Bundle Public Board 7 March 2024

Agenda attachments

Front cover PUBLIC
Membership
Register
Agenda public-7 March 2024 FINAL

155.24 Welcome, apologies and declarations of interest

Jackie Smith, Trust Chair

156.24 Staff story

Assurance

157.24 Draft minutes of the public meeting held on 11 January 2024

Jackie Smith, Trust Chair
Approval

157-24 QVH Board minutes- public- 11 January 2024 DRAFT V1

158.24 Matters arising and actions pending from previous meetings

Jackie Smith, Trust Chair
Review

158-24 PUBLIC Matters arising

159.24 Chair's report

Jackie Smith, Trust Chair
Assurance

159-24 Chair's report

160.24 Chief Executive's report

James Lowell, Chief Executive Officer
Assurance

160-24 CEO report
160-24.1 Media report

161.24 Developing the future of QVH- clinical service review and defining our local population

Abigail Jago, Chief Strategy Officer
Approval

161-24 (FC) Clinical service review
161-24 Clinical service review

162.24 Electronic patient record (EPR) business case

Maria Wheeler, Chief Finance Officer
Approval

162-24 EPR business case
162-24 Appendix one- EPR business case summary

163.24 Key strategic objectives 2024/25

James Lowell, Chief Executive Officer
Approval

163-24 Key strategic objectives
163-24.1 Key strategic objectives

164.24 Board assurance framework and corporate risk register

Leonora May, Company Secretary
Nicky Reeves, Chief Nursing Officer
Assurance

164-24 Board assurance framework and CRR
164-24.1 Appendix one- BAF summaries
164-24.2 Appendix two- BAF

164-24.3 Appendix three- CRR

165.24 Board effectiveness review

Jackie Smith, Trust Chair
Leonora May, Company Secretary
Assurance

165-24 Board effectiveness review
165.1-24 Appendix one- NED champion roles
165.2-24 Appendix two NRC ToR
165.3-24 Appendix three QSC ToR
165.4-24 Appendix four FPC ToR

166.24 Annual report on use of Trust seal

Leonora May, Company Secretary
Review

166-24 Annual report on the use of the Trust seal
166-24.1 Appendix one

167.24 Audit and risk committee assurance

Paul Dillon-Robinson, Non-Executive Director and committee Chair
Assurance

167-24 Audit and risk assurance

168.24 Quality and safety committee assurance

Shaun O'Leary, Non-Executive Director and committee Chair
Assurance

168-24 Quality and safety assurance

169.24 Quality and safety report

Nicky Reeves, Chief Nursing Officer
Tania Cubison, Chief Medical Officer
Assurance

169-24 Quality and safety report

170.24 Financial, workforce and operational performance assurance

Peter O'Donnell, Non-Executive Director and committee Chair
Assurance

170-24 Finance and performance assurance

171.24 Financial performance report

Maria Wheeler, Chief Finance Officer
Assurance

171-24 (FC)Finance report
171-24 Finance report

172.24 Workforce performance report

Rob Stevens, Interim Chief People Officer
Assurance

172-24 Workforce report

173.24 Eliminating sexual misconduct

Robert Stevens, Interim Chief People Officer
Tania Cubison, Chief Medical Officer
Approval

173-24 Eliminating sexual misconduct

174.24 Operational performance report

Kathy Brasier, Interim Chief Operating Officer
Assurance

174-24 Operations report

Jackie Smith, Trust Chair
Discussion

176.24 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 7 March 2024

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

MEMBERSHIP
BOARD OF DIRECTORS
March 2024

Members (voting):

Trust Chair	-	Jackie Smith
Senior Independent Director	-	Karen Norman
Non-Executive Directors	-	Paul Dillon-Robinson
	-	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 Engagement	-	Clare Pirie
Interim Chief People Officer	-	Rob Stevens
Interim Director of Operations	-	Kathy Brasier
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 & Engagement	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 & Engagement	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 7 March 2024
10.00-12.00

Agenda: session held in public		
WELCOME		
155-24	**Welcome, apologies and declarations of interest** *Jackie Smith, Trust Chair*	
STANDING ITEMS		**Purpose**
156-24	**Staff story**	*Assurance*
157-24	**Draft minutes of the public meeting held on 11 January 2024** *Jackie Smith, Trust Chair*	*Approval*
158-24	**Matters arising and actions pending from previous meetings** *Jackie Smith, Trust Chair*	*Review*
159-24	**Chair's report** *Jackie Smith, Trust Chair*	*Assurance*
160-24	**Chief Executive's report** *James Lowell, Chief Executive Officer*	*Assurance*
GOVERNANCE, STRATEGY AND RISK		
161-24	**Developing the future of QVH- clinical service review and defining our local population** *Abigail Jago, Chief Strategy Officer*	*Approval*
162-24	**Electronic patient record (EPR) business case** *Maria Wheeler, Chief Finance Officer*	*Approval*
163-24	**Key strategic objectives 2024/25** *James Lowell, Chief Executive Officer*	*Approval*
164-24	**Board assurance framework and corporate risk register** *Leonora May, Company Secretary* *Nicky Reeves, Chief Nursing Officer*	*Assurance*
165-24	**Board effectiveness review** *Jackie Smith, Trust Chair* *Leonora May, Company Secretary*	*Assurance*
166-24	**Annual report on use of Trust seal** *Leonora May, Company Secretary*	*Review*
167-24	**Audit and risk committee assurance** *Paul Dillon-Robinson, Non-Executive Director and committee Chair*	*Assurance*

Key strategic objectives 1 and 2: outstanding patient experience and world class clinical services		
168-24	**Quality and safety committee assurance** *Shaun O'Leary, Non-Executive Director and committee Chair*	*Assurance*
169-24	**Quality and safety report** *Nicky Reeves, Chief Nursing Officer* *Tania Cubison, Chief Medical Officer*	*Assurance*
Key strategic objective 4: financial sustainability		
170-24	**Financial, workforce and operational performance assurance** *Peter O'Donnell, Non-Executive Director and committee Chair*	*Assurance*
171-24	**Financial performance report** *Maria Wheeler, Chief Finance Officer*	*Assurance*
Key strategic objective 5: organisational excellence		
172-24	**Workforce performance report** *Rob Stevens, Interim Chief People Officer*	*Assurance*
173-24	**Eliminating sexual misconduct** *Robert Stevens, Interim Chief People Officer* *Tania Cubison, Chief Medical Officer*	*Approval*
Key strategic objective 3: operational excellence		
174-24	**Operational performance report** *Kathy Brasier, Interim Chief Operating Officer*	*Assurance*
MEETING CLOSURE		
175-24	**Any other business (by application to the Chair)** *Jackie Smith, Trust Chair*	*Discussion*
MEMBERS OF THE PUBLIC		
176-24	**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 11 January 2024** **Education centre, QVH**	
Present:	Jackie Smith	Trust Chair (voting) (Chair)
	Paul Dillon-Robinson (PDR)	Senior independent director (voting) (via MS Teams)
	Peter O'Donnell (POD)	Non-executive director (voting)
	Karen Norman (KN)	Non-executive director (voting)
	Shaun O'Leary (SOL)	Non-executive director (voting)
	Russell Hobby (RH)	Non-executive director (voting)
	James Lowell (JL)	Chief executive officer (voting)
	Maria Wheeler (MW)	Chief finance officer (voting)
	Nicky Reeves (NR)	Chief nursing officer (voting)
	Tania Cubison (TC)	Chief medical officer (voting)
	Robert Stevens (RS)	Interim chief people officer (non-voting)
	Abigail Jago (AJ)	Chief strategy officer (non-voting)
	Kathy Brasier (KB)	Interim Director of operations (non-voting)
In attendance:	Leonora May (LM)	Deputy company secretary (minutes)
	Sheila Perkins (SP)	Freedom to speak up guardian (for item 133-24)
Apologies:	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
Members of the public:	Three members of public, eight governors and ten members of staff	

Welcome

127-24 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board, including KB to her first Board meeting as interim Director of operations, and those observing the meeting including three members of public, eight governors, ten members of staff and the incoming Chief people officer and Chief operating officer.

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.

The Chair explained that item 134-24 would be taken after item 130-24.

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

PDR joined the meeting on MS Teams.

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

Standing items

128-24 **Patient story**

The patient whose story will be discussed at today's meeting was not present; instead, NR read the complaint received from a breast reconstruction patient to the Board.

The patient had attended a consultation to discuss the possibility of breast reconstruction surgery following a mastectomy due to breast cancer. The patient explained that the consultation was held in a small consulting room with four members of staff which felt crowded. She felt rushed when providing a summary of her treatment to the staff and felt that the consultant had made comments in a casual manner about the possibility of her cancer returning which scared her. The patient described how she felt extremely vulnerable and self-conscious taking her clothes off in the small room with four members of staff

	present and questioned whether it was necessary for them all to be present. Whilst describing the procedure, the consultant had used words which the patient thought to be flippant. The patient shared this complaint in the hope that it may help future patients and that staff can ensure kindness and consideration is a priority. TC explained that this complaint has been shared with the team and that there has been proactive learning following the patient's experience. The Trust now writes to patients who have had this surgery to ask about the adjectives that they would be comfortable with being used when talking about the procedure and the outcome. She explained that "pert" is a medical term, but she acknowledged that this patient found the language to be flippant. In response to questions raised by Board members, TC confirmed that she is satisfied that this is a one off incident. She explained that 23 other patients had fed back about a positive experience with the consultant and that the other staff present confirmed that they would have been comfortable to raise a concern with this consultant if they felt it was necessary. Discussion was had regarding the small space and the Board raised concerns that other patients might find this difficult too. In response, TC confirmed that the clinical rooms used are big enough but that the use of curtains to create the consultation space makes the space smaller. She agreed to consider what can be done to make these curtain spaces bigger. The Board were saddened by the experience of this patient and acknowledged the multiple issues raised and learning undertaken to date. The Board agreed that further work is required to ensure that staff feel able to speak up and raise concerns about more senior members of staff and that this should be a continued area of focus. The Board expressed thanks to the patient for sharing their story.
129-24	**Draft minutes of the public meeting held on 02 November 2023** The Board **agreed** that the minutes of the public Board meeting held on 02 November 2023 are a true and accurate record of that meeting and **approved** them on that basis.
130-24	**Matters arising and actions pending from previous meetings** The Board noted one pending action related to the performance dashboard. The operational performance report is being refreshed and a new reporting dashboard is due to be completed in April 2024. The Board **noted** the update.
131-24	**Chair's report** [this item was taken after item 134-24] JS presented her Chair's report to the Board. In response to a question from a Board member, JS invited the deputy lead governor to provide an update on the regular discussions held between the Chair, lead governor and deputy lead governor. The deputy lead governor explained that these meetings are an opportunity for the governors to raise any concerns and that they are able to talk about these openly with the Chair. She described these meetings as useful in supporting the governors to understand and undertake the role of holding the non-executive directors to account for the performance of the Board effectively. The Board **noted** the contents of the report.
132-24	**Chief Executive's report** JL presented the report to the Board, highlighting the following:

	- There is a commitment to form two provider collaboratives in NHS Sussex to support the delivery of the Improving Lives strategy. A committee in common is being developed to support this and QVH is an active partner in developing the provider collaboratives - There have been positive conversations with primary care colleagues about the future of the neighbourhood strategy. JL thanked primary care leaders for their support in developing the strategy - JL expressed thanks to all staff for their work and support during recent periods of industrial action In response to a question about organisational performance, JL reported that productivity is starting to increase but there is still more to do to ensure that the Trust gets the best from resources including theatres. Theatre productivity at QVH is above the national benchmark but a higher ambition is required to support improved access. In response to a question regarding how the provider collaboratives will work in practice, JL confirmed that the Chief executive officer's from across the system are working through this. The Chief medical officers are developing clinical networks and the governance structure is being worked through by governance leads. Discussion was had regarding the impact industrial action may have on relationships and NR confirmed that nurses from across the Trust are supportive of one another and focussing on maintaining patient safety. The Board **noted** the contents of the report.
Governance and strategy	
133-24	**Freedom to Speak Up Guardian report** SP presented the report as read and discussion was had regarding the contents of the report and the Trust's Freedom to Speak up function as follows: - NR confirmed that SP will step down from her role as Freedom to Speak up Guardian and that the Trust will commission an external provider to undertake this role to provide an additional layer of assurance and impartiality - The Board raised concern that a member of staff was concerned about repercussions from speaking up and questioned prevalent this issue is. SP thought that this is because it is a small Trust and when a member of staff raises a concern, it is usually clear who raised it - NR confirmed that there has recently been an increase in staff asking about how they can raise concerns but acknowledged there is further work to do - The Board acknowledged that there are cultural issues to be resolved to support staff in feeling safe to speak up, including developing psychological safety. RS confirmed that these will be clear areas of focus in the people, culture and organisational development strategy. The Board agreed that there is a need to demonstrate that when staff speak up they are protected The Board thanked SP for her time and commitment to the Freedom to Speak up role. The Board **noted** the contents of the report. [SP left the meeting]
134-24	**Strategic case for change and strategic option review** [this item was taken after item 130-24] JL introduced the item, explaining that this is a significant milestone for developing the future of the organisation.

AJ presented the report to the Board, highlighting the continued commitment to engagement throughout the development of the strategy explaining that feedback has been used to inform the strategic case for change and the options presented. The engagement completed to date has been independently reviewed.

AJ explained that the options presented have been developed in line with the case for change as presented and outlined option five as the preferred option; that QVH will be a hybrid provider, seeking to build on specialist/ regional services and also be an active local partner providing services and innovative neighbourhood hubs. AJ described what will be different, describing how the Trust would move away from organic and ad hoc growth to clear strategic intent when developing its offering. This option retains what is great about QVH, whilst ensuring focus on working in partnership with other organisations, developing a strengthened academic presence and working towards an innovative and collaborative future.

The Chair sought views from each Board member. Feedback on the options for consideration was received as follows:

- The Board recognised the extensive work completed to reach this position and praised work completed by AJ and the executive team
- The Board supported the continued commitment to engagement
- Discussion was had regarding finance and MW confirmed that being a hybrid provider will make QVH financially sustainable going forward
- The Board acknowledged the financial and capacity challenges faced by the NHS and agreed that it is important to consider how the Trust can contribute to supporting NHS Sussex and the wider NHS
- The Board recognised that collaboration is crucial in order to sustain the future of the Trust, in the context that it is the smallest acute Trust in the country
- The Board noted that a hybrid model would increase the resilience of the Trust's services, improving patient pathways and access, acknowledging the important of considering growth in demand
- In response to a question, AJ confirmed that providing regional and national services as well as providing community services complement one another and that neither elements on their own would ensure a sustainable future for QVH. The Board agreed that the interoperability of these two areas of focus for QVH will be important
- The Board noted that the next stage of strategy development will include the consideration regarding each service and fit with the hybrid model and strategic direction
- The Board agreed that it will be important to have sufficient controls in place to ensure that there is strategic intent behind the development of services in the future

The Board:

- **Approved** the case for change, and
- **Approved** option five as the preferred option; for QVH to be a hybrid provider, seeking to build on specialist/ regional services and also be an active local partner providing services and innovative neighbourhood hubs.

The Chair invited the lead governor to ask questions regarding the item discussed. The following questions were asked and responses given.

Question
Does the Trust have the right capacity in order to deliver the next phase of the strategy development?

Response

	AJ confirmed that the team is currently scoping the resources required to support the programme. AJ will lead the work with the support of the executive team. External specialist capacity will be utilised as and when required. Question How will you ensure Board focus on research to support the Trust being a centre of excellence? Response The Board agreed that research will be a key area of focus for the Trust going forward. TC confirmed that research and innovation will form one of the enabling strategies, and that the Trust will look to establish some strong academic partnerships to support this. Question Will other sources of funding be considered, specifically within the private sector? Response JL confirmed that all NHS organisations are considering ways in which to become more financially sustainable, and that it is recognised that private and research income could support sustainability for the Trust. Opportunities to work with private sector organisations are being considered.
135-24	**Audit and risk committee assurance** PDR presented the report to the Board, highlighting that the committee had considered the effectiveness of the Freedom to Speak up function including whistle blowing, noting that that processes are in place but that there is a requirement to consider the effectiveness. PDR reported that Azets LLP have been appointed as the Trust's external auditors and that the committee had received an indicative plan for the 2023/24 audit. The Board **noted** the contents of the report.
136-24	**Board assurance framework** JL presented the Board assurance framework to the Board, reporting that a significant amount of work has been undertaken to refresh the content and the format of the document in line with NHS best practice and CQC requirements. The current eight strategic risks were identified by the Board in July 2023 and will be reviewed by the Board as required going forward. The Board assurance framework is a monitoring tool used by the Board to assess how effectively the Trust's strategic risks are being managed. LM highlighted that this is the first iteration of the document, and that it is expected to develop and change over time. She reported that the Board assurance framework forms part of a wider programme of work that is still ongoing. The refresh of the corporate risk register and the Board review of risk appetite are important components currently in development. The Board considered and discussed the Board assurance framework as follows: - The Board welcomed the progress made to date to develop the Board assurance framework - There was a suggestion that the scores for the strategic risks may be too high and are not an accurate representation of the Trust's strategic risk profile - The Board agreed that the document should be simplified and shortened to ensure visibility of key concerns The Board expressed thanks to all who had contributed to the development of the Board assurance framework.

	The Board **noted** the report.
137-24	**Financial, workforce and operational performance assurance** POD presented the report to the Board, thanking colleagues for work completed to date to improve the presentation of performance data to the committee. He highlighted that operational performance is challenged due to the impact of industrial action and that the committee have requested further analysis on the Trust's waiting list position in order to obtain assurance that the waiting list is being managed effectively. The committee received an update on financial position and assurance that the Trust should break even at the end of the financial year despite industrial action. There has been improvement to estate maintenance. Discussion was had regarding workforce challenges and the committee has understood that although generic workforce challenges faced by the Trust are limited, there are cultural issues to be addressed including supporting staff to feel safe to speak up and addressing equality, diversity and inclusion challenges. In response to a question, POD confirmed that the committee have requested a further update on the impact that increased locum spend may have on activity. The Board **noted** the report.
138-24	**Financial performance** MW presented the report to the Board and confirmed that the Trust has achieved a break even position year to date and that it is expected that the Trust will achieve a break even position for the financial year end. The Trust is also forecast to meet its efficiency target for the financial year but there are challenges with the delivery of the capital programme. The Board **noted** the contents of the report.
139-24	**Annual business planning update 2024/25** MW provided an update regarding the development of the business plan for 2024/25, reporting that planning guidance has not yet been published although the plan is being developed in line with indicative planning guidance and the NHS Sussex longer term financial plan. The process had started in November 2023 and the baseline exercise is almost complete. Services have been engaged throughout the process to date. Discussion was had regarding efficiencies and MW confirmed that this is likely to be 5% and that this is in line with ambitions set out within the strategy. The Board requested that when the business plan is ready to be signed off that the detail regarding where the 5% efficiency will come from is included. It was agreed that this should be addressed with a degree of urgency. MW confirmed that the Board will have an opportunity to review the final draft plan in detail ahead of it being approved by the Board. This will be before the end of March 2024. The Board **noted** the contents of the report.
140-24	**Workforce performance report** RS presented the report to the Board, highlighting that: - There has been lots of work completed to address the Trust's equality, diversity and inclusion (EDI) challenges, including the development of new EDI objectives, the establishment of the EDI group who first met in December 2023, the commitment to

	an anti-racism strategy and the roll out of the QVH pride pledge including lanyards and badges which acts as a visible reminder of belonging to all staff - The Trust's vacancy levels are at a record low but there is work to be done to improve the time to hire rates - Staff survey results are expected to be published on 7 March 2024 In response to a question regarding what is causing workplace stress, RS confirmed that it is largely due to work pressure and team relationships. The Board **noted** the contents of the report.
141-24	**Operational performance report** KB presented the report to the Board and reported that industrial action is having a significant impact on activity. The focus remains on ensuring patient safety is maintained. Work is underway to understand the impact of industrial action. KB reported that there are concerns regarding meeting the 62 day cancer performance target due to complex referrals. Work with clinical leads and senior leadership team is ongoing to address this. A Board member sought clarity regarding the reference in the report to 'patients being validated back onto the PTL'. KB explained that there will be patients on the PTL with a long waiting position and that there is then a need to validate patient pathways to understand treatment plans to date. The Board **noted** the contents of the report.
142-24	**Quality and safety assurance report** KN presented the report to the Board, highlighting that the committee had reviewed the public and patient engagement strategy which it agreed to recommend to the Board for approval subject to some minor amendments. Discussion was had regarding CQC preparation, and NR confirmed that she is preparing a Board preparation pack which will be shared with the Board at its seminar in February 2024. Board members agreed that the aide memoire will be helpful but that the focus should be on quality of Board discussion and assurance sought and received to ensure that services are safe, effective, caring, responsive and well-led. The Board **noted** the report.
143-24	**Quality and safety report** NR presented the report to the Board, highlighting the public and patient engagement strategy which was appended. NR reported that there has been a small number of infection control issues but that there has been no evidence of onward transmission and that antimicrobial ward rounds have started which is an opportunity for clinical teams to discuss cases with a consultant microbiologist. The Board **noted** the report.
144-24	**Any other business (by application to the Chair)** There was no further business and the meeting closed.
145-24	**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 Will there be an increase in clinical and non-clinical staff to support the increased activity levels? Response JL explained that there is expected to be an increase in activity in the short term initially in order to clear waiting lists and more generally activity will increase. The Trust has started to recruit more substantive staff and six day services will be a focus area for the next year to support the sustainability of the organisation and waiting times. 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**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024		**Agenda reference:**	**159-24**	
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:	159-24
Date of meeting:	7 March 2024
Report from:	Jackie Smith, Trust Chair
Report author:	Jackie Smith, Trust Chair
Date of report:	28 February 2024
Appendices:	None

Chair's report

Appointments

On 4 March 2024, we welcomed Kirsten Timmins who joined the Trust as our substantive Chief operating officer. We are also looking forward to Helen Edmunds joining the Trust on 11 March 2024 as our Chief people officer.

I am really pleased to say that Leonora May has been appointed as the Company secretary. She will be supporting our Board and Council of Governors and leading on our corporate governance. She is also the counter fraud champion for QVH. More information about these appointments is included within the Chief executive's report.

I would like to thank Kathy Brasier, interim Director of operations and Rob Stevens, interim Chief people officer for their contributions to the Board during their time in post. This will be Rob's last Board meeting at QVH.

Service visits

Since the last Board meeting the non-executive directors have visited the human resources team and the radiology team. I have continued visiting services with the lead and deputy lead governor. We all visited Histopathology and most recently, the Peanut ward where we spoke to a family whose feedback was that the standard of care on the ward has been exemplary.

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. Specific issues raised by staff are followed up with executives or escalated through other routes as appropriate.

Other non-executive director activities

During February, a series of governor working groups were held with the Finance and Performance, Quality and safety and Strategic development committee Chairs, executive leads and governors.

I continue to meet regularly with our lead governor and deputy lead governor to discuss key issues. Other meetings include my regular catch up with the Sussex ICB chair and the chair for UHSX. James and I also had a valuable meeting with the chair and CEO for Kent and Medway ICB.

I was pleased to join the interview panel for Surrey and Sussex Healthcare NHS Trust to support the recruitment of a non-executive director at the end of January.

Strategic development committee

The Strategic development committee met on 21 February 2024. At the meeting the committee received an update on Trust strategy development and good progress is being made. The enabling strategies are in development and on track, with the

research and innovation strategy being a key enabler of the hybrid model with reliance of external partners for delivery.

The committee received a first draft of the communication and engagement plan and was assured by plans to connect with key stakeholders throughout the development of the strategy with a clear and consistent approach that build on the openness, inclusivity and transparency that the Trust has committed to.

The committee reviewed the clinical services options report that will be presented to the Board at today's meeting and supported workshops being completed throughout March to engage key members of clinical staff.

An update regarding the development of the key strategic objectives for 2024/25 was presented to the committee who supported the direction of travel and increased ambition.

The committee reviewed BAFs 4 (there is a risk that the Trust fails to secure its long term sustainability leading to closure of services and/ or the site) and 8 (there is a risk that the Trust does not develop and maintain collaborative relationships with partner organisations built on shared objectives and mutual trust that may impact adversely on the ability to deliver a sustainable future and trust strategy and improve the health of the populations we serve). Committee members were pleased to note the completion of key actions to manage these risks, including the strategy framework and milestones plan being in place and monitored, the decision making framework being agreed by the Board, and the development of the engagement plan and assurance that engagement to date has been effective. The overall assurance ratings for both of these BAFs for Q4 is green, indicating a high level of confidence that there are no serious issues and that the controls were effective.

Following the meeting, a governor working group meeting was held with the Trust Chair, Chief strategy officer and governors to discuss the clinical service option report.

The next meeting of the committee will be held on 20 March 2024, and the Chair will provide a further committee assurance report for the Board at its meeting in May 2024.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/04/2024		**Agenda reference:**	**160-24**	
Report title:	Chief Executive's report				
Sponsor:	James Lowell, Chief Executive Officer				
Author:	Clare Pirie, Director of Communications and Corporate Affairs Leonora May, Company Secretary 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: • Strategy development journey • Redefining our organisation • QVH Progress Pride Pledge • Showcasing our Healthcare Scientists				
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:					
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	160-24
Date of meeting:	7 March 2024
Report from:	James Lowell, Chief Executive Officer
Report author:	Clare Pirie, Director of Communications and Corporate Affairs Leonora May, Company Secretary Michelle Baillie, Communications Manager
Date of report:	22 February 2024

Chief Executive's report

Operational performance

QVH is excelling in some of our performance domains including the DMO1 diagnostic waiting time reporting for sleep services where we are performing at 89% compared to a national average of 73.2%. From a cancer perspective the Trust is performing at 86.2% in-month for our 62 day cancer pathway, with improvements made in skin and head and neck cancer. We remain on-track to deliver treatment to all long waiting patients by the end of March 2024.

As is best practice, we are currently undertaking a process to validate patients on our waiting lists.

Strategy development journey

At our public board meeting on Thursday 11 January 2024, our Board reached a significant milestone when we discussed a number of opportunities we have for the strategic direction of QVH. The discussions considered the context that we operate in and the need to make sure we have a clear identity going forwards – so we know both what we are and what we are not.

The board supported the option for us to become a hybrid provider, where we retain our highly specialised services whilst offering an innovative health and care offering to the local community. It gives us the chance to strengthen our clinical research output, develop collaborative partnerships and really build on our role as an anchor institution for East Grinstead, where our long-term sustainability is tied to the people we serve both as patients and staff. Importantly this option gives us the opportunity to deliver clinical, operational and financial sustainability.

A tremendous amount of work has taken place so far since we launched our strategy work in April 2023 and this marks organisational, non-executive, executive and governor alignment on the first of our strategic decisions. We also have the support of NHS England and our integrated care boards which is important for us. We have an ambitious programme of work between now and the Autumn when our strategy officially launches, including developing the clinical and enabling strategies that will underpin this work. We are also continuing the positive conversations we are having with our colleagues in primary care around the future development of our neighbourhood strategy.

I would like to thank everyone for their support and engagement so far – this is a very exciting time for us as an organisation.

Redefining our organisation

A significant amount of work has been completed to redefine our organisation following the well led review of leadership and governance undertaken by Deloitte in

2022/23. The report made recommendations in a number of areas including ‘raising the profile of the directorates’.

We are working to redefine our clinical leadership model and introduce triumvirate working across our clinical directorates and business units. We are currently talking to staff about how this will help us make sure all our services are clinically led by a team that represents all the staff groups and services under its management.

These changes will be supported by improved data for clinical directorates and business units, and a refreshed governance structure to help us review performance against agreed metrics, share successes and best practice, and manage risk and challenges. This will support improved clinical leadership, service and staff experience.

Our aim is to introduce this new structure from 1 April 2024, although we recognise it will take time and support to implement fully.

Executive team appointments
Kirsten Timmins joins QVH as our Chief Operating Officer on Monday 4 March. She was the Deputy Chief Operating Officer at South London and Maudsley NHS Foundation Trust, and has 20 years’ experience in performance management and improvement across the public sector. Kirsten has previously worked at the National Audit Office working with Parliament, The United Nations, Ministry of Defence, and International Development to influence policy, improve services, and increase transparency of government expenditure. She also worked for NHS England and Improvement working with trust boards and executive teams across South East England to improve leadership, governance and performance against the constitutional standards.

Also joining us in March is Helen Edmunds who will become our Chief People Officer. She joins us from NHS Kent and Medway where she was Director of People Strategy with strategic leadership for workforce development across the Kent and Medway integrated care system. Helen has previously held senior leadership roles in ambulance, provider trust, system and region across the people portfolio, including head of leadership and organisational development for the South East Leadership Academy and deputy director of workforce transformation for NHS England in the South West Region. She is an experienced system leader, delivering people and culture change programmes in several system and regional roles, bringing system partners together to deliver workforce programmes, supporting improved patient outcomes.

I am very grateful to Kathy Brasier, our Interim Director of Operations who has been heading up our operations team since October, and will be returning to her role as Deputy Director of Improvement and Strategy; and Rob Stevens, Interim Chief People Officer, who joined us in July on secondment from Guys and St Thomas’. They have both helped us deliver on a number of key objectives for the organisation including our strategic development.

Our new Company Secretary
Following a competitive external recruitment process, we have appointed Leonora May as our Company Secretary. Leonora stepped up from being Deputy Company Secretary whilst we recruited to this new role. Leonora’s background is in Law and she holds a Masters Degree in Corporate Governance and Law. She is an associate member of the Chartered Governance Institute. She will be reporting directly to me as Chief Executive Officer, supporting our Board and Council of Governors and

leading on our corporate governance. Leonora is also the Trust's counter fraud champion.

Delivering Improving Lives together
To support the delivery of the Improving Lives strategy, the organisational leaders across Sussex have agreed to establish Sussex Provider Collaboratives and a Sussex NHS Committee in Common. It is expected that the Committee in Common will be in place by the end of Q1 2024/25. Membership for QVH and for each of the seven provider trusts will include the Chair, Chief Executive Officer and one Non-Executive director. The Terms of reference for the Committee in Common are in development and will require approval from the Board.

Apprenticeship week
As a former apprentice myself, National Apprenticeship Week in February is an important week in the calendar. Although it has been more than two decades since I completed mine, it provided an important foundation for my career and gave me a love of learning. Apprenticeships offer the chance to earn and learn at the same time, and in the NHS can provide a career path and recognised qualifications. It is something we are particularly passionate about encouraging here at QVH.

We received an exceptional level of media coverage featuring the journey of Lisa, a member of QVH staff, from cabin crew to nursing, and the importance of apprenticeships providing 'skills for life', including on regional TV.

We also invited our apprentice 'graduates' to a celebratory tea party, supported by our QVH Charity, to celebrate their hard work and the contribution they make to QVH's exceptional reputation for patient care.

QVH Progress Pride Pledge
At the January public Board meeting we introduced the QVH Progress Pride lanyards and badges as a way of signifying a personal pledge to challenge discrimination towards LGBT+ people in our organisation and to support QVH being a place of inclusion and respect.

It is a sign of how our staff welcomed this approach that within 48 hours about 10% of our workforce had signed up to the pledge and numbers have continued to increase.

You will now see many of our staff wearing a progress pride badge or lanyard as a way to show that we are an open, non-judgemental, and inclusive place for people who identify as LGBT+. We also marked LGBT+ history month in February by flying a Progress Pride flag here at the Trust.

Land sale
On Thursday 18 January 2024 Mid Sussex District Council approved planning permission for 30 homes to be built on some unused land on our site which was sold to Brookworth Homes in 2020. They are progressing with the process and more information will be available in due course.

Industrial Action
At the time of writing we are planning for a further period of industrial action by junior doctors in February. Pay is a matter for Government and the trade unions, and everyone wants to see a resolution as soon as possible to ensure the NHS can continue to focus on delivering world class patient care to all those who need it.
I am grateful to colleagues across the organisation who have helped to plan for this period of industrial action, including rescheduling appointments and maintaining safe services for our patients.

Fire Safety Enforcement Notice
The Trust received a Fire Safety Enforcement Notice on 1 February 2024, following an inspection from West Sussex Fire and Rescue Services on 22 January 2024. We are working closely with West Sussex Fire and Rescue Services as we swiftly address the issues raised. We are required to have made all the necessary improvements by 3 June.

We have fire detection systems in place and as a predominantly single storey site we follow the recognised horizontal evacuation procedures for hospitals. We are addressing issues of record keeping, risk assessment and local induction for staff, as well as an external expert inspection of physical fire prevention measures.

Visit to QVH team at Medway Maritime Hospital

In January I was able to spend time with the QVH team at Medway where we have an embedded local admin team supporting our visiting clinical staff and enabling us to bring care closer to home for hundreds of patients in this part of Kent who need the specialist skills of QVH clinicians. The picture shows me and a member of the team, Amanda.

I am grateful to Medway's Chief Executive, Jayne Black for welcoming me as well as hosting our staff. This is an excellent example of NHS providers working in partnership; for more than 20 we have been able to reduce the need for patients to travel and provide access to the very best care.

Showcasing our Healthcare Scientists

We were delighted to welcome Victoria Chalker, Deputy Chief Scientific Officer for NHS England, to QVH on Monday 19 February.

A clinical scientist by background, she met some of our own Healthcare Scientists in our Sleep Disorder Centre, Corneoplastics Unit; Histopathology lab; Medical Photography studio; and Prosthetics lab – the largest maxillofacial prosthetics lab in Europe. Victoria spent time talking to the teams and finding

out more about how we are investing in developing our workforce and growing the next generation of Healthcare Scientists.

She was joined by Grace Weston, Healthcare Science Network Lead at NHS Sussex. Thank you to Nisa Pinto, Sleep Physiology Service Lead and acting Healthcare Science Lead, for arranging the visit and to all of the teams who spoke so passionately about what they do here at QVH.

Meeting our new starters
I have the pleasure of attending our monthly induction to meet our newest colleagues, welcoming them to QVH and finding out more about why they chose our organisation for the next part of their career.

On Friday 23 February I held the first of our new starter lunches, meeting some of the people who I had been on induction with, as well as colleagues who started just after. It was great to hear how they are getting on so far, and find out what they like about QVH as well as areas where we can look to improve.

Dangers of dog bites
We have seen a doubling in the number of patients referred to us with dog bite injuries compared to before the pandemic, from more superficial wounds to ones requiring multiple operations. Siva Kumar, one of our consultant plastic surgeons, featured on BBC South, BBC South East Today and BBC London, about the rise, which correlates with national data. He was joined by one of our patients, Darren, who suffered serious injuries to his hand just before Christmas. The piece aired on 12 January as well as on the BBC website and on regional radio.

Opportunities like this for us to work with the media to raise awareness and show how our skilled clinicians are able to support patients are really important.

Recommendation

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

Report to:	Board Directors
Agenda item:	160-24
Date of meeting:	7 March 2024
Report author:	Michelle Baillie, Communications Manager
Date of report:	28 February 2024

QVH media update – December 2023 and January 2024

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

Help us to help you
With increasing seasonal pressure on the NHS combined with junior doctors in England taking industrial action, Nicky Reeves, Chief Nursing Officer at Queen Victoria Hospital, joined other senior health leaders in Sussex to encourage the public to choose services wisely. On 20 December she spoke to ITV Meridian News about the important role Minor Injury Units play in supporting patients who need medical support for non life threatening conditions. The segment also featured a patient accessing help in the unit.

Queen Victoria Hospital was also mentioned in an accompanying release issued by NHS Sussex run on the Sussex Express website. This followed an ask made to the public earlier in the month also on the Sussex Express website to keep A&E free for critical care.

QVH Charity Christmas appeal
QVH Charity offered the public a hassle free way of making a difference for Christmas by helping decorate its virtual tree. Supporters were encouraged to make a donation and leave a message for staff, patients or their own friends and family, with proceeds funding projects at the hospital. RH Uncovered Magazine's East Grinstead edition ran a full page article about the appeal which was also featured on the Sussex Express website.

Transformative training
Queen Victoria Hospital's involvement in a new app which is hoped will "transform" mandatory fire safety training in NHS was featured on the FS Matters website. It uses interactive 360-degree video, virtual reality and a setting based on a digital twin of one of the hospital's wards.

The project was also mentioned on the IFSEC Global website the following month.

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

Dangers of dog bites
Siva Kumar, Consultant Plastic Surgeon, and Queen Victoria Hospital patient Darren Davies, helped raise awareness of the dangers of dog bites on BBC South East, BBC South East Today and BBC London. The piece shown on 12 January highlighted a doubling in the number of patients referred to the hospital with dog bite injuries compared to before the pandemic, a trend which correlates with national data.

The piece also featured on the front page of the BBC website, as well as the UK and England sections; BBC Radio Surrey, BBC Radio Sussex, BBC Radio Kent; and V2 Radio (including its website). Siva was also interviewed by Heart FM Sussex and Surrey run on 15 January. It was also picked up by The Mirror, quoting the BBC article.

Let's talk strategy
James Lowell, Chief Executive Officer, explained in an interview with the HSJ (behind the paywall) that he believes the hospital has a bright sustainable future and, as through its strategy development work, the Trust is discussing what its partners need and want it to be. The interview followed the January Public Board meeting which supported the principle of moving to a hybrid model of continuing to provide specialist services while also developing a local offer and increasing its focus on research.

Diagnostic tests closer to home
More than 6 million tests, scans and health checks have taken place at community diagnostic centres across the country, helping speed up diagnoses and treatments for NHS patients. The centres, including Queen Victoria Hospital's, were listed on the Government's website as part of the milestone achievement.

Land sale
Planning permission being granted to Brookworth Homes to build 30 homes on land sold by Queen Victoria Hospital attracted some media attention, mainly about road safety. It was picked up by the BBC News website (repeated on Yahoo News) and the Sussex Express website.

Progress pride pledge
The launch of the QVH Progress Pride Pledge, a sign of the hospital's commitment to being an inclusive organisation where colleagues and patients can be open about who they are and feel able to be their true self, was featured on the Surrey World website.

Burns warning
The parents of 11 year old Chloe Norris spoke to a range of media outlets about their daughter needing skin grafts after nail glue left her with burns to her hand. The coverage on BBC South East Today, The Mirror, Daily Mail Online, and Kent Online, mentions she was referred to "East Grinstead Hospital."

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024		**Agenda reference:**	**161-24**	
Report title:	**Developing the future QVH – clinical service review & defining our local population**				
Sponsor:	Abigail Jago, Chief strategy officer				
Author:	Abigail Jago, Chief strategy officer				
Appendices:	Appendix 1, 2 and 3 embedded in paper				
Executive summary					
Purpose of report:	Following Board approval of the proposed hybrid model in the January this report outlines the next key considerations in strategic thinking for the QVH strategy development. The paper specifically focuses upon work to date regarding the assessment and identification of the QVH 'local population' and emergent opportunities and considerations in relation to the clinical strategy.				
Summary of key issues	The paper outlines to the board: • The decision framework and principles for decision making that are guiding work to date • A summary of the current position, drivers for change and recommended opportunities to be explored in the next stage of strategic development for the following speciality level 'front line' clinical services: Minor injuries unit. Sleep disorder centre, Community services, Plastic surgery, Burns, oral maxilla-facial services (including Head and Neck / ENT cancer, orthodontics and ophthalmology • Proposed next steps to develop and deliver the clinical services strategy				
Recommendation:	To approve the draft paper and address the areas of discussion as set out above.				
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:	BAF 4 and 8. The paper sets out items that are material to the future ambition of the trust				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Leadership Team				
	Date:	13/2/24	Decision:	Approved	
Previously considered by:	Strategic Development Committee				
	Date:	21/2/24	Decision	Approved	
Next steps:	Implementation of outlined next steps				

Report to:	Board of Directors
Agenda item:	Clinical services review and defining our local population
Date of meeting:	21 February 2024
Report from:	Abigail Jago, Chief Strategy Officer
Report author:	Abigail Jago, Chief Strategy Officer
Date of report:	7 March 2024
Appendices:	Appendix 1, 2 and 3

Developing the future QVH – clinical service review & defining our local population

1 Background and introduction

In January 2024 as a first step in the strategy development of Queen Victoria Hospital Foundation NHS Trust (QVH), the trust board agreed to pursue a hybrid provider model. This option seeks to retain the provision of highly regarded specialist and regional services alongside an innovative health and care offer to the local population. The aim is to deliver both elements to mutual benefit to support resilience and clinical, operational and financial sustainability for the future. The hybrid provider model enables 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 modern health services.

The option supports the priorities identified from extensive stakeholder feedback and includes the following ambition:

- We will continue to 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 and wider system partners and population. Our centre of excellence will be strengthened by the development of formal university partnerships that support training, research, innovation and enhanced academic presence.
- We will work in partnership with other organisations to the benefit of patients aligned to our areas of specialism.
- We will, as an anchor institution, collaborate with our partners to provide an integrated neighbourhood hub that improves the health and wellbeing of our local population and supports the local community to thrive.

'Anchor institutions' are large organisations that are unlikely to relocate and have a significant stake in the local area. They have sizeable assets that can be used to support the social and economic factors that play a significant role in determining both long term health and health inequalities. Given that as an NHS organisation QVH is rooted in the local community – through size and scale it can positively contribute to the local area and make a difference to local people and partners in areas such as the use of estate, access to employment, skills and environmental impact.

With clarity regarding our strategic intent in terms of 'who we are and our purpose' the next stage in our strategic thinking is to consider the following:

1. What does the hybrid model mean for existing clinical services?
2. Who are our local population?
3. What partnerships might we be seeking and for which services?
4. What does the hybrid model mean for new services?
5. How do we effectively engage our strategic commissioning and provider partners in the planning of future services?
6. What is our definition of 'centre of excellence'?
7. What are our commercial and non NHS income opportunities?

This paper focuses upon the clinical service strategy development and the definition of the local population.

2 Clinical service strategy development and engagement

In regard to the future provision within our hybrid model consideration will be taken in regard to both existing and new services. This will include the following steps:

Step 1 - Review of existing clinical 'front line services' at a specialty level

Step 2 - Review of more granular elements of the services including subspecialty, patient cohorts and care settings (inpatient, outpatient etc) taking into account considerations set out in the agreed case for change. This is key to the clinical strategy development and will take place through co-design transformation orientated workshops

Step 3 – Review of our core clinical services that are critical to the delivery of our front line services e.g. imaging

Step 4 – Review of new potential services. This will be drawn from opportunities identified through clinical service and pathways reviews, an agreed strategic commissioning framework across Kent, Surrey and Sussex ICBs, provider/ partner discussions and identified service requirements informed by health needs analysis.

Engagement remains central to our strategy development and will be driven through further co-design workshops as part of a wider communications and engagement approach.

In the period since the last Board step one (review of front line clinical services) has been completed through a developed decision framework. This paper sets out the outcome of that initial assessment and poses recommendations of opportunities for consideration as per below. Following board approval step 2 will be progressed as the next stage in the strategy development.

3 Decision framework and principles for decision making

The established decision framework seeks to set out clear steps through which considerations and decisions are developed relating to our future services and wider organisational strategy. The framework incorporates the following 5 stages:

1. Understanding our current position – this stage has included the development of detailed analysis from quantitative, qualitative and comparative measures to understand our services. This includes a service led SWOT (strengths, weaknesses, opportunities, threats) analysis, independent feedback from extensive stakeholder engagement, current strategic considerations and a strategic scorecard analysis identifying key metrics that underpin the quadruple aim. The quadruple aim is widely accepted as a compass to optimise health system performance with the goal of simultaneous pursual of four dimensions – improving the health of the population, enhancing patient experience and outcomes, improving staff experience and delivering better value. The baseline data comprises of detailed analysis of financial viability and national cost comparators alongside key considerations in relation to both quality and workforce. Data sources include national benchmarking such as model hospital, GIRFT (Getting It Right First Time), national cost collection, national patient and staff surveys, gap assessments of national specifications in addition to trust data on quality and staffing performance indicators. (Please see Appendix 1 for detail).

2. Assessment - for each specialty level service a baseline data pack has been developed including a quantitative data score for factors relating to the quadruple aim, Boston matrix (a business tool that assesses cost and market share comparators) assessment of the service interdependencies and strategic considerations and population factors from the joint strategic needs assessment (JSNA). Thresholds for continuation of services include financial viability and strategic considerations.

3. Consider – The baseline data packs have been considered within an executive workshop and outputs discussed in a board seminar and hospital leadership team meeting to identify the proposed opportunities for consideration for each service. This hospital leadership team incorporates senior clinical leadership. The future options / direction 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). For each service the recommended opportunities for exploration in the next stage of strategy development is based on the analysis undertaken to date. It is important to note that the subsequent phase will be critical in identifying the detailed future plans for the clinical strategy.

4. Feasibility impact - at each stage of the decision process any proposed changes will be modelled to understand patient, staff, trust, partner and commissioner impact in relation to proposed changes.

5. Review and recommendation - Further engagement with stakeholders and commissioners will be undertaken as required and a final proposed strategy to the Board in the autumn.

4 Front line clinical service review

The following services have been reviewed and opportunities for consideration proposed as follows:

4.1 Minor Injuries Unit (MIU)

Service description: The MIU at QVH provides care and treatment for patients whose injuries or illness is not severe enough to require an A&E facility (category 3 emergency care). The unit is run by emergency practitioners who are experienced specialist nurses and paramedics who are able to assess, diagnose and treat a wide range of minor injuries and ailments for both adults and children over one year old. The nurse and paramedic led service operates 12 hours a day 365 days a year.

Current position and drivers: MIU has circa 17.5k attendances per annum which has increased in recent years in line with national trend due to community need and primary care pressures. The service currently accounts for circa 2.5% of trust commissioner income. The service works with primary care through provision of GP support in the unit and there is an opportunity for further partnership working with primary care, wider system partners and other QVH services (e.g. therapies) to develop new urgent care pathways to ensure that patients are being cared for in the right health setting at the right time. The estate provision for the service is not currently fit for purpose due to cramped conditions which needs to be addressed through the wider estate considerations. MIU delivers the key principles of the quadruple aim – the service is cost effective when compared nationally, the unit achieves excellent patient feedback with higher than average friends and family (FFT) results, performance in the unit is high with an average wait time to be seen of 36 minutes and over 99% patients are seen within 4hrs. MIU has high staff retention, and 84% of staff recommend QVH as a place to work.

Recommended opportunity and change: MIU is an integral part of the QVH local neighbourhood population offer, local health system and has high strategic fit with the hybrid model. The first stage analysis, consideration and recommendation to the board is that the service should be strengthened in partnership with primary care and system partners. This would not seek to increase the category of unit. The service should be developed within the context of a neighbourhood offer rather than a standalone service to optimise the delivery of improved patient pathways. It is proposed that a co-design approach should be utilised to consider the future offer for this service. It is proposed that this would be a key proposed shift in current position in regard to scope, model of care, scale and partnership working.

4.2 Sleep Disorder Centre

Service description: The Sleep Disorder Centre is the largest sleep centre in the South East outside London, and has a catchment area encompassing the whole of Sussex, much of Kent and Surrey, as well as parts of Hampshire. Insomnia patients travel from much further afield. The centre has a national reputation and frequently receives referrals for second opinions on sleep disorders from other units. The centre is one of few in the UK with facilities for a full range of treatments for sleep disordered breathing, including continuous positive airway pressure (CPAP), non-invasive ventilation (NIV), orthodontic services for mandibular advancement devices and surgery, including bi-maxillary osteotomy. Other treatments include a full range of pharmacological interventions and a cognitive behavioural therapy (CBT) service from a team of specialised psychotherapists. There is also a range of home diagnostic equipment, including pulse oximeters and portable monitoring devices.

Current position and drivers: Sleep services account for circa 7% of trust commissioner income and sees 26k outpatients and 1.4k admitted patients for overnight sleep studies per year. QVH sleep disorder centre as a service is more cost efficient than the average nationally when compared to other sleep services. The service achieves above average friend and family test results. There is high demand for the sleep service, with over 7k referrals per annum. The service has, in recent years, had challenges with staffing and diagnostic waits however the position for both has significantly improved and QVH diagnostic waits for the service are now some of the best nationally. Sleep disorder centre maintains high staff retention. There is a shift towards more home based care for this service and material opportunities to transform service delivery. The sleep service supports the national prevention agenda due to the long term impact of sleep deprivation and medical expertise supports resilience to the specialist services provided by QVH.

Recommended opportunity and change: The sleep disorder service is a regional and specialist service and has interdependencies with a number of trust services including diagnostics, orthodontics, maxillofacial and the medical presence supports resilience to the trust surgical services. The service therefore fits with the strategic direction of the organisation and can potentially provide additional system support for sleep services. It is proposed that QVH could build on the current service footprint and pursue the ambition to develop as a regional and national leader in this field. The service can also be a key element of future waiting well initiatives. All elements of the sleep service are to be reviewed to ensure the viability of delivery and future market share of each and related partnership consideration. There are physical capacity challenges within the service that need to be reviewed and addressed in line with consideration of service delivery transformation. Further work is also required to identify the opportunities to build upon the research portfolio of the service. The proposed opportunities for this service include a transformative model of care, increased market share, alignment to Community Diagnostic Centre offer and enhanced connectivity with other units although a single partner is not anticipated.

4.3 Community services

Service description: A suite of secondary care outpatient services are currently delivered with the QVH community services for the local population. Services include cardiology, rheumatology, general medical, care of the elderly and a Parkinson's nurse service. These services are accessible to GPs and the provision of services provides key medical support and resilience to the trust specialist services. The services are supported by QVH therapy teams. Service provision is delivered through a suite of service level agreements with partner trusts in Sussex and Surrey.

Current position and drivers for change: The community services offer has grown organically in recent years. These service account for circa 1% of trust commissioner income and see approximately 5k patients per year. The service costs are in line with the national average. Local intelligence from engagement activities highlight strong local experience and support for these services although patient feedback through the friends and family tests is currently below the total national average. The service model is arguably challenged in terms of resilience due to single handed services. Delivery of services is fundamental to the local population and support to the specialist footprint.

Recommended opportunity and change: The current arrangements within the community services offer require further resilience and support as the current service does not meet the full requirements of the future hybrid model. It is proposed that the model of care requires review as part of the innovative neighbourhood hub development rather than operating as separate services. This is critical to ensure that services have appropriate support, meet the needs of the local population and can additionally provide support and resilience to the specialist and regional footprint within the organisation. Consideration of the neighbourhood offer will need to consider and take into account the scope of service, the delivery model (which services QVH provides or works in partnership for others to provide) and role in the provision of integrated community teams and a local health and wellbeing offer. The recommendation is to materially redesign the service offer in line with partners as a core part of the future neighbourhood offer.

4.4 Plastic surgery

Service description: The QVH plastic surgery team is one of the largest in the country and provides plastic surgery and reconstruction to Kent, Surrey, Sussex and beyond. QVH is the primary provider of plastics surgery across Kent, Surrey and Sussex providing a range of plastic surgery services and additionally supports local providers in the provision of reconstruction and related requirements (for example for colorectal cancer surgery reconstruction) through job planned time. A significant amount of plastic surgery is delivered across Kent, Surrey and Sussex at other provider sites, including provision of plastic trauma services to UHSX. The service caters for adults and children.The service includes a team of 25 specialist consultants who work as part of a multidisciplinary team with surgeons in training, specialist nurses and therapists. Plastic Surgery consists of several subspecialties including breast, hands, lower limb, hands, skin and facial palsy.

Current position and drivers for change: Plastic Surgery accounts for 42% of total trust commissioner income and treats 60k outpatients and 12.5k admitted patients per year. There are also clear areas of unmet need across the region. The service meets the requirements of the quadruple aim – the service has excellent patient outcomes, achieves patient feedback in line with the national average and is more cost effective than when compared to the average nationally. Plastic Surgery has slightly lower than average staff retention score and slightly higher absence score, and there are some vacancies within the service. There is opportunity to further improve the service

Recommended opportunity and change: Plastic surgery is fundamental to the future of QVH and has very high strategic fit. It is proposed that QVH build further on the expertise and reputation of this service to develop as a leader from a regional national and international ambition perspective. It is proposed that the development of the service as the centre of excellence requires building upon research and innovation to ensure the future delivery of leading edge services. There is significant patient support for the provision of plastics services however there are some pathways that are disjointed and require review to optimise seamless care and an innovative model for the future. This includes ensuring that care is provided within the appropriate setting. Further work is required (and currently in progress) to understand the current position and consideration of each of the sub specialties within the service, patient cohorts and delivery of care within each of the key care settings. This work would identify any areas of change. Sub specialities include breast, hands, lower limb, skin and facial palsy. It is proposed that a co-design approach should be utilised to consider the future offer for this service including enhanced partnership opportunities for specific patient pathways. This would be a key proposed shift in current position in regard to the further development of a leading edge service.

4.5 Burns Service

Service description: QVH is one of 5 hospitals that provide acute and reconstructive burns care as part of the London and South East Regional Burns Network (LSEBN). QVH is a burns ‘unit’ and this level of in-patient burn care is for the moderate level of injury complexity and offers a separately

staffed, discrete ward. QVH additionally provides rehabilitation beds for the network area. The management of patients is through a risk based model in line with the network unit designation. Paediatric burns care is currently delivered as ambulatory service/day case care with acute burns up to 5% total body surface area (TBSA). Larger and inpatient burns are treated elsewhere. Patients are referred on a tertiary basis and although most patient come from within the catchment of Kent, Surrey and Sussex, the trust also manage patients from within the LSEBN area and via the National Burns Bed Bureau from other areas of the country. The majority of patients live within two hours travel time of the Burns Unit.

Current position and drivers for change: The burns service accounts for 6.6% of trust commissioner income and treats 4k outpatients and 600 admitted patients per year. Service costs are marginally higher than the national average however the service offers a material financial contribution to QVH. Specialist burns services are commissioned by NHSE specialist commissioning and the service will not be delegated to ICBs due to provision of the networked service at a regional level. The majority of services are provided on a non-elective basis under a block arrangement with NHSE. QVH is the only provider of burns care in Kent, Surrey, and Sussex, with other closest units and facilities falling geographically within Essex and London. The unit receives excellent patient feedback and high FFT scores. The service has had some challenges with staffing however this position has improved over the last year and 90% of staff would recommend QVH as a place to work. As part of the baseline review a gap analysis has been completed against the British Burns Association standards. Safety standards are met for this service. Outstanding gaps relate to co-location and services such as acute medical subspecialties which are not present 24/7. Access to radiology, haematology and therapies is available through on call provision. Some highly specialist interventions such as hemofiltration are not provided on site and so patients requiring this service and patients with complex medical needs or trauma are treated in other units. Laser treatment is compatible with QVH provision and this service is being developed. The compliance against standards is comparable / higher than other units within the Network.

Recommended opportunity and change: The burns service is specialist, regional and a key player in the London and South East burns network. The service achieves excellent patient feedback and although is not below average from a cost perspective the service offers a material trust contribution. This service has high strategic fit with the hybrid model. It is proposed that the burns service should, if supported by commissioners, continue with a focus upon developing both the research base, development of rehabilitation model of the service and strengthen acute medical support through the neighbourhood model. As a networked service further partnership working does not require consideration at this time.

4.6 Oral maxillofacial (including head and neck / ENT cancer)

Service description: One of the busiest in the UK, the QVH maxillofacial surgery department has nine consultant surgeons supported by medical and dental staff, specialist nurses and therapists. The service delivers head and neck cancer, orthognathic surgery, trauma, oral surgery, salivary glands and surgical dermatology. The service operates from a number of spoke sites across Kent, Surrey and Sussex in addition to services provided on the East Grinstead site. The QVH service also receives trauma referrals from across the region. The service caters for adults and children. QVH is successful at recruiting to medical posts however there are some challenges at a national level due to the dual degree requirement for the speciality.

Current position and drivers for change: OMFS (including ENT) accounts for circa 16% of trust commissioner income and cares for over 30k outpatients and 3.5k admitted patients per year. The maxillofacial service performs well in relation to the quadruple aim. It is at a specialty level more cost efficient than the average when compared nationally and has excellent patient feedback with 96% of respondents rating services as good or very good. 100% of staff within the staff survey would be happy with the standard of care provided. Services are commissioned through both ICB level for dental and non head and neck cancer sub specialities and specialist commissioning for head and neck cancer. Further delegation of Head and Neck services at an ICB level (likely 2025/26) may

bring further consideration to the configuration of H&N cancer services at a local level. In terms of market share OMFS currently provides approximately 20% of Kent, Surrey and Sussex activity.

Recommended opportunity and change: The OMFS service is a key provision within Kent, Surrey and Sussex. The service includes key specialist and regional services. Services perform well and it is proposed that there is an opportunity of ambition to seek to grow the service base to develop market share and role across the region. This includes the exploration of system leadership and partnership opportunities within this service remit. The direction of travel for this service can also look to build upon the research base and national / international reputation. It is important to review the subspecialty, patient cohorts and settings of care elements of the service to determine the strategic direction for these areas and to identify if there are any areas of service that may not be compatible with the hybrid model ambition or areas of focus. It is proposed that a co-design approach should be utilised to consider the future offer for this service including enhanced partnership opportunities for specific patient pathways. The potential opportunity could include a proposed shift in scale and further development of a leading edge service.

4.7 Orthodontics

Service description: The QVH specialist orthodontic team advises and treats children and adults with complex orthodontic problems. The team provide tertiary, specialist care for patients requiring orthodontics and jaw surgery, cleft lip and palate care, facial disharmony, facial anomaly, malalignment of the jaw and positional problems of teeth, buried / impacted teeth and sleep apnoea (care for patients with sleep disordered breathing). The service is integrated within both OMFS and sleep centre patient pathways. As identified by GIRFT the unit is one of the busiest nationally outside of the teaching hospitals. The service support the management of dental health as identified in the national children's core20 plus 5 through hosting mouth care and oral hygiene clinics from patients referred from orthodontics, OMFS and the children's ward.

Current position and drivers for change: The service accounts for circa 2.5% of trust commissioner income per annum and cares for approximately 1k new and 12.5k follow up patients per year. The orthodontic service performs well in regard to the quadruple aim considerations. Costs are in line with the national average and it achieves above average for patient feedback and FFT results. The service has a high retention of staff and average sickness and absence rates. From a market share perspective QVH delivers 22% of orthodontics activity for Kent, Surrey and Sussex. Dental activities now commissioned at an ICB level with delegation to ICBs from NHSE in 2022. The service is currently provided solely on the QVH site, so there is potential opportunity for growth through provision of off-site services in line with oral surgery services that are provided off-site.

Recommended opportunity and change: Orthodontics is a key service for the treatment of patients with complex orthodontic needs. The service is integral to the delivery of both OMFS and sleep disorders and it is proposed that the unit continues within the future service configuration in QVH. It is recommended that the scope of the service is considered in relation to the future trust model.

4.8 Corneo plastics

Service description: The corneo plastics service is a specialist and tertiary referral centre for complex corneal problems and oculoplastics. It is a high-profile and technologically advanced department that delivers high quality care in its sub-specialties and sets standards for care in the UK and internationally. The unit provides a range of services including glaucoma, corneal and ocular plastics. The service incorporates an eye bank which provides a number of services including eye donation recovery, corneal transplant preparation and stem cell growth. QVH performs modern small incision cataract surgery and takes referrals for expert opinion from all over the UK for complex cataract surgery and anterior segment reconstruction. The unit provides a range of services for glaucoma including minimally invasive surgery, laser and drainage devices. The team also offer specialist techniques in oculoplastic surgery including Mohs micrographic excision for eyelid tumour

management and facial palsy rehabilitation. Currently the service doesn't provide specialist vitro-retinal service with referral to SASH and UHSx for such services.

Current position and drivers for change: The service accounts for just over 10% of trust commissioner income and delivers 25k outpatient attendances and 3k inpatients per year. The corneo plastics service performs well in regard to the quadruple aim considerations. The service is more cost efficient against national comparators. Ophthalmology was rated 'Good' or 'Very Good' by 93.7% of FFT respondents, just under the NHSE average of 94%. The service struggles with physical capacity which needs to be addressed as part of the emergent estates strategy. The service maintains a high staff retention rate and a low absence rate. Ophthalmology services are currently commissioned by both ICB and NHSE in terms of specialised commissioning for treatments such as corneal grafts. Specialist commissioning for this service is due to be considered for delegation at an ICB level. The dates for delegation are yet to be confirmed at a national level.

Recommended opportunity and change: The corneal plastic service has high strategic fit within the hybrid model. The service offers innovative specialist expertise that can be developed at a regional, national and international level. Developing the research base for this may be a critical component of the future model. It is proposed that the development of the service should consider the scale of secondary care services which could, if capacity identified, support partner providers and systems. There are also further opportunities for the services to support training opportunities for medical students and clinicians in training. It is proposed that a co-design approach should be utilised to consider the future offer for this service including consideration of sub specialities, patient cohorts, settings of care, development of the specialist services, expanded research, wider system provision and consideration of partnership opportunities for specific patient pathways.

4.9 Next steps

Following review and support of the proposed direction of travel next steps are as follows:

- Speciality level co-design workshops to consider sub specialities, patient cohorts and pathways, settings of care (outpatient, non- elective, elective etc)
- Detailed consideration of partnership arrangements for services /care setting
- Develop of strategic commissioner framework
- Consideration of new potential services aligned to the hybrid model
- Development of an agreed definition / ambition of centre of excellence
- Consideration of commercial opportunities

5 Our populations

As the trust develops its clinical strategy it is critical to be clear in identifying the patient populations that the trust aims to serve. Patients travel from all over the UK for QVH services (please see Appendix 3). From a specialist and regional service perspective due to the broad geography of referrals focus will be upon trust patients.

In contrast however, the local aspect of the trust strategic ambition within the hybrid model seeks to be more than care of patients but additionally to support the health and wellbeing of the population and to help the community to thrive. Identifying the 'local population' is therefore key to ensure that when considering the future service configuration as an organisation QVH can be clear re health needs and the identification of key partners from a health, care and social economic perspective. Identifying the population is a complex task, with an added challenge for QVH of its location on the border of Kent, Surrey and Sussex administrative boundaries.

5.1 Principles of identifying our local population

The proposed population will not be 'hard boundaries' but will provide a core area in which to focus. In liaison with the Sussex public health team six options have been considered taking into account the following principles:

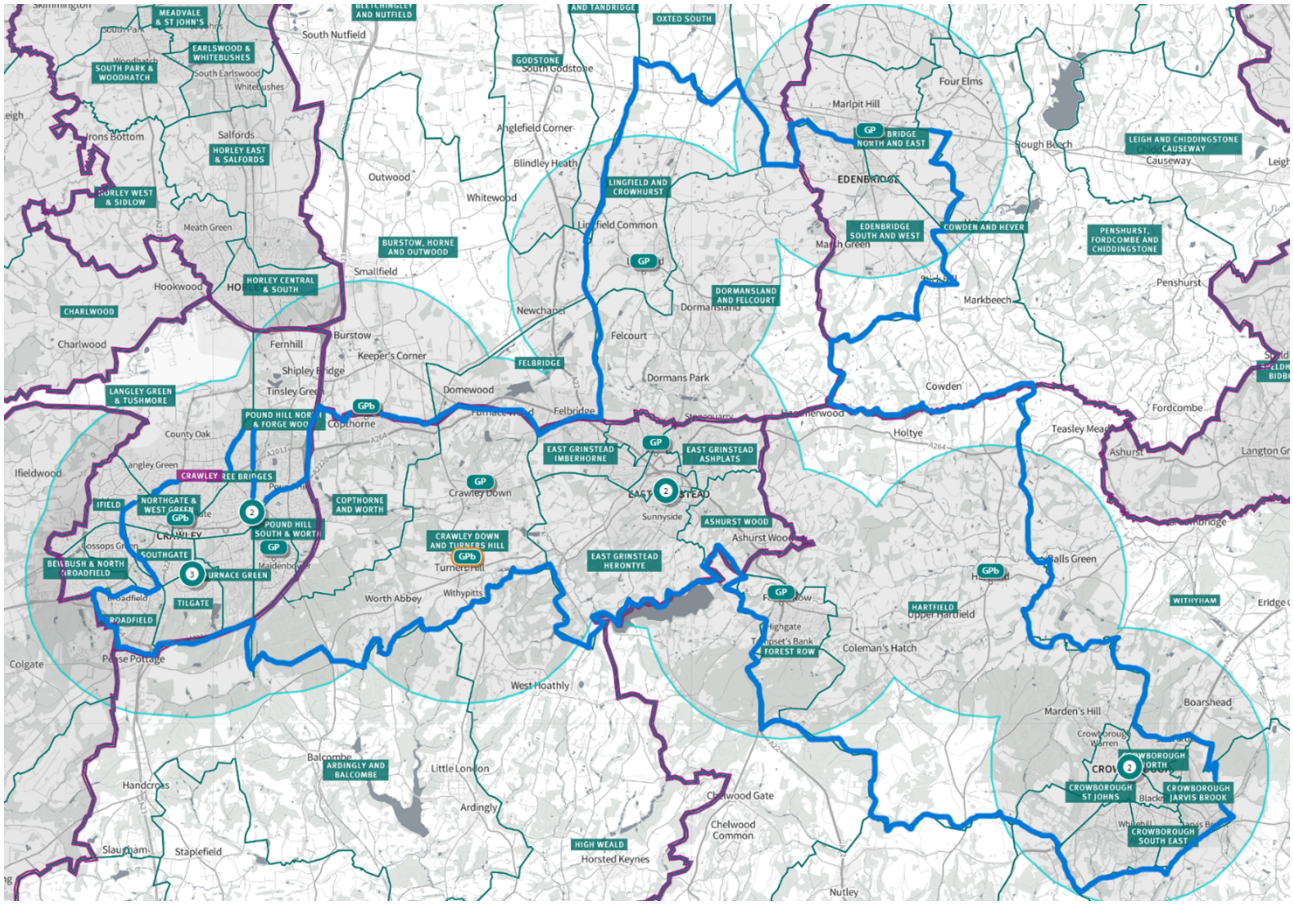
- **Geography clarity**: Ward, Administrative and County Boundaries, Accessibility
- **Population size** – the catchment area should be a workable size in order for efforts in effecting Health Inequalities to be most impactful.
    - OHID have provided catchment populations for NHS trusts which suggests QVH catchment population would be approximately 152k based on admissions data.
- **Proximity and alignment with partner agencies (including primary care,** partnerships strategy and CDC referring practices)
- **Collaboration opportunities with other local institutions** such as educational institutions, libraries, charities, local business, local authorities
- **Other Health Provider**/NHS Anchor Institutions – collaboration rather than duplication
- **Association of the population** with QVH as a local provider

5.2 Local population options

Options have been considered in relation to these principles as per below:

	Option	Option description and considerations
1	Sussex (West & East Sussex)	West and East Sussex, defined geographical boundary however neighbouring areas from Kent and Surrey are not included. Population of this area is c1.5 million and so deemed too large to have meaningful impact from a social economic perspective. Additionally much of Sussex is served by other NHS providers and for many parts of the population there is a risk of duplication and limited association with QVH as a 'local' provider
2	Mid Sussex	There is a clear and defined geographical boundary of Mid Sussex District Council and such an approach is in line with administrative boundaries. The population is in the region of 150k and so arguably a helpful catchment area. This option does however exclude some of the peripheral catchment that falls within the Kent and Surrey borders.
3	10k radius of QVH	This option enables the inclusion of populations on the borders of Kent and Surrey as well and Sussex and aligns with the core catchment area of core services such as MIU. The option also delivers proximity to local stakeholders and some key partner stakeholders. It is however challenging to quantify the population size and analysis of health needs is complication as this does not align with administrative boundaries. IT also excludes areas that may benefit from the QVH ambition to support communities – for example Crawley.
4.	Presumptive catchment area	This option aligns with the public health approach and includes GP practices where distance to QVH is less than distance to other acute hospitals. This is approximately an 8-10 miles area around QVH. A further cohort of practices were included if situated within the same electoral ward. Total population in the offer is c190, 000. Proximity also aligns with CDC GP referral base. This option includes East Grinstead and the borders of Kent, Surrey and Sussex.
5.	East Grinstead Geography	This option would focus upon the population of East Grinstead which is c26k. Although strong local association with the hospital this is arguably too small as a population to have optimum impact in the ambition to support local health and wellbeing and play a key role in helping communities to thrive. This option also does not embrace the borders of Kent and Surrey where there may be strong association with QVH.
6.	East Grinstead PCN	This option would align to East Grinstead primary care network. This covers a population of c48k. This is arguably too small a population to have a material impact and excludes the borders of Kent & Sussex. This is additionally a less clear boundary when undertake demographic and health needs assessments of the local area.

On consideration of all options the preferred and recommended option is the presumptive catchment area (option 4) as set out in the map below.



5.3 Next steps

Following the approval of the approach to the 'local population' element of the hybrid model next steps will be as follows:

- Health needs analysis
- Health, care and voluntary sector partners
- Anchor institution connections and opportunities
- Identification of relevant population / service users for co-design

The Strategic Development Committee are asked to:

1. **APPROVE** the proposed direction of travel for trust services
2. **APPROVE** the proposed approach for the identification of the 'local population' for the purposes of further strategy development

Appendices

Appendix 1

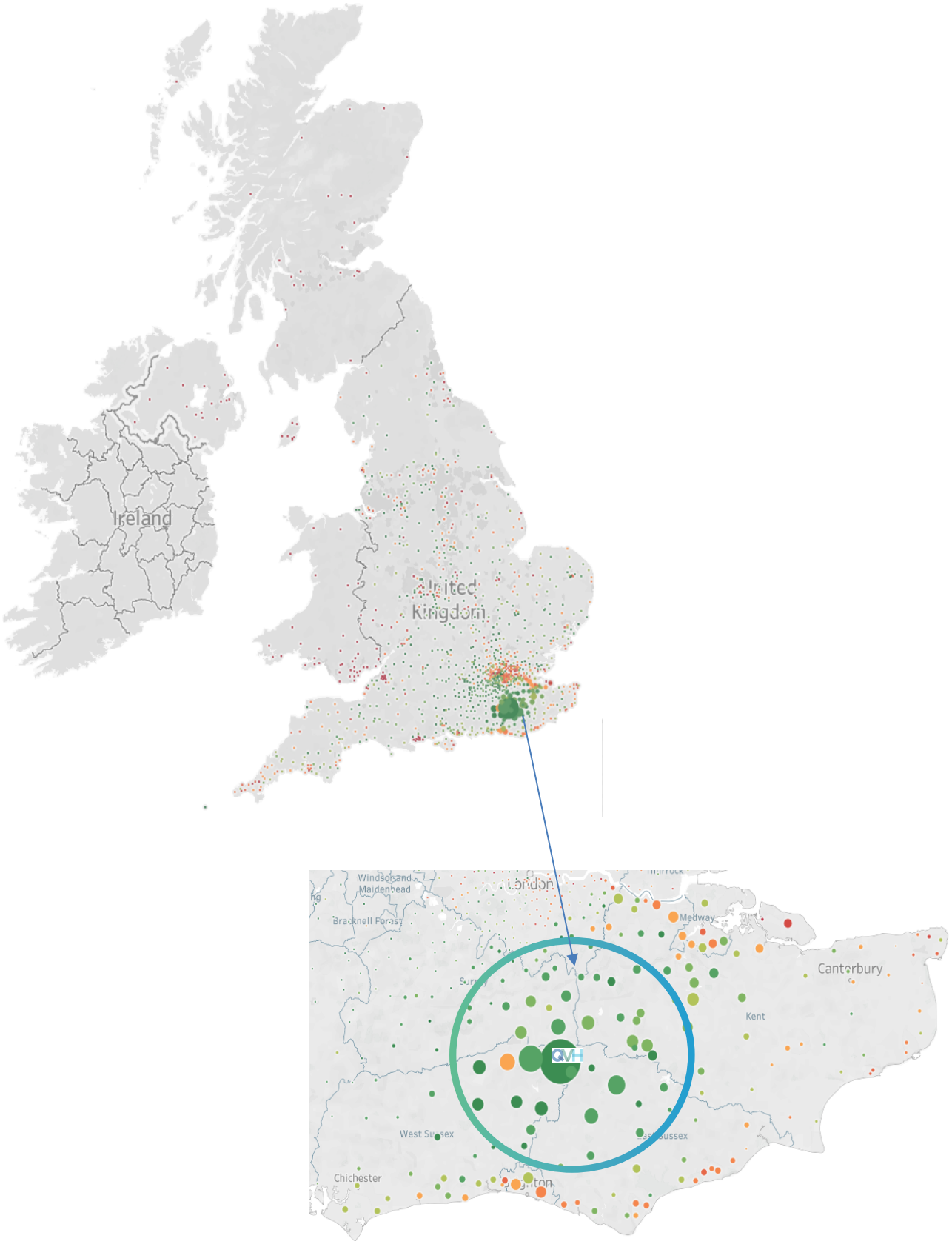
Category	Measure	Description	Data Source	Date of Data Capture
Current Position	Resource Intensity	Current no. of staff per service by FTE	QVH HR	Snapshot 31/12/2023
	Cost	Current cost of the service	National Cost Collection	2021/22 Financial Year
	Local Risk	Risk scores of existing local risks	Local Risk Register	Snapshot 24/10/2023
	Corporate Risk	Service risks relating to the corporate risk register	Corporate Risk Register	Snapshot 06/10/2023
Better Value	Cost Efficiency	Trust NCCI	National Cost Collection	2021/22 Financial Year
	Length of Stay	Elective Length of Stay at QVH	Model Hospital	Financial Year 20/21, 21/22, 22/23, depending on availability
	Length of Stay	Emergency Length of Stay QVH	Model Hospital	
Better Care	Length of Wait	Length of wait for QVH Service	NHSE Referral to Treatment Waiting Times	Snapshot RTT-July-2023
	FFT	Friends and Family test survey results - (% rated 'Good' or 'Very Good')	QVH Patient Experience Team	Range 01/04/2022 – 31/03/2023
	Complaints	Complaints by service	QVH Patient Experience Team	Range 01/04/2022 – 31/03/2023 - Based on the 'Opened' Date
	PALS	PALS by service	QVH Patient Experience Team	Range 01/04/2022 – 31/03/2023 – Based on Closure Date
	Staff Survey	Service staff % who would be happy with standard of care provided by organisation for a friend/family member	2022 Staff Survey	2022 Staff Survey
	Staff Survey	Nursing staff % who would be happy with standard of care provided by organisation for a friend/family member	2022 Staff Survey	2022 Staff Survey
Better Health	Waiting list size	RTT Waiting list size QVH	NHSE Referral to Treatment Waiting Times	Snapshot RTT-July-2023

Appendix 2

SERVICE CODE	SERVICE NAME
01	Emergency departments are a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients
02	Consultant led mono specialty accident and emergency service (e.g. Ophthalmology, dental) with designated accommodation for the reception of patients
03	Other type of A&E/minor injury activity with designated accommodation for the reception of accident and emergency patients. The department may be doctor led or nurse led and treats at least minor injuries and illnesses and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP practice or out-patient clinic) is excluded even though it may treat a number of patients with minor illness or injury. Excludes NHS walk-in centres
04	NHS walk in centres
T01NA	Type 01 non admitted

Appendix 3

Patients travel from all over the UK for QVH services with a concentrated cohort in the south east.



Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024	**Agenda reference:**	**162-24**		
Report title:	Electronic Patient Record (EPR) Business Case				
Sponsor:	Maria Wheeler, Chief Finance Officer				
Author:	Ellie Tallett Deputy Chief Finance Officer				
Appendices:	Appendix one: EPR business case summary				
Executive summary					
Purpose of report:	To seek ratification of the approval of the EPR business case at a private Board meeting on 8 February 2024				
Summary of key issues	• A summary of the business case is included at appendix one to this report. The business case was approved at a private Board meeting on 8 February 2024. • Procurement process is underway, anticipated to be completed at the end of February 2024 • Initiation & Mobilisation starts April 2024 • Phase 1 go live January/February 2025 • Phase 2 go live April 2025 • Phase 3 go live February 2026				
Recommendation:	For the Board to ratify its decision to approve the EPR business case at its private meeting on 8 February 2024				
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:	Finance and performance committee and Board				
	Date:	February 2024	Decision:	Approved	
Next steps:	Letter to be submitted to commissioners				

NHS
Queen Victoria Hospital
NHS Foundation Trust

Electronic Patient Record (EPR)

Full Business Case Overview

Strategic Context

The Full Business Case (FBC) sets out the rationale for investment in electronic patient record (EPR) for Queen Victoria NHS Foundation Trust (QVH).

This FBC sets out the rationale for investment in electronic patient record (EPR) for QVH. The required investment to deliver the investment objectives via the preferred option from Supplier A is expected to be a **capital** investment of **£12.359m** over 7 years (excluding non-recoverable VAT).

The Trust has recently given significant consideration to the strategic direction regarding its digital strategy and the clear requirement for improving access to patient information by implementing an Electronic Patient Record (EPR). As a result, the Trust's investment in digital solutions has often focussed on departmental or tactical solutions (best of breed). This has resulted in the Trust having a mixed estate of isolated specialist departmental systems which do not always integrate effectively.

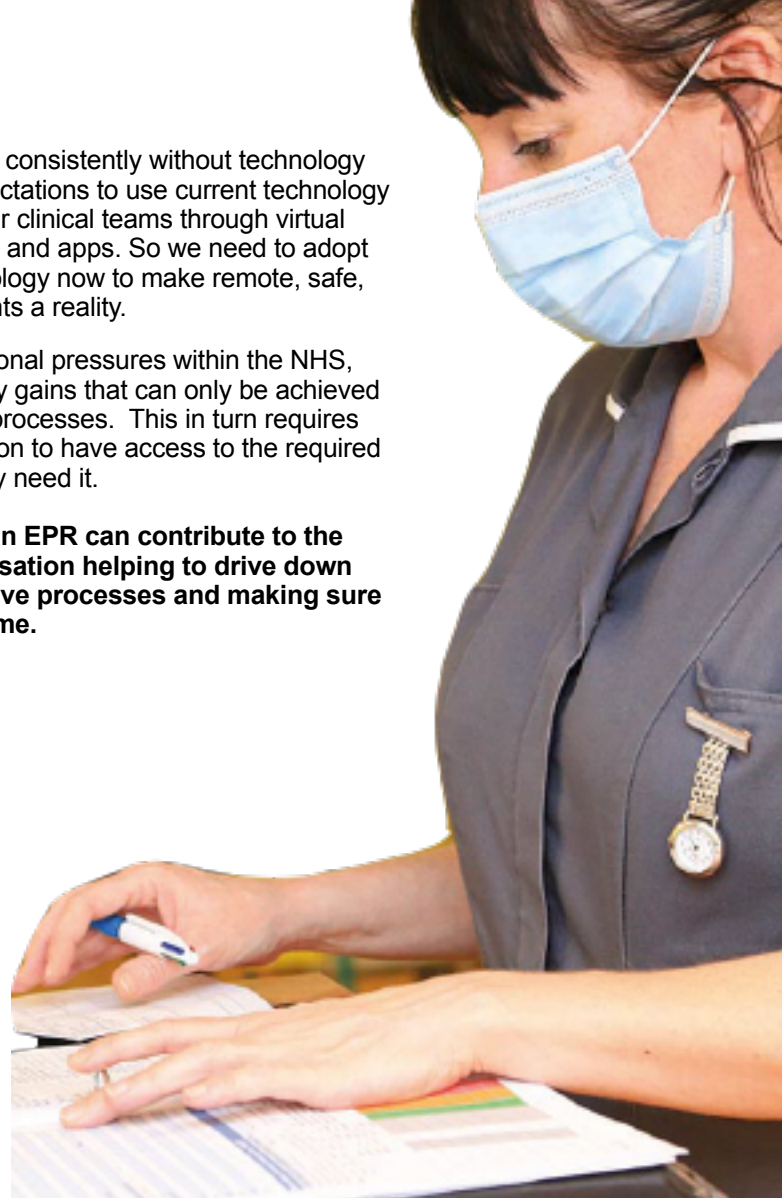
An EPR is an essential tool in the delivery of 21st century Acute healthcare. The principal aim of a successful EPR deployment is to improve clinical outcomes and safety for patients. EPR technology provides clinicians with modern clinical decision support tools at their finger-tips, reflecting best practice guidelines and recognised clinical standards. Powerful audit tools can monitor clinical practice and outcomes and minimise variations in clinical care, while electronic data validation and predictive clinical algorithms can reduce the number clinical errors or alert staff to potential hazards or deterioration in a patient's condition.

An EPR also supports improved safety and outcomes by providing a comprehensive clinical record and a single view of a patient's data in one place. It will also let multiple users view and update the patient's record at the same time from wherever they are on-site or remotely. This ensures that staff have access to the right information at the point when they need it, without logging into several different systems, or requiring a complex paper chase and series of phone calls. There is an added benefit, when EPRs work well, of improving staff morale and the working environment.

Today patients and their families have an expectation of seamless, integrated care between organisations providing their healthcare. Sharing patient data between primary, acute and community care is practically impossible to manage consistently without technology support. Patients also have expectations to use current technology to engage with hospitals and their clinical teams through virtual consultations, technology portals and apps. So we need to adopt the opportunity offered by technology now to make remote, safe, clinical interaction with our patients a reality.

The current financial and operational pressures within the NHS, require efficiency and productivity gains that can only be achieved through embedding changes to processes. This in turn requires staff in all areas of the organisation to have access to the required information when and where they need it.

This case demonstrates how an EPR can contribute to the overall efficiency of the organisation helping to drive down costs, automating administrative processes and making sure that things are right the first time.



QVH Strategic Objectives

The Trust is currently working on strategic plans to secure the long term future of the hospital in the context of challenges related to being one of the smallest acute trust in the country. The strategy will be designed to reflect the following structure to ensure that the patient is at the centre of everything we do.

The introduction of an EPR will support the organisational strategy by achieving the following objectives:

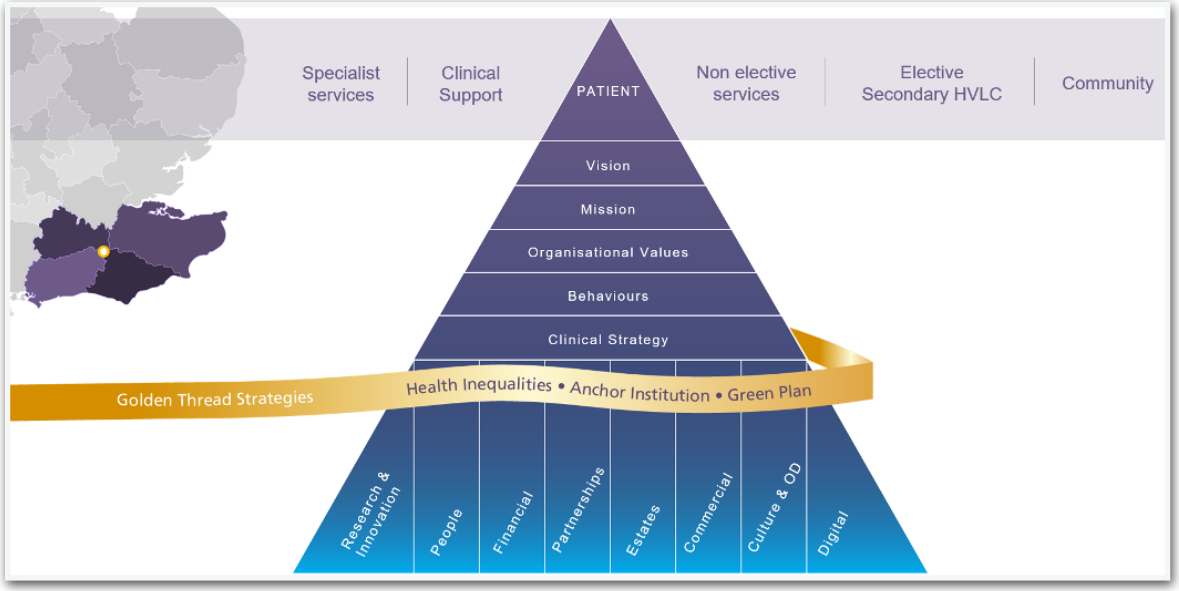
Improve patient experience
- All patient information in a central repository that is accessible to all at the point of need.
- A paper-lite approach to the recording of patient information by streamlining operational and clinical processes, removing unnecessary duplication of work.

Improve operational efficiency
- Increased operational productivity achieved through the availability of real-time information between clinicians, pharmacy, nursing teams and AHP's to minimise delays in the patient pathway.
- To achieve more effective control and management of expenditure across the Trust by ensuring that clinical time is used effectively.
- Reduced medication errors and incidents by improved medication reconciliation on admission and discharge.

Meet National objectives
- To be compliant with the DHSC and NHSE transformation plan to have an EPR at a core DCF standard by March 2026.
- To achieve HIMSS level 5 by March 2026.

Safe and secure IT systems
- By enabling the rationalisation of the current Trust clinical IT systems to include the replacement of aged and out-dated IT systems to be replaced with state-of-the-art technology and security.
- All systems should achieve 99.9% availability.

Enhanced partnership working
- A key objective of the Sussex Integrated Care System is to work together by being able to share and view common data effectively.



The guiding principles of the development of the strategy are as follows:

Economic Case

The FBC has built a set of long list options which were developed using a range of categories based on the Treasury Green Book Model. These options were developed through presentations workshops, along with meetings with clinical and operational staff and consultations with partner organisations. The options were further analysed against Trust strategic objectives and critical success factors, to identify the shortlist of options.

Below are the shortlisted options which were taken forward for further assessment during the preparation of this case.

Option 1: Do Nothing
This is the baseline option where we would maintain existing systems, which is the highest risk, therefore the 'do nothing' option doesn't exist.

Option 2: Best of Breed EPR
A best of breed EPR based upon the existing PAS at its core, integrated with the best available departmental systems and the procurement of a clinical portal to provide a central view of patient records.

Option 3: Enterprise EPR
End-to-end solution. Purchase a comprehensive solution from one vendor in order to obtain a single end-to-end solution that encompasses all application areas / modules.

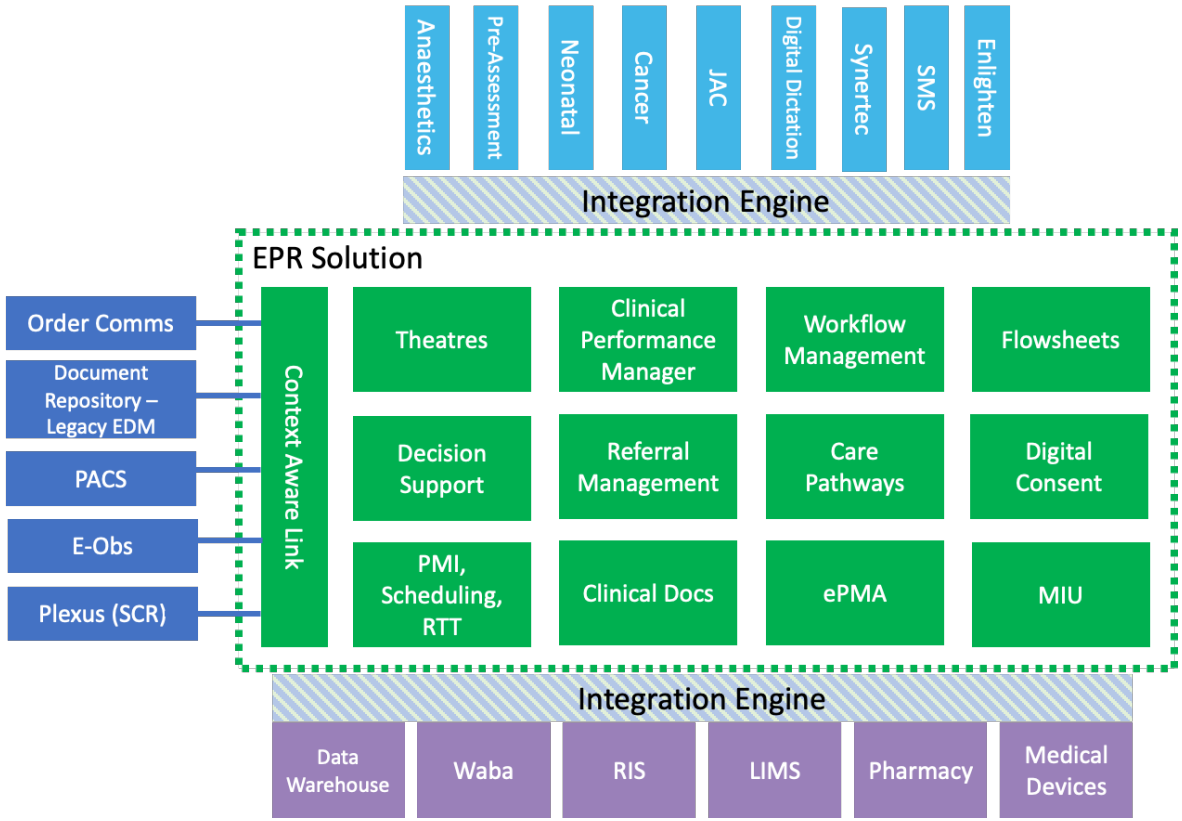
Costs per option £000	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
Option 3 - New Enterprise EPR									
- Capital	0	6,317	4,243	1,800	0	0	0	0	12,360
- Capital optimism bias uplift *	0	0	0	0	0	0	0	0	0
- Capital contingency **	0	0	0	0	0	0	0	0	0
- Capital total	0	6,317	4,243	1,800	0	0	0	0	12,360
- Revenue	0	0	540	666	666	666	666	663	3,870
- Revenue optimism bias uplift *	0	0	0	0	0	0	0	0	0
- Revenue contingency **	0	0	0	0	0	0	0	0	0
- Revenue total	0	0	540	666	666	666	666	663	3,870
- TOTAL CAPITAL + REVENUE	**0**	**6,317**	**4,783**	**2,466**	**666**	**666**	**666**	**663**	**16,230**

Economic Case

The PAS, which includes PMI, scheduling; and patient tracking including RTT will be fully integrated and the user will see this as one application with the new EPR. It will provide fully integrated analytics and reporting capabilities. The solution will offer flexible mobile user access and the capability for patient tracking throughout their journey through the Trust. The solution will include full integration to departmental systems such as LIMS and PACS, RIS to support order communications.

The **Supplier A EPR solution** will offer the Trust a significant **increase in functionality and capability** than what is currently available, where possible departmental systems will be replaced to become part of the EPR.

For areas such as **Theatres** new functionality will offer significant opportunity for **improving workflow and utilisation of resources.** Enterprise scheduling is part of the module which will allow much better visibility resources and capacity to increase operational efficiency. Added to this, **clinicians will no longer have to log into multiple systems** to gather all of the information required to make clinical decisions, i**mproving both safety and patient experience.**



Functional Area	Existing: Integrated	New: Core	New: Optional	Out of Scope
Vital Signs				
Order communications and results reporting				
PAS – Scheduling & waiting list management				
Patient tracking RTT				
Bed Management				
Clinical coding, outpatient procedure coding				
Document Management: EDRMS				
Analytics and reporting				
Clinical Noting				
Tracking Boards				
Trauma Boards				
ePMA				
Closed loop medication				
Workflow Management				
Minor Injuries Unit (MIU)				
Context Aware View				
Discharge Notifications				
Decision Support Tools				
Bed management				
Patient Access				
Research				
Document Archive				
Theatres				
Ophthalmology				
Digital dictation				
PACS				
Anaesthesia				
Radiology Information System				
LIMS				
GP Laboratory Links				
Pharmacy stock control				

Economic Case

Since approval of the OBC significant work has been completed to identify the potential benefits the EPR can offer the Trust. Although a comprehensive list, it is **expected that further benefits will be identified as the "To-Be" processes are mapped.**

A total of **34 benefits have been fully identified** - 28 Cash Releasing Benefits (CRB), 8 Non-Cash Releasing Benefits and 3 Societal.

Key Themes:

- Decommissioning systems and cancelling existing contracts circa **£3.2m**
- Staff efficiencies circa £**2.8m**, equates to 17 staff over 7 years
- Improved utilisation & productivity of theatres and clinics circa **£5m**
- This equates to **£863k per annum** and improvement of 2% on variable income utilisation / productivity

Top 5 Benefits - Saving per year, full effect from **Year 3** - Profiled over **7 years**

Ref	Title	Description	Value	Type
B01	Reduced admin for clinic prep time from integrated data	Significant time saved in Amin prep. Better clinical experience as all the information is available in one place. This promotes a holistic view of patients' clinical records. Expected saving of 20 mins of clinic prep per patient	£413,400	CRB
B04	Cost savings through decommissioning Legacy (Dedalus) PAS	New EPR will replace the ageing Patient Administration System (PAS) PAS will be an integral part of the EPR and no longer required as a separate system. Cancellation of existing Dedalus PAS licensing & support costs	£130,960	CRB
B31	Cost Savings Through Decommissiong Electronic Documentation Management (EDM)	The aim of this benefit is to: - Replace existing EDM System with New EPR. - Reduce the amount of time staff spend entering data/information on various systems which most do not integrate.	£150,000	CRB
B12	Reduced requirement for Paper Case notes: Removal of scanning contract	Digital system will reduce the efforts associated with paper notes in Health Records, Outpatient Clinics, Wards (ward clerks). Minor Injuries Unit (MIU) and Pharmacy.	£133,000	CRB
B35	Utilisation and Productivty Benefits	Ability to deliver more activity for no extra costs allows WLIs to reduce, repatriate private work and deliver more patients for no additional cost	£863,333	CRB

Commercial Case

The Trust has undertaken a f**ully compliant procurement exercise**, overseen by **London Procurement Partnership (LPP)** using the **Clinical Digital Solutions (CDS) Framework** as per the requirements of the NHS England Frontline Digitisation (FD) programme which is providing central funding to support the programme.

The process was completed over a period of **9 months** and involved **staff from across the Trust** at each stage to ensure that all requirements were met.

Phase 1

Pre-market engagement

- This was completed in March 2023 to test the market to see which suppliers would be interested in providing a solution for QVH
- Opportunity for suppliers to provide indicative costs to inform the Outline Business Case (OBC).
- Opportunity to test the Output Based Specification (OBS) outlining all of the Trust requirements to ensure these were deliverable by the market.

Phase 2

Preparation for Tender

- Further organisational engagement completed to review and refine the OBS, this included individual and group sessions with all departments across the Trust.
- Definition of appropriate evaluation criteria that will result in the most economically advantageous tender from both a price and quality perspective
- Drafting of all ITT documentation for review and approval.
- Development of payment milestones structure and approach for inclusion in the ITT documentation

Phase 3

Invitation to Tender (ITT) & evaluation

- Publication of the further competition to all suppliers
- Management of all written supplier clarifications
- Coordination and management of briefing sessions for all local evaluators prior to the receipt of bids.
- Facilitation and management of all scored demonstrations and evaluator scoring moderation sessions.
- Trust finance lead to undertake all price and financial evaluation.
- Contract award recommendation report for review and approval by the relevant Trust / ICS / Regional / National boards.

Phase 4

Contract finalisation & award

- Suppliers notified of outcome and issued the intent to award letters.
- Coordination of the standstill period and supplier debrief process.
- Management of the Contract Award Notice process following intent to award (preferred bidder status).
- Engagement with the Trust solicitors to assist in the contract negotiation process.
- Contract schedules reviewed and agreed with Supplier A, these will form part of the standard CDS framework contract.
- Contract signature

There is strategic and financial justification for procuring the **Supplier A EPR Shared Instance** solution to meet all of the Trusts' investment objectives.

The recommended procurement strategy to deliver the investment objectives via the preferred option, is to procure the **Supplier A EPR Shared Instance** solution directly via the LPP CDS Framework.

The contract term is proposed as 5 years, with an option to extend for a further 2 years.

A structured and compliant procurement process has taken place; the remaining stages of which are:

- Full Business Case approval;
- Executable contract agreed with vendor;
- Contract signing.

It is anticipated that this **process would be complete by end of February 2024.**

As part of the tender evaluation process the following activities were completed:

- Reviewing & scoring of supplier responses
- Moderation of evaluator scores
- Supplier demonstrations
- Moderation of evaluator scores
- Review & scoring of financial responses
- Final clarifications & scoring analysis

The evaluation process was well attended with 25 evaluators scoring the responses. The areas represented were **Burns & Plastics, Nursing, Therapies, Pharmacy, Radiology, Sleep, Corneo, MaxFax, Clinical Coding, Clinical systems, Business Intelligence, IG and IT.** With all grades of staff in attendance.

Financial Case

The programme costs include both capital and resource expenditure and cover licence fees, implementation and on-going running costs for both the Trust and the supplier of the preferred option.

At this stage, we have modelled the following capital / revenue split:

Capital Costs

- Annual supplier licence fees
- Supplier implementation costs
- Trust implementation costs

Revenue Costs

- Annual supplier support costs
- Additional Trust support staff ongoing costs - EPR post go-live support team

Year	0	1	2	3	4	5	6	7	
COSTS	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
Revenue	0		-540	-666	-666	-666	-666	-666	-3,870
Depreciation		0	-722	-1,450	-1,630	-1,630	-1,630	-1,630	-8,692
PDC	-109	-262	-300	-258	-184	-111	-37	0	-1,261
TOTAL COSTS	**- 109**	**- 262**	**- 1,562**	**- 2,374**	**- 2,480**	**- 2,407**	**- 2,333**	**- 2,296**	**- 13,823**
Benefits	0	242	1,837	1,837	1,837	1,837	1,837	1,837	**11,264**
Net I&E Impact	**- 109**	**- 20**	**275**	**- 537**	**- 643**	**- 570**	**- 496**	**- 459**	**- 2,559**

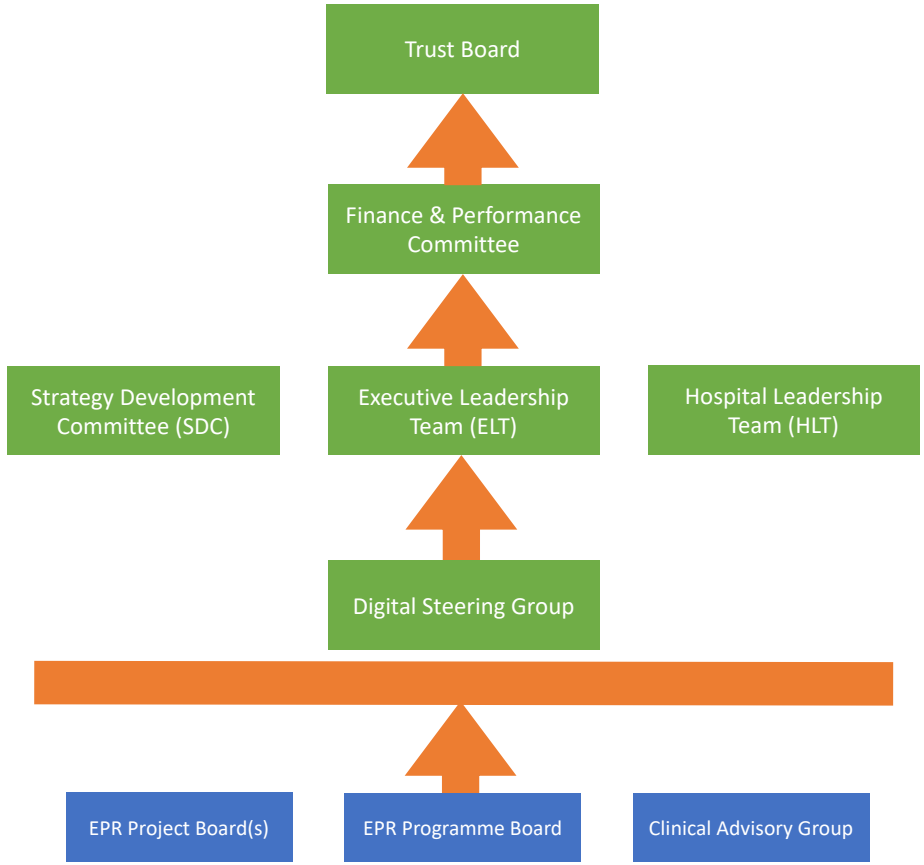
	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
Benefit of decommissioning systems	0	190	507	507	507	507	507	507	**3,232**
Staff savings	0	52	467	467	467	467	467	467	**2,854**
Productivity 85 to 87%	0	0	863	863	863	863	863	863	**5,178**
	0	**242**	**1,837**	**1837**	**1837**	**1837**	**1837**	**1837**	**11,264**

Management Case

The Programme will be managed using the principles of Managing Successful Programmes (MSP). Component Workstreams and Projects will be managed using the principles of Projects in Controlled Environments (PRINCE2) methodologies. Adoption of these methodology requires a programme management structure that has clear channels of communication to governance and decision-making forums.

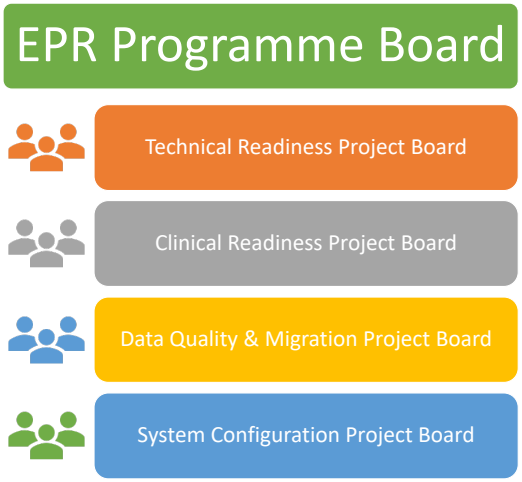
The construct of the Programme Team will be supported by role descriptions which specify the responsibilities, goals, limits of authority, relationships, skills, knowledge, and experience for all roles within the programme organisation.

The below diagram shows the proposed structure for the EPR Programme and its integration into existing Trust governance structures. It reflects the need to represent the organisation, end user, supplier and the external quality assurance role.



The EPR Programme Board will provide the overall direction to the EPR Programme. It has responsibility to commission enabling projects and committing the required resources. It has the authority to sign off the completion of each phase and authorises the start of the next phase.

An example of the relationship between the EPR Programme Board and its reporting Project Boards is set out below. These will be confirmed as part of Programme Initiation in Q1 2024/25.



Programme Risks - Top 3

- **Leadership priorities**: Competing priorities could mean senior leaders are unable to devote the time required for successful implementation
- **Lack of clinical engagement**: staff engagement is fundamental to successful delivery and benefit realisation, experience with existing systems may influence clinical staff's perception of the value of an EPR.
- **Lack of standardisation:** An EPR requires all users and teams to work in a standardised way; some areas may perceive they are outside of the remit of standard processes.

Management Case

Initiation & Mobilisation
Stage 1: Visioning and Mobilisation – Apr 24
Stage 2: Current State and Initiation – Jun 24

Phase 1 EPR Administration
Stage 3: Future State and Configuration – Aug 24
Stage 4: Validation (Testing, TTT, End User Training) – Nov 24
Stage 5: Go-Live Readiness – Jan 25
Stage 6: Go-Live – Feb 25

Phase 2 Trust-Wide Documentation
Stage 3: Future State and Configuration – Feb 25
Stage 4: Validation (Testing, TTT, End User Training) – Mar 25
Stage 6: Go-Live – Apr 25

Phase 3 EPMA / CLMM, OCRR, MUI
Stage 3: Future State and Configuration – Dec 25
Stage 4: Validation (Testing, TTT, End User Training) – Jan 26
Stage 6: Go-Live – Feb 26

The programme will be implemented across the four phases defined within the commercial case, over a two year period.
This provides a high level implementation plan. This was taken from the Supplier A tender response and subject to consultation and Trust approval.

Conclusion and Recommendations

The business case has identified that there are sufficient benefits and savings to be made for procuring an EPR and associated services for QVH. The recommendations to the Trust Board are to:

- Support the selection of **Option 3 - Supplier A Shared Instance** - as the most suitable and beneficial option to the Trust, to meet the scope of this Full Business Case;
- Complete contract negotiations and award the contract to Supplier A, in line with the mechanism and scope defined within this Full Business Case, and contract documents;
- Initiate an EPR implementation programme to commence Trust resourcing in March 2024.

Reduce requirement for Health Records to be pulled or scanned. Saving the cost of scanning that is currently outsourced.

Consolidation of IT systems, reducing user logons and application support costs.

Savings made on drug errors through the automation, protocol management, decision support, and availability of data.

Reduce reliance on paper processes, reducing errors, making data more readily available, reducing duplication and improving data quality.

Supports interoperability standards, aiding integrated services across the ICB and supporting business intelligence development.

Decision support tools providing advice and alerts to clinicians, supporting improved patient safety and increasing efficiencies.

Availability of data, ensuring patients are seen/treated with full record available. Enhancing patient experience, and improving outcomes.

Reduce time to complete a range of admin & clinical tasks. This will be done by automating some processes, and reducing duplicate data entry.

Reduce the admin burden of clinicians by ensuring that all information is accessed from the EPR. Ensuring they can spend more time with the patient.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/24	**Agenda reference:**	**163-24**		
Report title:	Strategic Objectives 2024/25				
Sponsor:	James Lowell, Chief Executive Officer				
Author:	Abigail Jago, Chief Strategy Officer				
Appendices:	Strategic Objectives 2024/25				
Executive summary					
Purpose of report:	To approve the proposed Strategic Objectives for 2024/25				
Summary of key issues	In line with our newly developed Integrated Assurance Framework (IAF), a proposed set of Strategic Objectives for the organisation have been developed for 2024/25 The IAF sets out proposed annual objectives, major projects, annual goals and watch metrics that will be delivered in 2024/25. The setting of an achievable number of measurable objectives has been adopted to ensure we have clear and realistic priorities for 2024/5 The Trust's Key Strategic Objectives will be revised following completion of the organisational strategy in Autumn 2024.				
Recommendation:	The Board is requested to review the strategic objectives document for 2024/25 and • **Approve** the allocation of objectives and major projects • **Approve** the approach for objective setting for 2024/25				
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:	Supports the Board Assurance Framework for all strategic risks				
Corporate risk register:	Supports the management of the Corporate Risk Register				
Regulation:	Supports the oversight and assurance of regulatory reporting to NHS England and CQC				
Legal:	None				
Resources:	To be assessed as part of the planning process				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:	To be presented to the Strategic Development Committee				

Report to:	Board of Directors
Agenda item:	Strategic Objectives 2024/25
Date of meeting:	13/02/2024
Report from:	James Lowell, Chief Executive Officer
Report author:	Abigail Jago, Chief Strategy Officer
Date of report:	28/02/2024
Appendices:	Strategic Objectives 2024/25

Introduction
In line with the newly developed Integrated Assurance Framework (IAF), a proposed set of Strategic Objectives for the organisation have been developed for 2024/25 (as per appendix 1).

This year's planning process has taken into account how we ensure that as an organisation we are not trying to deliver too many priorities in one year. To this end we propose a more targeted approach with the principle that we will focus on 5 key objectives and 5 major projects to achieve organisational wide alignment on delivery priorities over a 12 month period.

This methodology can be observed in many UK and international health organisations that have adopted comprehensive quality improvement (QI) methodologies and signals this structured approach as our direction of travel.

The strategic objectives we have proposed include the following:

Overarching key strategic objectives (KSO)	Rolled over for consistency from 2023/24 whilst we finalise the new strategy in 2024/25.
Annual objectives	Sets out the priority leading objective relating to the respective KSO
Major projects	Large complex change programmes that are integral to strategy delivery and require prioritisation and executive senior responsible officer leadership
Annual goals	Measures that have been identified to be actively worked upon to drive improvement and that will have the greatest impact on delivery of the trust priorities and strategy
Watch metrics	Measures that are linked to the delivery of the strategy but are not deemed to require additional active work over and above that in place as part of business as usual activities. These also include statutory and regulatory metrics for the organisation that we must continue to watch in year.

Strategic Objectives
The Key Strategic Objectives (KSO) headings have been maintained for 2024/25 in line with the current QVH 2020 strategy. Revised KSO will be developed in line with the new strategy planned launch in the autumn 2024. However, the definitions for the KSOs have been refreshed to align more closely with the current NHS landscape.

Annual Objectives
The annual objectives have been developed taking into account a number of sources including:

- **National expectations** – although the planning guidance for 2024/25 has not yet been published, an assumption has been made that the current key areas of focus will continue

including waiting time requirements. This assumption will be reviewed once the planning guidance has been released.

- **NHS Sussex ICB Shared Deliver Plan (SDP) priorities** – all executives have reviewed the current SDP and highlighted any areas that need to be taken into account and these have been included.
- **Executive Priorities** – all executives have provided their priorities and these are included
- **Quality Priorities** – following the organisational consideration of the quality priorities for next year, these have been agreed and included
- **Business Planning** – the plans developed by the directorates have been reviewed and any additional trust level projects have been considered and included

Major Projects

The major projects are those schemes highlighted as a priority by executives. Each scheme has a nominated executive lead and we have set the ambition to have no more than 5 major projects for the year. Priority projects for 24/25 are as follows:

- Implementation of the **Local Anaesthetic Unit**
- Implementation and further planning of the **Community Diagnostic Centre** programme
- Implementation of the Sussex **Pathology Network**
- Planning and implementation of year 1 of the **Electronic Patient Record** (EPR) programme
- Design and implementation of an organisation wide systematic **quality improvement** approach

In order to ensure capacity to deliver the proposed major projects the following areas of work have been de-prioritised as major projects to ensure capacity and capability within the organisation to deliver the results as required:

- **Roll out of ward accreditation**. It is proposed that this will be considered as part of year 2 of the future quality improvement roll out.
- **Theatre utilisation project**. It is proposed that for 24/25 this will be driven as part of business as usual leadership objectives rather than a transformation programme and will be managed as a watch metric.
- **Outpatient transformation project.** It is proposed that for 24/25 this will be driven as part of business as usual activities to deliver required productivity to meet activity plans rather than a broad remit cross trust transformation workstream and will be managed as a watch metric.
- **Antimicrobial stewardship project.** It is proposed that this is managed as a watch metric given work completed in year to date and the roll out of ePMA as part of the EPR system.
- **Patient co-design project.** It is proposed that this will be managed in line with the new patient involvement strategy and strategy development engagement work.

Annual Goals

- Whilst some annual goals have been identified, further work is underway to define the measurable goals and to agree a target for the year by the end of Q1 2024/25. The intent is to have no more than 5 trust wide annual goals and those agreed will be lead indicators in terms of improvement in key areas and or act as enabling building blocks which will allow delivery of future ambitions in subsequent years e.g. 95% ethnic coding is critical to our Health Inequalities work.

Watch Metrics

- Work is in progress to set out a suite of watch metrics that will be monitored during the year. These are currently being developed based on a review of the current metrics reported and to consider if any local or mandated external metrics are missing that should

be added. This work is due to conclude in March 2024 so that we can begin reporting for the new financial year.

Recommendations

The Board is requested to review the strategic objectives document for 2024/25 and

- APPROVE the allocation of objectives and major projects
- APPROVE the approach for objective setting for 2024/25

Strategic objectives for 24/25

Queen Victoria Hospital NHS Foundation Trust

	KSO 1 Outstanding Patient Care	KSO 2 World Class Clinical Services	KSO 3 Operational Excellence	KSO 4 Financial Sustainability	KSO 5 Organisational Excellence
Key strategic objective detail	› We will deliver safe and compassionate care for our patients	› We will deliver excellent clinical and patient outcomes	› We will deliver timely and efficient care for our patients.	› We will maximise the use of our resources to deliver best value and treat the maximum number of patients	› We will support an engaged and motivated workforce as a well led organisation and excellent partner
Annual objective	› To improve understanding of health inequalities (QP) (SDP) through ethnicity coding (SDP), smoking (SDP) and drinking status of patients *(Executive Lead: COO)* and enhance the experience of patients with additional needs (QP) (SDP) – *(Executive lead CNO)*	› To deliver a Patient Reported Outcome Measure (PROM) in every business unit so that we have consistent patient outcome information available for our clinical services.	› To deliver constitutional standards relating to access to care including cancer, diagnostics, referral to treat (RTT) and urgent care in line with national requirements. (SDP)	› To achieve financial sustainability for the organisation and break even position.	To implement the trust Integrated Assurance Framework (IAF) to support the provision of accountability and transparency in relation to the delivery of annual business plans, comprehensive governance, continuous improvement and delivery of strategic aims.
Major projects		› To implement and optimise an on site Local Anaesthetic Unit - *(Executive lead CNO)*	› To deliver the Community Diagnostics Centre programme – *(Executive lead CFO)* › To deliver Sussex Pathology Network Programme - *(Executive Lead CMO)* › To deliver year 1 of the Electronic Patient Record – *(Executive Lead COO)*		› Design and implementation of a systematic quality improvement approach across the organisation (QP) (SDP) - *(Executive Lead CSO)*
Annual goals	› 95% ethnic coding › Smoking status recording	› Patient Reported Outcome Measure (PROM)	› No patient waits > 65 weeks for first definitive treatment by September 2024	› Break even	
Watch metrics	› Inpatient survey › Antimicrobial stewardship audits › Falls › Oliver McGowan training compliance	› To be determined through PROM development	› Constitutional standards › Theatre/Outpatient productivity	› Capital CDEL › Cash › Better value	› EDI › Staff survey/pulse survey › Staff metrics › Mandatory training

QP = Quality Priorities / SDP – NHS Sussex ICB Shared Delivery Plan

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024		**Agenda reference:**	164-24	
Report title:	Board assurance framework (BAF) and Corporate risk register (CRR)				
Sponsor:	Leonora May, Company secretary Nicky Reeves, Chief nursing officer				
Author:	Leonora May, Company secretary Nicky Reeves, Chief nursing officer				
Appendices:	Appendix one: Board assurance framework summaries Appendix two: Board assurance framework Appendix three: Corporate risk register				
Executive summary					
Purpose of report:	To present the Board assurance framework (BAF) and Corporate risk register (CRR) to the Board				
Summary of key issues	- All BAFs reviewed in detail by the appropriate sub-committees during February 2024. Any assurance regarding committee assessments of the effectiveness of controls is included within the sub-committee assurance reports to the Board - The updates to the BAFs made between Q3 and Q4 are included within the BAF summaries at appendix one - An executive summary for each BAF is included within the report				
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)				
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:	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 sub-committees during February 2024				
Next steps:	NA				

Report to:	Board Directors
Agenda item:	164-24
Date of meeting:	7 March 2024
Report from:	Leonora May, Company secretary Nicky Reeves, Chief nursing officer
Report author:	Leonora May, Company secretary Nicky Reeves, Chief nursing officer
Date of report:	26 February 2024
Appendices:	Appendix one: Board assurance framework summaries Appendix two: Board assurance framework Appendix three: Corporate risk register

Board assurance framework (BAF) and Corporate risk register (CRR)

Board assurance framework (BAF)

The BAF is an important component of the Trust's risk management framework, functioning as the monitoring tool used by the Board to assess how effectively the Trust's strategic risks are being managed. A strategic risk is defined as a risk to the delivery of one or more of the key strategic objectives identified by the Board.

The role of the Board in relation to the BAF is to 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 and 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).

Since the Board's last review, the BAF documents have been reviewed and updated including overall assurance ratings and scores. The updates made from Q3 to Q4 are set out within the BAF summaries at appendix one. None of the risks have yet achieved their target score. All strategic risks were reviewed by the responsible sub-committee during February which provided scrutiny on the content of the allocated risks in order to provide assurance to the Board on the effectiveness of existing controls and further actions being taken to address gaps identified. Assurance regarding committee assessments of the effectiveness of controls is included within the sub-committee assurance reports to the Board.

Executive summary BAF 1

The controls have been reviewed to ensure that they are strategic and high level. There are now seven key controls for this strategic risk. Key actions completed to manage the strategic risk include:

- A review of the process for updating out of date policies
- A review of gaps in CQC actions from previous inspections and actions taken to address them
- PSIRF methodology being rolled out
- Regular reporting to the committee in learning from serious incidents

The completion of these actions has resulted in four identified gaps in control reducing.

The current risk score remains at 15, with further action to be taken to manage the risk before it can be reduced. The consequence of the risk materialising remains a five (severe). The overall assurance RAG rating is amber for Q4 which demonstrates

medium confidence indicating that there is further action to be taken to ensure that the controls are effective.

Executive summary BAF 2
Key actions completed to manage the strategic risk include the recruitment of a resourcing business partner and the establishment of kay staff networks to support workplace belonging.

The current risk score remains at 12 with further action to be taken to manage the risk required as set out within the BAF document. The overall assurance RAG rating remains as amber for Q4 which demonstrates medium confidence indicating that there are some issues that need to be monitored and addressed.

Executive summary BAF3
Key actions completed to manage the strategic risk include the recruitment of a substantive Director of estates and facilities. The gaps in controls have increased from 13 to 15 with external authorising engineers being appointed and attending safety groups identified as key gaps in control.

The current risk score remains at 15 with further action taken to manage the risk required as set out within the BAF document. The overall assurance RAG rating remains as amber for Q4 which demonstrates medium confidence indicating that there are some issues that need to be monitored and addressed.

Executive summary BAF 4
The controls have been reviewed to ensure that they are strategic and high level. There are now five key controls for this strategic risk. Key actions completed to manage the strategic risk include the strategy framework and milestone plan being in place and monitored, and the decision making framework being agreed by the Board. The completion of these actions has resulted in two identified gaps in control and assurance reducing and the current risk score reducing from 15 to 12. The overall assurance RAG rating is green for Q4 which demonstrates high confidence indicating that there are no serious issues and the controls are currently effective.

Executive summary BAF5
The controls for this risk have been reviewed to ensure that they are strategic and high level. There are now five key controls for this risk. The gaps in controls have also reduced from 16 to 6. Key actions completed to reduce the gaps in controls include staff awareness ahead of CQC inspection, review of FTSU framework, increased visibility of Board members and the scheduling of review against licence conditions and Code of governance by the audit and risk committee as well as a gap analysis completed against the CQC well-led key lines of inquiry.

The majority of assurances have been rated as green and the overall assurance RAG rating for Q4 is green demonstrating high confidence indicating that there are no serious issues. The current risk score has been reduced from 15 to 12.

Executive summary BAF6
Key actions are on track for completion by the dates set out within the BAF document. The gaps in assurance have increased from five to eight with key gaps added including triangulation and validation of the business plan for 2024/25 and the budget holder training pack requiring further work. These gaps are addressed by the action plan.

The current risk score remains at 12 with further action taken to manage the risk required as set out within the BAF document. The overall assurance RAG rating remains as amber for Q4 which demonstrates medium confidence indicating that there are some issues that need to be monitored and addressed.

Executive summary BAF7
Key actions completed to manage the strategic risk include the development of the digital strategy and the scheduling of cyber security training for the Board.

The majority of assurances have been rated as green and the overall assurance RAG rating for Q4 is green demonstrating high confidence indicating that there are no serious issues. The current risk score remains at 12 with further action taken to manage the risk required as set out within the BAF document.

Executive summary BAF 8
Key actions completed to manage the strategic risk include the development of a Trust engagement plan, well led recommendations related to external partner relationships actioned and the independent review of strategy stakeholder feedback being complete and providing a high level of assurance that engagement has been effective. The completion of these actions has resulted in two identified gaps in control and assurance reducing and the current risk score reducing from 15 to 12. The overall assurance RAG rating is green for Q4 which demonstrates high confidence indicating that there are no serious issues and the controls are currently effective.

Corporate risk register
The content and format of the CRR has been 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.

Corporate risks must score 15 and over to be incorporated and these risks inform the BAF scores and rationale. Three risks are currently scoring 16 with the remaining seven scoring 15.

There are currently 10 corporate risks on the register, all have been reviewed and updated by the executive leads and reviewed at the relevant sub-committee meetings during February 2024. The full CRR has been included as appendix three to this report.

Recommendation
The Board is asked to:

- 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)
- **Note** the revised Corporate risk register

APPENDIX 1 – BAF 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 April 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 Nursing officer	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	12	6	Sep 24	SD	**GREEN**
05	**Compliance breach (non-clinical)**	Chief Executive	20	12	8	Mar 24	F&P	**GREEN**
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	**GREEN**
08	**Partner organisations**	Chief Executive	25	12	6	Jul 24	SD	**GREEN**

[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

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**	**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**	**7**
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**	**10**
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	**20** L1 (8)- 4G,3A,1R L2 (9)- 2G,6A L3 (3)-2G,1A
Committee: Quality and Safety Committee	**Gaps in assurance**	N/A	N/A	**9**	**9**
Principal Exec: Chief Nurse	**Current Risk Score**	N/A	N/A	**15**	**15**
Date added: September 2023	**Target Risk Score and Date**	N/A	N/A	**10** (Dec 24)	**10** (Dec 24)
Date last discussed: 23 November 2024 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	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**	**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**	**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**	**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	**21** L1 (8)- 4G, 4A L2 (12)- 5G, 7A L3 (1)- 1G
Committee: Finance and Performance Committee	**Gaps in assurance**	N/A	N/A	**10**	**10**
Principal Exec: Chief People Officer	**Current Risk Score**	N/A	N/A	**12**	**12**
Date added: September 2023	**Target Risk Score and Date**	N/A	N/A	**9** (Mar 25)	**9** **(Mar 25)**
Date last discussed: 23 November 2023 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	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**	**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**	**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**	**15**
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	**14** L1 (3)- 1G, 2R L2 (6)- 2G, 4A L3 (4)- 3A
Committee: Finance and performance committee	**Gaps in assurance**	N/A	N/A	**9**	**9**
Principal Exec: Chief finance officer	**Current Risk Score**	N/A	N/A	**15**	**15**
Date added: 12 October 2023	**Target Risk Score and Date**	N/A	N/A	**10** (Jun 24)	**10** (Jun 24)
Date last discussed: 24 October 2023 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	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**	**GREEN**
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**	**5**
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**	**1**
Strategic Aim: KSO 1-5	**Assurances and RAG rating**	N/A	N/A	**8** L1 (0) L2 (6) - 6G L3 (2) - 2G	**8** L1 (0) L2 (6) - 6G L3 (2) - 2G
Committee: Strategic Development Committee	**Gaps in assurance**	N/A	N/A	**1**	**0**
Principal Exec: Chief Executive Officer	**Current Risk Score**	N/A	N/A	**15**	**12**
Date added: September 2023	**Target Risk Score and Date**	N/A	N/A	**10** (Sep 24)	**6** (Sept 24)
Date last discussed: 13 February 2024 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	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**	**GREEN**
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**	**5**
Consequences: potential harm to people, regulatory intervention, criminal prosecution, financial losses and reputational damage	**Gaps in Controls**	N/A	N/A	**16**	**6**
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	**10** L1 (0) L2 (8)- 5G, 3A L3 (2)- 2G
Committee: Finance and Performance Committee	**Gaps in assurance**	N/A	N/A	**9**	**9**
Principal Exec: Chief Executive Officer	**Current Risk Score**	N/A	N/A	**15**	**12**
Date added: September 2023	**Target Risk Score Target Risk Score and Date**	N/A	N/A	**10** (Mar 24)	**8** (Mar 24)
Date last discussed: 23 November 2023 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	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**	**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**	**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**	**10**
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	**13** L1 (2)- 2A L2 (8)- 2G, 6A L3 (5)- 2G, 3A
Committee: Finance and Performance committee	**Gaps in assurance**	N/A	N/A	**5**	**8**
Principal Exec: Chief Finance Officer	**Current Risk Score**	N/A	N/A	**12**	**12**
Date added: September 2023	**Target Risk Score and Date**	N/A	N/A	**9** (Mar 29)	**9** (Mar 29)
Date last discussed: 23 November 2023 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	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**	**GREEN**
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**	**11**
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**	**7**
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	**14** L1 (1)- 1G L2 (10)- 9G, 1A L3 (3)- 2G, 1A
Committee: Finance and Performance Committee	**Gaps in assurance**	N/A	N/A	**4**	**4**
Principal Exec: Chief Strategy Officer	**Current Risk Score**	N/A	N/A	**12**	**12**
Date added: September 2023	**Target Risk Score**	N/A	N/A	**8** (Target date = Jul 24)	**8** (Target date = Jul 24)
Date last discussed: 13 November (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	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**	**GREEN**
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**	**4**
Consequences: failure to achieve system and Trust objectives, negative impact on patient outcomes and experience	**Gaps in Controls**	N/A	N/A	**5**	**3**
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	**12** L1 (3) - 3G L2 (7) -6G,1A L3 (2) – 1G,1A
Committee: Strategic Development Committee	**Gaps in assurance**	N/A	N/A	**2**	**0**
Principal Exec: Chief Executive Officer	**Current Risk Score**	N/A	N/A	**15**	**12**
Date added: September 2023	**Target Risk Score**	N/A	N/A	**10** (Target date = Jul 24)	**6** (Target date = Jul 24)
Date last discussed: 13 February 2024 (ELT)	**Risk appetite and max tolerance**	N/A	N/A	TBC	**TBC**

Appendix two

Strategic Aim: KSOs 1, 2 and 3	**Overall Assurance Rating (RAG)**	**Q1**	**Q2**	**Q3**	**Q4**
		N/A	N/A	**AMBER**	**AMBER**
Risk Ref & Description: <u>01 – There is a risk that the Trust fails to deliver safe, effective, caring, responsive and well-led 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 2023	
Principal Exec	Chief Nursing Officer	Date Reviewed:		9 February 2024	
Supporting Exec(s)	Chief Medical Officer Director of Operations	Last discussed:		13 February 2024 (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 horizon scanning for changes to legislation and care standards and 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) Process for staff checking for new policies and procedures and keeping up to date (refer action 3 and longer term actions) Introduction to policy locations at local induction (refer to action 3 and longer term actions Review of which networks we should be aligned with externally (refer to action 11) Not meeting all national standards (refer action 13)	<u>1st line:</u> Governance meetings for all services which do not meet national standards. Minutes available at Clinical Governance Group (January 2024, Amber) <u>2nd line:</u> Mandatory Training reports generated by Learning and Development Centre and shared to department heads (February 2024, Amber) Out of date policy reports are presented to the Q&S Committee (October 2023, Amber) Minutes of meetings seen in Q&S committee for Nursing Quality Forum (January 2024, Green) Out of date policy report seen at Q&S, F&P and Audit and Risk 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) Confirmation is required as to route of assurance for information shared via Hospital Management Team Meeting (refer action 4)	
2. Documented agreement of compliance responsibilities with service providers such as independent sector,	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 ICS to review, incidents and risks (February 2024, Green)		None	

Sterile services suppliers and Service level agreement provider		Use of Datix reporting to review issues(February 2024, Green) Medical Devices Group meeting reviews new kit (January 2024, Amber) Approval Process of change of practice via Clinical Governance Group well embedded (October 2023 Green)	
3. 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 (February 2024, 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)
4. CQC preparation utilising benchmarking and self assessment allows us to understand potential gaps and areas for development	None	1st Line: CQC preparation self-assessment has been completed and is being reviewed to identify gaps (February 2024, Amber) 1st line 5 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 and Board seminar. (January 2024, Green)	None
5. Learning from incidents and SIs. Patient Safety and Incident Response Framework (PSIRF) policy and plan in place	None	2nd Line: Q&S and CGG review serious incidents and Formal internal investigations as required (last tabled February 2024, Green) 3rd Line Minutes of ICB quality review meetings and SI panels – action plans monitored via Q&S (December 2023, Green) Internal Audit review risk management on an annual basis (January 2023, Amber)	None
6. 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)

7. 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 (January 2024, Amber) ARC receives regular FTSU reporting (December 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) Assurance from external FTSU provider

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	April 2024	Chief Nurse	On track
2. ELT review of MAST data	May 2024	CPO	Not yet started
3. Develop policy lists for local inductions, add process for socialisation of new policies to the Policy for policies and explore digital solution for easy access	April 2024	CPO and Head of Risk	Not yet started
4. Identify governance routes for HMT and CD Meetings	April 2024	CMO and CS	Review of Trust corporate governance in line with well led review
5. To reinvigorate process for reviewing out of date policies	February 2024	Head of Risk	Complete
6. To review gaps in CQC actions from previous inspection and take action to address	December 2023	Chief Nurse	Complete. Action plans being managed via ELT
7. Roll out of PSIRF methodology	January 2024	Head of Risk	Complete
8. To develop action plan addressing learning from self-assessment	January 2024	Chief Nurse	Complete. Board presentation and information pack created for Board members
9. Clinical audit learnings to be robustly rolled out via clinical governance group with assurance reporting to ARC	May 2024	CMO	On track
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	On track
12. Regular reporting on learning from serious incidents to the quality and safety committee established	April 2024	CNO CMO	Complete. CMO to take learning to QSC
13. Review national standards and gap analysis (linked to Corporate risk register number 3)	April 2024	CMO, CDs	On track
14. Review QNet search function and consider renaming some of the frequent accessed policies	April 2024	Comms manager	Not yet started
15. Assessment of all Clinical SLAs to identify areas of concern	February 2024	CFO and CMO	Not yet started

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	Assurance Rating (RAG)	Q1	Q2	Q3	Q4
		n/a	n/a	Amber	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:	December 2023
Principal Exec	Chief People Officer	Date Reviewed:	19 February 2024
Supporting Exec(s)	NA	Last discussed:	ELT 20 February 2024
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). Legacy **Trust values** require review supported by a **behavioural framework** to enable culture and OD work (Refer to action 9).	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 (Monthly, Amber). Monthly service meetings / Local Faculty Group meetings with medical trainees (Monthly, Amber). 2nd Line: Bi-monthly exception reporting to F&P and Board on Trust performance (Dec 23, Amber). Monitoring and review of workforce strategy through Strategy Development Group (SDG) (Jan 24, 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

	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 (Jan 24, 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 (Jan 24, Green). Monthly reporting on VPR to ICB (Jan 24, 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 (Feb 24, Green). 2nd Line: Bi-monthly reporting in workforce performance report to F&P and Board (Dec 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	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 (Feb 24, Green). 2nd line: Bi-monthly exception reporting in workforce performance report to Education and Development Group, F&P and Board (Jan 24, 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.

non-mandatory training / CPD funding, **work 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. (Jan 24 / Amber). 2nd Line: Bi-monthly exception reporting to F&P and Board on Trust performance (Dec 23 / Amber). Monitoring and review of workforce strategy through Strategy Development Group (SDG) (Dec 24 / Amber).Bimonthly summary and exception reporting at ICB sub groups and People Deliver Board (Jan 224 / 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 - Tender	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	

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

Risk Ref & Description: **<u>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</u>**
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:	16 February 2024
Supporting Exec(s)	Chief strategy officer	Last discussed:	20 February 2024(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)	Produce a detailed 5 year backlog maintenance plan informed by the six facet survey (refer to action 2) plus any urgent estates issues arising Review survey results on an annual basis and adjust backlog maintenance plan as needed (refer to action 11)	<u>1st line:</u> Action plan progress tracked within estates team on a monthly basis (Green) <u>2nd line:</u> 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) <u>3rd line:</u> 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. External Authorising Engineers, (AEs), for medical gasses, water, fire, lifts ,ventilation and electrical to independently test controls, and provide	AE's must be appointed in writing and perform an annual audit of the site with recommendations for improvement.	<u>2nd line:</u> AEs attend and contribute to QVH safety groups meetings which are minuted. Contributions include the provision of interim and annual reports; the latter provides assurance on the controls in place.	Estates team to create a spreadsheet to show service, name of AE, contract period and reporting arrangements (refer to action 6)

support in the event of deterioration of the essential services (e.g. advice on remediation) Findings from third party reviews are sighted by estates team in order to raise / update the departmental risk register	AE's would attend their relevant Safety Group meetings as set out in the HTM's. QVH do not yet have all the necessary safety groups set up.	Assurance rating determined as Amber based on the 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) Fully integrated CAFM system needed for estates and facilities which would incorporate SFG20 to schedule PPM's based on updated asset register (refer to longer term actions)	1st line: Reporting progress on PPM to F&P quarterly (Feb 24, Red)	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 by September showing the current status of the 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	1st line: Summarised PAM results to be routinely reviewed and 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 (Amber)	
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)	2nd line: The monthly estates and facilities steering group (attended by risk function) have oversight of the estates risk register. Meetings are minuted (Amber)	

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. To produce a central Asset list for all essential plant	30 May 2024	Interim associate director of estates and facilities (IADEF)	In progress – completion in Q1 2024/25
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	30 May 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	29 February 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	30 April 2024	IADEF	In progress – completion April 2024
7. Estates to provide a summary report to F&P to highlight any exceptions arising from the AE annual reports	31 March 2024	IADEF	In progress – completion in March 2024
8. Estates structure, including roles and responsibilities, require review and updating	30 April 2024	IADEF	In progress – completion in Q1 24/25
9. Commence summarised reporting of PAM results to F&P	30 April 2024	IADEF	In progress – completion in January 2024
10. Review and update estates risk register	31 March 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	30 May 2024	IADEF	In progress – completion in Q1 24/25
13. Recruitment of a substantive Associate Director of Estates and Facilities	Completed	Chief Finance Officer	Completed

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

- Development of the Estates Strategy - Started February 2024, dependant on the clinical strategy Target completion August 2024
- Rebuild the Hospital Site – New hospital Programme – Timeline to be confirmed
- Purchase and launch new CAFM system with SFG20 software to support planned preventative maintenance – May 2024
- Estates team to consider assurance mechanisms once asset register and updated PPM are in place – May 2024
- Establish robust contract management processes and improve compliance with procurement regulations – May 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 – May 2024
- Reporting on the status of BCP reviews / tests to the monthly estates and facilities steering group and Emergency Planning Lead – May 2024
- Estates team to create schedule for quarterly service review meetings in 2024, with all suppliers to have had initial meeting by May 2024
- Internal review of effectiveness of standard operating procedures – May 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	GREEN
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:		8 February 2023	
Supporting Exec(s)	Chief Strategy Officer	Last discussed:		ELT 13 February 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)	2 (unlikely)		6 (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 (commenced Nov 23 ongoing, Green) Update provided to Board seminar (Feb 24, Green) <u>3rd line:</u> High level options board paper share with ICB who reported being supportive of the approach (Jan 24, 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 monthly basis as part of SDC paper review (Feb 24, Green) Framework and milestone update provided to Board seminar (Feb 24, Green) Milestone update to be provided at SDC meetings by CSO with subsequent written committee assurance report provided by SDC Chair to the Board (Feb 24 Green)		None	
3. Clear and robust internal governance arrangements for decision making aligned to strategy objectives have been	None	<u>2nd line:</u>		None	

agreed by Chief Executive Officer / Board Chair and documented. This includes the initiation of the Strategic Development Committee (SDC) to oversee strategic development / implementation and provide assurance and advice to the Board		Annual committee review process provides assurance to the Board that the SDC is delivering in line with its terms of reference (Green). 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. In progress	CSO	On track

Longer term actions (with indicative timeframe e.g. Q1 2024/25)
1. Review of strategic options – January 2024 - March 2024 Board – January Board paper complete and March planned 2. Phase 3 engagement plans – January – March 2024 – Plan complete and will be reviewed at February SDC

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	GREEN

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:	17 February 2024
Supporting Exec(s)	Chief Finance Officer Company Secretary	Last discussed:	ELT 20 February 2024
Risk Assessment	**Consequence**	**Likelihood**	**Score**
Inherent Risk Rating	5 (Severe)	4 (Likely)	20
Current Risk Rating	4 (Major)	3 (Possible)	12
Target Risk Rating	4 (Major)	2 (Unlikely)	8 (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, Standing orders, Standing financial instructions, Scheme of delegation, Terms of reference and policies (non-clinical)	Code of conduct for Governors needs updating (refer to action 8) Training for budget holders regarding standing financial instructions and scheme of delegation (Refer to action 2) Absence of introduction to policy locations at local induction and of core mandatory policies list (e.g. policies for line managers, information governance, business standards) and lack of adequate training on policy creation / maintenance ("policy for policies") (refer to action 3) New fit and proper person record for Board members and self-attestation forms completed (refer to action 5)	<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, shows some non-compliance) (December 2023, Amber) Policy log and review process reported to ARC annually shows some policies are out of date (December 2023, Amber) with Board assurance via the committee assurance report Annual report to Audit & Risk Committee (ARC) on compliance with business standards policy shows all declarations for 2023/24 are complete (December 23, Green) <u>3rd Line:</u> External audit of compliance with SFIs etc annually which is included in the annual report shows no material concerns (June 2023, Green)	Review of licence conditions and code of governance compliance by ARC (scheduled for March 2024) Review of compliance with fit and proper persons policy by ARC (scheduled for March 2024) Standalone review of annual governance statement by ARC (scheduled for March 2024 Review of outcome of counter fraud local proactive exercise review of declarations of interest (before end of March 2024)
2. Processes in place including: - staff induction (corporate and local non-clinical) with mandatory and statutory training (MAST) - horizon scanning for changes to legislation and communication of changes in statutory and regulatory requirements		<u>2nd line:</u> Internal reporting of MAST training compliance to executive leadership team, general managers, heads of departments and line managers once per month shows 90% compliance (February 2024, 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 4)

- review of compliance against Constitutional documents and statutory and regulatory requirements - Compliance incident framework in place enabling the appropriate investigation, resolution and reporting of incidents tracked through Datix (non-clinical)		Report to ARC and Board- Review of Annual governance statement annually demonstrates a sounds system of internal control (June 2023, Green) Self-certification of compliance with Trust licence conditions reported to the Board shows compliance (May 2023, Green)	Assurance that workforce compliance checks and local inductions have been completed and are effective (refer to action 3)
3. CQC preparation action plan for the well-led domain	Continuous improvement framework (refer action 7)	2nd line: Gap analysis against CQC well led KLOE's completed and reported to ELT shows work completed to address actions from previous inspections. QI framework being procured (January 2024, Green)	Reporting on effectiveness of actions completed to address recommendations from the well-led review (refer action 5) Reporting of effectiveness of continuous improvement framework (refer action 7)
4. 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 shows no material concerns (February 2024, Green)	
5. Freedom to Speak Up framework in place	External freedom to speak up guardian in place (planned for Q1 2024/25)	2nd line: Board receive quarterly freedom to speak up reports including updates on numbers of "speak ups", whistleblowing and "Tell Nicky" demonstrate requirement for external freedom to speak up guardian (Board January 2024, Amber)	Reporting on effectiveness of freedom to speak up function once external freedom to speak up guardian in place

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Delivery and reporting of Trust-wide programme of increased visibility of exec and non-exec colleagues	February 2024	CNO and CS	On track
2. 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	March 2024	CFO and CS	On track
3. 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	March 2024	CPO and HoR	On track
4. Development of integrated assurance framework	April 2024	CSO	On track
5. Fit and proper person information for each Board member collated and available on ESR, as well as new self-attestation forms completed	March 2024	CS	On track
6. Reporting on effectiveness of actions completed to address recommendations from the well led review	May 2024	CS	On track
7. Implement continuous improvement framework	May 2024		
8. Code of conduct for governors to be updated	May 2024		

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

None

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	AMBER

Risk Ref & Description: 06 – There is a risk that the Trust is unable to deliver medium to long term financial sustainability
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:	February 2024
Supporting Exec(s)	Chief Executive Officer	Last discussed:	ELT 20 February 2024
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.	2nd line: Progress updates and outputs are reported through the internal governance framework including steering group, ELT, F&P, Board (Green) through Nov to Mar 3rd line: 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. + Triangulation and validation of the Business plan for 2024/25. (refer to action 9)
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).	3rd line: 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)	1st and 2nd line: Monthly directorate performance review meetings provide assurance that budget holder meetings have occurred, and the financial position is understood (Amber)	Budget Holder Training pack was left by previous employee for implementation, this needs further work. A roll out plan will be in place before end of March 2024.
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)	1st and 2nd line: Reporting to ELT & F&P committees (Amber)	Budget Holder Training pack was left by previous employee for implementation, this needs further work. A roll out plan will be in place before end of March 2024.

5. ICB review of monthly provider finance report provides external scrutiny and CFO peer challenge on financial risks at a system level which enables the Trust to put in place appropriate mitigations	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.	3rd line: System governance in place to evidence review of provider reports 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
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. Budget Holder Training pack was left by previous employee for implementation, this needs further work. A roll out plan will be in place before end of March 2024.
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 (Amber)	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)	2nd line: Internal audit report on contract management. Only partial assurance (Amber)	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 roll out to start Q4 23/24
2. Rollout of formal Budget holder training	March 2024	Chief Finance officer	On track for roll out to start Q4 23/24
3. Financial governance training for budget holders	March 2024	Chief Finance Officer	On track for roll out to start 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 8. Work with the system to develop provider collaboratives to drive productivity and efficiency 9. Triangulation and validation of assumptions in financial plan by external body	March 2024 March 2025 March 2025	Chief Finance Officer ELT Chief Finance Officer	On Track for completion Q4 23/24 On Track for completion Q4 23/24 On Track for completion Q4 23/24
Longer term actions (with indicative timeframe e.g. Q1 2024)			
- Introduce new financial reports that allow strategic oversight and operational performance to be measured (Q1 2024) - Introduce focused Programme Delivery for all efficiencies identified through business planning (Q1 2024) - Identify opportunities for income growth as part of system collaboration (Q1 2024)			
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	GREEN

Risk Ref & Description: **<u>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</u>**
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:	8 February 2024
Supporting Exec(s)	Director of operations	Last discussed:	13 February (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)	<u>2nd line:</u> 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)	<u>2nd line:</u> Monthly reporting of compliance internally produced by L&D team and issued to service mangers for following up non-compliance shows 90% compliance (Green) 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) <u>3rd line:</u>	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 and Board Seminar (Feb 2024, Green)	Draft strategy to be approved at ELT and SDC prior to Board sign off (refer to action 4)
11. Development of 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 – comms out about phishing emails / updates via connect, MFA comms about new security policy – ongoing comms
3. Include a SIEM tool into business planning for 24/25	January - March 2024	Head of IT	In progress in terms of business planning process submissions
4. Development of digital strategy with Board support	December2023	CIO / CSO	Complete. Board seminar review of strategy. Further iterations required based on clinical services strategy and incoming CDIO
5. Reconciliation of all digital programmes and reporting to digital steering committee	April 2024	CIO/CSO/ICS	In progress as part of wider governance review in April 2024.
6. Board development dates for cyber security training	February 2024	CSO / CIO	Complete – date confirmed Feb 24
7. Management of programmes and project governance to be considered within trust wide governance review	April 2024	CSO / DCS	In progress

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

- Project resource assessment and planning exercise – Quarter 1 2024. Interim PMO lead recruitment in progress.
- 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 – in progress as part of wider governance review. 2024
- Data migration, data quality strategy to be drafted under the EPR programme strategy (Q1 24/25 FY)

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

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

Risk Ref & Description: **<u>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</u>**
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 February 2023
Supporting Exec(s)	Chief Strategy Officer	Last discussed:	13 February 2024 (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	3 (Moderate)	2 (Unlikely)	6 (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	<u>1st line:</u> Engagement tracker in place to report progress against plan; this is reviewed weekly by the strategy team (Green) <u>2nd line:</u> The first phase engagement plan was presented to the Strategic Development Committee (SDC) on July 2023 (Green). Second phase engagement plan complete and planned for review at ELT and SDC February 2024. Verbal engagement updates to continue to be 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. Revised engagement plan to be shared with governor SDC working group February 2024 (Green) <u>3rd line:</u> Independent review of stakeholder feedback gathered as part of the engagement plan received in January 2024. Report provides positive assurance regarding engagement activities undertaken (Green)	None identified

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, 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)	Lack of QVH partnership plan and strategy; this will be developed as an enabling strategy within the overall Trust strategy development programme 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) 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)	None identified
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 4) 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. Update communications and engagement plan to be shared and discussed at February 2024 SDC (September 23, Green) Engagement update reported to Governors (quarterly), JLNC (quarterly), HMT (monthly), Governor working group (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	None identified	2nd line: Action plan reported bi-monthly to ELT (Green) Assurance reporting regarding external partner engagement and relationships presented to SDC on ongoing basis as part of strategy updates (Green)	None identified

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 / Comms Manager	Complete
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	CMO / CSO / NED leadership roles for provider collaboratives
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		

Appendix three

ID	Opened	Title	Description	Risk Cause	Controls in place	Executive Lead	Handler	Risk Type	Rating (initial)	Rating (current)	Rating (Target)	Progress/Updates	KSO
1351	11/02/2024	Financial sustainability	There is a risk that if the Trust fails to develop a sustainable strategic plan, aligned financial plan, deliver planned patient activity targets, secure associated income from commissioners, deliver agreed levels of efficiency improvement, and maintain effective control of costs, there will be an adverse impact on the longer term financial sustainability of the Trust. Causes include: 1. Failure to secure investment from Sussex ICB and other Commissioners 2. Failure to manage and deliver efficiency and cost improvement plans in the longer term. 3. Failure to manage and mitigate the impact of Funding convergence and other Allocation adjustments over the longer term 4. Failure to manage inflationary cost pressures and mitigate them 5. Failure to allocate and/or attract significant revenue and additional capital will inhibit the Trust's ability to adhere to statutory compliance, as well as the ability to rectify the identified backlog maintenance. 6. Failure to develop and deliver a		1. The development of robust and credible financial plans based on agreed National and Local planning guidance 2. Internal financial control and management procedures which support the delivery of services within available funding and resources 3. Adherence to Trust Standing Orders and Standing Financial Instructions• Regular Financial and Performance reports to relevant Committees and Board 4. A rolling Internal Audit programme 5. External Audit of Accounts and Reports 6. Care Quality Commission (CQC) assessments 7. A range of external reports to NHSE	Wheeler, Maria	Tallett, Ellie	Finance	20	16	9	No change this time to the financial risk score. The Financial position is likely to achieve breakeven with Contracts agreed and most areas of financial known and provided against.	KSO4: Financial Sustainability
1348	11/02/2024	Major incident	There is a risk of inadequate handling of a major incident at site requiring enaction of the business continuity / crisis management plans (e.g. cyber incident, fire, infection outbreak, failure of critical third party supplier)		1. Up to date emergency plan 2. Programme of exercising and testing for emergency plan 3. Annual peer review of emergency plan 4. Internal audit review of emergency plan	Reeves, Nicola	Blackburn, Liz	Regulatory and Compliance	20	15	10	December 2023 - formal feedback not yet received. January 2024 - still awaiting formal notification from assurance visit February 2024 - Formal notification following assurance visit, As discussed at the final meeting in October 2023 QVH have been assessed as substantially compliant against the NHSE EPRR Core Standards.	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services, KSO3: Operational Excellence, KSO4: Financial Sustainability, KSO5: Organisational Excellence
1352	11/02/2024	Mental capacity act	There is a risk that that patients are not being assessed as per Mental Capacity act caused by variability in the assessment of patients capacity, resulting in patients being treated without appropriate capacity assessments.		1. Awareness raised in meetings 2. Bespoke training for schedulers and secretaries 3. Barrister workshop annually two hour specialist MCA training 4. Training for consultants 5. Adult mental capacity lead in place	Reeves, Nicola	Blackburn, Liz	Regulatory and Compliance	20	16	8	January 2024 - Medical MCA training in December cancelled due to lack of uptake. MCA Audit ongoing February 2024 - MCA audit in progress	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services
1345	11/02/2024	National clinical standards	There is a risk that the Trust does not meet national clinical standards for the services that it provides due to resource constraints, resulting in patient harm or a negative impact on patient outcomes/ experiences		1. Existing functional SLA for paediatrics and part time physician 2. Clinical services review 3. Use of Early Warning Sytems such as PEWS and NEWS2 to identify deterirating pateint. 4. Outreach in place	Cubison, Tania	Cubison, Tania	Regulatory and Compliance	20	15	10	Jan 24. Gap analysis refreshed, discussions re new appointments in ITU/medicine underway. T and F group planned for ITU cons cover. December 2023 - NEWS2 in place, QVH PEWS in place in paediatrics to be rationalised with national guidance	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services
1292	22/11/2022	Overarching Corporate Risk - Securing a sustainable future for QVH	There is a risk of not being able to secure a sustainable future for QVH resulting in potential impact on existing services and future of the hospital.	Risk exists due to multiple causes including the absence of an agreed strategic plan, challenges re: resilience and capability of some required trust services, estate condition, workforce challenges and financial considerations.	Controls in place include the appointment of a Director of Strategy & Partnerships with the primary remit to develop and deliver the strategic plan. Clinical Services stock take being carried out to inform clinical strategy	Jago, Abigail	Brasier, Kathy	Regulatory and Compliance	15	15	10	September 28th - Phase 1 complete Phase 2 - Co-design workshops x2 have taken place - QVH staff and Local population. Data collection underway. 2 further sessions planned in the next two weeks Resourcing - Project Support Officer commence din post WC 25.09.2023 with PM due to start 02.10.2023 Engagement continues with internal and external stakeholders, tracker maintained and themes collated. Stakeholder Engagement Group first meeting has taken place. Low level of attendance due to a variety of issues, minutes to be shared and individuals touched base with to ensure aware of process and are in agreement. Financial baseline including service line reporting in train with benchmarking data aligned. Initial scenario setting options will be formulated following final workshops, linking in with the clinical baseline and SWOT analysis. Review of reset of trust vision and values to be mapped through, work underway to address options available.	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services, KSO3: Operational Excellence, KSO4: Financial Sustainability, undefined
1353	11/02/2024	Partnership and commissioner risk	There is a risk that changes to wider NHS provider partner and commissioner arrangements may impact the future organisational resilience for QVH		1. Engagement plan for strategy development in place to ensure effective external engagement 2. Executive level connections to system and commissioner forums and leaders	Jago, Abigail	Jago, Abigail	Regulatory and Compliance	25	15	10	1. Phase 1 and 2 engagement complete including partnership discussions. 2. Targeted discussions taking place at CEO and Chair level with key provider partners and ICBs 3. QVH is co-leading the acute provider collaborative in Sussex and CEO and Chair members of the committee in common 4. CMO / CSO allocated to support / provide leadership to provider collaborative programm	
1342	05/02/2024	Patient transfers (1)	There is a risk of the Trust accepting patients with a higher level of complex care required than is available on the site due to poor decision making and/ or miscommunication, resulting in the need to transfer the patient to an alternative site which could have a negative impact on patient safety, health outcomes and experiences		1. Monitoring of patient transfer records to identify any potential negative impacts on outcomes and experience in order to identify lessons learnt 2. Guidance and standard operating procedures for accepting patients	Reeves, Nicola	Blackburn, Liz	Patient Safety, Outcomes and Experience	20	15	10	- December 2023 - MDT working February 2024 - PSIRF plan and policy with ICB for ratification	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services

1344	11/02/2024	Patient transfers (2)	There is a risk that a patient already accepted by the Trust for treatment requires a level of complex care that is not available on the site due to a deterioration in condition, resulting in the need to transfer the patient to an alternative site which could have a negative impact on patient safety, health outcomes and experiences		1. Existing functional SLA for paediatrics and part time physician. 2. Use of Early Warning systems such as PEWS and NEWS2 3. Relevant staff have undergone Advanced Life Support traingina dn Emergency Paediatric Lifesupport and specific SIM triangin for airmay management and deterioration	Reeves, Nicola	Blackburn, Liz	Patient Safety, Outcomes and Experience	20	15	10	December 2023 - NEWS2 in place, QVH PEWS in place in paediatrics to be rationalised with national guidance. January 2024 - PEW guidance still be reviewed February 2024 - Still being reviewed, needs to be entered in to existing EObs software, with the supplier	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services
1350	11/02/2024	Speaking up	There is a risk that the Trust's speak up framework is inadequate to ensure that concerns are raised and dealt with appropriately, resulting in the potential for risks to materialise including patient and workforce safety and reputational damage		1. FTSU guardian in place 2. FTSU policy in place and available to all staff 3. Raising awareness regarding FTSU- recent all staff meetings 4. Now established monthly review meeting between FTSU, chief people officer and chief nurse	Reeves, Nicola	Reeves, Nicola	Regulatory and Compliance	20	16	9	January 2024 - update to A&R. Report to Jan Board. Outsource company identified February 2024 - Internal audit in to speak up arrangements in progress. New provider going through procurement checks	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services
1189	08/12/2020	Workforce succession planning: radiology	There is a risk that, due to insufficient staff, the consistent provision of imaging across all modalities will be adversely affected. This could impact the following: - Diagnostic turnaround times for imaging and report - poor DM01 performance. - Poor staff and patient safety metrics - Higher instances for errors (datix reportable) - Higher attrition rates with poor staff wellbeing metrics - Worse financial position if reliant on agency/locum staff - Less resilience in the imaging service - CDC expectation of 7 day working. Not possible currently within available workforce.	-National shortage of qualified staff -Specialist centre so less engagement from newly qualified staff - Marketing QVH against other surrounding trusts who have higher pay or higher profile - small workforce means less resiliency in times of flux - 50% of the workforce at / approaching retirement age - difficulties recruiting - multiple failed recruitment drives previously and currently. - system level parity of pay for similar roles	- monitoring staff levels and asking for bank / agency if needed - advent of apprentice roles - training US post available to assist with shortfall and succession planning - team engagement for career conversations/ wellbeing check ins - HEE funding for course	Brasier, Kathy	Solanki, Sarah	Regulatory and Compliance	15	15	9	12/01/2024 - Further new b3 started over festive period. Recruited bank sonographer. Maternity leave sonographer position candidates unsuitable. Two shortlisted for sonographer 0.6 WTE post and interviews booked (current sonographer is retiring). B7 reporting / supt radiographer handed in notice this week, so a further vacancy. No suitable candidates for locum consultant general radiologist post. RSM in discussion with interim COO and clinical lead radiologist re. plan going forward. Outsourcing to reduce backlog of reporting to reduce risk of harm from delayed reporting. PACS manager being pulled back to UHSx, there is a different risk relating to the risks associated with this. 04/12/2023 - New b5 and b6 radiographers have started today. New b3 started two weeks ago. 5PA locum consultant to start tomorrow. Established consultants changing PAs. RSM in discussions with interim COO and clinical lead radiologist re. longer term plan.	KSO1: Outstanding Patient Experience, KSO2: World Class Clinical Services, KSO3: Operational Excellence, KSO5: Organisational Excellence

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024		**Agenda reference:**	**165-24**	
Report title:	Board effectiveness review				
Sponsor:	Jackie Smith, Trust Chair Leonora May, Company secretary				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one: NED champion roles, Appendix two: Nomination and remuneration committee ToR, Appendix three: Quality and safety committee ToR, Appendix four: Finance and performance committee ToR				
Executive summary					
Purpose of report:	The purpose of the report is to consider the effectiveness and composition of the Trust Board and identify any further action required to ensure effectiveness. Revised committee terms of reference are included for approval.				
Summary of key issues	- Board composition is in line with the Trust's Constitution - Succession planning for executive roles to be completed by November 2024 - Succession planning for Non-executive director roles has started. The recruitment process will start in July 2024 - Action plan to address recommendations from the well led review to be completed before 1 April 2024				
Recommendation:	• **Agree** the contents of this evaluation, noting that it will be referenced in the 2023/24 annual report and accounts • **Approve** the revised terms of reference for the Nomination and remuneration, Finance and performance and Quality and safety committees				
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:	Risk management framework reviewed per the recommendations from the well-led review- new Board assurance framework implemented				
Corporate risk register:	Risk management framework reviewed per the recommendations from the well-led review- Corporate risk register refined				
Regulation:	Code of governance for NHS provider trusts Trust Constitution				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	Board effectiveness survey completed during March 2024				

Report to:	Board Directors
Agenda item:	165-24
Date of meeting:	7 March 2024
Report from:	Jackie Smith, Trust Chair Leonora May, Company secretary
Report author:	Leonora May, Company secretary
Date of report:	28 February 2024
Appendices:	Appendix one: NED champion roles Appendix two: Nomination and remuneration committee ToR Appendix three: Quality and safety committee ToR Appendix four: Finance and performance committee ToR

Board effectiveness review

Introduction and background

The purpose of this report is to consider the effectiveness and composition of the Trust Board of Directors and identify any further action required to ensure that the Board has the skills and experience required. The Code of governance for NHS provider trusts requires the Board to evaluate its effectiveness and that of its sub-committees and individual directors annually. The details of the annual evaluation will be included within the Trust's annual report and account for 2023/24.

Board composition

The Trust's Constitution states that the composition of the Board should be as follows:

31.1 The Trust is to have a Board of Directors. It shall comprise both Executive Directors and Non-Executive Directors, at least half of which, excluding the Chair, should comprise Non-Executive Directors determined by the Board to be independent.

31.2 The Board of Directors is to comprise:

- *31.2.1 the following Non-Executive Directors:*
  - *31.2.1.1 a Chair; and*
  - *31.2.1.2 at least four other Non-Executive Directors.*
- *31.2.2 the following Executive Directors:*
  - *31.2.2.1 a Chief Executive (who shall be the Accounting Officer);*
  - *31.2.2.2 a Finance Director; and*
  - *31.2.2.3 at least two other Executive Directors.*

31.3 One of the Executive Directors is to be a Registered Medical Practitioner or a Registered Dentist.

31.4 One of the Executive Directors is to be a Registered Nurse or a Registered Midwife.

31.5 Subject to the provisions of paragraphs 31.3 and 31.4 above, the Board of Directors shall determine any change in the number of Directors, provided that any change in the number shall be in the range set out at paragraph 31.2 above, and that the number of Non-Executive Directors (including the Chair) shall always be greater than the number of Executive Directors. The Council of Governors shall be consulted if the changes relate to the Non-Executive Directors

The Trust Board comprises four voting executive directors and six voting non-executive directors, including the Chair, meaning that more than half of the Board comprises non-executive directors. The Board has a senior independent director as required by the Trust's Constitution. The Chief medical officer is a voting member of the Board and is a registered medical practitioner, and the Chief nursing officer is a voting member of the Board and is a registered nurse. The Chief executive officer and Chief finance officer are also voting members of the Board and it is proposed that the Chief operating officer is a voting member of the Board

The Trust has established four key non-executive director champion roles in line with the NHSE guidance on enhancing Board oversight which identifies the following four statutory roles applicable to QVH:

1. Wellbeing guardian
2. Freedom to speak up champion
3. Doctors disciplinary champion
4. Security management champion

The detail of these roles is included within appendix one to this report. The doctor's disciplinary champion role is a shared role allocated to a non-executive director on a case by case basis.

The Code of Governance for NHS Provider trusts states that the Board of Directors and its committees should have a diversity of skills, experience and knowledge. The Board should be of sufficient size for the requirements of its duties, but should not be so large to be unwieldy. Consideration should be given to the length of service of the board of directors as a whole and membership regularly refreshed. The Board should consider its composition and diversity. A Board skills matrix and review of diversity will be completed during May 2024.

From 11 March 2024, all substantive executive roles will be filled following the appointment of the substantive Chief people officer and Chief operating officer.

Succession planning

The Code of governance for NHS provider trusts states that an effective succession plan should be maintained for Board members and senior management. It goes on to state that succession plans should be based on merit and objective criteria and, within this context should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths.

The Trust is currently developing its succession plan for Board members and senior management with further reporting to the Nomination and remuneration committee scheduled for November 2024. The succession plan will include the promotion of diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths as well as confirming the overall readiness and risk status of successors for core roles as well as the following:

- Number or percentage of critical roles that could be filled internally
- Critical positions with 2+ identified successors
- Number or percentage of critical roles filled internally
- Average length of readiness
- Estimation of leadership turnover expected in the coming year based on known and/or high risk of leaving figures

Currently two non-executive directors are on their second term of three years and their second terms will end during 2025. The recruitment process to fill the two posts

will begin in July 2024 following approval to proceed from the Council of Governors. The recruitment process will be based on merit and objective criteria and, within this context, promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths.

Board development
As well formal training, personal development is achieved through networks, shadowing, opportunities provided at no cost by national bodies such as NHS Providers, Healthcare Financial Management Association, NHS England as well as more specialist professional bodies. Board members at QVH have a strong presence in national and regional professional bodies, both contributing and benefiting from these relationships and opportunities.

All individual members of the Board, both executive and non-executive, have participated in development opportunities during 2023/24 and will refresh personal development plans on an ongoing basis and as part of the annual appraisal and fit and proper persons review processes. 360 degree feedback was sought for executive director appraisals during the year, and feedback was sought from all Board members and key stakeholders for non-executive director appraisals.

Throughout the year a number of new directors have joined the Board. New directors attend the corporate induction which has a strong focus on our values, and the nature of the work carried out at QVH, with statutory and mandatory training followed up outside of this. The Company secretary also provides a tailored local induction programme for new directors.

Consideration has been given to the skills needed for the development of the Trust's strategy, increased partnership working and organisational development. The Board has agreed the below five priorities which were a focus for 2023/24 Board development and will continue to be a focus for 2024/25. A Board development plan is in place for 2024/25 with a focus on these priorities.

1. Trust and transparency
2. Patients at the Centre
3. Focus on priorities for the future
4. Fearless, bold, and frank, while carrying ambiguity
5. Learning through experience and insights

Board effectiveness
The Trust commissioned Deloitte to undertake a well lead review of its leadership and governance throughout December 2022- February 2023. The Board created an action plan based on the recommendations from the review to ensure that the Trust is well led.

The review included a desktop review of relevant documentation, a board effectiveness survey that was completed by all Board members, a governor survey, interviews with each member of the Board and with a sample of senior staff, observation of Board, subcommittee and business unit performance review meetings, four staff focus groups and telephone interviews with external stakeholders.

The review identified the following six themes.

<u>Theme 1: Developing the Board</u>
At the time of the review the executive team had a high reliance on interims and the reviewers commented on limitations in experience of best practice and the need to modernise processes. Board members recognised the need to improve cohesion,

and the appointment of new non-executive directors and substantive executives was an opportunity for the Board to reset the organisation as it formulates a new strategy and sets direction for the Trust. Board development has been a key focus for the year as outlined above. An Executive portfolio review was completed in November 2023 to bring greater clarity of roles and accountability throughout the senior leadership team.

Theme 2: Raising the profile of directorates
In line with the recommendations of the review, the Trust is updating its clinical business unit structures at QVH in line with modern good practice. The reviewers described the need to establish triumvirate working, with clear roles, responsibilities and accountabilities in directorate leadership teams. Clinical leaders need sufficient time for their leadership roles. Performance review meetings are now directorate led forums.

Theme 3: Strategic engagement
In line with the recommendations of the review, the Trust established a major programme of engagement to win the hearts and minds of stakeholders as it sets the strategy and reinvigorates values. A full engagement plan with careful communications and active listening has been developed and implemented including an independent review of activities to date. The work in this area has been highly praised by staff and external stakeholders.

Theme 4: Governance flows
Given the scale of strategic change required the strategic development committee has been established to cover the broad remit of strategic developments. The reviewers recommended additional improvements to provide clarity on the role of various governance forums from ward to Board and this work is in progress for implementation by 1 April 2024.

The trust has reviewed its internal ward to board assurance and organisational framework and will launch the new integrated assurance framework with refreshed organisational structure in April 2024.

Theme 5: Risk management
The reviewers noted that while the Trust has the key components of a risk management framework and uses key risk management tools, this could be improved and risk management could be more thoroughly embedded at directorate and business unit level. This work is almost complete. A new Board assurance framework has been developed and the corporate risk register has been refined. The development of an updated risk management policy is underway and the Board will agree its risk appetite in April 2024. The remit of the Audit committee has been reviewed to include an increases focus on the Trust's risk management systems.

Theme 6: Stakeholders
Recommendations included raising the visibility of Board members with staff and delivering a more structured approach to engagement on patient pathways and within services; this work has been completed and a new approach to Board visibility has been rolled out. External stakeholders see the Trust as a willing partner and there is opportunity for a greater external focus; the Chief strategy officer was a vacant role at the time of the review and the executive team are now playing an important role in increasing external focus.

In addition, the reviewers made a number of comments about the culture of the organisation. This included a building of momentum around equality, diversity and

inclusion, a number of initiatives linked to staff wellbeing, and a culture of learning from incidents. There is an opportunity to continue build on this, and to review the many mechanisms that the Trust has for hearing staff concerns ensuring the value of each is clear.

Following the completion of the action plan to address the recommendations from the review, the Board will review its own effectiveness, completing a survey during March 2024, the results of which will be presented to the Board in May 2024. The survey will focus on The Board's role in strategy, culture and equality diversity and inclusion as well as relationships, behaviour, partnerships and development.

Committee effectiveness
Each committee agrees a framework for a review of its effectiveness and the adequacy of its terms of reference and work plan. To avoid adding undue pressure on resources and ensure evaluations are effective, the Trust has implemented a three year rolling programme of full evaluations and light touch reviews in alternate years.

During 2023/24, so far the Quality and safety, Nomination and remuneration and Finance and performance committees have undertaken a review of their effectiveness, with the reports presented in full at a meeting that followed and any findings requiring escalation to the Board included in the committee assurance reports to the Board. The Strategic development committee, Audit and risk committee and Charity committee will each complete their effectiveness review during March 2024.

Each committee reviews its terms of reference and work plan annually. The terms of reference for the Nomination and remuneration, Finance and performance and Quality and safety committee are included as appendices to this report and are recommended by the committees for approval. The Strategic development committee and Audit and risk committee will undertake the review of their terms of reference during March 2024.

Recommendation
The Board is asked to:

- **Agree** the contents of this evaluation, noting that it will be referenced in the 2023/24 annual report and accounts
- **Approve** the Chief operating officer being a voting member of the Board
- **Approve** the revised terms of reference for the Nomination and remuneration, Finance and performance and Quality and safety committees

Appendix one: Non-Executive Director Champion Roles

The approach set out below is aligned to national guidance *Enhancing board oversight: A new approach to non-executive director champion roles* (December 2021). Board oversight and assurance for other issues is embedded in governance arrangements and an audit trail of discussions and actions is provided in the minutes of relevant committees.

Role	Requirement	QVH implementation
Wellbeing guardian	This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision. The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials.	KN is designated NED
FTSU NED champion	The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation. The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report). All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why. A full description of NED responsibilities can be found in the FTSU supplementary information.	SOL is designated NED
Doctors disciplinary NED champion/independent member	Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as "the designated member" to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only.	Shared role allocated to NED on a case-by-case basis

Role	Requirement	QVH implementation
Security management NED champion	Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement. While promotion of security management in its broadest sense should be discharged through the designated NED, relevant committees may wish to oversee specific functions related to counter fraud and violence/aggression. Boards should make their own local arrangements for the strategic oversight of security of assets and estates.	PDR is designated NED

Terms of reference
Name of governance body
Nomination and Remuneration Committee
Constitution
The Nomination and remuneration committee (the Committee) is constituted as a statutory non-executive committee of the Trust's Board of Directors.
Accountability
The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.
Authority
The Committee is authorised by the Board of Directors to: • Appoint or remove the chief executive, and set the remuneration and allowances and other terms and conditions of office of the chief executive. • Appoint or remove the other executive directors and set the remuneration and allowances and other terms and conditions of office of the executive directors, in collaboration with the chief executive. • Consider any activity within its terms of reference. • Seek relevant information from within the Trust. (All departments and employees are required to co-operate with any request made by the committee). • Instruct independent consultants in respect of executive director remuneration. • Request the services and attendance of any other individuals and authorities with relevant experience and expertise if it considers this necessary to exercise its functions.
Purpose

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

- Determine remuneration packages and contractual terms of the executive management team in line with benchmarking and national guidance.

Duties and responsibilities

Duties (nominations)

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

Duties (remuneration)

- Establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully and collaborate effectively with system partners, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust. To do this, the committee will:
    - Follow the national NHSE VSM (very senior manager) pay strategy and associated QVH VSM pay principles in respect of executive board directors and other positions that report to the chief executive.
    - Use market benchmarking analysis in the annual determination of remuneration of executive directors and other positions that report to the chief executive.
    - Be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases.
    - Ensure that increases are not made where Trust or individual performance do not justify them.
    - Ensure that pay arrangements provide equal pay for work of equal value.
    - Take into account internal relativities between the executive team and with other senior posts, both Agenda for Change and non-Agenda for Change.
    - Ensure transparent processes so that individuals know how their pay might be increased and third parties can be clear that the processes are auditable and compliant.

  - Ensure that any performance-related element of executive directors' remuneration is transparent, stretching and designed to promote the long-term sustainability of the Trust. The committee will should take as a baseline for performance any required competencies specified in the job description for the post.
  - Monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this as well as continuing professional and personal development plans when reviewing changes to remuneration levels.
- Recommend and monitor the level and structure of remuneration for senior management. The Board defines senior management this purpose as the first layer of management below Board level.

- The Committee will work with the chief executive to determine the remuneration of the other executive directors.

Responsibilities

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

- To identify and appoint candidates to fill posts within its remit as and when they arise.
- In doing so, to adhere to relevant laws, regulations, trust policies and the principles and provisions regarding the levels and components of executive directors' remuneration as defined by section E of the Code of governance for NHS provider trusts.
- To be sensitive to other pay and employment conditions in the Trust and elsewhere in the NHS, especially when determining annual salary increases.
- To keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.
- To give full consideration to and make plans for succession planning for the chief executive and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.
- To sponsor the Trust's leadership development and talent management programmes to support succession plans and meet specific recruitment and retention needs.
- To ratify the process for medical and dental Clinical Excellence Awards
- To review executive team skillsets, identify any gaps and consider how they should be addressed

Meetings

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

The Committee will usually meet four times a year.

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

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

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

Conflicts of interest

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

Chairing

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

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

Secretariat

The ~~Director of corporate affairs and communications~~Company secretary, working closely with the chief people officer, shall be the secretary to the Committee and provide administrative support and advice to the Chair and membership. The duties of the secretary shall include but not be limited to:

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

Membership

Members with voting rights

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

Ex-officio attendees without voting rights

- Chief Executive
- Chief People Officer

In attendance without voting rights

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

Quorum

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

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

Attendance

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

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

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

Papers

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

Reporting

The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting. The Committee chair shall prepare a report of each Committee meeting for submission to the Board of Directors at its next formal business meeting.

Review

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency.

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

* Definitions

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

Terms of Reference

Name of governance body

Quality & Safety (Q&S) Committee

Constitution

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

Accountability

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

Authority

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

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

Purpose

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

- The quality and safety of clinical care delivered by the Trust at either its hub site in East Grinstead or any other of its spoke sites.
- Patient, service user, family and carer satisfaction with services
- The management and mitigation of clinical risk.
- The governance of the Trust's clinical systems and processes.

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

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

To fulfil its purpose, the committee will also:

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

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

Duties and Responsibilities

Duties

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

Responsibilities

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

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

Meetings

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

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

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

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

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

Chairing

The Committee shall be chaired by a ~~n~~Non-~~e~~Executive ~~d~~Director, appointed by the Trust Chair following discussion with the Board of Directors.

If the Chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the Committee shall be chaired by one of the other ~~n~~Non-~~e~~Executive ~~d~~Director members of the Committee.

Secretariat

The Governance Officer shall be the secretary to the Committee and shall provide administrative support and advice to the ~~c~~Chair and membership. The duties of the ~~s~~Secretary shall include but not be limited to:

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

Membership

Members

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

- Three ~~n~~Non-~~e~~Executive ~~d~~Directors
- Chief Nursing Officer
- Chief Medical Officer
- Chief Operating Officer
- ~~Chief Executive~~
- ~~Chief Nurse~~
- ~~Deputy Chief Nurse~~
- ~~Medical Director~~
- ~~Chief Finance Officer~~
- ~~Director of Operations~~
- ~~Chief People Officer~~

- ~~Head of Risk and Patient Safety~~
- ~~Head of Quality and Compliance~~
- ~~Clinical Director for Clinical Governance~~
- ~~Allied health Professional Lead~~
- ~~Chief Pharmacist~~

Designated deputies will attend as appropriate

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

- Chief Executive
- Deputy Chief Nurse
- Chief People Officer
- Head of Risk and Patient Safety
- Head of Quality and Compliance
- Clinical Director for Clinical Governance
- Allied ~~h~~Health Professional Lead
- Chief Pharmacist
- The secretary to the Committee (for the purposes described above)
- Director of ~~c~~Communication and ~~e~~Engagements ~~& corporate affairs~~
- Clinical ~~d~~Director of ~~r~~Research & ~~i~~Innovation
- ~~Director of strategy and partnerships~~Chief Strategy Officer
- ~~Chair of the Board~~
- The Trust's internal auditor
- NHS Sussex ICS~~B~~ Quality Representative
- Other invitees as appropriate by prior agreement with the Chair

The ~~c~~Chair and members of the ~~c~~Committee shall commit to work together according to the principles established by the Trust's policy for engagement between the Board of Directors and Council of Governors.

Quorum

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

- Two ~~n~~Non-~~e~~Executive ~~d~~Directors (incl. chair of committee)
- Either the Chief ~~Nurse or Deputy Director of Nursing~~Nursing Officer or Chief Medical Officer
- ~~One other director~~
- ~~Two other members~~

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

Attendance

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

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

Papers

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

Reporting

The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting.

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

Papers will be circulated to all ~~n~~Non-~~e~~Executive ~~d~~Directors to provide additional assurance.

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

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

Final and approved minutes of Committee meetings shall be circulated to the ~~clinical cabinet and Nnon-eExecutive dDirectors~~Committee members and attendees. The Committee ~~c~~Chair shall provide an annual report to the Audit and Risk committee to provide assurance on the governance arrangements.

The Committee ~~cc~~Chair shall report at quarterly meetings of the Council of Governors and facilitate the Governor working group for the Committee~~.~~

Review

On an annual basis, t~~T~~he ~~c~~Committee will review ~~on an annual basis~~ its own performance and terms of reference, to ensure that it is operating effectively and in line with best practice. The outcomes of this review will be reported in writing to the Board.

The next scheduled review of these terms of reference will be undertaken by the Committee in January 2025~~4~~ in anticipation of approval by the Board of Directors at its meeting in March 2025~~4~~.

Definitions

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

Terms of reference

Name of governance body

Finance and Performance Committee (F&PC)

Constitution

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

Accountability

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

Authority

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

Purpose

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

- Delivery of financial, operational and workforce performance plans and targets.

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

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

To fulfil its purpose, the Committee will also:

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

Duties and responsibilities

Duties

Financial and operational performance

- Review and challenge construction of operational and financial plans for the planning period as defined by the regulators.
- Review, interpret and challenge in-year financial and operational performance.
- Review, interpret and challenge workforce profile metrics including sickness absence, people management, bank and agency usage, statutory and mandatory training compliance and recruitment.

- Oversee the development and delivery of any corrective action plans and advise the Board of Directors accordingly.
- Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the Board of Directors.
- Refer issues of quality or specific aspects of the Quality and Safety Committee's remit, and maintain communication between the two committees to provide joint assurance to the Board of Directors.

Corporate risks

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

Estates and Facilities maintenance programmes

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

Information management and technology performance and development

- Oversee the development, delivery and performance of the Trust's information, management and technology strategic projects and programme as agreed by the Board of Directors

Capital and other investment programmes and decisions

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

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

~~Cost improvemen~~Better value~~t~~ plans

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

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

Responsibilities

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

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

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

- Capital and other investment programmes.
- Cost improvement plans.
-

Charing

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

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

Meetings

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

The Committee will meet formally bi-monthly~~, on the fourth Monday of the month~~.

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

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

Secretariat

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

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

Membership

Members with voting rights

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

- Three Non-Executive Directors (including Committee chair)
- Chief Executive Officer
- Chief Finance Officer
- ~~Director of Operations~~Chief Operating Officer
- Chief People Officer
- Chief Nursing Officer OR Chief Medical Officer

~~Ex-officio members without voting rights~~

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

In attendance ~~without voting rights~~

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

- The secretary to the Committee (for the purposes described above).

- Any member of the Board of Directors or senior manager considered appropriate by the chair of the Committee.

Quorum

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

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

Attendance

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

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

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

Papers

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

Reporting

The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting.

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

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

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

Review

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency.

The next scheduled review of these terms of reference will be undertaken by the Committee in February 2025~~January 2024~~ in anticipation of approval by the Board of

Directors at its meeting in March 2054.
***Definitions**
In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024		**Agenda reference:**	166-24	
Report title:	Annual report on the use of the Trust seal 2023/24				
Sponsor:	Leonora May, Company secretary				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one: entry to register of sealing 2023/24 1/24				
Executive summary					
Purpose of report:	To provide the board with an update on the use of the Trust seal, in line with the requirement within section 10 of the Trust's Standing orders				
Summary of key issues	There has been one use of the Trust seal since the last annual report: 1. Planning obligation by way of agreement, pursuant to S106 of the Town and Country Planning Act 1990 relating to land at Queen Victoria Hospital, Oakfield Way, East Grinstead; parties (1) Mid Sussex District Council (2) West Sussex County Council (3) Queen Victoria Hospital NHS Foundation Trust (4) Brookworth Homes Limited				
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:	BAF5- compliance- ensures compliance with the Trust's Standing orders				
Corporate risk register:	None				
Regulation:	Ensures compliance with the Trust's Standing orders				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board Directors
Agenda item:	166-24
Date of meeting:	7 March 2024
Report from:	Leonora May, Company secretary
Report author:	Leonora May, Company secretary
Date of report:	26 February 2024
Appendices:	Appendix one: entry to register of sealing 2023/24 1/24

Annual report on the use of the Trust seal 2023/24

Introduction

The purpose of this paper is to provide the Board with an update on the use of the Trust seal, in line with the requirement in section 10 of the Trust's Standing Orders.

Background

S.10 of the Trust's Standing orders state:

Sealing of Documents

10.2 Documents can only be sealed once they have been authorised by a resolution of the Board of Directors or of a committee thereof, or where the Board of Directors has delegated its powers.

10.3 Building, engineering, property or capital documents do not require authorisation by Board of Directors or a committee thereof, but before presenting for seal these documents do require the approval and signature of the Chief Finance Officer (or an officer nominated by them) and the authorisation and countersignature of the Chief Executive (or an officer nominated by them who shall not be within the originating directorate).

10.4 The fixing of the seal shall be authenticated by the signature of the Chair (or the Deputy Chair in the absence of the Chair) and one Executive Director.

Register of sealing

10.5 An entry of every sealing shall be made in a record provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least annually. The report shall contain details of the description of the document and date of sealing.

Annual report

Since 1 April 2023, the Trust seal has been affixed to one document on 13 February 2024 as authorised by the Chief executive officer and Chief finance officer. The seal was attested by the Trust Chair and Chief executive officer. The entry to the register of sealing is appended to this report and was related to the land sale:

1/24: Planning obligation by way of agreement, pursuant to S106 of the Town and Country Planning Act 1990 relating to land at Queen Victoria Hospital, Oakfield Way, East Grinstead; parties (1) Mid Sussex District Council (2) West Sussex County

Council (3) Queen Victoria Hospital NHS Foundation Trust (4) Brookworth Homes Limited

Recommendation
The Board is asked to **note** this annual report of sealings.

NHS
Queen Victoria Hospital
NHS Foundation Trust

REGISTER FORM

To be completed for each use of the Trust's seal

Date	Description	Authorised Signatory CEO and DoF or nominee
13/02/2024	Planning Obligation by way of Agreement, pursuant to Section 106 of the Town and Country Planning Act 1990 relating to land at Queen Victoria Hospital, Oakfield Way, East Grinstead Parties- (1) Mid Sussex District Council (2) West Sussex County Council (3) Queen Victoria Hospital NHS Foundation Trust (4) Brookworth Homes Limited	Maria Wheeler - James Lowell

Ref 1/24.

Report cover-page					
References					
Meeting title:	Business meeting of the Board of Directors				
Meeting date:	07/03/2024		**Agenda reference:**	167-24	
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 (14 February 2024)				
Summary of key issues	Potential changes to the governing documents, such as the scheme of delegation, were discussed in principle, along with collaboration arrangements at ICS level. Updates on the annual report and accounts, with associated audit, were provided to give assurance that a plan is in place Updates on internal audit and local counter fraud were received				
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:	This was an extra meeting that did not specifically address the BAF, but the entire assurance framework will be at the centre of future meetings				
Corporate risk register:	No specific coverage of the corporate risk register, although both internal audit and counter fraud indicative plans are risk-based.				
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:					
	Date:		Decision:		
Next steps:	Review by board				

Report to:	Board Directors
Agenda item:	167-24
Date of meeting:	7 March 2024
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:	27 February 2024
Appendices:	None

Audit and Risk Committee assurance report

Introduction

The audit and risk committee met on 14 February 2024.

Executive summary

Governance changes: The committee held early discussions on some proposed changes to the main governing documents, such as the scheme of delegation, considering increasing the financial levels of some decision-making, and this is part of a wider review looking at the governance structure that will return to the committee before discussion at the board. There was also discussion on the potential governance of collaboration arrangements within the ICS. This is still work-in-progress and it was emphasised that the board needed to understand the importance of these.

Annual Report and Accounts: Planning for the completion and audit of the 2023/24 annual report and accounts was discussed and assurance gained that there is a plan in place that all are signed up to. The committee encouraged management to consider how long the annual report has become and the cost/benefit of the time involved in the additional work above the mandatory requirements.

Changes to accounting policies, etc: It was confirmed that there are no significant changes to accounting policies, treatments, judgement and estimations expected this year. These can have an impact on the year-end process.

External audit: Azets, the trust's new external auditors, are making progress with their planning and introduction to the Trust. They have arranged time for a handover from KPMG.

Internal audit: RSM reported on two pieces of work with "reasonable" levels of assurance. Management were challenged about the time taken to implement a couple of agreed management actions from previous audit, albeit of medium priority, but turnover of staff has been a factor. An indicative plan for next year was produced, in light to the impending tender for services, and a few suggestions for changes to be considered were made.

Counter Fraud: The local counter fraud specialist provided an update as well as an indicative plan for next year. The committee raised the "lessons learned" from the Post Office and Horizon issue, in terms of the behaviours from investigators. Robust assurance was given that counter fraud in the NHS is handled in a much more professional manner and to a higher standard, than would have been the case with the Post Office.

Internal audit / LCFS tender: The committee held a private meeting to discuss the tender for internal audit and counter fraud services that is coming up. The plan is to be able to make a decision around mid-May.

Recommendation

The Board is asked to **NOTE** the matters above and discuss any issues.

References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024		**Agenda reference:**	**168-24**	
Report title:	Quality and Safety Assurance				
Sponsor:	Shaun O'Leary, Non-Executive Director and committee Chair				
Author:	Riya Jose, Governance Officer Leonora May, 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 Safety Committee at its meeting on 26 February 2024.				
Summary of key issues	- There has been one serious incident since the previous meeting - Clinical harm reviews have been completed for patients whose cases were closed or paused incorrectly - There have been improvements in microbiology support – from the external provider and through recruitment to a key post				
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 at its meeting in February 2024				
Corporate risk register:	Corporate risk register reviewed at the committee meeting in February 2024				
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:	268-24
Date of meeting:	7 March 2024
Report from:	Shaun O'Leary, Non-Executive Director and committee Chair
Report author:	Riya Jose, Governance Officer Leonora May, Company Secretary
Date of report:	27 February 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 26 February 2024.

Clinical quality and patient safety

The committee reviewed a recent serious incident, focusing on the timely and effective response. Positive feedback from the Integrated Care Board (ICB) on our prompt reporting and management of the incident was acknowledged. This incident underscores our commitment to swift, transparent handling and continuous improvement in care delivery. The committee endorsed the decision to undertake an external peer review to seek clarity about the adherence to agreed processes in relation to the serious incident.

The refinement of the clinical harm review process has resulted in a focus on patient groups most at risk, particularly in cancer care. The goal is to proactively identify and prevent harm by closely monitoring and reviewing cases where delays or other issues might lead to clinical harm. The committee raised concern regard the planned non-RTT waiting lists, noting that approximately 35 patients were identified with incorrectly closed or paused pathways, mainly due to administrative errors. Clinical harm reviews have subsequently been completed for these patients. Comprehensive actions are being undertaken to rectify these issues, including patient validation, surgery scheduling and a Route Cause Analysis to ensure rigour of understanding how the situation arose initially, and the resulting actions and learning. A staff training programme has been implemented to prevent future administrative errors.

The committee received a clinical audit update, including actions completed to date to revise the clinical audit report. This report aims to ensure full compliance with NICE standards and address previously identified inaccuracies.

The committee noted challenges regarding completion of the last step (Step 5) of the WHO surgical safety checklist, and sought further assurance regarding how this is being addressed at its next meeting. It also requested benchmarking data from other organisations regarding compliance.

Infection prevention and control

The committee received an update on progress in effectively managing the risk related to antimicrobial prescribing. There has been significant improvement in microbiologist engagement, with participation increasing to two virtual ward rounds weekly. This enhancement is vital for effective infection control and patient care. The anticipated start of a recently recruited antimicrobial pharmacist in April is expected to strengthen our infection prevention and control efforts. Addressing staffing shortages, particularly amongst bank staff and rotating doctors, remains a priority.

The committee agreed to refer the matter regarding the absence of a ventilation authorised person to the Finance and Performance Committee.

Estate
The committee noted challenges with the estate, specifically relating to leaking roofs which have been fixed numerous times. This highlighted an issue regarding estates capacity and capability and the importance of contract management. This issue will be referred to the Finance and Performance Committee for inclusion in its ongoing oversight.

Risk
The committee reviewed BAF1- patient outcomes and the corporate risks within its remit. Debate was had regarding the consequence score of the BAF as being 5 (severe) and the committee challenged whether this should be lower given the controls in place to manage the risk. This was felt to be a wider corporate issue, not just relevant to Quality and Safety committee – and an agreed, standardised approach is requested from the Board. The corporate risk related to the mental capacity act was agreed to be a concern and progress in this area requires ongoing regular reporting.

Governance
The committee reviewed it work plan for 2024/25 which is expected to evolve with the implementation of the integrated assurance framework and the Quality Improvement workstream. The committee also reviewed its terms of reference and has made some suggested changes to the membership and frequency of meetings for approval by the Board to ensure effectiveness of discussions and decision-making processes, including reducing membership and alternating meeting formats.

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:	07/03/2024		**Agenda reference:**	169-24	
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:					
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 Committee's attention should be drawn to the following key areas detailed in the reports: • Progress with seasonal flu vaccinations • Recruitment of antimicrobial pharmacist • Patient-Led Assessments of the Care Environment (PLACE) Inspection Results • Achievement of Q3 CQUINS • Positive media coverage of our nursing apprentices				
Recommendation:	Approval				
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:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	If approved today, present at next board meeting.				

Board Report

Contents

Summary - Chief Nurse and Chief Medical Officer

QVH always strives to deliver high quality, safe effective care to all our patients.

This report reviews data from December 2023 and January 2024

General Updates:

The SI reported in December 2023 has been closed at the ICB scrutiny panel

Patient safety corporate risk registers and the Board Assurance Framework for patient services have been discussed at February Quality and Safety Committee

Regular monthly meeting of Allied Health Professionals and Health Care Scientist now in place with CNO. Rich discussions around workforce planning, educational opportunities and the physical infrastructure of the estate. The ICB Chief AHP is planning to visit and meet the team in late March.

The deputy chief scientific officer visited in February and saw a number of Health Care Scientists in practice.

We had incredibly positive news coverage on our apprentice programme for nurses focussing on Lisa Debruslais.

We have successfully appointed and antimicrobial pharmacist who will commence in April 2024.

The seasonal flu vaccination campaign continues, results so far are below.

Role	Percentage vaccinated
All doctors	**41%**
Qualified Nurses	**55%**
Other professional Staff	**55%**
Support to clinical staff	**61%**

CQUIN update – Quarter Three

CQUIN01 - Flu vaccinations for frontline healthcare workers: Vaccination clinics run from Occupational health and roaming vaccinators. On site Covid vaccine clinic run via ABC. Currently sitting at 69% compliance which includes opt outs.
CQUIN02 - Supporting patients to drink, eat and mobilise (DrEaM) after surgery: Data collection continues, exceeding target of 80% compliance.
CQUIN03 - Prompt switching of intravenous to oral antibiotic: No significant changes to previous quarters. Introduction of twice weekly microbiology virtual wards rounds. Antimicrobial champions identified within the clinical staff. Antimicrobial stewardship rolling agenda item at Joint Hospital Clinical Governance meeting.
CQUIN11 - Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery: No data submission required this quarter.
CQUIN12 - Assessment and documentation of pressure ulcer risk: Now exceeding maximum compliance, focus on education and training for staff including Pressure ulcer ‘escape room’ run in critical care.

Quality Priorities – Quarter Three

Improve anti-microbial stewardship at QVH

- Q3 partially achieved

Introduce an Inter-professional Leadership Programme;

The QVH (LEEP) Leadership Program

- Q3 achieved

Patient Experience; Improving Patient co-design of services

- Q3 achieved

Patient-Led Assessments of the Care Environment (PLACE) Inspection Results

The results of the above have been published and a multidisciplinary Task and Finish group has met to lead on an action plan which will be monitored via the patient experience group.

Safe Performance Indicators (1)

Metrics not appropriate for SPC XmR reporting

KPI Description	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Number of Serious Incidents reported (including IG breaches)	2	0	0	0	0	0	0	0	1	0	1	0	0
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	2	0	1	0	1	0	0	0	2	0	1	0	0
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	1	0	0	0	1	0	0	0	1	1	0	1
No of patient safety incidents with severe harm or death	0	0	1	0	0	0	0	0	0	0	0	0	0
Rate of Serious Incidents per 1,000 bed days	2.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0
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)	3	2	0	0	0	0	1	0	2	2	1	0	0
No of Grade 3 and 4 pressure ulcer reported (hospital acquired) (and ungradeable)	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcer assessment completed on admission (%) (quarterly)						94%			95%			96%	
Ward patients with sepsis receiving antibiotic therapy within one hour (total number)	0	0	1	0	1	1	1	1	0	0	0	0	
			100%		100%	100%	100%	100%					
Number of HCAI Root Cause Analysis (RCA) and Post Infection Review (PIR) undertaken	1	No reportable infections	No reportable infections	No reportable infections	No reportable infections	No reportable infections	1	1	No reportable infections	No reportable infections	No reportable infections	No reportable infections	2
No of CDI reported (Trust acquired, post 72hrs after admission)	1	0	0	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)	1	0	0	0	0	0	1	1	0	0	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	1
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	6	2	2	2	2	4	1	5	3	9	3

There was one moderate harm incident reported in relation to a delayed pathway for a MF patient which is under review.

There are 2 HCAI RCA/ post infection reviews in progress, the final summaries identifying learning will be included in the IPC Q4 report

- A MSSA bacteraemia developed by a long stay Burns patients
- A hospital acquired MRSA in a wound

Safe Performance Indicators (2)

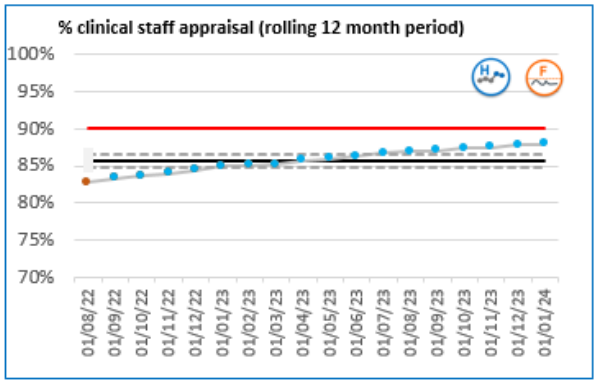
KPI	Latest month	Measure	Target /Limit	Variation	Assurance	Mean
Number of patient safety incidents with no harm near miss	Jan 24	47	-			37
No of medication administration incidents reported	Jan 24	6.0	-			3.2
Number of formal Complaints received	Jan 24	7	-			5
Number of Complaints per 1,000 bed days	Jan 24	6.7	-			5.9
% of complaints acknowledged within three working days	Jan 24	86%	99%			95%
FFT recommendation - Inpatient Adult	Jan 24	100%	90%			99%
FFT recommendation - Inpatient Children	Jan 24	100%	90%			100%
FFT recommendation - MIU	Jan 24	94%	90%			94%
FFT recommendation - Outpatients	Jan 24	97%	90%			95%
% FFT Recommendation Rate Overall	Jan 24	97%	90%			96%
FFT response - Inpatient	Jan 24	40%	25%			43%
FFT response - Inpatient Children	Jan 24	18%	25%			33%
FFT response - MIU	Jan 24	23%	25%			23%
FFT response - Outpatients	Jan 24	21%	25%			18%
FFT Response Rate overall	Jan 24	29%	25%			22%
No. of low/no harm falls	Jan 24	2	-			3
Rate of falls per 1,000 patient bed days	Jan 24	1.9	-			3.2
Patient falls assessment completed within 24 hrs of admissions	Jan 24	100%	100%			98%
Rate of pressure ulcer per 1,000 patient bed days	Jan 24	0.0	-			0.8
Occupational Health data no. of contaminated Sharps injuries for staff	Jan 24	4	-			3
Infection prevention and control training compliance (all staff clinical and non clinical)	Jan 24	90%	90%			92%
Emergency Re-Admissions within 30 days	Jan 24	1.9%	2.2%			2.3%
Safer staffing compliance (inc Site)	Nov 23	99%	99%			99%
% clinical staff appraisal (rolling 12 month period)	Jan 24	88%	90%			86%
% non-clinical staff appraisal (rolling 12 month period)	Jan 24	80%	90%			80%

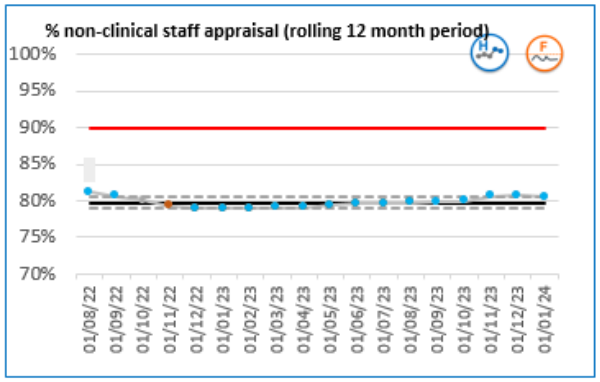
Safe Performance Indicators (2)

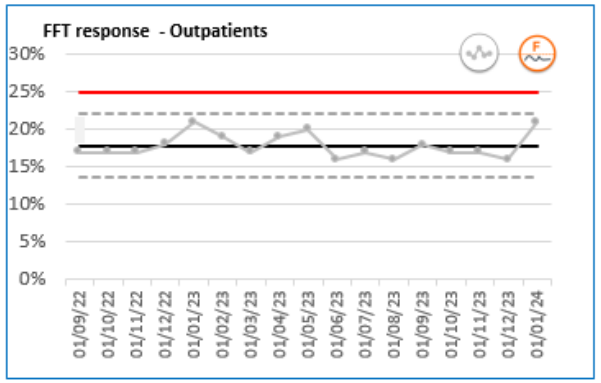
The number of medication incident reported continues to show monthly variation but this does not demonstrate cause for concern.

There are 3 indicators which have not achieved the targets so far for the year to date;

- The % of clinical staff having in date appraisals continues to be on an improving trajectory, with all the Consultants now having 'in date' appraisals. The challenge remains the rotational trainee doctors. Our non-clinical manager's continue to focus on improving appraisal compliance.
- There was a significant increase in the FFT response for outpatients in January.





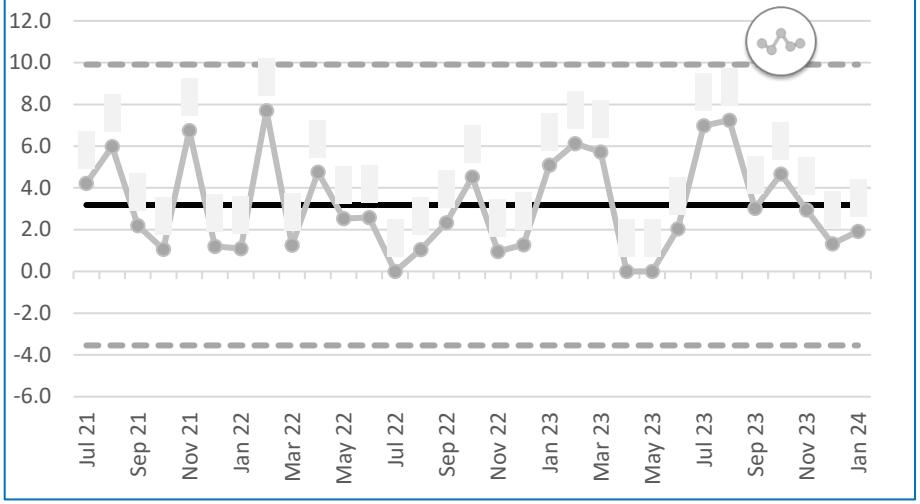


Safe Performance Indicators – Falls & Pressure Ulcer

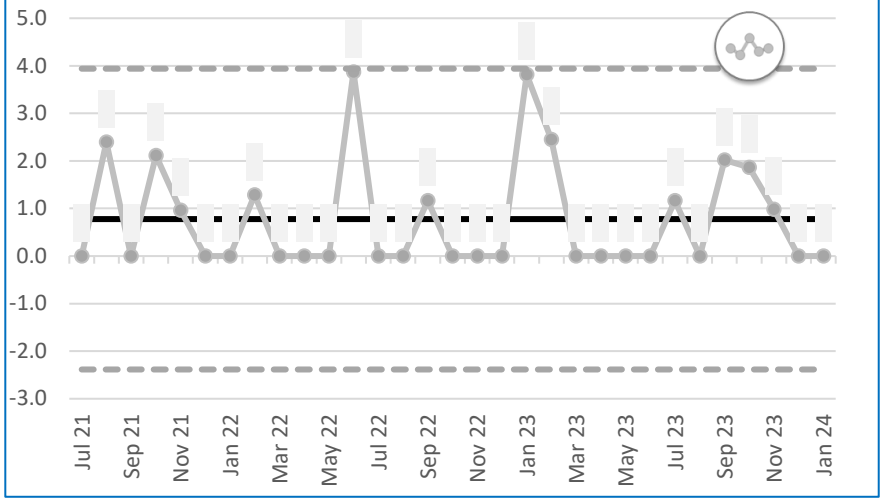
Our falls rate continues to be variable but within expected limits and lower than the national average. There have been no inpatient falls resulting in harm during the financial year to date

QVH acquired Pressure Ulcers continue to be within normal variability, with an average of less than 1 per month per 1000 bed days and none reported in Dec/Jan. Current processes provide assurance of care.

Rate of falls per 1,000 patient bed days

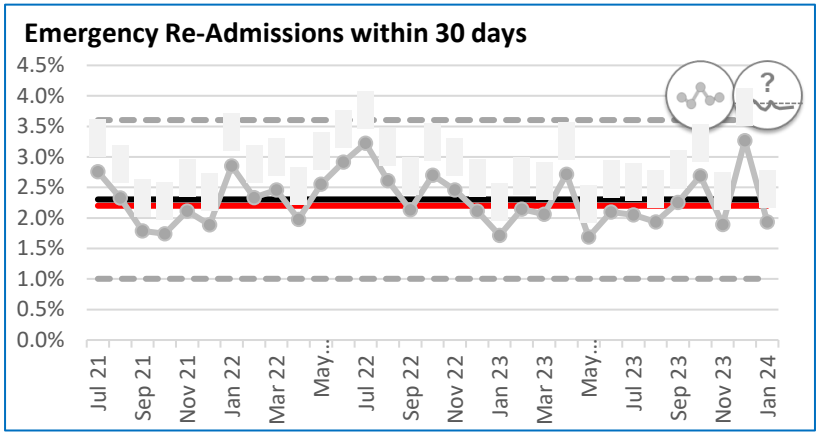


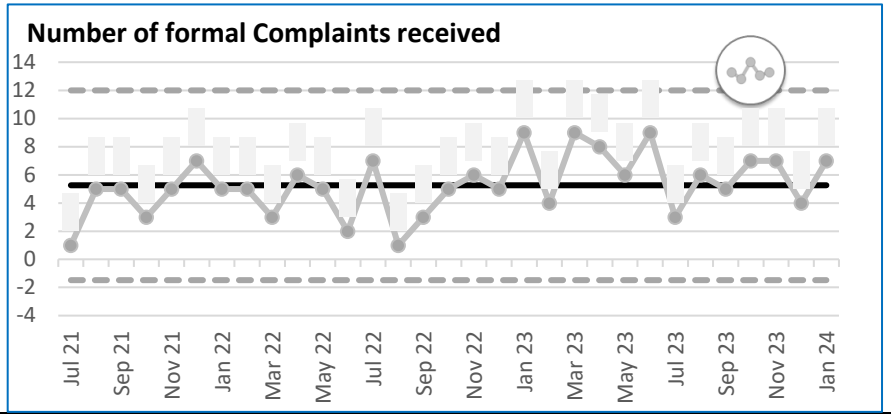
Rate of pressure ulcer per 1,000 patient bed days



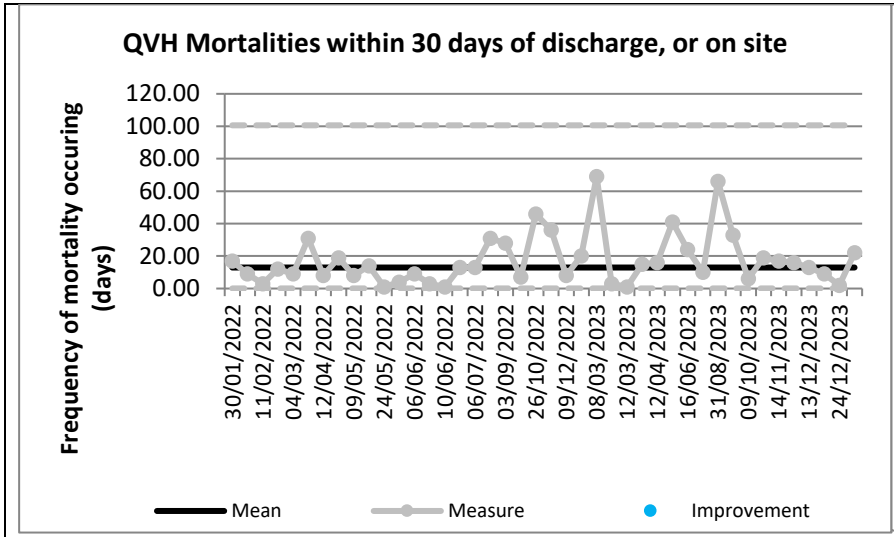
Effective Indicators

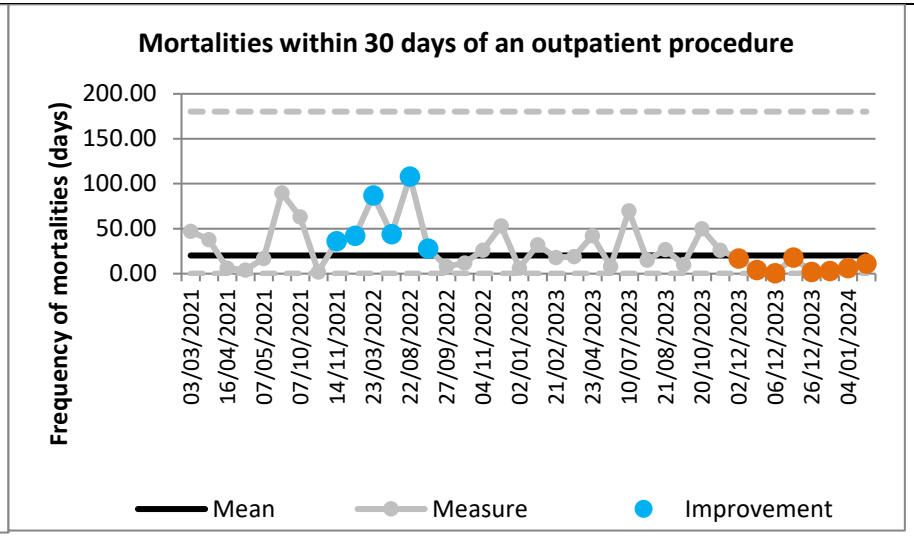
Re-admission rates remain within expected levels. Specialty governance leads review, and discuss any re-admissions of concern which are escalated to the CGG if required.





There has been an increase in complaints received over the last year. The number received over December/ January is within expected variation of the 'new norm'. All complaints are shared with department leads to share within the team.





Mortalities are reviewed as per policy, and the frequency of occurrence of death is within expected variation.

Mortalities are reviewed as per policy, and the frequency of occurrence of death is within expected variation. During December/ January there were more frequent outpatient mortalities which are under review. No mortalities of concern i.e due to any issues with QVH care have been identified.

Nursing Workforce - Performance Indicators

Metrics	Q4 2022-23		Q1 2023-24			Q2 2023-24			Q3 2023-24			Q4 23/24	12 month average
Nursing Workforce	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
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	343	343	343	343	343	343	343	343	343	343	345
Staff In Post WTE	330	328	331	333	333	335	335	342	345	346	349	349	338
Agency Total worked in month WTE	3	5	8	6	7	7	11	8	8	10	12	12	8
Bank WTE Total worked in month WTE	39	47	35	33	34	32	37	38	36	37	33	42	37
Staff in Post Vacancy WTE	21	24	12	10	10	9	9	1	-1	-2	-5	-5	7
Vacancies % Including Bank & Agency Usage	3%	1%	2%	3%	2%	3%	0%	-1%	-1%	-2%	-3%	-5%	0%
Staff in Post Vacancies %	6%	7%	4%	3%	3%	3%	3%	0%	0%	-1%	-2%	-2%	2%
Qualified Nurses (NMC) Vacancies WTE	32	35	13	15	17	17	17	15	12	10	11	11	17
Theatre Practitioners (AHP) Vacancies	1.75	1.75	2.04	2.04	1.04	1.04	2.04	-0.96	-0.96	-1.96	-1.72	-1.72	0.4
Band 2 & 3 HCSW Vacancies WTE Clinical support to clinical staff	-6	-7	0	-3	-3	-6	-5	-3	-4	-4	-6	-7	-5
Band 2 & 3 HCSW Vacancies WTE Non clinical support to clinical staff	3	3	0	0	0	0	0	-1	0	0	1	1	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)	-8	-8	-2	-4	-5	-4	-5	-10	-9	-7	-6	-6	-6

Safe staffing levels have been maintained across the Trust.

Metrics	Q4 2022-23		Q1 2023-24			Q2 2023-24			Q3 2023-24			Q4 23/24	12 month average
Workforce	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
Trust rolling Annual Turnover % Excluding Trainee Doctors	8%	8%	8%	9%	9%	8%	8%	9%	9%	8%	8%	7%	
Starters WTE In month excluding HEE doctors	1	5	3	4	2	5	3	5	8	7	3	6	4
Leavers WTE In month excluding HEE doctors	0	2	3	4	2	2	1	2	5	0	3	3	2
12 month sickness rate (all sickness)	5.1%	5.0%	5.0%	4.9%	4.8%	4.7%	4.6%	4.6%	4.6%	4.7%	4.4%		
Monthly Sickness Absence % All Sickness	4.9%	5.1%	4.8%	3.2%	3.1%	3.6%	3.5%	5.1%	5.4%	6.1%	5.2%		

Medical Workforce - Performance Indicators

Metrics	Q4 2022-23		Q1 2023-24			Q2 2023-24			Q3 2023-24			Q4 23/24	12 month rolling
Medical Workforce	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
Turnover rate in month, excluding trainees	0%	1%	1%	0%	2%	0%	3%	3%	1%	0%	3%	0%	11%
Turnover in month including trainees 9%	1%	3%	6%	1%	1%	2%	10%	0%	4%	0%	2%	2%	36%
Management cases monthly	1	1	0	0	0	0	0	1	0	0	1	1	5
Sickness rate monthly on total medical/dental headcount	1%	2%	1%	1%	1%	2%	1%	3%	2%	2%	2%		
Appraisal rate monthly (Clinical)	86%	86%	89%	88%	89%	90%	89%	89%	88%	87%	89%	87%	88%
Mandatory training monthly	86%	88%	89%	88%	89%	89%	89%	86%	88%	89%	90%	92%	
Exception Reporting – Education and Training	1	3	2	0	1	2	0	2	1	0	0	2	
Exception Reporting – Hours	2	5	0	4	8	1	5	3	6	7	1	0	

Medical & Dental Staffing	Induction plans are in place for February and the details for the April rotation are showing minimal rota gaps at this stage. There were more educational exception reports than hours/pattern reports in Jan. Both reports were from OMFS trainees who were moved to cover service instead of operating with their consultant. MAST compliance for medical and dental staff is now at over 90% for permanent and fixed term staff.
Education	The KSS Dean visited QVH on 30 Jan and was pleased to meet with the DME and MEM, as well as the Chief Executive, Chief Medical Officer, CPO, specialty education representatives and most importantly trainee reps. Following the successful roll out of LEEP 3 in December, LEEP 4 has now been advertised to those who have completed 1-3, and new dates for another cohort are being advertised for 24/25. At the recent Local Faculty Group meetings and Junior Doctors Forum, trainees raised concerns regarding overbooked clinics and supervision in Plas X lists, length of time to recruit to Trust posts, and the Dental Core Trainee rota. All concerns are being followed up on with the relevant department.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024	**Agenda reference:**	**170-24**		
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 26 February 2024.				
Summary of key issues:	- The Trust continues to remain compliant with the Faster Diagnosis Standard. - Industrial action continues to have an adverse impact on RTT performance and although deteriorating, QVH is performing higher than the national average for all waiting brackets. Cancer performance is pressured and the January outlook is negative given industrial action and system pressures. - The Trust is performing well against workforce key performance indicators. - An update on the Trust's bank and agency workforce position provided reassurance that the increase in costs are linked to the increase in activity. - The Trust continues to report and forecast a breakeven position and efficiencies are being delivered and discussed the progress on financial planning. - There is significant underspend on the capital programme. The need to progress plans at pace to ensure spend of the allocation for 2023/24 has been highlighted to capital leads. - The committee had an update from the estates team on the actions being taken on fire safety prevention. - The committee reviewed BAFs 02, 03, 05, 06 and 07 and welcomed the introduction of a summary report. The committee will be seeking further assurance on the delivery of these action linked to the improvement of the culture of the organisation.				
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					
Next steps:	None				

Report to:	Board Directors
Agenda item:	170-24
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:	27 February 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 26 February 2024.

Operational performance
The committee received and reviewed the month 9 operational performance. The Trust continues to remain compliant with the Faster Diagnosis Standard. The 62 day backlog has reduced with the running of additional Saturday theatre sessions and improvement plans are in place for all cancer specialities. Industrial action continues to have an adverse impact on RTT performance and although deteriorating, QVH is performing higher than the national average for all waiting brackets. There is concern that system pressures and the industrial action is pressuring cancer performance in January. There continues to be a positive improvement in the DMO1 performance for sleep, in line with improving trajectory. Theatre utilisation achieved 85.9% against a target of 85%. Discussion was had on the validation of the waiting list validation which is being undertaken.

The committee was updated on the work underway to substantiate the waiting list data and asked for regular progress reports, there will also be separate seminar for committee members to review the waiting list management.

The committee received an update on the action being taken to deliver full assurance against the Trust's national assurance outpatient self-assessment. There is further work to do to deliver full assurance for aspects of validation and outpatient follow-up appointments. The committee was pleased to note the significant amount of work undertaken to develop Patient Initiated Follow Up (PIFU) pathways for patients with the Trust achieving 1.92% in month 11 against a target of 2.8%.

Workforce
The Trust continues to perform well against workforce key performance indicators. The Equality, Diversity and Inclusion (EDI) Group is now fully established. Progress is being made in reducing the time to hire metrics. As requested, the committee received an update on the Trust's bank and agency workforce position which provided reassurance that the increase in costs are linked to the increase in activity.

Finance
The Trust continues to report and forecast a breakeven position and efficiencies are being delivered. There is significant underspend on the capital programme. It has been highlighted to capital leads in Estates and Medical Devices on the need to progress plans at pace to ensure spend of the allocation for 2023/24. Discussion was had on the business planning for process 2024/25 and further details on this will be provided as part of discussion at the private meeting of the Board.

The committee received an update on the capital plan for 2024/25; the key areas for spend for the Trust will be the next phase of IT programme delivery, medical devices and addressing the estate, as identified in the six facet survey as well at the delivery of the Electronic Patient Record (EPR) and Community Diagnostic Centre (CDC).

Board Assurance Framework
The committee reviewed BAFs 02, 03, 05, 06 and 07 and welcomed the introduction of a summary report. The committee noted the key actions completed to manage the strategic risk 07 which has resulted in a change to the overall assurance rating from amber to green. The overall assurance RAG rating for quarter 4 for BAF05 has also moved to green, demonstrating that there are no serious issues.

The committee highlighted the importance of the development of the workforce strategy, especially given the staff resources and capability which will be required to deliver the future strategy and key Trust projects. The actions set out in BAF 02 which are linked to the improvement of the culture of the organisation were noted and the committee will be seeking further assurance on the delivery of these actions.

Other
- The interim head of estates gave a detailed updated on fire safety at QVH. Progress is being made with the improvement work and there are clear actions and owners. There was also an update on the upgrading the electrical infrastructure in order to improve resilience across the site.
- The three corporate risks monitored by the committee were reviewed.
- The feedback from the committee's light touch effectiveness review undertaken was considered. The quality of the reports remains an area for improvement.
- The committee received an update on the work being undertaken on the EPR programme initiation delivery. The committee will continue to receive regular updates on the implementation as the programme progresses.
- The committee approved its annual assurance report regarding oversight of the Trust's risk management and internal control for submission to the Audit and risk committee.

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:	26/02/2024		**Agenda reference:**	**171-24**	
Report title:	Financial Performance				
Sponsor:	Maria Wheeler, Chief Finance Officer				
Author:	Ellie Tallett Deputy Chief Finance Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide an update on M10 financial performance				
Summary of key issues	The key headline planning items for update are: • The Trust are holding their break even position in month and forecast for year end • Cash is stable • Efficiencies are being delivered • We are significantly underspent on Capital, full details are in the capital paper. • Areas of the balance sheet require further analysis				
Recommendation:	To note the M10 financial performance				
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:					

Queen Victoria Hospital
NHS Foundation Trust

Financial Performance M10 2024

February 2024

Ellie Tallett. Deputy Chief Financial Officer

Executive Summary

Financial Metric	Period	Result Month 10
Income & Expenditure	YTD	Breakeven
	Year End Forecast	Breakeven
Cash at Bank	YTD	£11.252m
Capital Spend	Plan YTD	£11.4m
	Actual YTD	£3.192m
BPPC (Combined NHS & non NHS)	YTD Volume (%)	93.7%
	YTD Value (%)	92.8%
Efficiencies	Plan YTD	£4.5m
	Actual YTD	£4.5m
	Year End Forecast	£5.5m (5.5%)

Headlines:

- The Trust are holding their break even position
- Cash is stable
- Efficiencies are being delivered
- We are significantly underspent on Capital, at M10 behind plan, expected to recover by Y/E.

- Areas of the balance sheet require further analysis
- Focus is required on Capital spend

Income & Expenditure

Queen Victoria Hospital
NHS Foundation Trust

Financial Performance Month 10 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	6,993	7,920	8,283	363	74,310	79,202	79,318	116	95,042	94,757	(285)
Other Operating Income	867	246	373	126	3,367	2,465	3,704	1,239	2,958	4,084	1,126
Total Income	7,859	8,167	8,656	489	77,677	81,667	83,021	1,355	98,000	98,841	841
Pay											
Substantive	(4,522)	(5,086)	(4,915)	171	(44,626)	(50,859)	(48,802)	2,057	(61,031)	(58,691)	2,340
Bank	(382)	(257)	(506)	(249)	(3,369)	(2,554)	(3,578)	(1,024)	(3,068)	(4,122)	(1,054)
Agency	(108)	(40)	(192)	(152)	(953)	(402)	(1,399)	(998)	(482)	(1,429)	(947)
Total Pay	(5,012)	(5,383)	(5,613)	(230)	(48,947)	(53,815)	(53,780)	36	(64,581)	(64,242)	339
Total Non Pay	(2,342)	(2,294)	(2,534)	(241)	(23,975)	(22,949)	(24,149)	(1,200)	(27,536)	(28,091)	(555)
Total Non Operational Expenditure	(526)	(490)	(531)	(40)	(4,954)	(4,903)	(5,321)	(418)	(5,883)	(6,785)	(902)
Total Expenditure	(7,879)	(8,167)	(8,678)	(511)	(77,877)	(81,667)	(83,249)	(1,583)	(98,000)	(99,119)	(1,119)
Surplus / (Deficit)	(20)	(0)	(22)	(22)	(200)	(0)	(228)	(228)	0	(277)	(277)
TechnicalAdjustments	(343)		22	22	200		228	228		277	277
Adjusted Surplus / (Deficit)	(363)	(0)	(0)	0	0	(0)	0	0	0	(0)	(0)

- At the close of January, the Trust has achieved a breakeven position and retained cash balances of £11.252m. The Forecast Outturn is Breakeven.
- Overperformance on Patient Activity income activity has generated additional £1.7m which we have agreed to give back to the system, this is not reflected in I&E income.
- As a result of Industrial Action, additional pay costs have been incurred of currently £1.45m to January 2024.
- Inflationary pressures are being felt in Utilities and Food. Risks are appearing in contract negotiations for 2024/25.
- Efficiencies of £4.5m have been delivered in line with the plan.
- Overall Pay costs are under plan year to date as vacancies in substantive posts are offset by temporary staff costs. The increase trend of temporary staff costs needs to be managed to ensure expenditure stays within budget this reporting year.
- Increased Substantive staff costs & FTE are due to successful recruitment. Increase trend of temp staff is due to the increase in activity.
- Medical devices were running at £800k overspend, an agreement with the system to cover £533k of CPAP devices has been built into the M10 numbers.

Patient Activity Income:

Queen Victoria Hospital
NHS Foundation Trust

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

- Activity: NHSE published ERF achievement is 109% for M1 to M7, with a current M10 estimated achievement of 120% compared to the same month in 19/20.
- The M10 estimated YTD position is 113% VWA.
- Estimated YTD ERF contract value adjustment is an over performance of £1.9M YTD.
- Forecast position at year end is 113% with the IA costs hitting £1.9m. With the baseline for February and March being tougher then previous months we are not expecting a significant improvement in the finances for the last two months.

	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%	£132k
October	117%	£226k
November	120% (Est)	£0k
December	130% (Est)	£183k
January	120% (Est)	£124k
Total	113% (YTD Estimate)	£1,457k

Efficiencies

Queen Victoria Hospital
NHS Foundation Trust

Efficiency Savings 2023/24 YTD	Actual	Actual	Actual	Actual	Actual	Plan	Actual	Variance	Plan	Forecast	Variance
	30/09/2023	31/10/2023	30/11/2023	31/12/2023	31/01/2024	31/01/2024	31/01/2024	31/01/2024	31/03/2024	31/03/2024	31/03/2024
	Month 6	Month 7	Month 8	Month 9	Month 10	YTD	YTD	YTD	Year ending	Year ending	Year ending
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Efficiency Savings - by category											
Pay Efficiencies											
Establishment reviews	288	282	288	286	286	2,876	2,869	(7)	3,452	3,452	0
Service re-design - pay	0	0	0	0	0	1,500	0	(1,500)	1,800	300	(1,500)
Other - pay (Non-recurrent Vacancies	168	167	169	171	171	0	1,651	1,651	0	1,686	1,686
Total Pay	**456**	**449**	**457**	**456**	**456**	4,376	**4,520**	**144**	5,252	5,396	144
Non-pay Efficiencies											
Medicines optimisation	0	0	0	0	0	0	0		0		0
Procurement (excl drugs) -non-clinica	3	3	3	3	3	0	30	30	0	39	39
Service re-design - Non-pay	0	0	0	0	0	166		(166)	201	35	(166)
Total Non-Pay	**3**	**3**	**3**	**3**	**3**	166	**30**	**(136)**	201	65	**(136)**
Total Income	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Efficiencies	**459**	**452**	**460**	**459**	**459**	4,542	4,550	8	5,453	5,461	8

- The requirement for delivery of 5.5% efficiency was 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% is being 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.

Balance Sheet

Queen Victoria Hospital
NHS Foundation Trust

Prior year end	£'000	Month end actual	Var on PY.
64,028	**Non-current assets**	**62,878**	**(1,150)**
1,072	Inventory	1,069	(3)
8,403	Trade and other receivables	4,612	(3,791)
11,725	Cash	11,160	(565)
21,200	**Current assets**	**16,841**	**(4,359)**
(944)	Borrowings	(2,122)	(1,178)
(17,734)	Trade and other payables	(12,387)	5,347
(2,637)	Other liabilities	(2,336)	301
(21,315)	**Current liabilities**	**(16,845)**	**4,470**
(2,106)	Borrowings	(1,285)	821
(745)	Other liabilities	(756)	(11)
(2,851)	**Non-current liabilities**	**(2,041)**	**810**
61,062	**Net assets employed**	**60,833**	**(23,938)**
24,546	Public dividend capital	24,546	0
18,177	Retained earnings	17,949	228
118,339	Revaluation reserve	18,338	1
61,062	T		

Key messages:

- Non-current assets are £1.2m lower than year end, mainly being the net impact of investment expenditure and depreciation.
- Trade and other receivables are £4.6m (56% of average monthly income). Work is underway to recover debts as quickly as possible to aid the cash position, a review will take place of any large longstanding disputes within the balance which will also involve settling creditor debt once finalised.
- Cash has decreased by £0.5m since the start of the financial year, the Trust has been stable all year.
- Trade and other payables are £12.3m (492% of average monthly non-pay expenditure), this will be reviewed before the next set of accounts are produced.

Capital

- Capital Expenditure is £3.192m at the close of January from a year to date plan (as per original planning assumptions at the start of the year) of £11.4m.

- The Forecast to year end is:

✓ £6,430m Budget for the EPR and CDC projects (funded by PDC)

✓ £4.787m Forecast for internally funded (funded by internally generated CRL)

- It has been highlighted to Capital leads in Estates and Medical Devices that they need to progress at pace to spend the capital allocation for 2023/24.
- IFRS16 leases; we currently have a confirmation that this class of capital will be fully funded from the allocated IFRS 16 funding made available to the system.

Capital Performance @M10 2023/24		YTD Actuals (£000)	YTD Plan (£000)	YTD Variance (£000)	Annual Plan (£000)	Forecast (£000)
Externally Funded (by PDC)	EPR - Central Programme	481	3,750	(3,269)	4,500	4,500
	CDC - Central Programme	505	1,608	(1,103)	1,930	1,930
	Estates - CRL Not Agreed by the ICS	0	845	(845)	1,014	0
	Total Externally Funded Schemes	**987**	**6,203**	**(5,217)**	**7,444**	**6,430**
Internally Funded	Medical Devices	64	500	(436)	600	1,346
	IM & T	303	821	(518)	985	1,511
	Estates - Backlog Maintenance	643	2,485	(1,842)	2,982	1,930
	Business cases	0	208	(208)	250	0
	Total Internally Funded Schemes	**1,010**	**4,014**	**(3,004)**	**4,817**	**4,787**
Unfunded (Funding stream tbc)	New Lease - MRI Scanner	787	787	0	0	787
	New Lease - Theatre Power Banks	408	408	(0)	0	408
	Total Unfunded Schemes	**1,195**	**1,195**	**0**	**0**	**1,195**
	Total 2023/24 Capex Programme	**3,192**	**11,413**	**(8,221)**	**12,261**	**12,412**

Sussex System Financial Summary @ month 9

Queen Victoria Hospital
NHS Foundation Trust

	System YTD Summary - I&E (£000s)				
Organisation	**YTD Plan**	**YTD Forecast** (NHSE submission 28.11)	**YTD Actual**	**Actual vs Plan** Variance (adverse)/ favourable	**Actual vs Forecast** Variance (adverse)/ favourable
ESHT	-	125	(2,487)	(2,487)	(2,612)
QVH	4	-	-	(4)	-
SCFT	(739)	(847)	(875)	(136)	(28)
SPFT	(3,515)	(3,896)	(3,923)	(408)	(27)
UHSx	(5,584)	(18,078)	(26,060)	(20,476)	(7,982)
ICB	-	(12,000)	(12,023)	(12,023)	(23)
Total	**(9,834)**	**(34,696)**	**(45,368)**	**(35,534)**	**(10,672)**

These are M9 numbers. At time of writing the system m10 position was not available.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024	**Agenda reference:**	172-24		
Report title:	Workforce and Organisation Development Report				
Sponsor:	Robert Stevens, interim Chief people officer				
Author:	Lawrence Anderson, deputy Chief people officer Robert Stevens, interim Chief people officer				
Appendices:	None				
Executive summary					
Purpose of report:	Workforce performance update - Review of priorities, KPIs, department and programme updates				
Summary of key issues	To commend the work done to continue to deliver our EDI Objectives (including the EDI Group, Workplace Belonging events, Progress Pride / celebration of LGBT+ History Month, commitment to Sexual Safety and widening participation work), review of consultant Bank rates and support for increased activity, MAST training including Oliver McGowan and Staff Survey. Our few hotspot recruitment areas, triangulation of cultural issues and slight drop in appraisal compliance remain a priority and we are currently undertaking an important consultation with our hospital leadership team on the introduction of improved clinical leadership through triumvirate working, as specified by our Well Led review (2023).				
Recommendation:	For information				
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:	n/a				
	Date:		Decision:		
Next steps:	In report				

Report to:	Public Board
Agenda item:	172-23
Date of meeting:	4 January 2024
Report from:	Rob Stevens, Interim Chief People Officer
Report authors:	Rob Stevens, Interim Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	27 February 2024
Appendices:	None

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

Summary
The Trust continues to maintain some of the best workforce key performance indicators (KPI's) and survey results in the 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 January and February we have moved forward with a number of workforce priorities across the organisation and now have a fully functioning EDI Group. Coupled with this we have launched the QVH Progress Pride Pledge and marked LGBT+ history month in February. We have strengthened our position in supporting staff networks, identifying budgetary resource and are currently undertaking our first Workforce Belonging listening events.

There continues to be a tremendous amount of work underway to support our Trust and workforce transformation. In support of our operational performance we have implemented new consultant Bank pay rates, implemented new vacancy control processes and had a positive review meeting with the South East NHSE temporary staffing lead. We have launched our "Organisation Redesign – Clinical Leadership and Triumvirate Working" consultation paper and are continuing to develop our "Workforce and Culture" enabling strategy.

We are embedding our online new starter portal and employment checking process, continue to work on our time to hire and small number of recruitment hotspots, have advertised our new Business Partner and People Promise Manager posts and look forward to welcoming our new substantive Chief People Officer in March. On 7 March we will also be sharing our staff survey results, the first findings of which indicate positive progress in our collective approach to people management and staff engagement.

As Interim CPO, I am sad to be leaving but honoured to have been able to work with such an amazing directorate team, executive and board as part of this incredible organisation. I wish you all the very best and have no doubt in our continued success.

Workforce KPIs

Establishment
Substantive Trust establishment is 1082.98 WTE. Inclusive of temporary staffing this increases to 1125.14 WTE.

Substantive vacancy has increased to 32.66 WTE (3.11%) attributed mainly to establishment changes. There was an increase in starters with 13.11 WTE starting in January (3.3 more than December) and 12.61 WTE leavers.

Medical and Dental are showing 7.40 WTE vacancies with AHP showing as over established. NMC vacancies have risen slightly to 13.09 WTE, driven by Theatres.

Bank use (89.10 WTE in month) was up on December (70.86 WTE) and likewise agency use increased slightly to 20.05 WTE in January. Driven by our use of nursing staff, this level of use reflects both specific patient care needs and our current activity (currently 20% above in-year plan). A recent meeting with our NHSE Temporary Staffing lead also established that we continue to maintain some of the best temporary staffing metrics in the region.

Resourcing
Time to hire has risen by 3.30 days since December 2023 but remains within the KPI. This increase is due to a number of factors, including an increase in activity (19 more adverts placed and 53 more on boarding activities in month).

Team resilience continues to improve within the main resourcing team, although our search for a new Medical workforce business partner is ongoing.

Workforce services
The Workforce Services team has completed the immediate establishment data work to reconcile the ledger to the ESR establishment and is working on our annual workforce planning submission to NHSE.

The reintroduction of a vacancy control panel in January has improved oversight of the posts we are recruiting in line with our regional colleagues and is now also improving our due diligence in relation to our long term temporary staffing, starting salaries and additional pay.

The workforce services team is now fully established and service level issues with our payroll service provider are being addressed.

Temporary staffing
The Trust continues to receive pressure to pay above the agency cap for specific medical roles. This is partly driven by the knock-on effect of the BMA Bank rate cards and the rates being paid by other local providers. New consultant bank rates have now also been agreed and published with significant work completed on health roster and ESR to ensure payments are correct.

Sickness
The rolling 12 month sickness absence rate remains below 4% (3.70% in December). Short term and long term sickness absence rates have both started to decrease.

Employee Relations
There are a total of 39 employee relations cases; 7 informal, 13 formal and 2 appeals.

The team have seen an increase in informal cases progressing to formal processes, but also an increase in team development interventions. The team have been working a number of policy updates that will be published in the coming months.

Appraisal & MAST

Appraisal compliance saw a decrease of 2.48% from 85.81% to 83.33% (950/1140) in January 2024. The number of appraisals that have expired by more than 3 months has increased in January to 82 from 60 last month. This has been raised at performance meetings and departments have been asked to reduce numbers.

MAST compliance saw an increase of 0.34% in January 2024, year on year. The Trust has seen an increase of 0.46% from 91.08% to 91.54% (Jan 23 vs Jan 24).

Oliver McGowan mandatory training launched on 21 Sept 2023. As at 31 January 2024, all staff compliance rate was 73.11% (976/1335). The Trust target is to achieve 90% compliance by 30 April 2024. Tier 2 of the training is in development and has still to be agreed on the rollout across the SHCP.

Trust workforce programmes

Equality, Diversity and Inclusion

Work continues at pace on the Trust's EDI Objectives. The Trust's EDI group has been meeting monthly since December and has agreed its Terms of Reference. Some key developments have already been made. Members of the group will facilitate a number of Workforce belonging listening events in February and March. Staff Networks also now have an assigned annual budget of £1500 each. A subgroup of the EDI group has also now met to review our end-to-end recruitment processes.

The Educational Funding Panel agreed for funding for 6 Deaf Awareness Workshops for staff at QVH. The first two sessions have been delivered has been extremely well received.

Culture and OD, inc. Speak Up

The Executive Leadership team have given their commitment to eliminate Sexual Misconduct and are recommending we sign up to the NHSE Charter on Sexual Safety (on the Board Agenda). The charter makes 10 key commitments and the Trust is pledging to have all of these in place by no later than July 2024, with a number already actioned.

Work continues to revise the Trust's approach to Speak Up across the organisation. The Trust has engaged with a new external provider to support us from April 2024, and this work will be integral to our ongoing work to triangulate our cultural intelligence and proactively enquire into areas that are a potential cause for concern.

Widening Participation

In 2024 QVH is holding two work experience events offering two events on 9 May and 28 November. Applications opened 1 March 2024. Work experience placement applications also are currently being shortlisted.

QVH apprenticeships are showing a year on year increase from 14 in 2022/23 to 17 to date. Take up for apprenticeships from diverse backgrounds continues to be an issue and we will continue to promote diversity in our apprenticeship communications and case studies.

QVH has previously offered English support classes for staff for whom English in a second language. Four sessions have been arranged with a focus on written communication.

Appraisal Quality and Assurance

Work continues on the 9 recommendations approved by F&P in July 2023. An action plan has been agreed and Task & Finish group are working through it.

Key objectives for the next quarter are to undertake a review of managerial spans of control across the Trust to understand where there are line managers with a number of direct reports. This work will coincide with the Trust wide structure review to highlight areas of concern. Testing continues on the electronic appraisal documentation to aid the introduction of ESR Self Service across the Trust for all managers and staff.

Wellbeing

January saw our first visit from the Barclays van, giving staff and volunteers a chance to seek support and advice regarding things like budgeting, frauds, scams and many other queries.

In February we celebrated LGBT history month and raised the Pride flag at the front of the hospital.

Occupational Health retender

The tender for this outsourced service was been previously delayed but is now on track. Our current provider Cordell Health have agreed to a six month extension on existing terms and pricing while we complete the process.

Violence Prevention and Reduction (VPR)

The Trust VPR group continues to meet on a monthly basis.

The group have committed to a number of key actions in 2024 and have developed two separate action plans to address the national standards. The Trust's key challenges are with verbal abuse from patients and visitors but also staff on staff.

Current works focused on ensuring the Trust's VPR policy is fully revised to ensure the national standards, Sussex VPR strategy and our Trust's VPR objectives are addressed. The group are also reviewing the literature sent to perpetrators of abuse by the Trust, reviewing changes to reporting, including the use of QR codes and the introduction of a "Just Culture" approach to case investigation.

The group has also received an initial report from Changing Futures Programme who undertook a Trauma Informed Walkthrough of the QVH site (akin to the 15 steps programme). This report looks to identify where those with lived experience may be more susceptible to committing violence or aggression, or if there are things within our buildings and site that could contribute to heightened anxieties leading to Violence or abuse.

Staff Survey/NQPS

QVH NHS Staff Survey closed on 24 November 2023 with 59% of QVH eligible staff (658/1119) completing compared to 56% in 2022 (609/1081).

The 2023 staff survey results has been scheduled for the 24th June 2024 Finance & Performance committee meeting and the 4th July 2024 Board meeting.

NQPS Q4 20203/24 closed on 31st January 2024 and included questions on Speaking Up at QVH this quarter. Results will be available shortly and the data relating to speak up has been passed to the Chief Nurse for consideration.

Redefining our organisation – Clinical leadership and triumvirate working

Following the Deloitte Well Led Review published in March 2023, we have begun an informal consultation to implement triumvirate working (Clinical Director, Head of Nursing and General Manager) within our clinical directorates and business units.

The proposed changes are intended to establish clear lines of clinical leadership and support our forthcoming integrated assurance framework. In relation to this, we have led pre-consultation with our Hospital Leadership Team in January 2024 to review the changes with those directly affected.

Alongside this, we have reviewed the structure of our four clinical directorates and are particularly recommending that the core (clinical) services currently in Perioperative, join MIU, Sleep and Community as part of Core and Community Services.

For affected clinical directors and leads this consultation precedes job planning discussions to increase the leadership PA allocation of medical staff and introduces the opportunity for non-medical clinical leads to apply for vacant clinical director and lead roles. For other staff the main changes for some staff include a change in line manager and / or realignment of their service within the directorate structure.

There are no job losses or other reductions in staffing proposed as part of these changes, which directly affect approximately 60 staff, but will pave the way for operationally implementing the attached (draft) organisational structure.

Consultation will run for 30 days including a number of weekly face to face and Teams consultation meetings and the opportunity for affected staff to meet with their line manager.

Recommendation
It is recommended that the Board **notes** the contents of the report.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024	**Agenda reference:**	**173-24**		
Report title:	Eliminating sexual misconduct				
Sponsor:	Robert Stevens, interim Chief people officer Tania Cubison, Chief medical officer				
Author:	Rob Stevens, Interim Chief People Officer				
Appendices:	None				
Executive summary					
Purpose of report:	As a Board to adopt the charter on sexual safety in healthcare and provide assurance on our progress in meeting its requirements.				
Summary of key issues	On 4 September 2023, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. Signatories commit to a zero-tolerance approach to unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to implementing ten core principles and actions to help achieve this. Like us, most Trusts, including many of our neighbouring providers are working towards meeting all ten commitments by July 2024. As a Board we agree to become a signatory to this charter and launch it at Team Brief the same month.				
Recommendation:	For **approval**				
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 at this stage				
Assurance route					
Previously considered by:	ELT on 13 February 2024				
	Date:		Decision:		
Next steps:	Launch at Team Brief supported by BMA on 19 March 2024				

Report to:	Trust Board
Agenda item:	Sexual safety in healthcare
Date of meeting:	07 March 2024
Report from:	Robert Stevens, interim Chief people officer Tania Cubison, Chief medical officer
Report author:	Rob Stevens, interim Chief people officer
Date of report:	20 February 2024
Appendices:	Three cited in report

Eliminating sexual misconduct in healthcare

Introduction

"Breaking the Silence – Addressing sexual misconduct in healthcare" was published by the Royal College of Surgeons in September 2023**.**

In the report, the research into the experience of surgical healthcare workers found that two thirds of women and a third of men had been the target of sexual harassment and a third or women and a quarter of men had been sexually assaulted in the five years preceding the survey.

Only 16% of affected participants reported their experience. QVH had no reported cases in the same timeframe, but has since had 1 reported case, which has been dealt with.

Not only is sexual misconduct potentially a criminal matter, but is also known to be associated with inappropriate behaviour towards patients, impact on working environments, health outcomes and the career prospects of the victims.

As a surgical centre of excellence it is imperative on everyone to be active in rebuking and eliminating sexual misconduct in a culture of openness, learning and reflection**.**

Charter on sexual safety

On 4 September 2023, NHS England launched its first ever sexual safety charter (**Appendix 1**) in collaboration with key partners across the healthcare system and invited all providers to become signatories.
Signatories commit to a zero-tolerance approach to unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to implementing ten core principles and actions to help achieve this.

Like us, most Trusts, including many of our neighbouring providers are working towards meeting all ten commitments by July 2024.

We will be asking the Board in March to agree to become a signatory to this charter and would like to launch it at Team Brief the same month.

Sexual safety implementation plan

Eradicating sexual misconduct relates to all staff, however they identify. The detail of the actions in **Appendix 2** below also reference goals identified by the BMA as part of its related pledge to ending sexism in medicine and we welcome the BMA's support for ending sexual safety and look forward to welcoming our regional representative Ruth Baird at a launch of charter at the March Team Brief. **Appendix 3** is a progress update against those goals

Recommendation
The Board is asked to **approve** these proposals

Appendix 1 – Charter on Sexual Safety

"As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:

1. *We will actively work to eradicate sexual harassment and abuse in the workplace.*

2. *We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.*

3. *We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.*

4. *We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.*

5. *We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.*

6. *We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.*

7. *We will ensure appropriate, specific, and clear training is in place.*

8. *We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.*

9. *We will take all reports seriously and appropriate and timely action will be taken in all cases.*

10. *We will capture and share data on prevalence and staff experience transparently. These commitments will apply to everyone in our organisation equally.*

Where any of the above is not currently in place, we commit to work towards ensuring it is in place by July 2024."

Appendix 2 – Sexual safety implementation plan

1. To communicate regularly on the importance of a positive workplace culture and share experience of building civility at work, psychological safety and a just culture

2. Introduce sexual misconduct awareness into the induction of all staff and especially junior doctors

3. Review our policies in the light of the findings of the report and consider any additional guidance required

4. Support our Speak Up action plan to ensure access and awareness of the ways to raise concerns at work

5. Ensure that colleagues working in Workforce and OD, and especially those supporting case investigation work have received training on first response and appropriate subsequent advice for staff and their managers on sexual misconduct

6. Ensure learning on sexual misconduct is integrated into B&H and EDI training for new and existing staff, including access to active bystander / unconscious bias training and especially for clinical supervisors, education leads and training programme directors.

7. Ensure our case management enables us to keep a record of any current or future cases of sexual misconduct, how they were dealt with and submit these for periodic audit.

8. Support new questions on sexual misconduct being introduced into the Staff Survey and GMC Survey from 2024.

9. Work in partnership with our Women's network and EDI Group to review and monitor these objectives

10. To review our support for flexible working and the career paths for junior doctors and consultants.

Appendix 3 – Progress update

No.	Action	Key steps	Lead	Status
1	To communicate regularly on the importance of a positive workplace culture and share experience of building civility at work, psychological safety and a just culture	Monthly Team Brief Topics and 3 x Workplace Belonging listening groups booked in February and March 24.	Gemma Farley	Ongoing
2	Introduce sexual misconduct awareness into the induction of all staff and especially junior doctors	Doctors induction updated and Trust induction to follow	Helen Moore and Annette Byers	Ongoing - Planned to complete April 2024
3	Review our policies in the light of the findings of the report and consider any additional guidance required	Review of Dignity and Conduct policies with EDI group lens applied	Gemma Farley	Ongoing - Planned to complete June 2024
		Domestic Violence and Abuse Policy revised and implemented on 24th July 2023. Violence Prevention and Reduction policy currently being revised by VPR Group for April 2024	Lawrence Anderson	Ongoing - Planned to complete April 24
4	Support our Speak Up action plan to ensure access and awareness of the ways to raise concerns at work	Action Plan developed and engaging with third party to deliver independent Speak up service while we reform our internal support and governance.	Nicky Reeves / Sheila Perkins	Ongoing
5	Ensure that colleagues working in Workforce and OD, and especially those supporting case investigation work have received training on first response and appropriate subsequent advice for staff and their managers on sexual misconduct	Training with Capsticks for ER and Wellbeing team on sexual safety in the workplace - 2 hour in-person workshop. Capsticks to propose training on sexual safety in the workplace for SMT. New guidance and process/flowchart to be developed following training.	Gemma Farley	Ongoing
6	Ensure learning on sexual misconduct is integrated into B&H and EDI training for new and existing staff, including access to active bystander / unconscious bias training and especially for clinical supervisors, education leads and training programme directors.	No ESR eLearning available at present. Pending national development and raising within the region.	Annette Byers	Ongoing
		Review of trainee doctors induction to incorporate information on Charter. Will look into additional training provision for ESs	Helen Moore	Complete
		Reference to new guidance and process/flowchart to be developed following training	Gemma Farley	Ongoing
7	Ensure our case management enables us to keep a record of any current or future cases of sexual misconduct, how they were dealt with and submit these for periodic audit.	Separate tab on ER casework tracker	Gemma Farley	Complete

8	Support new questions on sexual misconduct being introduced into the Staff Survey and GMC Survey from 2024	Specific questions cannot be accessed locally. GMC will notify Trust of any concerns raised by trainees as part of survey	Helen Moore	Complete
		New questions in place as part of quarterly and national staff survey	Annette Byers	
9	Work in partnership with our Women's network and EDI Group to review and monitor these objectives	Nicky Reeves leading sexual misconduct charter discussion at Women's Colleague Network planned for 4th March	Nicky Reeves	Ongoing
10	To review our support for flexible working and the career paths for junior doctors and consultants.	Updated flexible working policy	Gemma Farley	Ongoing - Planned to complete May 24

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/03/2024		**Agenda reference:**	174-24	
Report title:	**Operational performance**				
Sponsor:	Kathy Brasier, Interim Director of Operations				
Author:	Kathy Brasier, Interim Director of Operations Maddy Johnson, Business Support Manager				
Appendices:	Operational Performance data report M10				
Executive summary					
Purpose of report:	This report outlines the highlights of the operational performance for M10 and M9				
Summary of key issues	Key highlights include; • Cancer performance: achieved FDS and 62 day combined standards, and the 62 day backlog has reduced. 31 day combined performance remains a challenge • RTT performance: although deteriorating, QVH is performing higher than national average for all waiting brackets. 52WW achieved trajectory for M10. 78WW and 65WW positions are adversely impacted by industrial action (IA), further planned IA is likely to prevent achieving zero 65WW by M12. • DMO1 is below target but remains on an improving trajectory. Sleep continues to be challenged but the forward look suggests recovery • Activity plan not met for M10, largely driven by elective activity underachievement; 99% of plan achieved YTD • Theatre utilisation and cancellations on the day are achieving target; QVH theatre utilisation continues to be in the highest national quartile • Outpatient PIFU performance is the highest on QVH record for M10, and hospital cancellations continue to meet target. Outpatient DNAs and patient cancellations on the day remain challenged.				
Recommendation:	The Board is asked to **NOTE** the operational performance				
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:	Finance and Performance Committee				
	Date:	26.02.24	Decision:		
Next steps					

Report to:	Board of Directors
Agenda item:	174-24
Date of meeting:	07/03/2024
Report from:	Kathy Brasier – Interim Director of Operations
Report author:	Kathy Brasier, Interim Director of Operations Maddy Johnson, Business Support Manager
Date of report:	15 February 2024
Appendices:	Operational Performance data report

Operational performance

Introduction

This report outlines the highlights of QVH operational performance for M10, noting that Cancer Waiting Times (CWT) standards are reported a month behind therefore will be M9.

Cancer performance

Faster Diagnosis Standard (FDS)

FDS performance continues to achieve target reporting 89.1% in M9. When benchmarked against national and regional M9 data, the Trust is performing above average: Sussex ICB reported 71% and the national position was 74%.

62 day combined

The Trust now is reporting combined 62 Day Standards in line with changes to CWT targets. The Trust achieved target in M9 reporting 86.2% which is much higher than the regional and national average: for M9 the Sussex ICB reported 62.5% and the national average was 65.9%.

Skin has met this target for two consecutive months, returning to similar levels reported in Q1 2023-24. Similarly, Head and Neck achieved the 62 day target in M9 for the first time since December 2022.

31 day combined

As with the 62 day standard, the Trust now is reporting combined 31 Day Standards in line with changes to CWT targets. The Trust reported 85.7% in M9, this is below the national target of 96% and below regional (91.1%) and national (87.5%) averages for M9. Performance is particularly challenged by Sentinel Lymph Node Biopsy (SLNB) capacity within Skin. There are a number of actions in place to mitigate this, for example the service is trialing a new piece of surgical equipment which will reduce reliance on external providers who often have capacity issues.

62 day backlog

The 62 day backlog reduced to 55 patients in M10; this is the lowest reported figure since M4. Within the 62 day backlog figure there are 15 patients over 104 days, largely driven by Skin. Although Skin continues to be the most challenged area within the backlog, the Skin 62 day backlog figure has reduced by 23% compared to previous month primarily due to running additional Saturday lists. Improvement plans are in place for all cancer specialties.

Referral to Treatment (RTT) Performance

RTT 78 week wait

The Trust reported 15 patients waiting 78 weeks in M10 which has reduced by 1 compared to M9. Performance is challenged by late referrals from other providers, medically complex pathways and capacity lost due to industrial action (IA). These patients are tracked weekly at service level and prioritised

where clinically appropriate. Challenges with theatre capacity continue to be mitigated through reallocating of theatre lists between specialties and scheduling additional Saturday waitlist initiative sessions.

QVH patients waiting over 78 weeks make up 2.2% of the 78 week waiting patients across the Sussex ICB.

	Revised 78WW trajectory **		
	Jan	**Feb**	**Mar**
Plastics	9	8	5
MF all	0	0	0
OD	1	1	0
Corneo	0	1	1
	10	**10**	**6**

RTT 65 week wait

For M10, the Trust reported 95 patients waiting 65 weeks against the original internal trajectory of 94. This is a reduction of 20 patients compared to the previous month. While performance continues to be challenged by late referrals, theatre staffing and capacity, all specialties achieved their revised trajectories for M10 and 65WW patients continue to be prioritised for scheduling where clinically appropriate.

	Revised 65WW trajectory **		
	Jan	**Feb**	**Mar**
Plastics	70	50	25
MF all	11	13	2
OD	11	10	3
Corneo	3	4	1
	95	**77**	**31**

*** The above revised trajectories were produced following the December and January IA, however given the planned February IA this will need to be revisited. It is therefore unlikely that the Trust will be able to report 0 x 65 week waits by M12.*

When benchmarked against regional and national data, QVH is performing above average; in M9, the Sussex ICB reported 1.9% of RTT patients waiting over 65 weeks and the national position was 1.3%, whereas QVH reported 0.6% for the same period.

RTT 52 week wait

52 week performance has achieved trajectory for M10. The Trust reported 465 patients waiting over 52 weeks against the revised internal trajectory of 699. When benchmarked against national data, QVH is performing consistently above average for 52 week waits; the national look back for M9 was 4.4% of RTT patients waiting over 52 weeks, whereas QVH reported 2.9% for the same period.

RTT 18 week wait

Reporting 57.6% for M10. The overall 18 week wait position is deteriorating significantly, this is to be expected as we focus our efforts on seeing the urgent, clinical priority and long waiting patients. When benchmarked against national data, QVH is performing above average; the national look back for M9 was 56.6%, whereas QVH reported 57.9% for the same period.

Industrial Action (IA)

A further announcement of industrial action for junior doctors, commencing 24 February through to 28 February 2024, has significantly reduced theatre and outpatient capacity across all specialties.

During this period a plan is in place to protect urgent, clinical priority and long waiting patients where possible.

This will again significantly reduce the trusts ability to deliver in month performance trajectories, impacting the zero 78 and 65 week waiting patients by the end M12. Recovery of the lost capacity continues to be a challenge as the year end approaches but is being worked through in detail.

DMO1
The Trust reported 88% in M10; this is below the national target of 95%, however this compares to 53% reported in the same month of the previous year. The main challenge continues to be within the Sleep service which reported 72% for M10 with 221 breaches, however this has improved significantly compared to the same month of the previous year which reported 24% with 1093 breaches. Unvalidated M11 Sleep DMO1 performance appears to be in recovery, this is monitored weekly.

Radiology continues to exceed target, reporting 97% in M10 despite the impact of equipment outages and estates challenges.

When benchmarked against national data, the Trust is performing above average: national M9 DMO1 position was 73.2%, whereas QVH reported 89% for the same period.

Activity against plan
The Trust achieved 90% of plan in M10. Underperformance was largely driven by elective activity which was adversely impacted by industrial action across all services. Year to date, however, 99% of plan has been achieved with particular overachievement in outpatient procedures, notably within Ophthalmology.

Transformation performance - Theatres
Theatre utilisation achieved target reporting 85.9% for M10. The Trust's theatre utilisation is excellent when benchmarked against peers and we continue to perform within the highest national quartile.

Cancellations on the day have also achieved target for four consecutive months. The unvalidated M11 position appears to be deteriorating, but there is work ongoing to ensure a clear and consistent cancellation escalations process is in place, as well as targeted work to reduce ophthalmic cancellations related to blood pressure through agreement of a standardised criteria.

Transformation performance - Outpatients
The percentage of patients added to Patient Initiated Follow Up (PIFU) pathways has improved in M10, reporting the highest level on QVH record (1.9%). The Trust is now 0.9% away from achieving the 2.8% target. Further PIFU pathways are in development to go live in M11.

Hospital cancellations continue to achieve target reporting 2.8% in M10, well below the 4% KPI.

Outpatient performance related to DNAs and patient cancellations on the day continue to be challenged. DNAs remain above the 4% target reporting 5% in M10, work continues at service level to target areas of opportunity and a deep dive is underway within therapies. It is worth noting that the DNA rate has been gradually reducing since the 5.5% peak reported in M5.

Recommendation
The Board is asked to **NOTE** the operational performance.