
Bank WTE Total worked in month WTE		76.91	73.73	79.53	79.19	82.46	81.44	80.23	**80.20**
Staff in Post Vacancy WTE		72.22	60.03	55.31	50.91	49.71	59.31	36.42	**23.48**
Vacancies % Including Bank & Agency Usage	8%	1.56%	3.27%	1.96%	1.75%	1.15%	0.23%	**-1.65%**	**-3.46%**
Staff in Post Vacancies %	8%	7.03%	5.88%	5.41%	4.98%	4.87%	5.68%	3.49%	2.25%
Trust rolling Annual Turnover % Excluding Trainee Doctors	10%	13.27%	12.92%	13.55%	12.50%	**12.84%**	12.92%	**12.37%**	**11.86%**
Starters WTE In month excluding HEE doctors		9.07	11.21	8.87	13.80	11.95	17.17	23.81	**17.84**
Leavers WTE In month excluding HEE doctors		7.48	7.43	11.93	7.12	10.18	4.75	9.87	**3.79**
12 Month Rolling Stability % Remained employed for the 12 month period	85%	**82.43%**	87.44%	87.45%	88.03%	85.15%	87.18%	88.10%	**87.83%**
24 Month Rolling Stability % Remained employed for the 24 month period	85%	**74.70%**	76.09%	76.95%	77.68%	75.78%	77.52%	78.03%	**77.34%**
12 month sickness rate (all sickness)	3%	4.18%	**4.11%**	**4.02%**	**3.92%**	**3.90%**	**3.88%**	**3.84%**	**TBC**
12 month sickness rate of which is Long Term		1.85%	1.89%	1.89%	2.05%	1.86%	1.83%	1.75%	**TBC**
12 month sickness rate of which is Short Term		2.33%	2.21%	2.14%	1.87%	2.04%	2.06%	2.09%	**TBC**
Monthly Sickness Absence % All Sickness		4.75%	0.03	2.57%	3.28%	3.52%	3.72%	3.93%	**TBC**

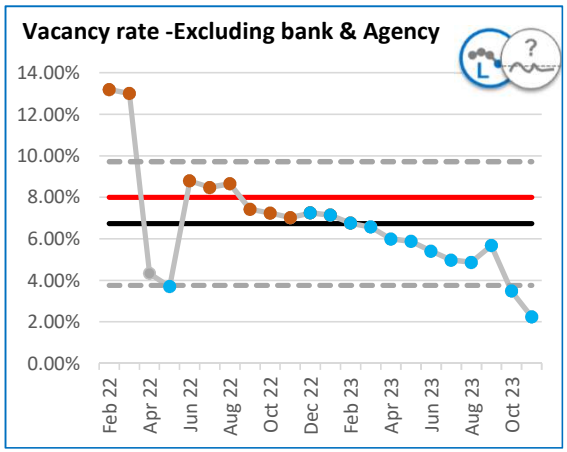
	KPI	Nov-22	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
% staff appraisal compliant	90%	80.56%	85.46%	86.65%	86.95%	86.11%	85.10%	83.83%	84.43%
% staff appraisal compliant AfC only		81.92%	85.85%	87.15%	87.63%	86.76%	85.38%	83.76%	83.89%
% staff appraisal compliant M&D		73.41%	83.33%	81.07%	83.13%	82.12%	83.54%	84.24%	87.29%
Statutory & Mandatory Training	90%	92.16%	93.04%	93.37%	93.55%	93.67%	93.57%	93.63%	93.30%
Statutory & Mandatory Training Bank only		81.37%	83.15%	83.69%	83.81%	85.81%	85.63%	85.06%	84.45%
Statutory & Mandatory Training AfC only		93.70%	94.22%	94.23%	94.39%	94.56%	95.01%	94.83%	94.44%
Statutory & Mandatory Training M&D		85.48%	87.65%	89.45%	89.64%	89.13%	86.84%	88.03%	88.35%

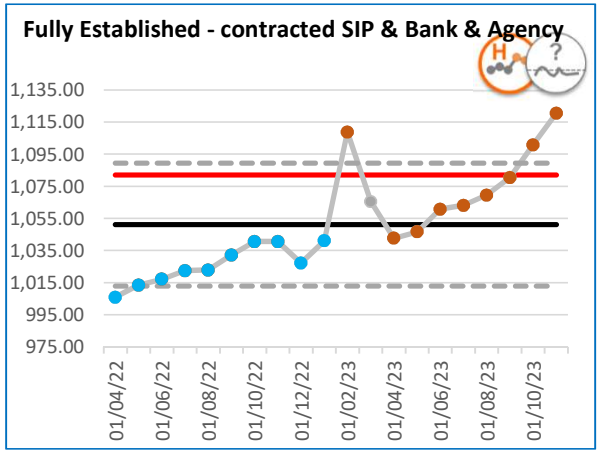
Staff Engagement (NQPS & NHS Staff Survey)	2023/24 Qtr. 1 (141 responses) 7.0 out of 10	2023/24 Qtr. 2 (168 responses) 7.1 out of 10	**2022/23 Q3. National Staff Survey 7.4 out of 10**	2022/23 Qtr. 4 (145 responses) 7.0 out of 10
Treatment NQPS & NHS Staff Survey results to indicate likelihood of recommending QVH to friends & family to receive care or treatment	2023/24 Qrt. 1 Strongly Agree/Agree: Strongly disagree/disagree 133 = 94.3% : 1 = 0.71%	2023/24 Qrt. 2 Strongly Agree/Agree: Strongly disagree/disagree 157 = 93.5% : 1 = 0.60%	**2022-23 National Survey Strongly Agree/Agree: Strongly disagree/disagree 557 = 92% : 10 = 1%**	2022/23 Qrt. 4 Strongly Agree/Agree: Strongly disagree/disagree 132 = 95.7% : 2 = 1.46%

Workforce Summary

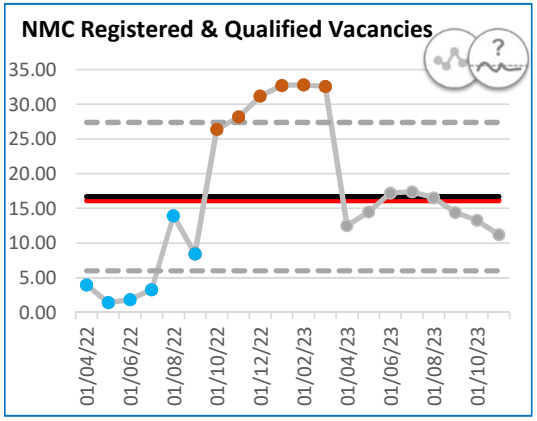
Queen Victoria Hospital
NHS Foundation Trust

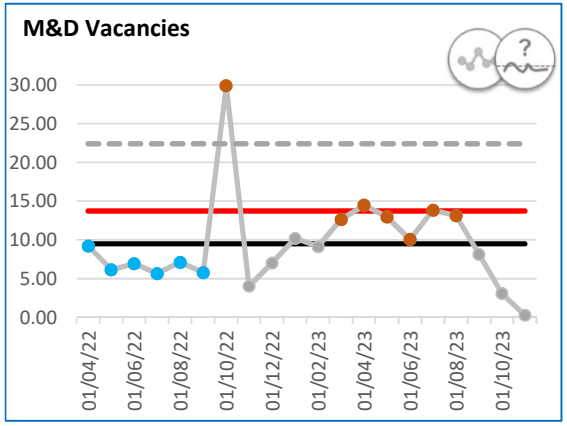


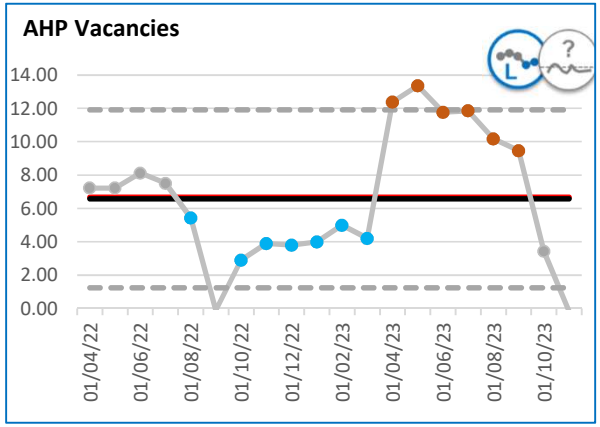




Key Observations:
Vacancy rate continues to fall across the trust month on month and is also visible in NMC, M&D and AHP establishments.





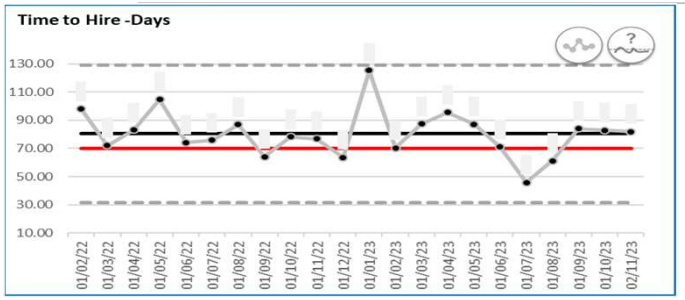


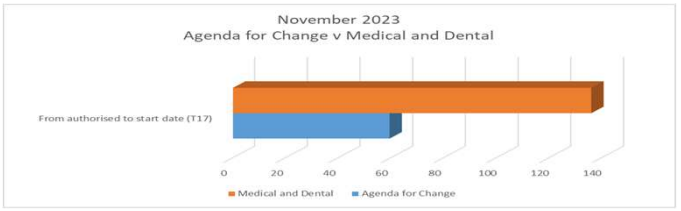
Key Concerns:
Despite fall in vacancy rate the bank and agency usage continues to increase bringing us over our establishment.

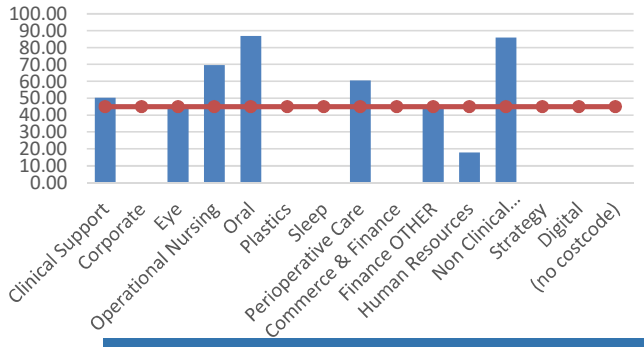
Resourcing Activity

Queen Victoria Hospital NHS Foundation Trust

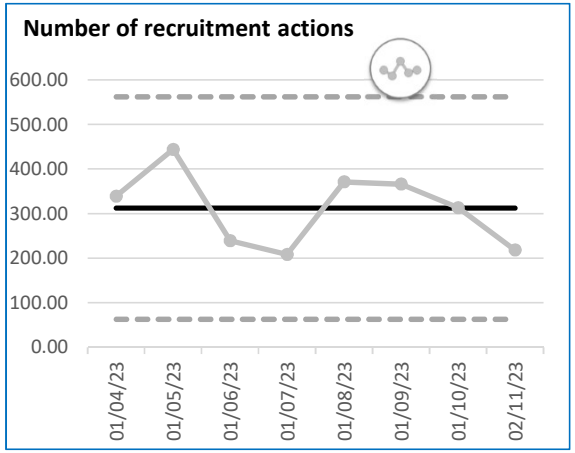
Time to Hire

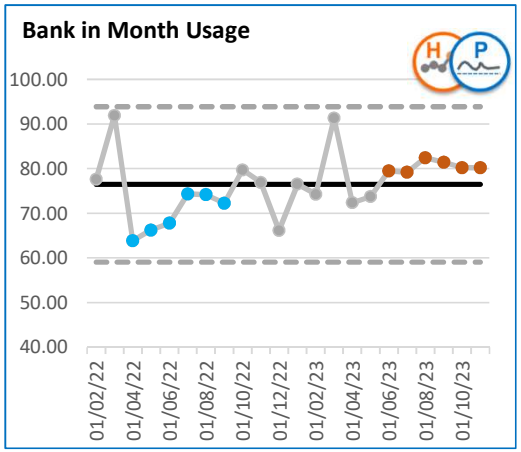


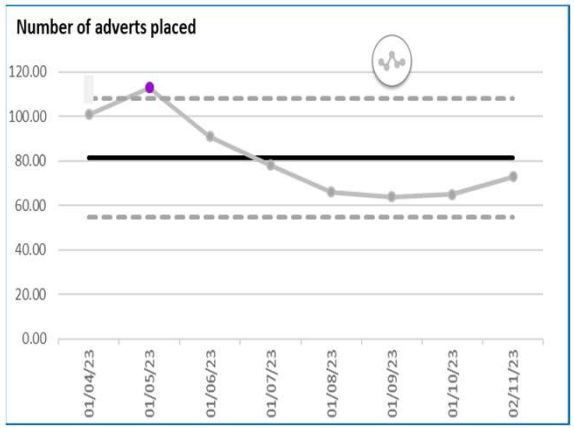


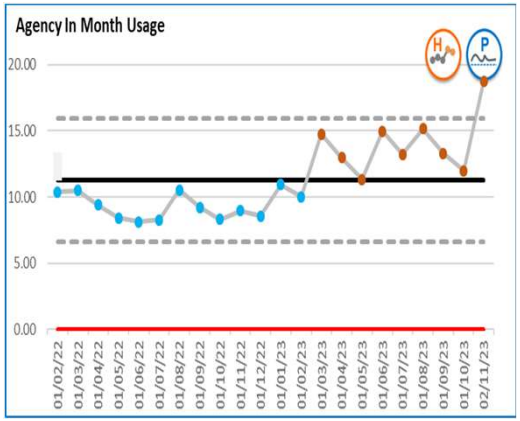


Bank and Agency Usage









Key Observations:
Time to hire has not increased over the last 3 months, still remains above KPI but has significantly improved.

As with this time of year recruitment activity has dropped in actions by the team, however I would expect this to increase again over the next couple of months with the volumes of adverts placed increasing.

Key Concerns:
Agency usage has increased considerably in November with Bank usage levelling out but still high.

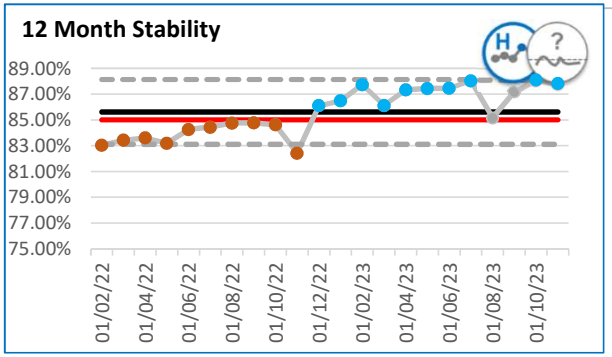
18.73 WTE was used in agency in November. High usage areas are 8.71 in Nursing and Midwifery and 5.71 in Admin and Estates with a stated reason as vacancy cover

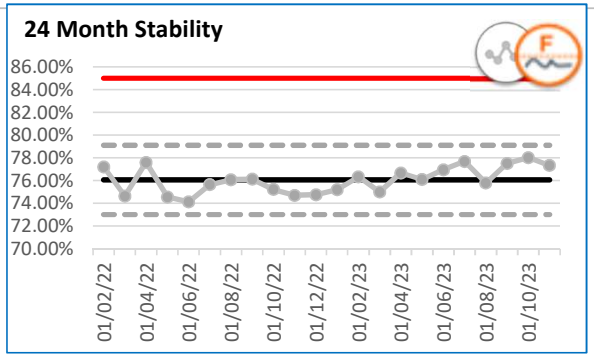
Medical recruitment activity remains the outlier in time to appoint with AfC under 60 days and M&D at 130 with Oral, Non Clinical infrastructure and Operational nursing taking the longest.

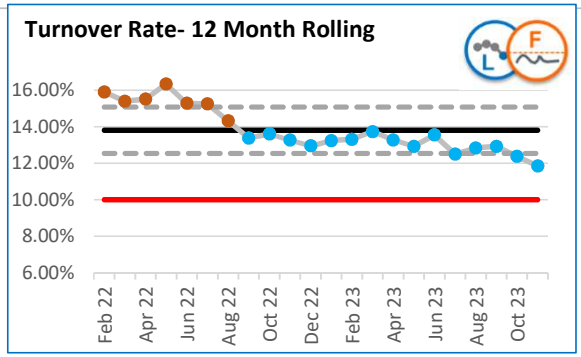
In order to help address the Medical Time to Hire we are currently recruiting a Medical Business partner and allocating a dedicated resource from recruitment to support. The main driver for medical time to hire is the time taken to shortlist and receive an interview outcome.

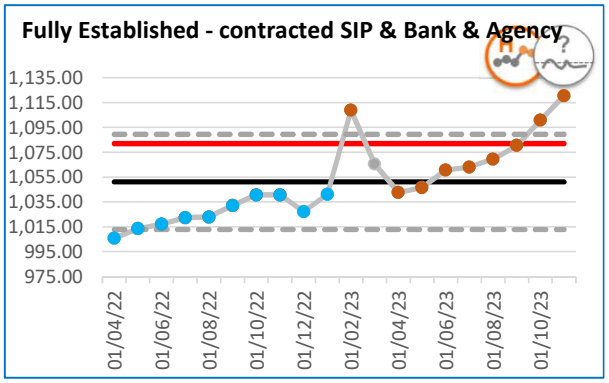
Workforce Retention

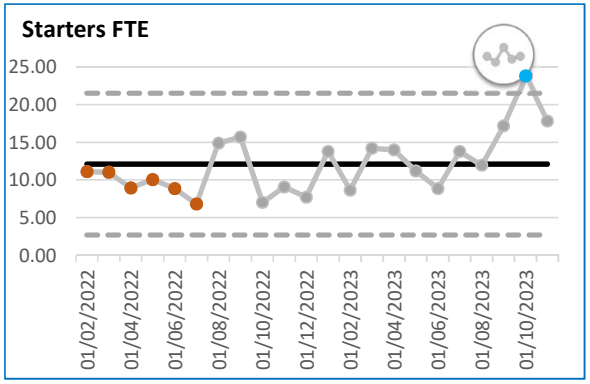
Queen Victoria Hospital
NHS Foundation Trust

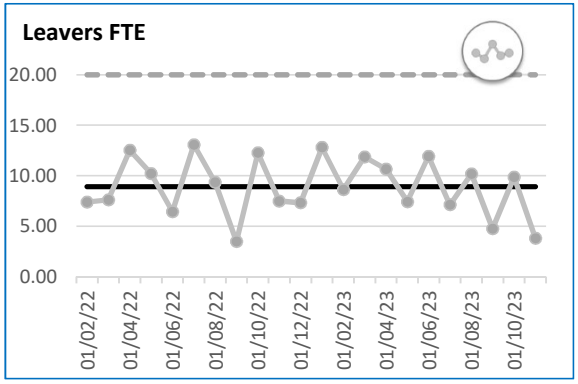












Key Observations:
Stability continues to be in a good place with less leavers than starters again in November.

12 month rolling turnover is also reducing month on month. Within this, there are areas of higher turnover including our AHP's within Clinical Support who have a 24.98% turnover, Admin and Clerical within Eyes at 19.82% and Admin and Clerical in Finance at 18.98%.

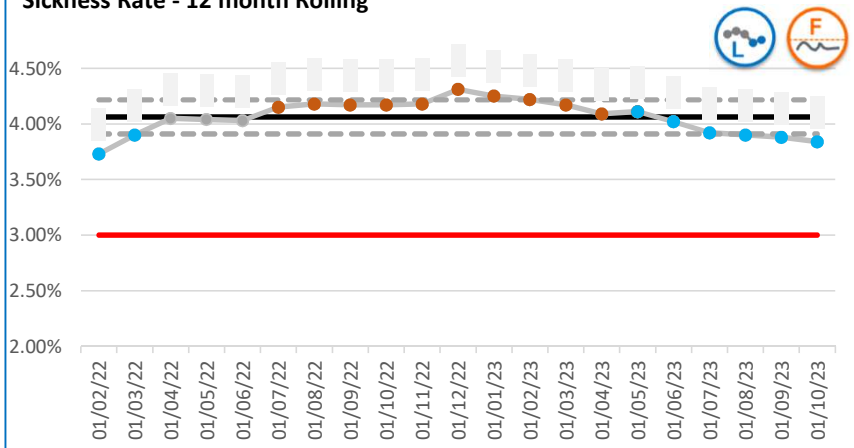
Key Concerns:
Most reasons for leaving remain blank with this not being completed by managers at the time of completing leavers paperwork.

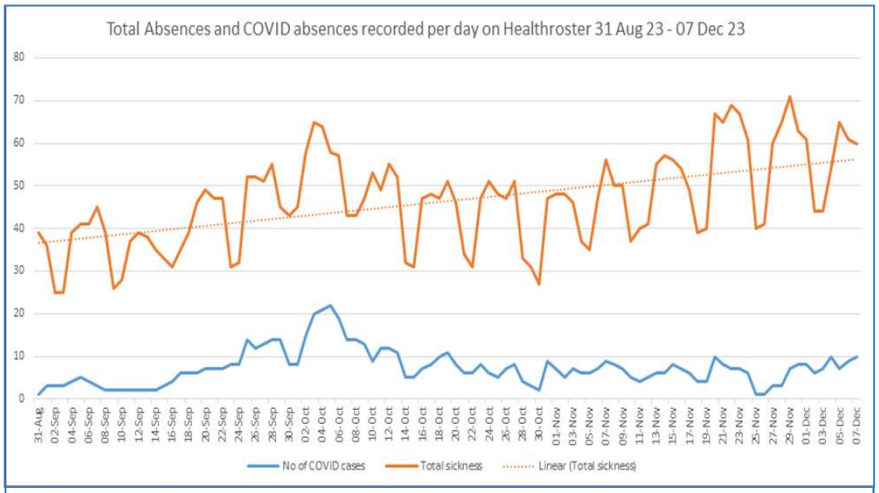
Work life Balance was the main recorded reason for leaving.

Health and Wellbeing of Staff

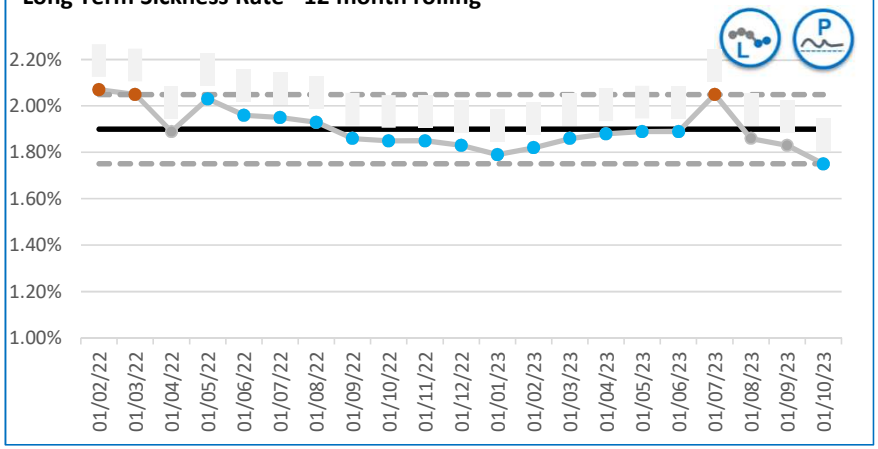
Queen Victoria Hospital
NHS Foundation Trust

Sickness Rate - 12 month Rolling

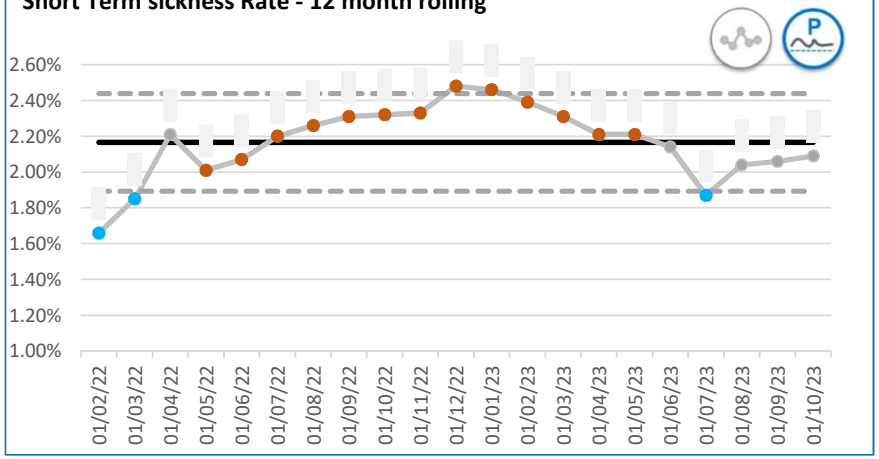




Long Term Sickness Rate - 12 month rolling



Short Term sickness Rate - 12 month rolling



Key Observations:

October saw a further reduction in the rolling 12 month sickness absence rate month on month from a high of 4.31% in Dec22 to 3.84% in Oct23. However the in month rate is continuing to see an increase, driven by the continually increasing short term sickness absence rate.

The long term sickness absence rate in the rolling 12 months has seen a reduction for a third month, and a low of 1.75%.

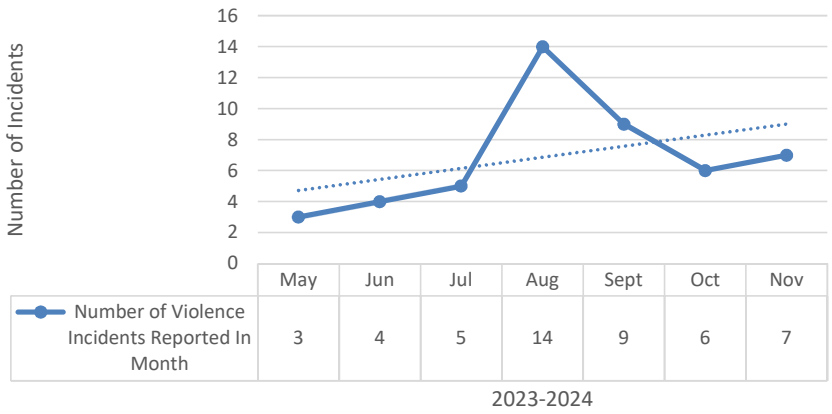
Key Concerns:

As anticipated, short term sickness absence has continued to increase. Covid related sickness absences peaked at the beginning of Oct23 but has remained below n=10 throughout Nov and into Dec23.

Health & Wellbeing of Staff

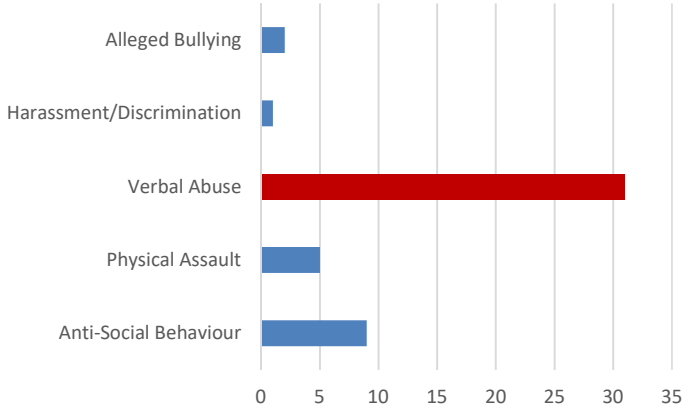
Queen Victoria Hospital NHS Foundation Trust

Incidents of Violence and Abuse against Staff Reported



	May	Jun	Jul	Aug	Sept	Oct	Nov
Number of Violence Incidents Reported In Month	3	4	5	14	9	6	7

Number of Reported Incidents 23-24



Key Observations:

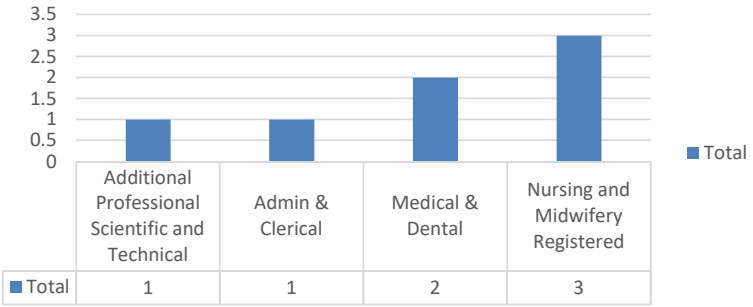
November has seen a continuation of verbal abuse incidents as the common factor the Trust is reporting however the levels being reported are within current trends. Of the incidents reported in November 6 were patient to staff and 1 was staff on staff (bullying).

Overall trend across the year is a slight increase in reporting of incidents which is positive.

Key Concerns:

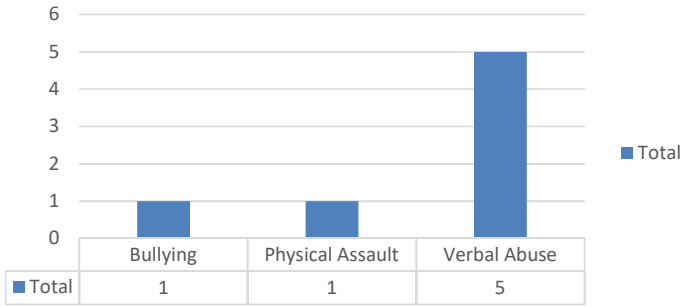
Under reporting of incidents continues to be a concern, 7 incidents in a month is unlikely to be a true reflection of levels experienced.

Staff Group reporting Violence and Abuse Nov 2023



	Additional Professional Scientific and Technical	Admin & Clerical	Medical & Dental	Nursing and Midwifery Registered
Total	1	1	2	3

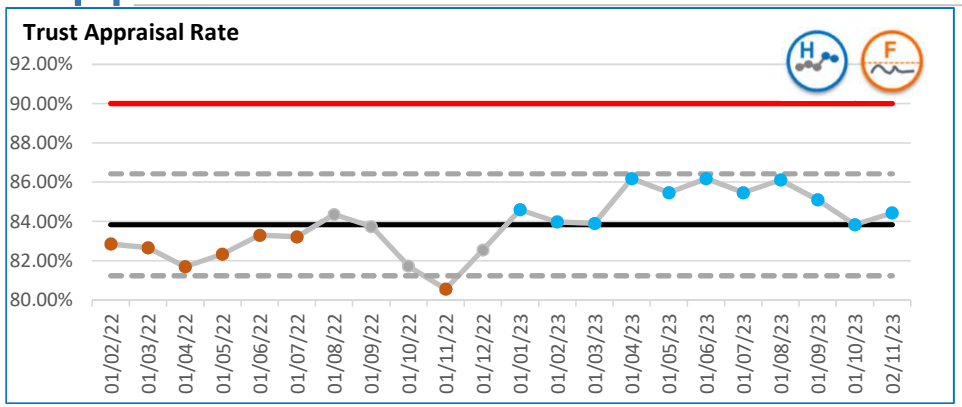
Category of Violence and Abuse Nov 2023

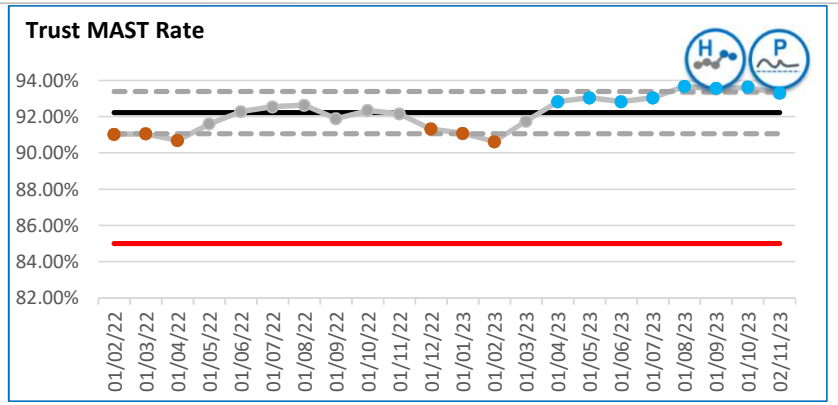


	Bullying	Physical Assault	Verbal Abuse
Total	1	1	5

Organisational Development & Learning
Appraisal & MAST

Queen Victoria Hospital NHS Foundation Trust





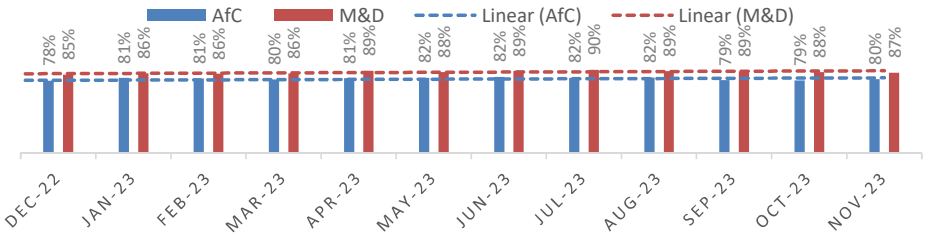
Appraisal staff group data	Assignment Count	Required	Achieved	Compliance %	Prev month	Month on month diff
% staff appraisal	1137	1137	960	**84.43%**	83.83%	0.60%
% staff appraisal - AfC only	956	956	802	**83.89%**	83.76%	0.13%
% staff appraisal - M&D	181	181	158	**87.29%**	84.24%	3.05%

2023 Expired > 3 months	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	82	84	72	51	62	61	75	66				
AfC	61	64	54	41	46	47	64	53				
Medical & Dental	21	20	18	10	16	14	11	13				

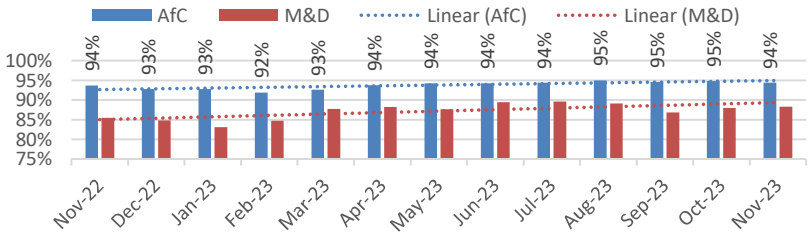
MAST staff group data	Assignment Count	Required	Achieved	Compliance %	Prev month	diff month on month
MAST	1137	13917	12985	**93.30%**	93.63%	-0.33%
MAST - Bank only	194	2437	2058	**84.45%**	85.06%	-0.61%
MAST - AfC only	956	11317	10688	**94.44%**	94.83%	-0.39%
MAST - M&D	181	2600	2297	**88.35%**	88.03%	0.32%

Oliver McGowan MAST Training			
Assignment Count	Required	Achieved	Compliance %
1331	1331	703	52.82%

Appraisal Benchmarking



MAST Benchmarking



Key Observations:

Appraisals:
New appraisal paperwork and toolkit launched. Aim to improve quality of appraisal conversations and include H&W and career conversation. Managers training commences Dec 23.

PDR rates increased 0.60% with an increase of 3.05% for M&D staff. Expired appraisals decreased in Nov 23.

MAST training:
Compliance remains above 90% for the 59th consecutive month. A slight decrease of 0.33% in Nov, but year on year there is an increase of 1.14% from 92.16% in Nov 22 to 93.30% in Nov 23.

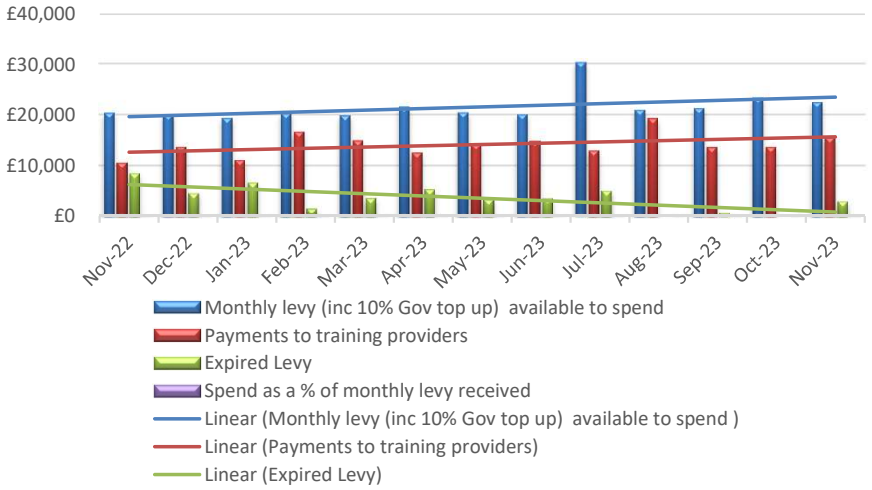
Key Concerns:
Appraisals:
PDR rates for AfC increased by 0.13% but are lower than M&D compliance at 83.76%.

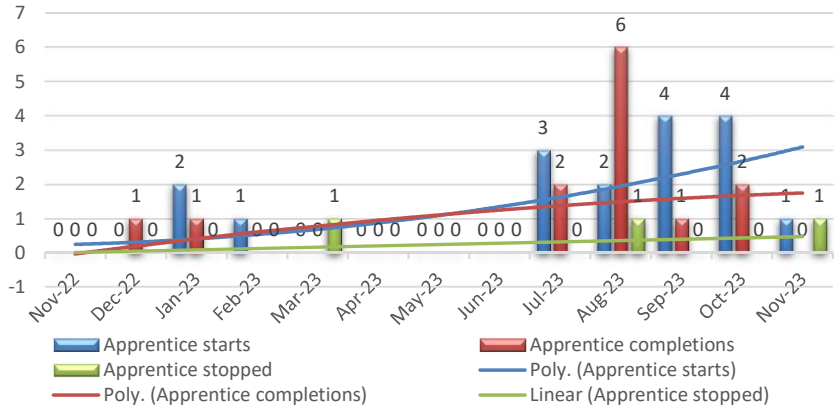
MAST:
Any SMEs are contacted by OD&L where MAST areas are AMBER or RED and are targeted to staff out of date.

Organisational Development & Learning

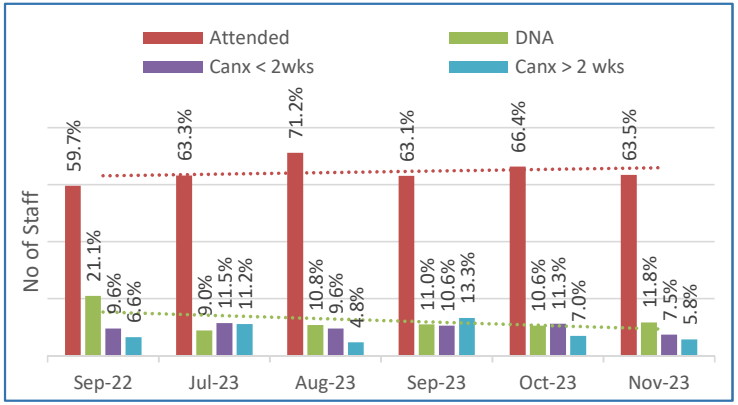
Queen Victoria Hospital NHS Foundation Trust

Apprenticeship levy and uptake data





Course attendance data



Key Observations:
Apprenticeship data shows monthly levy spend increasing and a greater uptake in apprenticeships in the last quarter.

Work Experience events are now scheduled for further dates in 2024.

Course attendance continues to increase and DNAs remain consistent.

NHSSS23 closed 24 Nov 2023 with 58.80% of eligible staff (658/1119) completing, compared to 56% in 2022 609/1081.

NHSSS23 response rates

Locality 4	R	%	Locality 4	R	%
Corporate Affairs (n=11)	11	100.0%	ITU (n=23)	18	78.3%
Appointments & RTT (n=24)	15	62.5%	Head & Neck (n=15)	9	60.0%
Strategy, Ops Management & Board (n=15)	12	80.0%	MIU (n=14)	5	35.7%
Commerce & Procurement (n=16)	11	68.8%	MacMillian (n=13)	9	69.2%
Finance & Senior Management Team (n=16)	11	68.8%	Therapies (n=50)	37	74.0%
BI & IMT (n=16)	11	68.80%	Radiology (inc CDC) & Med Photography (n=51)	30	58.8%
Clinical Systems (n=13)	8	61.50%	Histopathology (n=13)	8	61.5%
Building & Engineering (n=13)	6	46.2%	Pharmacy (n=12)	8	66.7%
Hotel services, Catering & telephones (n=22)	9	40.9%	General Specialities & Healthrecords (n=25)	16	64.0%
Domestic & portering (n=37)	16	43.2%	Corneoplastics, Eye Bank & Optical (n=34)	16	47.1%
Human Resources (n=20)	18	90.0%	Maxillofacial (n=55)	29	52.7%
Education (n=10)	9	90.0%	Orthodontics (n=23)	10	43.5%
Specialist Nursing (n=49)	33	67.3%	Prosthetics (n=13)	8	61.5%
Paediatrics (n=25)	16	64.0%	Theatres (n=96)	41	42.7%
Main Outpatients inc CDC (n=26)	20	76.9%	Pre Assessment (n=14)	11	78.6%
Canadian Wing (n=51)	25	49.0%	Day Surgery (n=33)	15	45.5%
Site Practitioners (n=15)	12	80.00%	Recovery (n=14)	4	28.6%
Maxillofacial Nursing (n=26)	16	61.5%	Anaesthetics (n=40)	23	57.5%
CorneoPlastic Nursing (n=20)	18	90.0%	Plastics (n=92)	38	41.3%
Burns Centre (n=25)	16	64.0%	Sleep (n=39)	30	76.9%

Medical Education – Dec (Nov data)

Queen Victoria Hospital NHS Foundation Trust

Teaching and training courses

- Plastics monthly teaching morning: 6 November
- Plastics weekly teaching: 2, 9, 16, 23 30 November
- Dental foundation training: 1, 8, 15, 22, 29 November
- LEEP 2 (cohort 2): 3 November
- Anaesthetics regional teaching day: 20 November

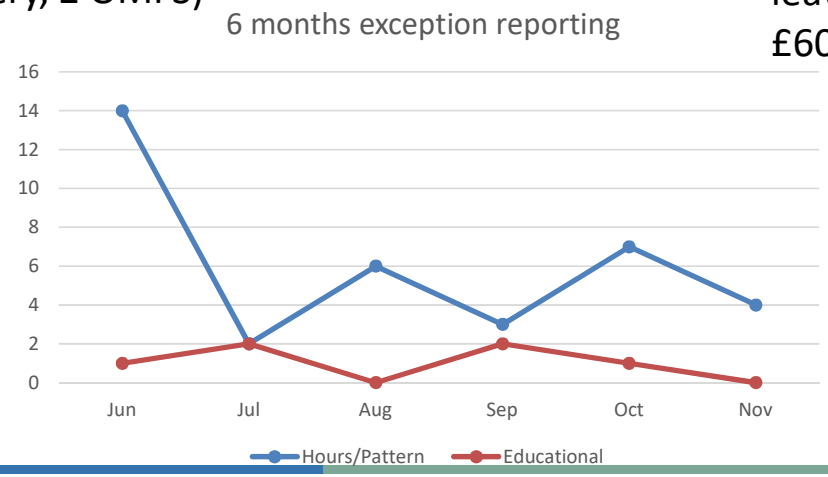
Junior doctor exception reports submitted

Hours/working pattern:

- 4 (2 Plastic Surgery, 2 OMFS)

Training:

- 0



NHSE relocation claims for trainee doctors submitted £2801.67

NHSE study leave claims for trainee doctors submitted £3883.95

Trust medical and dental study leave claims approved £6077.06

Key Observations:

No doctors induction in November but a number of ad hoc new starters joined the Trust and will attend Trust induction.

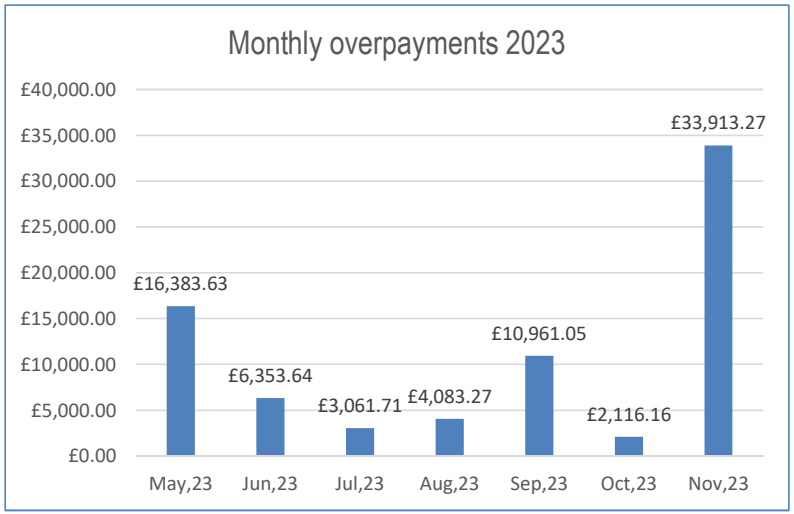
The second cohort of LEEP training is underway and has had excellent feedback from delegates.

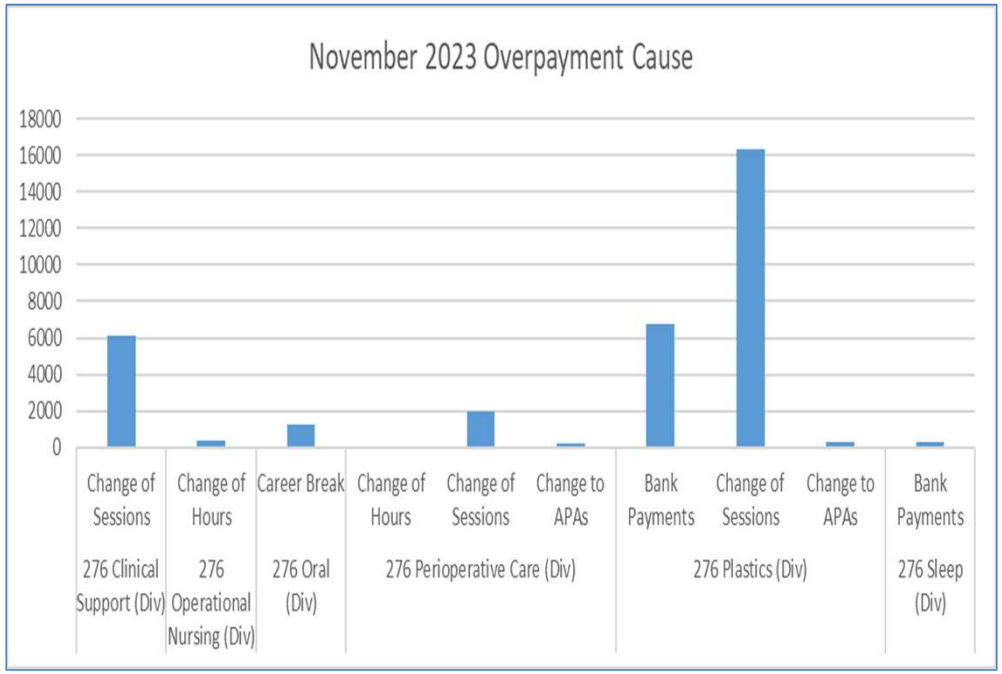
Hours/pattern related exception reports decreased in November and there were no training reports. The Guardian of Safe Working Hours works with departments to close reports and ensure action is taken.

Key Concerns:

New starter names for February Deanery trainees have been released. There are gaps in Anaesthetics due to the number of LTFT trainees. MedEd and Medical Workforce will support the tutor to look at this.

Overpayments





Key Concerns:

All over payments shown are "client" errors (QVH), due to late paperwork or processing of bank shifts. The key driver for the £33k in month overpayment is the late receipt of paperwork for any changes in hours within Plastics.

Despite reminders of process and when deadlines and the receipt of late paperwork within Workforce and Rostering continues to be a high.

Over the last month it has been highlighted that there are number of historic errors and inconsistencies between the job planning system and ESR leading to overpayments within the consultant body. A reconciliation process is underway by Ops and it is anticipated that there will be further issues to arise

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11 January 2024	**Agenda reference:**	**140-24**		
Report title:	Workforce and Organisation Development performance report				
Sponsor:	Robert Stevens, Interim Chief People Officer				
Author:	Lawrence Anderson, Deputy Chief People Officer				
Appendices:	Appendix one: workforce performance report				
Executive summary					
Purpose of report:	To update the Board on workforce performance				
Summary of key issues	• The Trust continues to report strong and improving workforce performance indicators in many areas, including vacancy, sickness, appraisal and MAST. • Our NHS Staff Survey response rate has increased in year to 68.5%. • Bank and agency use and spend remain under review in light of inflationary pressures and continued over-performance on activity plans • Our EDI Group is now established and we are focused on implementing our EDI objectives and the design of our new People and Culture Strategy.				
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:	Key controls (sickness absence, vacancy and turnover) better than South East average (based on NHSE Month 6 data)				
Corporate risk register:	No significant corporate risks identified				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	n/a				
	Date:		Decision:		
Next steps:	In report				

Report to:	Trust Board
Agenda item:	140-23
Date of meeting:	11 January 2024
Report from:	Rob Stevens, Interim Chief People Officer
Report authors:	Rob Stevens, Interim Chief People Officer
Date of report:	3 January 2024
Appendices:	Appendix one: workforce performance report

Workforce and Organisational Development report
(November data / performance unless otherwise stated)

Summary

The Trust retains some of the best workforce key performance indicators (KPI's) and survey results in the NHSE South East region. We have continued to provide extensive health and wellbeing support, increase the number of apprentices we support, reconcile our establishment with finance, bring stability to the workforce leadership team, shed light on the equality, diversity, inclusion (EDI) and cultural challenges facing our workforce and work in closer partnership with our regional colleagues on issues, including on temporary staffing, leadership and talent, violence and aggression.

In September 2023 our Board recommitted to eliminating racism and endorsed our first ever EDI objectives. We have just launched our first ever EDI Group, are in the process of relaunching our EDI networks and undertaking a trust wide listening exercise into the areas of the staff survey that indicate we need to do more to ensure all of our staff have a strong personal sense of workplace belonging.

We were pleased to increase our annual staff survey return in November. Over 58% of eligible staff took the time to complete the survey and we have also been pleased with the uptake of the new Oliver McGowan training, which over 63% of staff have now completed. We were also pleased to see a number of apprentices qualify, including at degree level.

There continues to be a tremendous amount of work underway to support our trust and workforce transformation, underlined by the introduction of HR Recruitment Partners in response to the needs of services and ongoing work on our organisational structure and we look forward to continuing to develop a new strategy for People and Culture and welcoming a new substantive Chief People Officer in 2024.

Workforce exceptions

<u>Vacancy and establishment</u>

Substantive vacancy has reduced to 23.5 WTE (2.25%) driven by the medical, dental and AHP workforces. By comparison the NHSE South East average is 8.6% (based on month 6 data).

Despite the Trust being near full establishment there continues to be an increase in agency usage. Bank use has not changed in month. As a trust we are over established in month when Bank (80.2 WTE) and agency (18.7 WTE) are taken into account, driven primarily by nursing. The combined total is 1120.5 WTE against an establishment of 1083 WTE. However this is consistent with our clinical over performance against activity plans.

The reintroduction of a vacancy control panel from January will enabling closer monitoring of all non-patient facing vacancies being advertised along with bank and agency requests on a weekly basis.

<u>Resourcing</u>

Time to hire has not risen in the last 3 months but remains above KPI. Benchmark data is not available.

With the implementation of digital ID checks from early December and the development of new resourcing business partner roles within medical and general recruitment we anticipate time to hire will reduce considerably over the coming months.

Temporary staffing

Agency spend is above plan, but reflective of the additional clinical activity the Trust has undertaken. Bank spend a proportion of pay budget is 3rd lowest in the South East region.

The Trust also continues to receive pressure to pay above the agency cap for specific roles, esp. in Medical. This is partly driven by the knock-on effect of the BMA Bank rate cards and the impact this is having on rates paid by other local providers. Waiting List Initiative rates have been refreshed and we are reviewing further changes to other Bank rates with our Staff Side and regional partners.

Sickness

In October the rolling 12 month sickness absence rate remained below 4% (3.84% in October), having peaked in December 2022. As anticipated, short term sickness absence rates have gradually increased as we progress through the winter months, but Covid cases remained below 10 a day in November and December. The NHSE South East average is 4.4%.

Employee Relations

There are a total of 32 employee relations cases including 7 formal and 1 appeal hearing.

Within the Trust ER caseload, the team are supporting 3 teams where culture and civility issues require intensive support and intervention. Action plans have been developed with internal and external facilitation being provided. The team are also applying the HSE Stress indicator tool to identify and address the causes of work related stress in three departments.

Appraisal compliance

Appraisal compliance saw an increase of 0.60% from 83.83% to 84.43% (960/1137) in November 2023. Further details on the work currently underway is highlighted below. Appraisal compliance has shown a 2% increase both AfC and Medical & Dental Staff when compared to November 2022.

Mandatory and Statutory Training (MAST) Compliance

MAST compliance remains above 90% for the 59th consecutive month (since 2018). There has been a slight decrease of 0.33% in November 2023, but year on year there is an increase of 1.14% from 92.16% to 93.30% (Nov 22 vs Nov 23).

Oliver McGowan mandatory on-line training launched on 21 Sept 2023. As at 2 January 2024, the permanent compliance rate was 63% against a target of 70% by the end of February 2024.

Trust workforce programmes

Equality, Diversity and Inclusion

Work continues at pace on the Trust's plan to address the EDI challenges. The Trust's EDI group met for the first time formally in December to set the agenda and tone for the work it needs to achieve over the coming months. In November the Trust wide Team Brief delivered a powerful message on EDI to the Trust and re-committed the Trust's alignment to the Sussex Anti-Racism statement.

An enquiry into our end to end Recruitment processes is underway to identify areas which can be more inclusive for both external and internal recruitment activity alongside additional analysis into the Trust's Gender Pay Gap. Work is commencing on the Workplace Belonging (Listening) project and there is extensive ongoing work underway to understand our gender pay gap and establish realistic interventions to bring this down even more quickly.

Culture and OD, inc. Speak Up

Following events at Countess of Chester and the recommendations of the recent independent report into sexual misconduct in healthcare, the Workforce and OD team are working closely with the CNO and CMO to respond to the call to ensure all staff are able to speak up and tackle incidents effectively.

Much of the work will be led through the Speak up Guardian and CMO supported by the forthcoming work on workplace belonging and trust commitment to the national charter to eliminate sexual misconduct.

Trust workforce projects

Appraisal Quality and Assurance

Work continues to take place on the 9 recommendations approved by F&P in July. An action plan has been agreed and Task & Finish group are working through it.

An update report is provided in the papers this month. A new Appraisal Form and Toolkit has been launched in December 2023 alongside a training package and guidance documentation with the aim of improving the quality of appraisals at QVH. The new process now includes conversations that focus on the Health & Wellbeing of individuals and a targeted career conversation. The Trust continues to explore electronic capabilities for undertaking an appraisal which are being developed ahead of testing in January 2023 and piloting in both clinical and non-clinical areas. Further training and a survey will follow.

Health and Wellbeing

In November and December the Trust has promoted disability history month, International men's day and men's mental health, alongside self-care week and carers awareness. 16 days of action against domestic violence spanned both months and a meeting of the LGBTIQ+ network took place. The team are looking at a plan for 2024 and in collaboration with other Trusts in the NHS Sussex ICB on initiatives and sharing speakers, promotions, webinars, etc.

Occupational Health retender

The tender for this service has been delayed owing to challenges identified in the Procurement team, however the tendering process has now closed and undergoing a scoring and shortlisting process to be concluded in December.

This must be completed by 31st March 2024 in readiness for a new provider to commence on 1st April 2024. Delays are not currently critical to the current deadline and delivery date of 31st March 2024 but are being managed closely.

Resourcing / Informatics

A quality improvement project on digital ID checking and on boarding continues to progress. Our Digital ID platform launched in December, and the New Starter Portal forms have been delayed, however these will be operational in January 2024.

Violence Prevention and Reduction (VPR)

A Trust VPR group has been established and meets on a monthly basis. An update report is provided in the papers this month.

The group have committed to a number of key actions in 2024 and have developed two separate action plans to address the national standards and also the key actions that will be taken to increase reporting of incidents and reduce the levels of violence and aggression at the Trust. It is identified that the Trust's key challenges are with verbal abuse from patients and visitors but also staff on staff.

The group will be looking to increase awareness and communication around the work that is being done on VPR in February with a view to an easier reporting mechanism for violence and abuse incidents, support for those who have been subject to such activity, and additional training activities that will be made available.

The trust's progress was presented to the Sussex ICS VPR programme board in November

Staff Survey

QVH NHS Staff Survey closed on 24 November 2023 with 58.5% of QVH eligible staff (658/1119) completing compared to 56% in 2022 (609/1081). The increase was particularly driven in year by our nursing workforce.

Once initial reports have been received work will be undertaken to analyse the findings in January/February 2024. All results will be under Embargo until early March 2024.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/01/2024		**Agenda reference:**	**141-24**	
Report title:	**Operational performance**				
Sponsor:	Kathy Brasier, Interim Director of Operations				
Author:	Kathy Brasier, Interim Director of Operations				
Appendices:	Appendix one: Operational performance data				
Executive summary					
Purpose of report:	This report outlines the highlights of the operational performance for M8				
Summary of key issues	Key highlights include; • **Cancer** - FDS compliance, with 62 day performance challenged. Late referrals are being escalated and discussed with providers supported by the cancer alliance. Action plan being formulated to improve the trust position across all specialities. Teledermatology pathway is removing around 50% of patients from the waiting list at first outpatient appointment. • **RTT18** - Increase in total waiting list size from M7 to M8; this is an increase of 2.8%. To ensure capacity is available for the management of the long waiting patients at both 78 and 65 weeks, theatre capacity has been re-allocated between specialties. • Two Super Saturdays have been mobilised in M8 increasing the weekend activity by 125% Three session days are also commencing as from January 2024 for plastics and eyes. • **IA** - with the announcement of further industrial action for junior doctors, stretching from 20-22 December 2023 and then subsequently 3-9 January 24, theatre and outpatient capacity has significantly reduced across all specialties. During these periods the plan is to protect clinical priority and long waiting patients where possible. This will significantly reduce the trusts ability to deliver in month performance trajectories • **DMO1** - Radiology DMO1 performance remains high reporting 99.2% with the sleep position continuing to improve in line with trajectory, reporting 84.3% in M8, with numbers on the DMO1 waiting list and the number of breaches reducing month on month.				
Recommendation:	The Board is asked to **NOTE** the operational performance and be assured of the improving trust position				
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:					
Regulation:	NHSE, ICB				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps	To continue to manage 78 and 65ww patients by year end and to ensure cancer performance continues to improve to ensure patient pathways are managed appropriately				

Report to:	Board of Directors
Agenda item:	141-24
Date of meeting:	4 January 2024
Report from:	Kathy Brasier – Interim Director of Operations
Report author:	Kathy Brasier – Interim Director of Operations
Date of report:	21 December 2023
Appendices:	None

Operational performance

Introduction

This report outlines the highlights of the operational performance for M8.

Cancer

62 day

19 breaches reported in November these were associated with skin (16), Head & Neck (1) and breast (2). However, the trust continue to remain compliant with the FDS standard.

13 patient referrals for skin were received late with 4 of those received over 104 days. Work is underway, with support of the Surrey and Sussex Cancer Alliance, to liaise with the referring trust to manage all referrals received in a timely manner. The trust ccontinues to report high volumes of complex pathways, due to patient comorbidities which require input from multiple healthcare professionals, internally and externally.

The teledermatology pathway is removing around 50% of patients from the waiting list at first outpatient appointment. This will impact positively on performance moving forwards, whilst improving patient experience and associated outcomes, informing patients early in their pathway if their lesions are benign.

2ww

The trust continues to monitor urgent suspected cancer (2WW) internally, although from M7 this is no longer a reportable cancer metric. The trust has remained below the 2WW target for M7 with the overall 2WW performance at 83.3%, which is a modest increase.

Skin 2ww referrals for M8 compared with M8 in 2022 have increased by 23.9%, this is a year to date increase of 9.7%. Head & Neck 2ww referrals for M8 compared with M8 2022 have increased by 5.0%, a year to date increase of 7.7%.

RTT18

Increase in total waiting list size from M7 to M8; this is an increase of 2.8%. Waiting list validation has taken place where 6% of patient responses indicated for removal from the list (60 patients).

- In order to support the management of the long waiters at both 78 and 65 weeks theatre capacity has been re-allocated between specialties. Two Super Saturdays have been mobilised in M8 increasing the weekend activity by 125% and three session days are also commencing as from January 2024. This is planned to continue throughout the remainder of the financial year to enable additional theatre capacity. This indicative additional capacity is planned to be sufficient to support recovery driving the long waiting position to 0 by the end of March 2024. The revised trajectory submitted to the ICB in M7 is below;

Trust		Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
	52 week trajectory					

52 week without IA and additional capacity identified	565	674	699	738	731
65 week trajectory					
65 week with no IA and additional capacity identified	121	133	94	52	0
78 week trajectory					
78 week with no IA and additional capacity identified	11	11	8	4	0

78ww
For M8 the trust is reporting 13 patients, an increase from 5 patients in M7. 2 late referrals were received during this reporting period for maxillofacial (89w) and plastics (85w) services with two further 'pop-ons' (patients that have been validated back on to the PTL), which is unusually high for the service.

65ww
The waiting list management meeting structure has been refreshed to strengthen multidisciplinary input across specialties from M9, ensuring close monitoring and oversight of all long waiting and urgent patients.

Industrial Action (IA)
With the announcement of further industrial action for junior doctors, stretching from 20-22 December 2023 and then subsequently 3-9 January 24, theatre and outpatient capacity has significantly reduced across all specialties. During these periods the plan is to protect clinical priority and long waiting patients where possible.

This period of action will significantly reduce the trusts ability to deliver in month performance trajectories. This will place pressure upon skin, breast and head and neck oncology, which is likely to change the profile of the additional capacity that is being generated. Already several long-waiters have been displaced to accommodate oncology patients in these specialties. Recovery is being staged at this same time as well as managing additional demands of IA in parallel.

DMO1
The overall Trust DMO1 position has increased to 93% in M8, despite remaining below target (95%) performance continues to be on an improving trajectory.

Radiology DMO1 performance remains high reporting 99.2% with the sleep position continuing to improve in line with trajectory, reporting 84.3% in M8, with numbers on the DMO1 waiting list and the number of breaches reducing month on month.

The majority of Sleep patients are waiting longer than 6 weeks.

Recommendation
The Board is asked to **NOTE** the operational performance and be assured of the improving position.

Operational Performance Report M8

Kathy Brasier, Interim Director of Operations

December 2023

Contents

Performance Summary

Queen Victoria Hospital NHS Foundation Trust

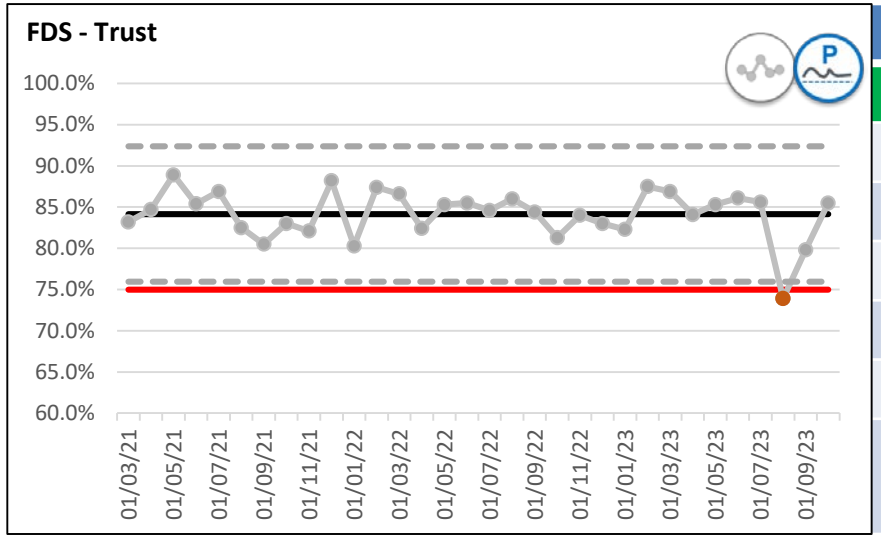
Category	KPI	Latest month	Measure	Target	Variation	Assurance	YE Forecast *
Cancer	Cancer - Faster Diagnosis Standard	Oct 23	85.5%	75.0%		P	85.1%
Cancer	Cancer - 62 day+ backlog (internal trajectory)	Nov 23	70	-	H		25
Cancer	Cancer - 62 day combined	Oct 23	72.0%	85.0%		?	85.0%
Diagnostics	DM01 % - Diagnostic tests within 6 wks - Total	Nov 23	93%	95%	H	F	95%
Diagnostics	DM01 % - Diagnostic tests within 6 wks - Sleep	Nov 23	84.3%	95.0%	H	F	95.0%
Diagnostics	DM01 % - Diagnostic tests within 6 wks - exc. Sleep	Nov 23	98.7%	95.0%		P	98.0%
RTT	RTT - Total Waiting List Size	Nov 23	17851	-	↑		19266
RTT	RTT 78	Nov 23	13	0		?	0
RTT	RTT 65	Nov 23	92	0	H	F	0
RTT	RTT 52	Nov 23	489	734	H	P	734
Activity	Activity - Elective Recovery Increase (admitted) % against 23/24 plan	Nov 23	93%	100%		?	94%
Activity	Activity - Elective Recovery Increase (non-admitted) % against 23/24 plan	Nov 23	105%	100%		?	106%
Theatres	Theatre Utilisation - QVH site - uncapped (GIRFT target)	Nov 23	83.4%	85.0%		?	85.0%
Theatres	Theatre Utilisation - TMC site (GIRFT target)	Nov 23	93.0%	85.0%	H	?	90.0%
MIU	MIU % discharged < 4hrs	Nov 23	99.3%	95.0%		P	99.0%

*Year end forecast positions are subject to the impact of further industrial action

Cancer Performance

FDS – October (M7) 2023

Queen Victoria Hospital NHS Foundation Trust



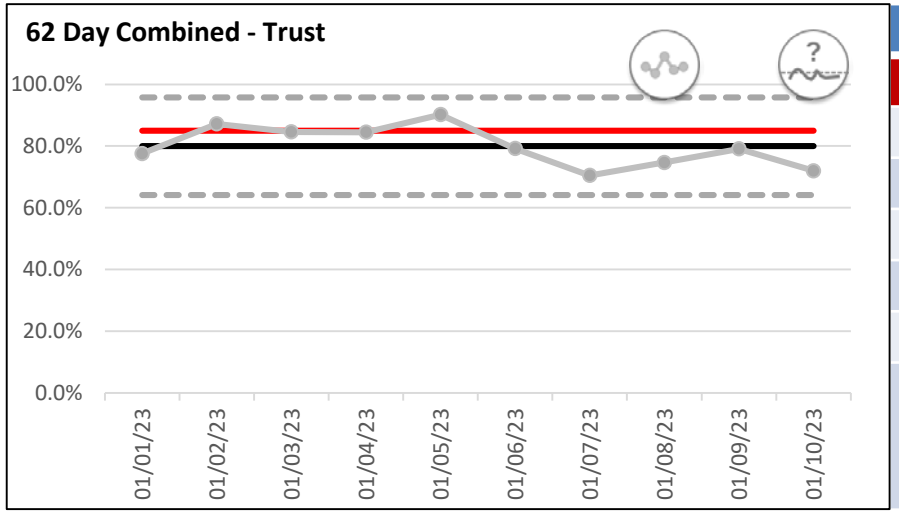
Oct-23
85.5%
National Target
75%
Target (ICB)
80%
Variance/Assurance
No statistical change. Assurance of meeting the target.

	Updates since previous month	Current issues	Future actions
Faster Diagnosis Standard	• **Achieved target reporting 85.5%** in M7, with plastics achieving 87%. • M5 performance data resubmission to NHS Digital has been delayed, however M5 actual position was 80.9% which passes the national target. • Weekly service level FDS meetings embedded to review potential FDS breaches with new patient level data report. • Process for faster results letter sign off now in place within Plastics.	• Outpatient and diagnostic clinic capacity	• Skin: Increased teledermatology capacity by 4 clinics per week due to locum dermatologist, start date delayed to M10; expecting around 50% of patients removed at first OPA
		• ENT vacancy	• ENT Fellow starting in M8 which will give additional clinical capacity
		• Impact of industrial action	• Additional capacity identified to aid recovery • Closely monitoring FDS via additional meetings to enable proactive management of pathways
		• Workforce	• Exploring a joint ENT post with a partner Trust; approved by the executive management team. Target recruitment date by end of M10

Cancer Performance

62 Day Performance – October (M7) 2023

Queen Victoria Hospital NHS Foundation Trust

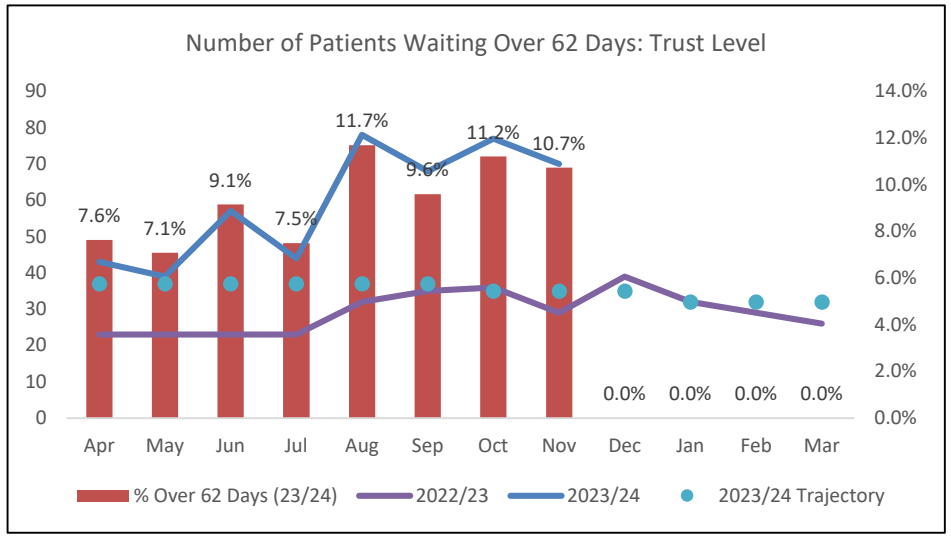


Oct-23
72.0%
National Target
85%
Target (internal)
86%
Variance/Assurance
No statistical change. No assurance of meeting the target regularly.

	Updates since previous month	Current issues	Future actions
62 Day Combined	• Now reporting combined 62 Day Standards in line with change to Cancer Waiting Times. Data prior to October 2023 is shadow reporting only • Reporting **72.0% in M7**, not achieving target. • Reporting 78.5 treatments with 22 breaches; largest volume of breaches is within Skin with 15 • Appointed an additional skin consultant to increase capacity	• Complex pathways, late referrals and patient choice	• Improvement in internal data reporting for 62D performance from M8 • Recovery trajectories developed in M9, with a projected improvement to a compliant position by M12 for Skin
		• Internal and External diagnostic delays for H&N	• Ensuring that specific reference to DMO1 diagnostic standards and expected turnaround times are included within contracts.
		• Outpatient and theatre capacity	• Skin: additional 7 all day theatre lists being scheduled in week during M7 and M8, as well as ad hoc Saturday super lists being implement in M8 and M9 with intended throughput of up to 12 skin cases per list
		• Impact of industrial action	• Twice weekly recovery meeting to review impact of IA and proactively adjust capacity response
		• Late cancellations of Breast immediate lists due to unavailability of visiting surgeons	• Plans to recruit a TIG fellow to enable QVH to deliver mastectomies and reduce reliance on referring providers
		• Workforce	• Exploring apprenticeship posts and joint recruitment schemes across the ICB

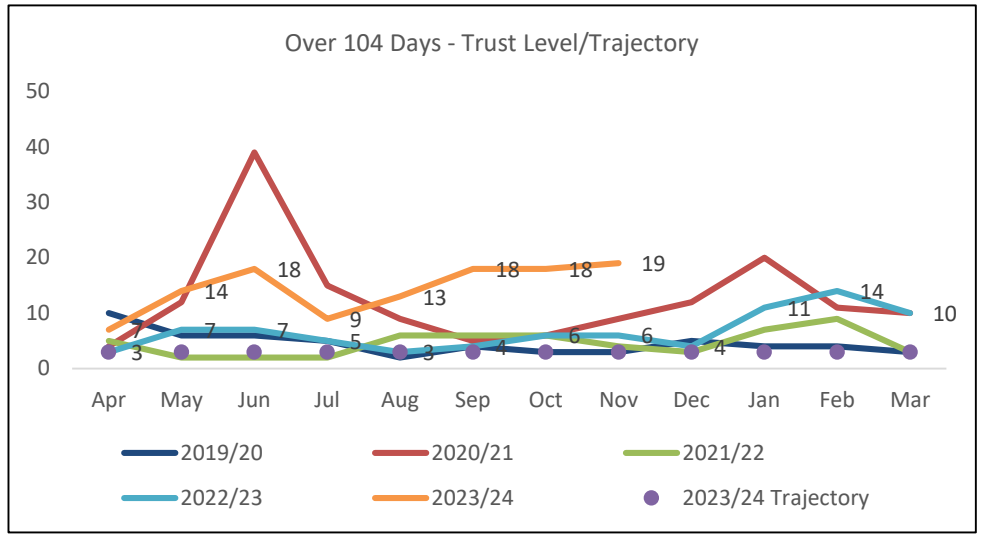
Cancer Performance

62 Day backlog – November (M8) 2023



Nov -23
70
Trajectory
35
10.7%
PTL Target
5%
Achievement
Not met

104 Day – November (M8) 2023



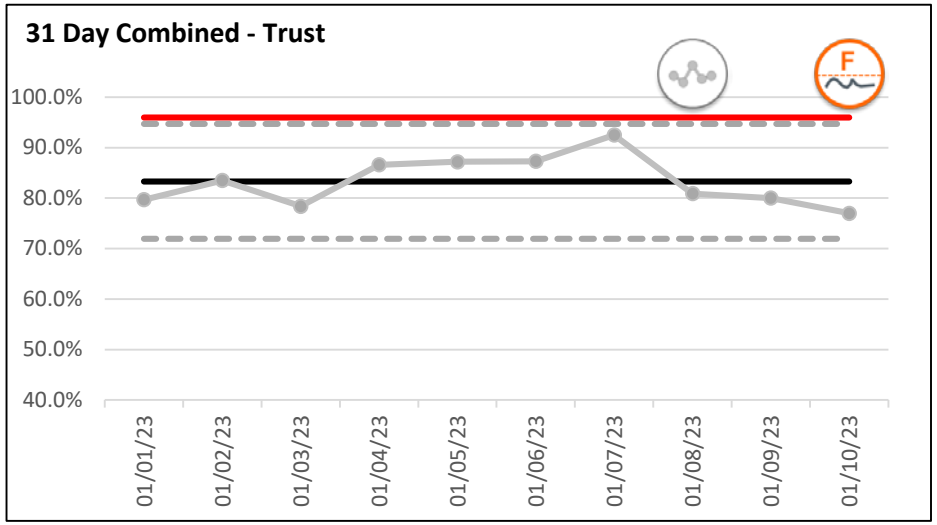
Nov-23
19
Trajectory
3
Achievement
Not met

	Updates since previous month	Current issues	Future actions
62 Day backlog	• Reporting 70 patients in M8; decreased by 7 from M7 • The Skin position has increased from 54 in M7 to 57 in M8 and continues to be the most challenged area for 62 day performance.	• Complex pathways, late referrals and patient choice	• Continued close monitoring at twice weekly PTL meeting; patient level discussions
104 Days	• 104 day patients are included in the 62 day cohort • M8 reporting a sustained number of patients at 19 patients: Skin (16), Breast (2) and Head & Neck (1). • High volume of complex pathways, due to patient comorbidities which require input from multiple healthcare professionals, internally and externally (e.g. primary care, community, safeguarding, CNS).	• Capacity	• Skin: Increased teledermatology capacity by 4 clinics per week due to locum dermatologist, start date delayed to M10; expecting around 50% of patients removed at first OPA • Skin: Super Saturday sessions in M8 and M9 have taken place to reduce numbers tipping into the backlog • Weekly 62 day backlog meeting with plastics clinical lead • Re-review of national cancer standards as they apply to delayed patients on 62 day backlog
		• Workforce	• Exploring apprenticeship posts and joint recruitment schemes across the ICB
		• Internal and External diagnostic delays for H&N	• Ensuring that specific reference to DMO1 diagnostic standards and expected turnaround times are included within contracts.

Cancer Performance

31 Day – October (M7)

Queen Victoria Hospital NHS Foundation Trust



Oct-23
77.0%
National Target
96%
Variance/ Assurance
Variation of concerning nature. No assurance of meeting the target regularly.

	Updates since previous month	Current issues	Future actions
31 Day Combined	• Now reporting combined 31 Day Standards in line with change to Cancer Waiting Times. Data prior to October 2023 is shadowing report only. • Reporting **77.0% in M7** • There were 178 treatments for M7 with 41 breaches • Specialty performance; Skin 76.8%, Head & Neck 94.1% and Breast 50.0%. • Declining 31D Decision to Treat position driven by elective capacity within Skin. • 31D subsequent performance also remains challenged due to Sentinel Lymph Node Biopsy (SLNB) capacity within Skin.	• Outpatient and Theatre Capacity	• Skin: additional 7 all day theatre lists being scheduled in week during M7 and M8, as well as ad hoc Saturday super lists being implement in M8 and M9 with intended throughput of up to 12 skin cases per list • Recovery trajectories developed in M9, with a projected improvement to a compliant position by M12 for Skin
		• Staff capacity and skill mix	• Recruiting a Breast TIG fellow and a teledermatologist
		• Complex pathways and patient choice	• Increased senior oversight and leadership of pathway management
		SLNB cohort within Skin: • Treatment capacity • Clinical Nurse Specialists availability for clinics • Surgical staff skill mix	• Planning additional SLNB weekend lists from M10, subject to theatre staffing • Skin: Additional SLNB outpatient clinic capacity scheduled for M8 • Skin: Displacing routine in week outpatient capacity to accommodate SLNB patients • Utilising some lists at TMC for additional SLNB capacity

Diagnostic Performance (DMO1)

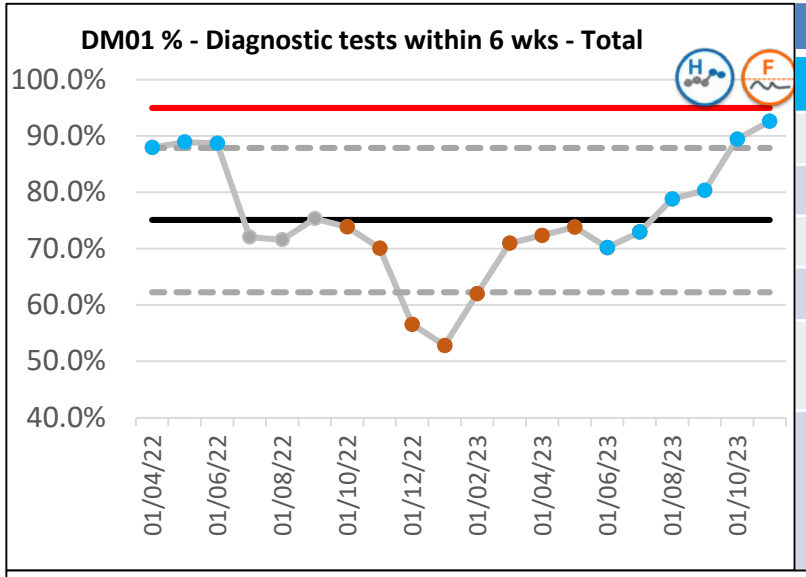
November (M8)

DMO1 NATIONAL POSITION: *(look back – Oct 23)*	
National DMO1: 75.3%	**QVH DMO1:** 89%

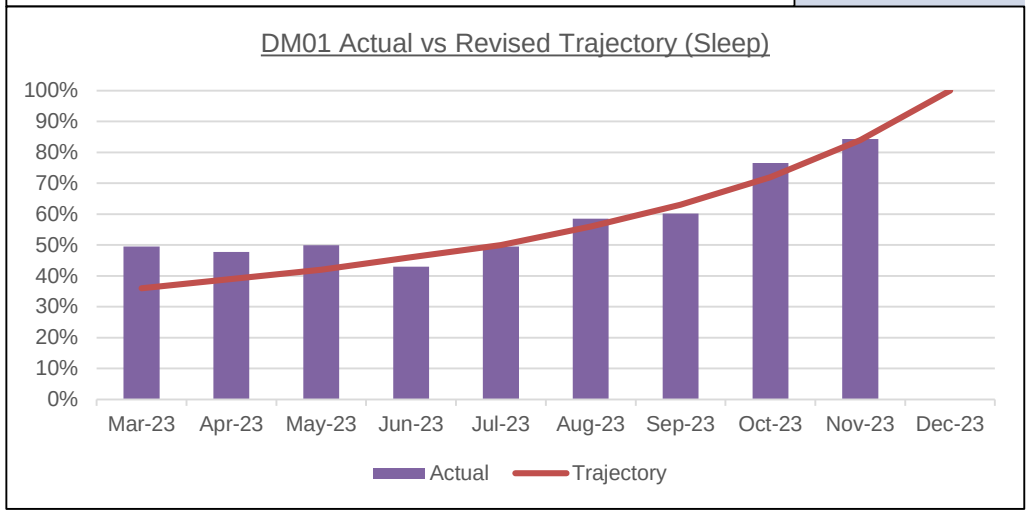
Updates since previous month

- The overall Trust position has **increased to 93% in M8**; we remain below target (95%) but performance is improving
- Radiology DMO1 performance remains high reporting 99.2% in M8
- Sleep DMO1 position continues to improve in line with trajectory, reporting 84.3% in M8, with numbers on the DMO1 waiting list and the number of breaches reducing month on month
- The majority of Sleep patients waiting longer than 6 weeks, have their diagnostic appointment booked
- Sleep launched new service in M8 to support patients undertaking Polysomnography tests at home

Current issues	Future actions
The majority of breaches in Sleep are Polysomnography cases	Expansion of the new Polysomnography home testing service. Projected additional activity for the home testing is 80 patients per month from M10.
External outsourced capacity and turnaround times	Sleep are working with an external polysomnography supplier to understand and improve outsourced turnaround times As the new home testing service expands, the numbers being sent to external suppliers will reduce.
Numbers of referrals into Sleep have increased from M7 after several months of relative stability.	Continued monitoring of referral levels to assess demand and capacity
Staffing to support additional admin requirements	Continued use of bank staff, although challenged by availability



Nov-23
93%
National Target
95% by Mar-24
Internal Target
95% by Mar-24
Variance/ Assurance
Improving variance. Consistently failing target.



RTT Performance – Total waiting list
November (M8)

Queen Victoria Hospital NHS Foundation Trust

Updates since previous month
• Increase in total waiting list size from M7 to M8; increased by 2.8%
• PTL validation – 65% response rate. 6% of responses indicated for removal from PTL (60 patients)
• Scenario modelling undertaken - revised trajectory developed assuming no further IA and realisation of planned additionality.

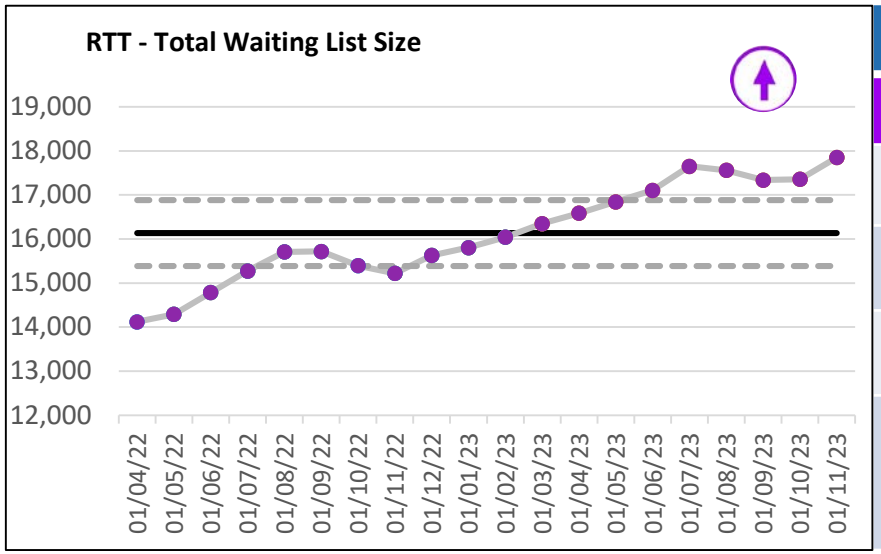
Current issues	Future actions
• Capacity shortfalls due to theatre workforce issues.	• Exploring the potential of utilising insourcing company to improve staffing levels. • Continued optimisation and focused management of theatre lists showing underutilisation.
• Capacity shortfalls due to industrial action.	• Protecting clinical priorities and long waiting patients where possible.
• Capacity shortfalls in Orthodontics (Hypodontia Services)	• Plan On A Page developed for expansion of Hypodontia service, delivered in partnership with GSTT. Further discussions with GSTT ongoing.
• Referral demand and pathway management.	• RTT PTL management information platform will enable future proactive management of the waiting list. Initial introductory training session undertaken.

RTT NATIONAL POSITION: ***(look back – Oct 23)***

National RTT18:	QVH RTT18:
58.2%	60.6%

52WW NATIONAL POSITION: ***(look back –Oct 23)***

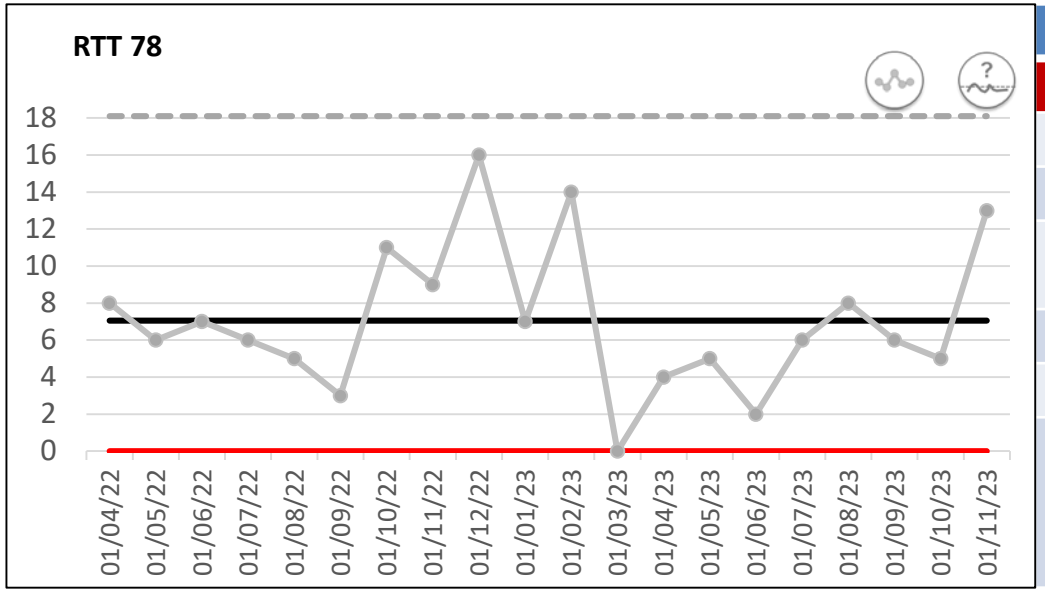
National % >52WW:	QVH % >52WW:
4.9%	2.6%



Nov-23
17,851
Target
n/a
Variance
Increasing variance.

RTT Performance – 78 Week Wait
November (M8)

Queen Victoria Hospital NHS Foundation Trust

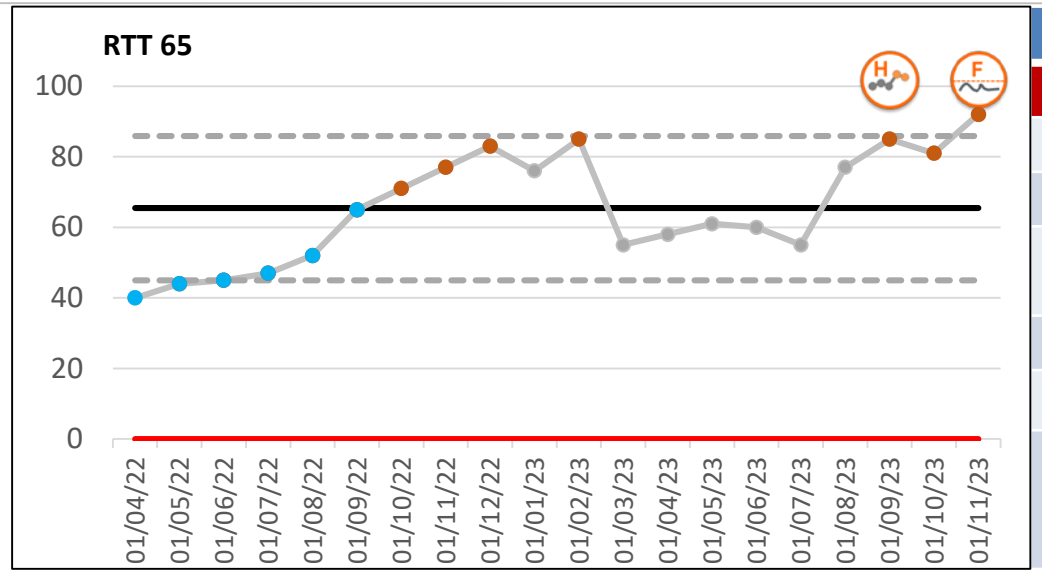


Nov-23
13
National Target
0 by Mar-24
Revised internal trajectory Nov
11
Variance/ Assurance
No significant statistical change. No assurance of meeting target.

	Updates since previous month	Current issues	Future actions
78WW	• Reporting 13 patients in M8, increased from 5 in M7 • Reporting 9 patients in Plastics, 3 patients in OMFS, 1 in Corneo	• Late referrals from other providers	• Highlight late referrals on PTL to enable proactive management of pathway challenges
		• Complex pathways	• Patients over 78WW are tracked weekly at service level and prioritised for outpatient appointments and admission, scheduled where clinically appropriate
		• Capacity	• Re-allocation of theatre capacity between specialties. Super Saturdays have been mobilised from M8. Indicative capacity sufficient to support recovery.
		• Workforce	• Exploring alternative routes for increasing workforce through HBS UK
		• Recovery from industrial action and planning for future industrial action	• Continued close monitoring at service level against agreed trajectory.

RTT Performance – 65 Week Wait
November (M8)

Queen Victoria Hospital NHS Foundation Trust



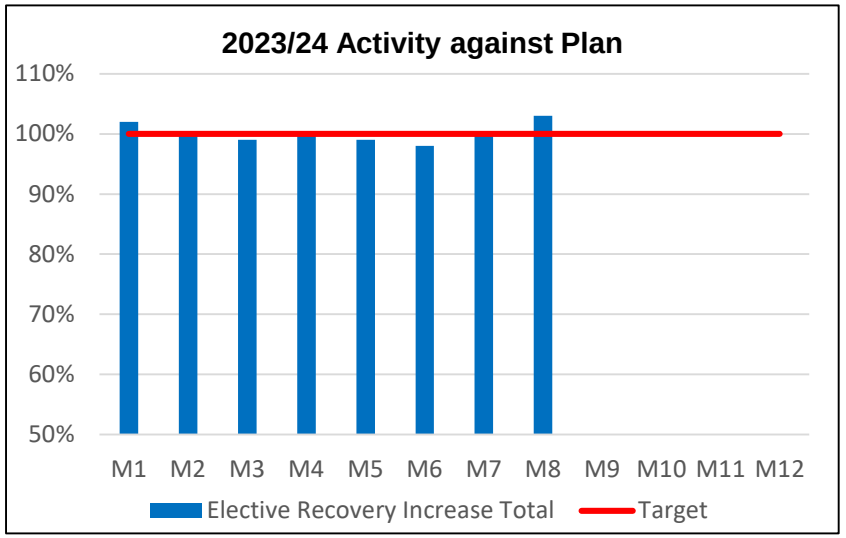
Nov-23
92
National Target
0 by Mar-24
Revised internal trajectory Nov
121
Variance/ Assurance
Deteriorating variance. Failing target.

	Updates since previous month	Current issues	Future actions
65WW	• Reporting 92 patients in M8, increased from 81 patients in M7. • Reporting 66 patients in Plastics, 22 in MF (9 of which are Orthodontics), 2 in Corneo and 2 in Sleep. • Weekly tracking of patients without a booked appointment who have the potential to be 65WW by 31 March 2024 within "relaunched PTL process. • Orthodontics, Breast and Mohs (Skin) identified as at risk areas moving forward.	• Theatre staffing challenges	• Exploring alternative routes for increasing workforce through HBS UK
		• Capacity	• Prioritisation of 65WW and most clinically urgent patients for scheduling M10 - M12 • Plastics: Skin, Mohs and Breast additional Saturday lists initiated from M8. • Plastics and Corneo mobilising planned 3 session days from M10 – 12. • Plastics: expanding use of additional TMC lists to include RTT patients • Orthodontics: additional clinic dates identified to increase capacity, however continued hypodontia gap being addressed.
		• Late referrals	• Continued close monitoring at service level • Highlight late referrals on PTL to enable proactive management of pathway challenges
		• Patient choice	• Appropriate use of 3AMC codes to record patient choice active monitoring.
		• Referral numbers and pathway management	• PTL meeting structure refreshed to strengthen multidisciplinary input into PTL management across specialties from M9

Activity vs Plan

Queen Victoria Hospital NHS Foundation Trust

Elective Recovery Group	POD Grouping	M1 % against Activity Plan	M2 % against Activity Plan	M3 % against Activity Plan	M4 % against Activity Plan	M5 % against Activity Plan	M6 % against Activity Plan	M7 % against Activity Plan	M8 % against Activity Plan	YTD
Elective Recovery Increase	Day Case Total	87%	98%	90%	85%	84%	88%	83%	93%	89%
	Elective Total	91%	93%	102%	81%	83%	105%	92%	92%	92%
	First Outpatients Total	104%	100%	101%	95%	91%	96%	101%	99%	98%
	Outpatient Procedures Total	105%	101%	99%	112%	117%	103%	106%	113%	107%
Elective Recovery Increase Total		**102%**	**100%**	**99%**	**100%**	**99%**	**98%**	**100%**	**103%**	**100%**



	Updates since previous month	Current issues	Future actions
M8 Activity	• Day case and Elective activity under plan. Day case driven largely by Plastics. Elective driven by case complexity. • Additional Saturday lists undertaken in M8 equating to an additional 75% all day theatre sessions delivered to support management of long waiting patients. • First Outpatient appointments and Outpatient Procedures activity both broadly hitting or exceeding plan. • Overall 103% of plan delivered in M8.	• Continued challenges around theatre staffing leading to loss of capacity. • Realisation of productivity potential in theatres and outpatients, although theatre utilisation is excellent when benchmarked against peers. • Planned Industrial Action in M9 and M10. • Additional capacity required for elective recovery	• Exploring alternative routes for increasing workforce through HBS UK • Continued optimisation and focused management of theatre lists showing underutilisation • Theatre Productivity and Outpatient Transformation workstreams continue to focus on areas of opportunity. • Review of capacity allocation and continued additionality being identified in specific specialties to bridge gap. • Additional step change to Saturday activity planned for theatres where required associated with elective recovery • Planning to increase delivery of additional Saturday all day theatre sessions to 125% in M9

Transformation Performance Summary

Queen Victoria Hospital NHS Foundation Trust

KPIs - Theatres	Latest month	Measure	Target	Variation	Assurance
Theatre Utilisation (National GIRFT Target)	Nov 23	83.4%	85.0%		
Cancellations on the day - % of all elective activity	Nov 23	5.0%	5.0%		
Elective Late Starts Average (Mins)	Nov 23	12	15		
Elective Early Finish Average (mins)	Nov 23	22	30		

KPIs - Outpatients	Latest month	Measure	Target	Variation	Assurance
Outpatients - Follow up reduction against 19/20	Nov 23	14%	25%		
Outpatients - PIFU % utilisation (local target)	Nov 23	1.5%	2.8%		F
Outpatients - Missed appointments (DNAs)	Nov 23	5.0%	4.0%		F
Outpatients - % Patient cancellations on the day	Nov 23	1.6%	1.0%		
Outpatients - % Hospital cancellations within 5 days of OPA	Nov 23	2.9%	4.0%		
Outpatients - % Virtual activity	Nov 23	21.8%	25.0%	L	

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:	11/01/2024		**Agenda reference:**	**142-24**	
Report title:	Quality and safety assurance				
Sponsor:	Karen Norman, non-executive director and committee Chair				
Author:	Leonora May, deputy company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of the report is to provide assurance on matters considered and discussed by the quality and governance committee at its meeting on 18 December 2023 and its seminar on 27 November 2023.				
Summary of key issues	- One serious incident declared during the period and one downgraded - Improvements made to pathways and mitigations in place to prevent clinical harm - Further assurance required regarding the mitigation of the antimicrobial prescribing risk - 14 formal complaints received during October and November 2024				
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:	BAF 1- patient services reviewed by the committee Chair				
Corporate risk register:	Corporate risk register reviewed at the meeting				
Regulation:	Health and Social Care Act 2008 CQC standards of quality and safety				
Legal:	As above				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	142-24
Date of meeting:	11 January 2024
Report from:	Karen Norman, non-executive director and committee Chair
Report author:	Leonora May, deputy company secretary
Date of report:	3 January 2024
Appendices:	None

Quality and safety assurance

Introduction

This purpose of this report is to provide the Board with assurance on matters considered by the quality and safety committee at its meeting on 18 December 2023 and its seminar on 27 November 2023.

Clinical quality and patient safety

There has been one serious incident declared during the period and one serious incident was downgraded. Learning from recent incidents was shared, and the committee were assured that it is effectively embedded.

The committee received an update regarding clinical harm reviews, noting that a small number of patients were identified by the cancer pathway 104 day harm review process for review, as well as cancer patients who have delayed pathways that do not breach standards. The committee were assured that these cases have been investigated and that lessons learned have been implemented to make improvements to pathways. Routine 52 week clinical harm reviews have been stopped as it did not produce useful outcomes.

Infection prevention and control

The committee raised concern regarding a lack of a 'Ventilation Authorised Person' and the associated service level agreement not being overseen. Further assurance on the mitigation of the risk was requested for the committee's next meeting.

The committee received assurance that the risk related to antimicrobial prescribing is being closely monitored by the antimicrobial steering group, noting that challenges are faced due to the antimicrobial pharmacist position being difficult to recruit to. There has been notable improvement with the initiation of bi-weekly ward rounds. The committee have requested further assurance regarding the mitigation of this risk, including receipt of the compliance audit reports.

There has been an increase in covid-19 amongst staff.

Patient experience

The Trust received 14 formal complaints during October and November 2023. The main themes are delays to treatment and perceived incorrect treatment. Ten of the complaints have been resolved and closed. The committee took assurance from this report.

Public and patient engagement strategy

The committee received and approved the final public and patient engagement strategy, endorsed by the patient experience group. Subject to minor amendments related to incorporating wider partnerships and providing clarity regarding the

meaning of being an anchor institution, it was agreed to recommend this strategy to the Trust Board for approval.

CQC preparedness
The committee received an update regarding preparedness for an upcoming CQC inspection. It noted challenges, including the need to develop a quality improvement programme (which is in progress), the absence of an onsite paediatrician, waiting lists and compliance with the mental capacity act. The committee will continue to monitor CQC preparedness ahead of an inspection and sought further assurance on risks identified.

Seminar
The committee held its annual seminar on 27 November 2023.Topics for discussion included:

- Patient safety incident response framework (PSIRF- the committee received an update regarding the new framework and its application at QVH
- Problem sensing Boards- the committee recognised the importance of recognising and valuing the perspective of quieter individuals, emphasising trust-building and the critical role of listening skills in gathering soft intelligence, as well as understanding both the positive and negative aspects of the organisation's culture through analysis and professional scepticism. The committee also recognised the challenges faced by smaller trusts including potential fears of speaking up and a need to address this

Other

- Quarter two quality priorities have been met
- The committee received the NICE and clinical audit programme, noting commitment to adhering to NICE guidelines and challenges in obtaining timely responses from clinical staff. Work to ensure new policies are aligned to NICE guidelines is ongoing. Further assurance was sought on this item
- The committee received a report regarding the clinical corporate risks, noting risks related to patient transfers, meeting national clinical standards, speaking up and the mental capacity act. The new framework is work in progress and a meeting will be held in January to enable further discussion and revision

Recommendation
The Board is asked to **note** the contents and recommendations of the report, the assurance where given and the risks identified.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	11/01/2024		**Agenda reference:**	**143-24**	
Report title:	Quality & Safety Board Report				
Sponsor:	Nicky Reeves, Chief Nurse Tania Cubison, Chief Medical Officer				
Author:	Nicky Reeves, Chief Nurse, Tania Cubison, Chief Medical Officer				
Appendices:	Appendix one: Public and patient engagement strategy				
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: • 1 serious incident reported and under investigation • A small number of infection control issues highlighted, no evidence of onward transmission • Progress with Covid and Seasonal Flu vaccination campaigns • The Public and Patient Engagement Strategy has been approved at Quality and Safety Committee and will be launched during January 2024 • The QVH approach to the implementation of Patient Incident Response Framework (PSIRF) and PSIRF policy were approved at the December Quality and Safety Committee				
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:	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:	Q&S				
	Date:	18/12/2023	Decision:	Approved	

Board Report

Contents

Summary - Chief Nurse and Chief Medical Officer

We continue to see positive patient feedback via our patient experience report, friends and family test, individual written plaudits and online via Care Opinion.

Following the review of both "speak up" arrangements within the organisation following the Letby case and also following the recent publication of the report "Breaking the Silence, Addressing Sexual Misconduct in Healthcare" work continues to ensure our staff are feeling safe and confident to raise concerns. The chief nurse and chief medical officer are the executive leads for these areas

The Public and Patient Engagement Strategy has been created and has been reviewed and approved in the Quality and Safety Committee prior to being launched in January 2024. The Strategy is in **appendix 1** for information.

There has been one SI declared and one separate patient incident resulting in moderate harm reported which are being investigated.

The seasonal flu vaccination campaign has commenced. We also ran a successful Covid 19 campaign in which we vaccinated approximately 200 staff

There have been small numbers of infection control cases identified as below, of note, there has been no onward transmission of infection in any of these cases demonstrating positive infection control knowledge and precautions:-
1 case of Invasive group A (IGAS) identified
2 cases of E.coli bacteraemia identified
1 CPE positive case identified
1 Vancomycin-resistant enterococci identified in a wound swab
4 small covid clusters in staff groups

Quality and Safety Committee discussed and approved the Trust plan and policy for the implementation of Patient Safety incident Response Framework (PSIRF)

Both the CNO and CMO continue to do regularly walkabouts to hear staff and patients concerns and feedback

The virtual antimicrobial ward rounds have now started. This is a twice a week opportunity for the QVH clinical teams to discuss cases with a consultant microbiologist using the teams platform. The Deputy Medical Director has been central to this very welcome addition to our service.

Safe Performance Indicators (1)

Metrics not appropriate for SPC XmR reporting

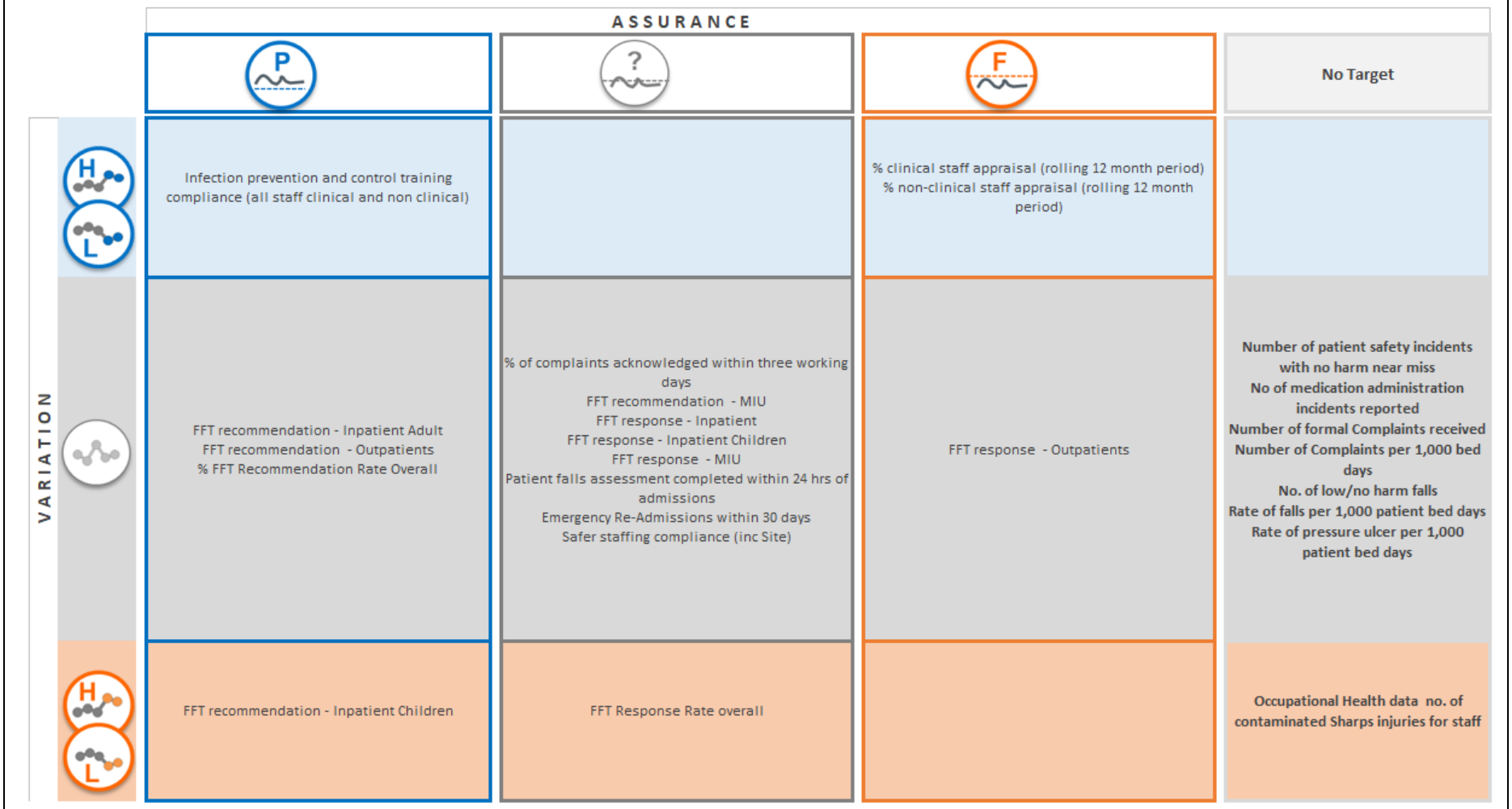
KPI Description	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Number of Serious Incidents reported (including IG breaches)	1	0	2	0	0	0	0	0	0	0	1	0	1
Compliance with Duty of Candour % of instances complied with Duty of Candour			100 %		100 %		100 %				100 %		100 %
Number of Duty of Candour notifications moderate harm or above	0	0	2	0	1	0	1	0	0	0	2	0	1
Number of Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0
No of patient safety incidents with moderate harm	0	0	0	1	0	0	0	1	0	0	0	0	1
No of patient safety incidents with severe harm or death	0	0	0	0	1	0	0	0	0	0	0	0	0
Rate of Serious Incidents per 1,000 bed days	1.0	0.0	2.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0
No of Mixed Sex Accommodation (MSA) breaches reported	0	0	0	0	0	0	0	0	0	0	0	0	0
No of falls resulting in moderate or severe harm or death	0	0	0	0	0	0	0	0	0	0	0	0	0
No. of pressure ulcer development category 2 (hospital acquired)	0	0	3	2	0	0	0	0	1	0	2	2	1
No of Grade 3 and 4 pressure ulcer reported (hospital acquired)	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcer assessment completed on admission (%)								94%			95%		
Ward patients with sepsis receiving antibiotic therapy within one hour (total number)	1	1	0	0	1	0	1	1	1	1	0	0	0
	100 %	100 %			100 %		100 %	100 %	100 %	100 %			
Number of HCAI Root Cause Analysis (RCA) and Post Infection Review (PIR) undertaken	No reportable infections	No reportable infections	100 %	No reportable infections	No reportable infections	No reportable infections	No reportable infections	No reportable infections	100 %	100 %	No reportable infections	No reportable infections	No reportable infections
No of CDI reported (Trust acquired, post 72hrs after admission)	0	0	1	0	0	0	0	0	0	0	0	0	0
No of MRSAs reported (Trust acquired, post 48hrs after admission)	0	0	0	0	0	0	0	0	0	0	0	0	0
No of E.coli reported (Trust acquired, post 48hrs after admission)	0	0	1	0	0	0	0	0	1	1	0	0	0
No of MSSA reported (Trust acquired, post 48hrs after admission)	0	0	0	0	0	0	0	0	0	0	0	0	0
Confirmation Infection Control Audits are undertaken	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Crude mortality (all patients)	1	2	1	2	6	2	1	2	2	2	1	4	2

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.

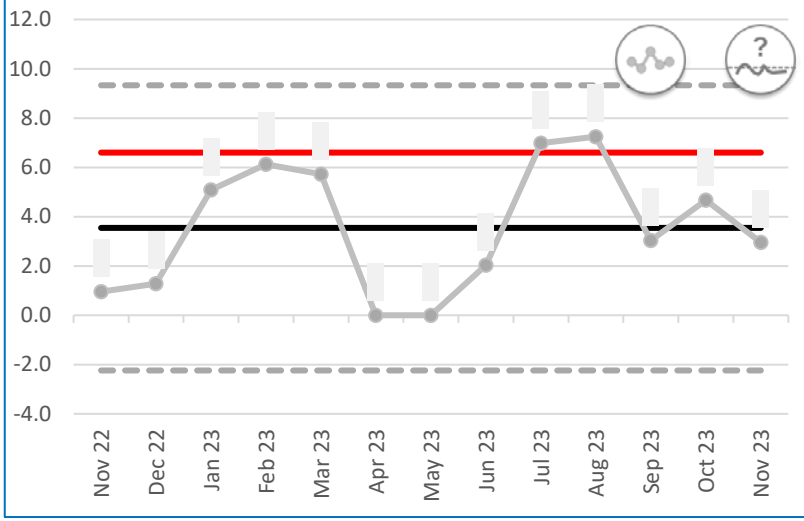
KPI	Latest month	Measure	Target	Variation	Assurance
Number of patient safety incidents with no harm nea	Nov 23	46	-		
No of medication administration incidents reported	Nov 23	4.0	-		
Number of formal Complaints received	Nov 23	7	-		
Number of Complaints per 1,000 bed days	Nov 23	6.9	-		
% of complaints acknowledged within three working	Nov 23	100%	99%		
FFT recommendation - Inpatient Adult	Nov 23	100%	90%		P
FFT recommendation - Inpatient Children	Nov 23	98%	90%	L	P
FFT recommendation - MIU	Nov 23	91%	90%		
FFT recommendation - Outpatients	Nov 23	94%	90%		P
% FFT Recommendation Rate Overall	Nov 23	95%	90%		P
FFT response - Inpatient	Nov 23	45%	25%		
FFT response - Inpatient Children	Nov 23	30%	25%		
FFT response - MIU	Nov 23	22%	25%		
FFT response - Outpatients	Nov 23	17%	25%		F
FFT Response Rate overall	Nov 23	20%	25%	L	
No. of low/no harm falls	Nov 23	3	-		
Rate of falls per 1,000 patient bed days	Nov 23	3.0	-		
Patient falls assessment completed within 24 hrs of a	Nov 23	100%	100%		
Rate of pressure ulcer per 1,000 patient bed days	Nov 23	1.0	-		
Occupational Health data no. of contaminated Sharps	Nov 23	8	-	H	
Infection prevention and control training compliance	Nov 23	99%	90%	H	P
Emergency Re-Admissions within 30 days	Nov 23	1.5%	2.2%		
Safer staffing compliance (inc Site)	Nov 23	99%	99%		
% clinical staff appraisal (rolling 12 month period)	Nov 23	88%	90%	H	F
% non-clinical staff appraisal (rolling 12 month perioc	Nov 23	81%	90%	H	F


ASSURANCE
P
?
F
No Target
VARIATION
H
L
Infection prevention and control training compliance (all staff clinical and non clinical)
% clinical staff appraisal (rolling 12 month period)
% non-clinical staff appraisal (rolling 12 month period)
FFT recommendation - Inpatient Adult
FFT recommendation - Outpatients
% FFT Recommendation Rate Overall
% of complaints acknowledged within three working days
FFT recommendation - MIU
FFT response - Inpatient
FFT response - Inpatient Children
FFT response - MIU
Patient falls assessment completed within 24 hrs of admissions
Emergency Re-Admissions within 30 days
Safer staffing compliance (inc Site)
FFT response - Outpatients
Number of patient safety incidents with no harm near miss
No of medication administration incidents reported
Number of formal Complaints received
Number of Complaints per 1,000 bed days
No. of low/no harm falls
Rate of falls per 1,000 patient bed days
Rate of pressure ulcer per 1,000 patient bed days
H
L
FFT recommendation - Inpatient Children
FFT Response Rate overall
Occupational Health data no. of contaminated Sharps injuries for staff

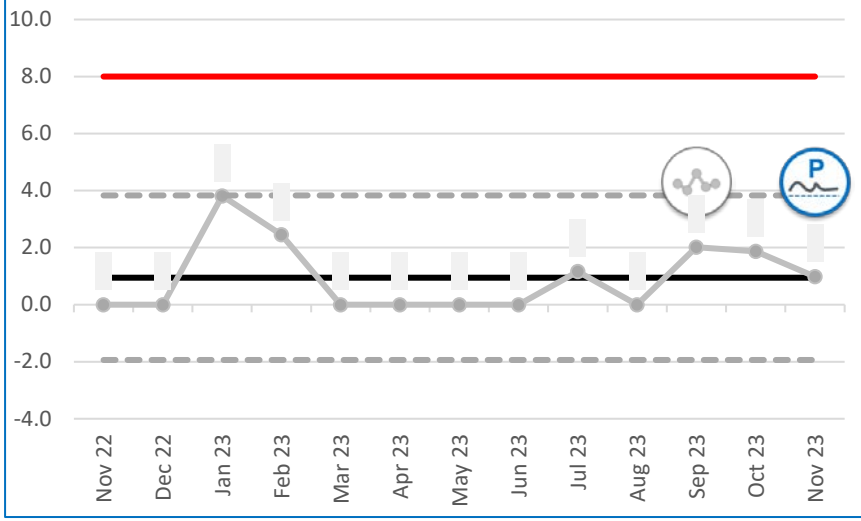
Safe Performance Indicators – Falls & Pressure Ulcers

Our fall rate continues to be variable but within expected limits and lower than the national average.
QVH acquired Pressure Ulcers continues within normal variability, with an average of less than 1 per month, per 1000 bed days. Current process provide assurance of care. CQUIN results show improvement in documentation is required.

Rate of falls per 1,000 patient bed days



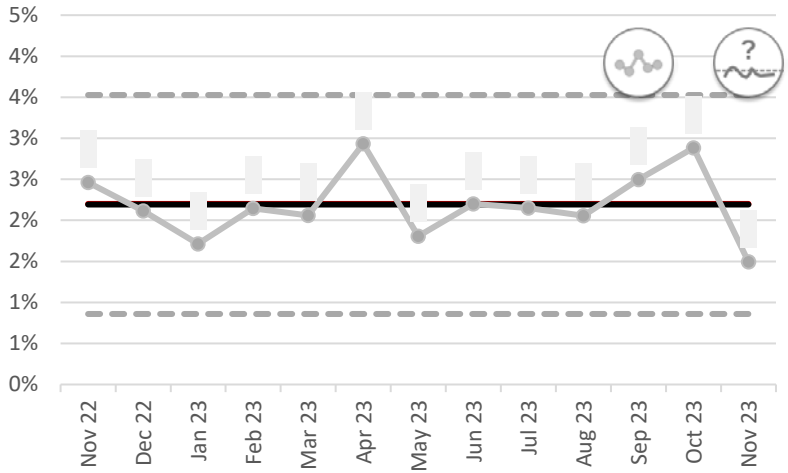
Rate of pressure ulcer per 1,000 patient bed days



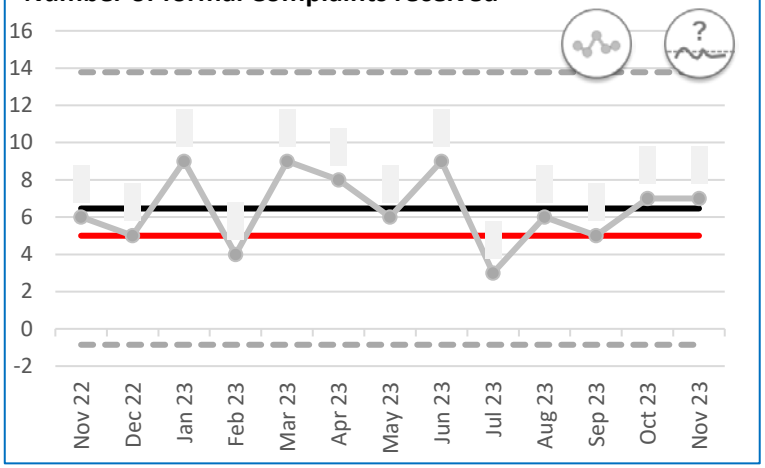
Effective Indicators (1)

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 report to CGG quarterly.

Emergency Re-Admissions within 30 days



Number of formal Complaints received



Complaints are slightly higher than our average but remain within expected variation. All complaints are shared with department leads to share within the team.

There has been an increase in the number of SI reported in the last year, compared to 4 in the previous two years. Mortalities are reviewed as per policy

Nursing Workforce - Performance Indicators

Metrics	Q3 2022-23	Q4 2022-23			Q1 2023-24			Q2 2023-24			Q3 2023-24		12 month average
Nursing Workforce	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	
Establishment WTE Including Bank & Agency	384	384	384	384	384	384	384	384	384	384	384	384	384
Establishment WTE excluding Bank & Agency	352	352	352	352	343	343	343	343	343	343	343	343	346
Staff In Post WTE	328	329	330	328	331	333	333	335	335	342	345	346	335
Agency Total worked in month WTE	2	3	3	5	8	6	7	7	11	8	8	10	7
Bank WTE Total worked in month WTE	31	35	39	47	35	33	34	32	37	38	36	37	36
Staff in Post Vacancy WTE	24	22	21	24	12	10	10	9	9	1	-1	-2	12
Vacancies % Including Bank & Agency Usage	6%	4%	3%	1%	2%	3%	2%	3%	0%	-1%	-1%	-2%	2%
Staff in Post Vacancies %	7%	6%	6%	7%	4%	3%	3%	3%	3%	0%	0%	-1%	3%
Qualified Nurses (NMC) Vacancies WTE	27	27	32	35	13	15	17	17	17	15	12	10	20
Theatre Practitioners (AHP) Vacancies	1.75	1.75	1.75	1.75	2.04	2.04	1.04	1.04	2.04	-0.96	-0.96	-1.96	0.9
Band 2 & 3 HCSW Vacancies WTE Clinical support to clinical staff	-4	-5	-6	-7	0	-3	-3	-6	-5	-3	-4	-4	-4
Band 2 & 3 HCSW Vacancies WTE Non clinical support to clinical staff	3	3	3	3	0	0	0	0	0	-1	0	0	1
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)	-2	-5	-8	-8	-2	-4	-5	-4	-5	-10	-9	-7	-6
Trust rolling Annual Turnover % Excluding Trainee Doctors	9%	9%	8%	8%	8%	9%	9%	8%	8%	9%	9%	8%	
Starters WTE In month excluding HEE doctors	2	6	1	5	3	4	2	5	3	5	8	7	4
Leavers WTE In month excluding HEE doctors	3	3	0	2	3	4	2	2	1	2	5	0	2
12 month sickness rate (all sickness)	5.4%	5.2%	5.1%	5.0%	5.0%	4.9%	4.8%	4.7%	4.6%	4.6%	4.6%	#N/A	#N/A
Monthly Sickness Absence %All Sickness	8.0%	5.0%	4.9%	5.1%	4.8%	3.2%	3.1%	3.6%	3.5%	5.1%	5.4%	#N/A	#N/A

Safe staffing levels have been maintained across the Trust.

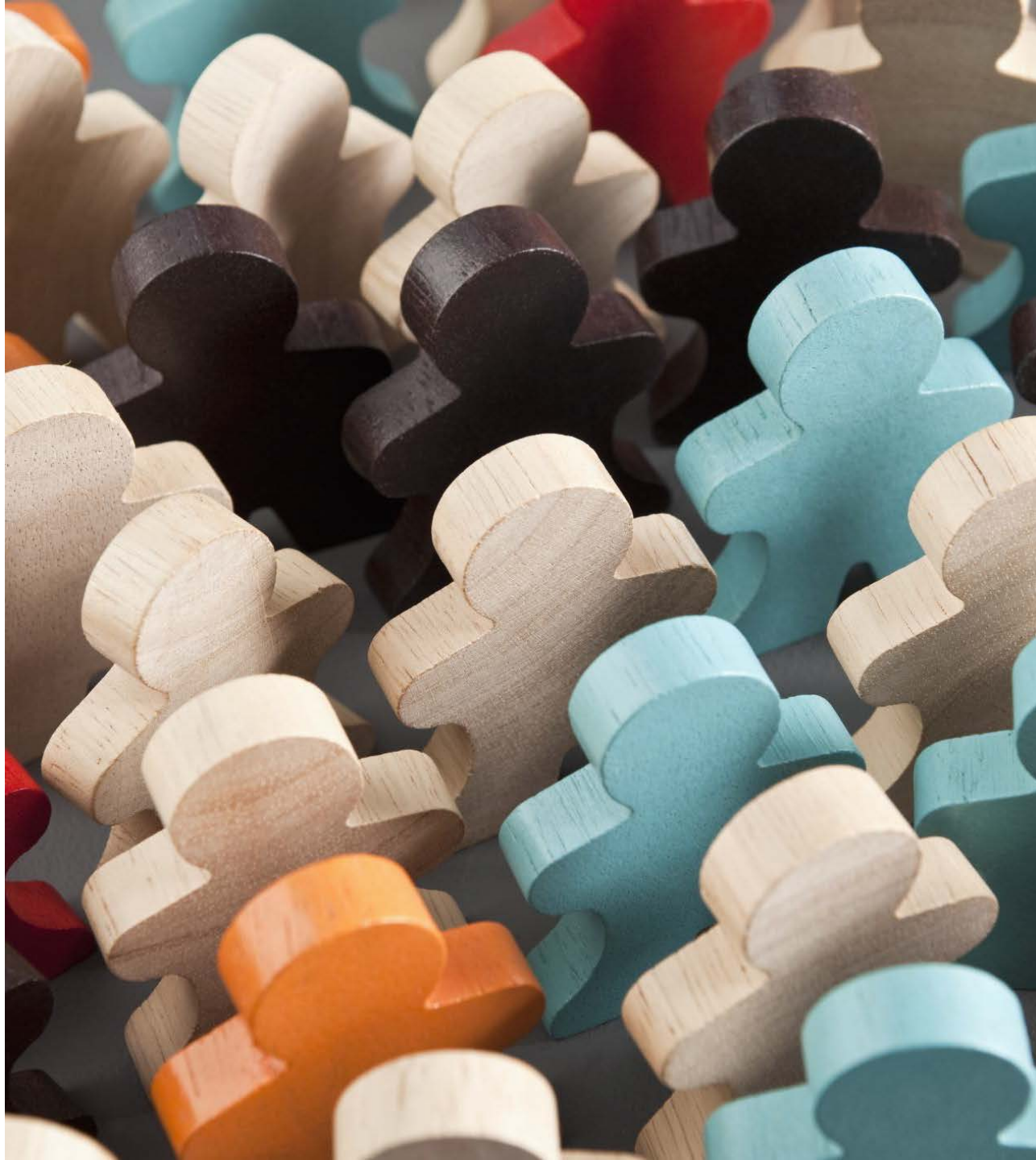
Medical Workforce - Performance Indicators

Metrics	Q3 2022-23	Q4 2022-23			Q1 2023-24			Q2 2023-24			Q3 2023-24		12 month rolling
Medical Workforce	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	
Turnover rate in month, excluding trainees	0%	4%	0%	1%	1%	0%	2%	0%	3%	3%	1%	0%	12%
Turnover in month including trainees 9%	0%	10%	1%	3%	6%	1%	1%	2%	10%	0%	4%	0%	41%
Management cases monthly	0	2	1	1	0	0	0	0	0	1	0	0	3
Sickness rate monthly on total medical/dental headcount	3%	1%	1%	2%	1%	1%	1%	2%	1%	3%	2%		
Appraisal rate monthly (including deanery trainees)	74%	77%	79%	80%	82%	83%	81%	83%	82%	84%			
Mandatory training monthly	86%	83%	86%	88%	89%	88%	89%	89%	89%	86%	88%	89%	88%
Exception Reporting – Education and Training	1	3	1	3	2	0	1	2	0	2	1	0	16
Exception Reporting – Hours	3	2	2	5	0	4	8	1	5	3	7	4	44

Medical & Dental Staffing	No doctors' induction in November but a number of ad hoc new starters joined the Trust and will attend Trust induction. New starter names for February Deanery trainees have been released. There are gaps in Anaesthetics due to the number of LTFT trainees. MedEd and Medical Workforce will support the tutor to look at this. Hours/pattern-related exception reports decreased in November and there were no training reports. The Guardian of Safe Working Hours works with departments to close reports and ensure action is taken.
Education	The Trust hosted the regional anaesthetics teaching day on 20 November, which was very well received. The second cohort of LEEP training continues to be popular, with delegates attending LEEP 2 on 3 November.

Better Together

A strategy for excellent patient experiences and meaningful public engagement at Queen Victoria Hospital



Better Together: why it is important

1

The NHS constitution says, ‘the NHS belongs to the people’. The services provided at QVH are founded on a common set of principles and values that bind together patients and public who use the services – and the staff.

2

QVH is committed to providing the highest quality care, the best clinical outcomes and a trusted, safe and positive patient experience.

3

QVH aims to serve patients effectively and safeguard high-quality services for the benefit of the people and populations served.

4

To make sure these shared commitments and aims are achieved, it is essential to reflect, learn, understand, be open to challenge and continuously seek to improve.

5

To achieve this, QVH takes a proactive approach to understanding how patients experience services and developing meaningful relationships with the public who might need to use services in the future.

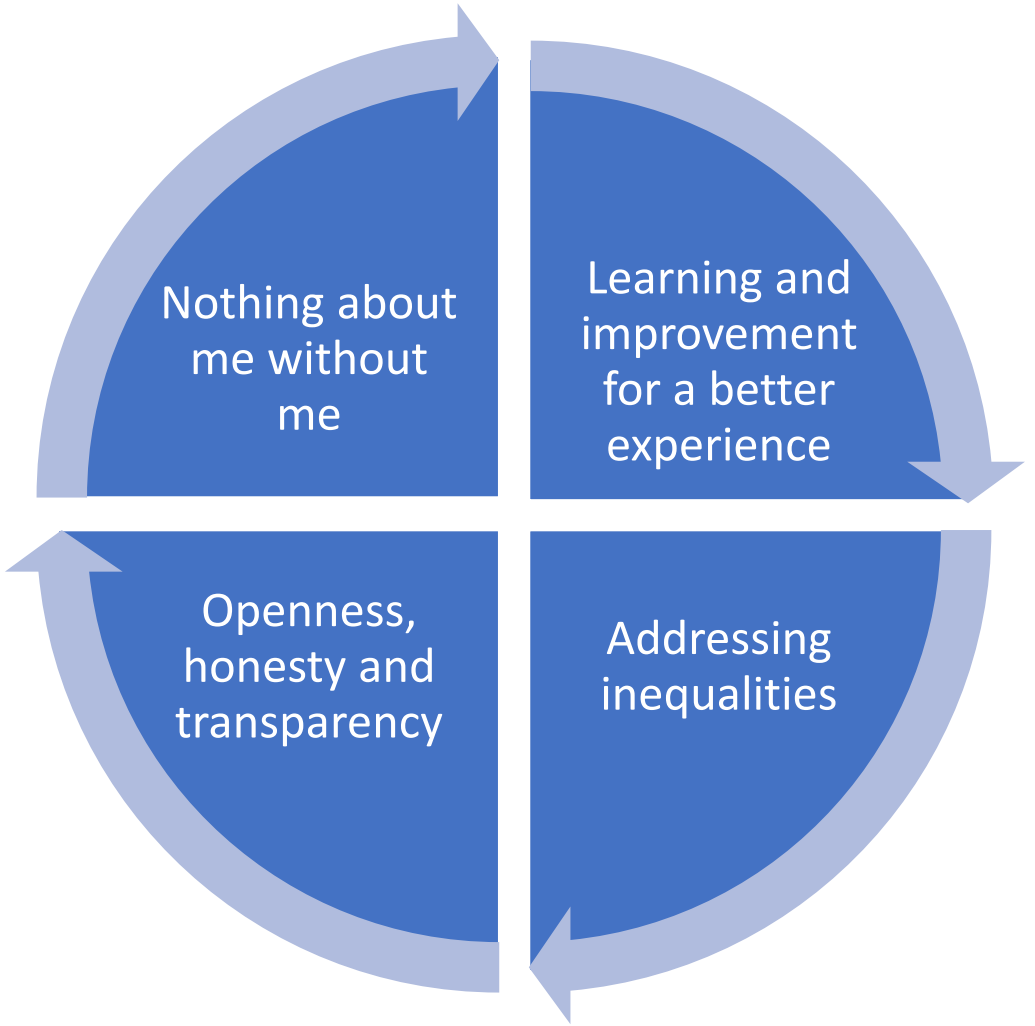
Better Together: The QVH commitments to engagement

These commitments have been developed to underpin and inform the way QVH engages with patients and the public.

Better Together: Ambitions

There are four main ambitions to drive the goal of excellent patient experiences and meaningful public engagement at QVH.

1. Nothing about me without me - meaningful engagement with patients and populations who use QVH services.
2. Learning and improvement for a better experience – welcoming all feedback and taking action as a result.
3. Identifying and addressing inequalities - voice and influence for those who are the least heard and experience worse outcomes.
4. Openness, honesty and transparency - QVH belongs to us all, decisions about the future will be made together.



Better Together: what difference will it make

Fundamental to this strategy is the vision and culture that comes from a learning organisation. It must be more than good words. This strategy represents a commitment that leads to action, increases safety and provides for the highest quality services for patients. Below, the ability to reflect, learn, understand and challenge to improve are shaped into what success looks like, including:

- Excellent holistic patient satisfaction, making every effort to hear from as many of our patients as possible about their experiences of services to ensure services are safe and of the highest quality.
- A transparent picture of what QVH does, that fits within the wider services of the NHS landscape so that patients know where, and who, to go to for the help and support they need.
- More chances to talk and to have a dialogue between QVH, patients and the public so that we are continuously improving what we do to best meet the needs of those who use our services.
- Hearing about experiences that fall below expectations will be welcomed as an opportunity to take rapid action when necessary to protect patients, learn and improve.
- All feedback about experiences from proactive and reactive sources will be systematically reviewed to understand what the issues are and any themes, working collaboratively with patients and the public to define and implement improvements.
- Being open and honest about what changes are made as a result of feedback and when changes are not possible we will explain why this is the case.

Better Together: QVH as part of a wider system of health and care.

Excellent patient experiences and meaningful public engagement is firmly embedded in partnerships with other providers of health and care within and across Integrated Care Systems.

QVH populations use a broad range of services across a diverse geographical area. To ensure we provide the highest quality care, the best clinical outcomes and a trusted, safe and positive patient experience we are committed to a joined-up approach to engagement.

QVH continue to use the expertise and wider resources of the Sussex Integrated Care System engagement team.

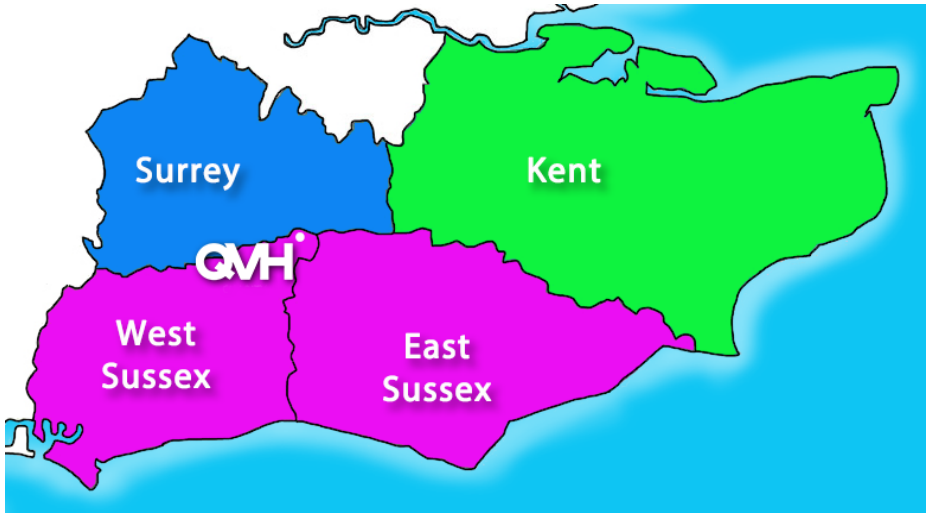
Some of our partners

- Sussex, Surrey and Kent Integrated Care Boards
- University Hospitals Sussex NHS Foundation Trust
- Primary Care, including GPs and pharmacies
- South East Coast Ambulance Service NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- Local Authority and social care providers
- Community and voluntary organisations

Understanding the QVH patient and public populations

QVH provides a unique set of specialist, community-based and general acute services across a large geographical area.

To make sure we fully understand the range of different patient and public needs and interests, it is useful to think of people who use the services of QVH being from three ‘populations’.



1. The local population
By this we mean people from East Grinstead and West Sussex accessing local health and care services.

2. Across Sussex
By this we mean, people using elective services from across the provider collaborative that spans Sussex.

3. Across the southeast and beyond
By this we mean people using specialist and regional services

Better together: the difference between patients and the public.

Within this strategy we recognise the difference between the things that matter to ‘patients’ actively using services and the ‘public’ who may have used services in the past or may use them in the future.

The table opposite shows the different perspectives of patients and the public. It is important to recognise that patients are members of the public and vice versa, however, acknowledging this difference helps to ensure there are strategies in place to benefit from hearing and learning directly from patients actively using services as well as from the wider public.

Patient Experience – ‘me, my care’	Public Engagement – ‘us, our care’
What was my experience of treatment and care like?	What ideas do the populations served by QVH have about how services should be improved?
Do I feel like my health is improved?	What are the health issues that matter most to the populations served by QVH and are they effectively being served?
Do I feel safe and protected from harm?	Can the populations that use the services of QVH access them when, where and how best meets their needs?
Who do I tell about an incident that occurred and is it recorded?	What are the expectations of the QVH populations and how do we know if they are being met?
Who do I complain to if something goes wrong?	How is QVH accountable to the populations it serves?

Better Together: how we hear from people

Proactive and reactive feedback comes into the Trust from patients and the public. This feedback is received across multiple channels to maximise accessibility for all and ensure that as much feedback as possible is gathered.

There are formal and informal ways for people to give feedback including surveys, audit and research projects, complaints, comments, compliments, claims and network meetings.

Feedback is also gathered to find out more about particular patient experiences and public need. This will be proactively achieved through local community groups meetings and social media

To make sure that feedback can be provided in the best way to suit the people giving it, feedback can be provided through channels such as trust governors and staff as well as automated systems, such as online feedback, text responses, social media and via QR codes.

We are always looking for more, and better, ways to hear from our patients and the public. We will always listen to suggestions that can help with this.

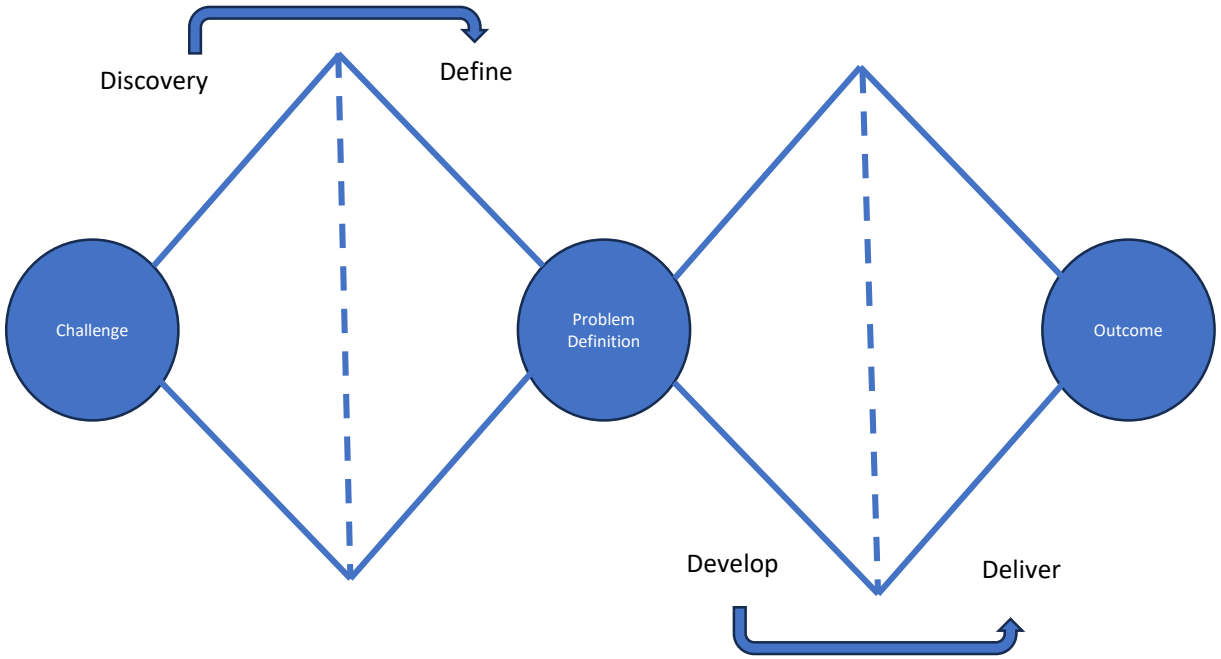
Better Together: what we do with what we hear?

The feedback provided by patients and the public is used to identify challenges and issues to the Trust' services. No one piece of feedback is used in isolation and the feedback in its entirety helps us to define a problem and any solutions.

We identify themes that run throughout what we hear. Changes are evidence led and we use quantitative and qualitative data to inform us. This means that what patients and the public say about our services is just as important as any rating.

We then work with our patients and the public to develop and deliver solutions and improvements.

Sometimes we are unable to make the necessary change to provide a desirable solution. In this case we are open and honest and capture what could be possible if or when any barrier is removed.



Better Together: what we are doing already?

Patient story at Board - Each Board meeting we start by asking a patient to join and share their experience of QVH. This can be focussed on an area for improvement or on a particular positive experience (which also provides learning), and puts the patient at the centre of the Board's thoughts as they commence their meeting.

Patient Experience Group – This group meets every other month to address ongoing projects and discussion points. The group includes patient representatives, the Trust's learning disability representative,and Healthwatch. Recent work includes discussion of this strategy. When required, public attendance will be encouraged

Policy and service changes - Every new policy and any service change goes through a formal process of identifying any equalities and quality impacts to ensure all patient groups receive an improved service. We are currently giving consideration to how we include the voice of the public in this process, to help us ensure changes meet the needs of our populations.

Patient satisfaction audits - A regular programme of audits report on patient satisfaction in each surgical specialty, the therapy team and the orthognathic team.

Patient support groups pre and post treatment - Facilitated by QVH health care professionals for patients and carers.

Better Together: what we are doing already?

National Inpatient Survey – QVH was the highest scoring trust in the country. It is pleasing to see the improvement from last year's good results in questions relating to hospital food and answering patients' questions about an operation or procedure before they had it; and explaining how the operation or procedure had gone.

National Cancer Survey – We have listened to the suggested adjustments that patient's tell us will make a big difference. This is to ensure that leaflets and other information given to patients contains the clinical nurse specialist name and contact details. This is made available at first and subsequent meetings for all patients.

National Children and Young People's Survey - QVH was the highest scoring trust in the country for both younger and older children

Friends and Family Test Survey – This applies to inpatients, outpatients and MIU, with scores some of the highest in the country. We are well underway with an outpatient improvement programme that considers the feedback shared through this survey. A 'you said….. we did' style feeds back in clinical areas on the changes made.

Build on our role as an **anchor organisation** by ensuring we are linked with the local schools to hear from them as well as promote the Trust brand for a career in healthcare

Better Together: leadership and governance

Dedicated senior leadership is essential for the delivery of the Better Together strategy for excellent patient experiences and meaningful public engagement.

- Ultimately this leadership comes from the Board and the Chief Nurse who sits as part of the Board.
- The Chief Nurse is accountable to the Board for the delivery of the Better Together strategy, through the Quality and Safety Committee. The committee is established to make sure that all reasonable steps are taken to manage risk and drive continuous improvement in quality and patient safety. This includes, rigorous reporting, risk analysis and learning from complaints.

Better Together: operational delivery

To ensure the effective delivery of this strategy the Chief Nurse and the Director of Communications and Corporate Affairs work closely together.

- The Chief Nurse along with the Patient Experience Manager lead on seeking and understanding patient experiences for learning and improvement and addressing inequalities.
- The Director of Communications and Corporate Affairs along with the Communications Manager will lead on meaningful engagement to achieve ‘nothing about me without me’ and openness, honesty and transparency to ensure decisions are made together.
- The Patient Experience Manager will collate a database of “interested” public who can be approached when engagement for specific issues is required

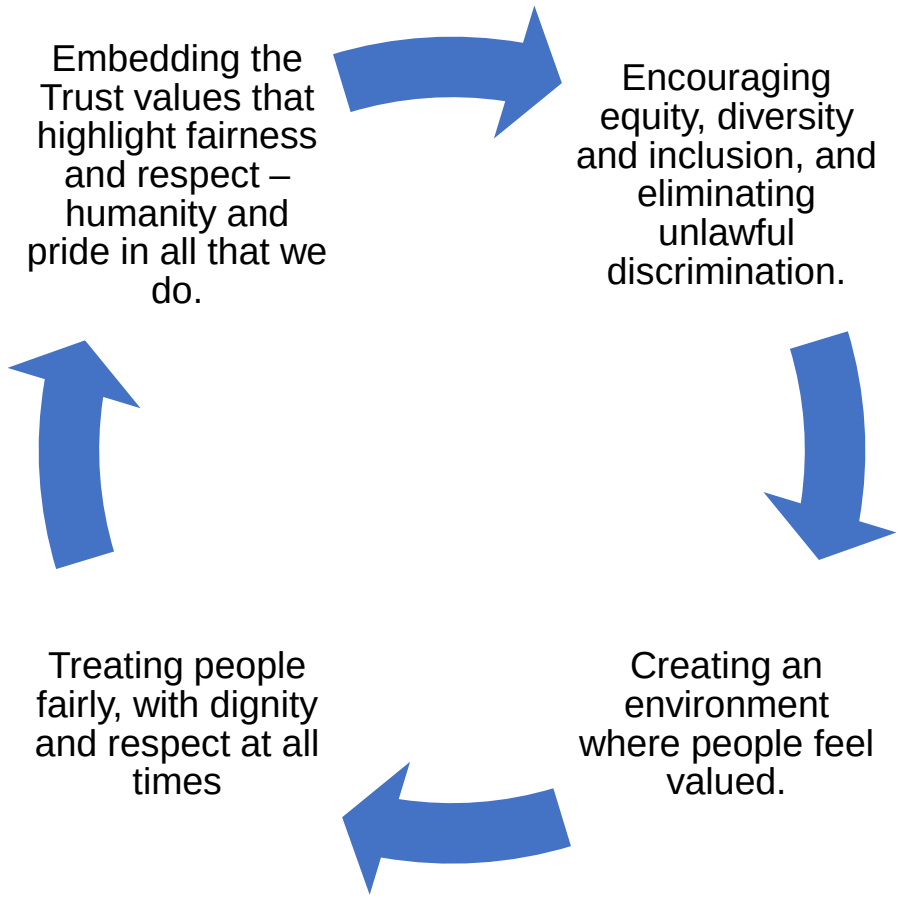
In keeping with the Better Together strategy and our ambitions, it is essential to involve patients and the public in the ongoing delivery and evaluation of this work.

This strategy has been developed with the involvement of patients, the public and representatives from Healthwatch.

To ensure we deliver on our ambitions we will report progress to a Better Together Patient Experiences and Public Engagement Group.

We will work with this group to ensure we deliver against this strategy. We will define specific measures of success and then work with the group to ensure we are delivering against our promises.

Better Together: Equity, diversity and inclusion



QVH recognises its legal responsibilities as contained in the Equality Act 2010 and the aims of the Public Sector Equality Duty (PSED) and apply these to our work to ensure excellent patient experiences and meaningful public engagement:

- To eliminate all unlawful discrimination, harassment and victimisation and other conduct prohibited under the Act
- To advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- To foster good relations between people who share a relevant protected characteristic and people who do not share it.
- The Trust also recognises its responsibility to meet the aims of the Accessible Information Standard. These are in place to make sure that people with sensory loss, sensory impairment, learning disability or communication need, have access to information that they can understand and any communication support they need.

This strategy will be kept under review in line with developments of the overarching Trust strategy taking place in 2023/24 and in no more than 12 months time by the Better Together Patient Experiences and Public Engagement Group.

Date of publication November 2023.