Bundle Public Board 4 July 2024

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- *Safeguarding annual report*
- *Infection, prevention and control annual report*
- *Emergency preparedness, resilience and response (EPRR) annual report*
- *Research and innovation annual report*
- *Consultant revalidation annual report*

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40.24 Financial, workforce and operational performance assurance
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Assurance

40-24 FPC assurance report to Board FINAL

41.24 Any other business (by application to the Chair)
Jackie Smith, Trust Chair
Discussion

42.24 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 4 July 2024

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

MEMBERSHIP
BOARD OF DIRECTORS
July 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
Chief Medical Officer	-	Tania Cubison
Chief Nursing Officer	-	Nicky Reeves
Chief Finance Officer	-	Maria Wheeler

In full attendance (non-voting):

Chief Strategy Officer	-	Abigail Jago
Chief People Officer	-	Helen Edmunds
Chief Operating Officer	-	Kirsten Timmins
Company Secretary	-	Leonora May

Annual declarations by directors 2024/25

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	Nil	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 coaching and training)	Nil	Nil

Karen Norman Non-Executive Director	Visiting Professor, School of Nursing, Allied and Public Health, Faculty of Science, Social Care and Education, Kingston University Visiting Professor, Doctorate in Management Programme, Complexity and Management Group, Business School, University of Hertfordshire Non-executive director (clinical) for the South East Coast Ambulance Service (from 8 July 2024)	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 Chief Medical Officer	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 Nursing Officer	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
Helen Edmunds Chief People Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Kirsten Timmins Chief Operating Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Fit and proper persons declaration

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

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board (voting)							
Jackie Smith Trust Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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 Chief Medical Officer	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 Nursing Officer	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
Helen Edmunds Chief People Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kirsten Timmins Chief Operating Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 4 July 2024
10.00-12.00

Agenda: session held in public		
WELCOME		
29-24	**Welcome, apologies and declarations of interest** *Jackie Smith, Trust Chair*	
STANDING ITEMS		**Purpose**
30-24	**Draft minutes of the public meeting held on 2 May 2024** *Jackie Smith, Trust Chair*	*Approval*
31-24	**Matters arising and actions pending from previous meetings** *Jackie Smith, Trust Chair*	*Review*
32-24	**Chair's report** *Jackie Smith, Trust Chair*	*Assurance*
33-24	**Chief Executive's report** *James Lowell, Chief Executive Officer*	*Assurance*
GOVERNANCE, STRATEGY AND RISK		
34-24	**Freedom to Speak up Guardian report** *Jackie Doherty, Freedom to speak up guardian*	*Assurance*
35-24	**Board assurance framework** *Leonora May, Company Secretary* *Nicky Reeves, Chief Nursing Officer*	*Assurance*
36-24	**Business plan 2024/25** *Maria Wheeler, Chief Finance Officer*	*Ratification*
PERFORMANCE		
37-24	**Integrated quality and performance report** *Kirsten Timmins, Chief Operating Officer*	*Assurance*
COMMITTEE ASSURANCE REPORTS		
38-24	**Audit and risk committee assurance** *Paul Dillon-Robinson, Non-Executive Director and committee Chair*	*Assurance*

39-24	**Quality and safety committee assurance incl. Quality and safety annual reports 2023/24:** • **Safeguarding annual report** • **Infection, prevention and control annual report** • **Emergency preparedness, resilience and response (EPRR) annual report** • **Research and innovation annual report** • **Consultant revalidation annual report** *Shaun O'Leary, Non-Executive Director and committee Chair* *Nicky Reeves, Chief Nursing Officer* *Tania Cubison, Chief Medical Officer*	*Assurance/ ratification*
40-24	**Financial, workforce and operational performance assurance** *Peter O'Donnell, Non-Executive Director and committee Chair*	*Assurance*
MEETING CLOSURE		
41-24	**Any other business (by application to the Chair)** *Jackie Smith, Trust Chair*	*Discussion*
MEMBERS OF PUBLIC		
42-24	**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*	

Document:	Minutes (FINAL)	
Meeting:	**Board of Directors (session in public)** **10.00-12 noon 2 May 2024** **Education centre, QVH**	
Present:	Jackie Smith	Trust Chair (voting) (Chair)
	Paul Dillon-Robinson (PDR)	Senior independent director (voting)
	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)
	Kirsten Timmins (KT)	Chief operating officer (voting)
	Helen Edmunds (HE)	Chief people officer (non-voting)
	Abigail Jago (AJ)	Chief strategy officer (non-voting)
In attendance:	Leonora May (LM)	Company Secretary (minutes)
Apologies:	None	
Members of the public:	Six governors and four members of staff	

Welcome

1-24 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board including KT and HE to their first public Board meeting, and those observing the meeting including six governors and four members of staff.

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

There were no apologies and the meeting was declared as being quorate.

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

Standing items

2-24 **Patient story**

NR shared a compliment from a patient who had received surgical treatment (breast deconstruction, mastectomy and reconstruction) at QVH in January 2024. The compliment included comments about how:

- Each member of staff had treated her with warmth and respect, particularly the nurse who was warm and kind and that she had utmost confidence in the team who were looking after her
- The preparation for the surgery led her to feel calm and confident about her surgery as she was anaesthetised
- The nurses and health care assistants working on on Margaret Dumcomb ward were beyond exceptional, with a clear culture of care engrained into the team
- The domestic and catering staff are 'unsung heroes', and demonstrated care and compassion in 'small' gestures which can mean the difference between receiving good enough care and her feeling like she was receiving holistic wrapped around care where she was at the 'soul and centre'

The Board thanked NR for sharing what was described as exemplary care received by a

	patient, and was pleased to recognise the important contribution from domestic and catering staff. The Board agreed that this patient centred culture must be retained throughout the development and implementation of the Trust's strategy. NR confirmed that the patient has been thanked for taking the time to share their story. The Board **noted** the patient story.
3-24	**Draft minutes of the public meeting held on 7 March 2024** The Board **agreed** that the minutes of the public Board meeting held on 7 March 2024 are a true and accurate record of that meeting and **approved** them on that basis.
4-24	**Matters arising and actions pending from previous meetings** The Board **noted** that there are two pending actions which are not yet due, and the updates within the report.
5-24	**Chair's report** JS reminded Board members to be mindful of using jargon when presenting reports for the benefit of those who observe the meeting. JS presented her report to the Board and reporting that she continues to visit services with the lead and deputy lead governors and that her Non-executive director colleagues have been encouraged to do the same. She reported that Cedi Frederick, Chair of NHS Kent and Medway ICB had attended the last Council of Governors meeting to present an update on the ICB to the Council of Governors and the Board which was insightful. JS highlighted that a meeting of the Strategic development committee working group for governors will be held on 14 May 2024, and she encouraged all governors to attend as this is a critical time for the development of the Trust's strategy. The Board **noted** the contents of the report.
6-24	**Chief Executive's report** JL presented the report to the Board, highlighting that: - The Trust's performance during 2023/24 was good with strong performance related to cancer diagnostics. The Trust had not met its target for 65 week waits for RTT patients. Ambitious targets have been set for the next year. He extended thanks to all staff for their great work during the year - It is a critical time for the development of the Trust's strategy as well as the development of the Trust's revised vision and values. Work to engage staff and stakeholder continues as a priority - Work to redefine the organisation and address the recommendations from the Trust's well led review is ongoing. The new organisational structure has been launched and clinical directors for each of the directorates have been appointed The Board considered and discussed the updates as follows: - The Board commended the Trust's operational performance for 2023/24 - A Board member asked about meeting the September deadline for the publication of the strategy and also about the level of clinical engagement throughout the development of the strategy. In response, JL acknowledged the challenging timeline which is still thought to be achievable, notwithstanding risks including changes to the political landscape, changes to ICB strategies and support from staff and stakeholders. NR and TC confirmed that clinical engagement has been strong and that clinical workshops have been a success - Discussion was had regarding the developing provider collaboratives and JL shared the hope that these reach the same level of maturity as others with delegated

	authority from the ICB to transform clinical services. The NHS Sussex provider collaboratives are at the start of their journey - In response to a question about feedback received from staff about the new organisational structure and triumvirate working, JL confirmed that staff recognise the need for change and are keen to see how it will work in practice. Colleagues are being support with new ways of working and staff engagement throughout the development of the structure was paramount - NR agreed to report to a future Board meeting the learning and outcomes for patients and staff related to the Schwartz rounds. **Action NR** The Board **noted** the contents of the report.
GOVERNANCE, STRATEGY AND RISK	
7-24	**Guardian of Safe Working report** TC presented the report to the Board. The Board commented on the quality of this report, specifically the lack of assurance and evidence, highlighting the list of issues and summary which concluded that there have not been many exceptions reports during the quarter with uncertainty about whether this is due to rotas working well or a reluctance to fill in exception reports. It was agreed that TC would ensure that appropriate assurance and evidence is provided next time. A Board member commented on the fines outlined within the report and asked whether further thought can be given to a more proactive approach. In response, TC confirmed that many of the fines were expected as the rotas were planned in advance and in the event that someone does get called, a fine will be issued due to the person not getting the correct amount of sleep. She confirmed that usually the rotas are planned appropriately but there are occasionally times where on call facilities need to be used. The Board **noted** the contents of the report.
8-24	**Company Secretary's report** LM presented the report to the Board and reported that: - The Trust had complied with its standard and additional licence conditions during 2023/24. There is no requirement to self-certify this year as in previous years. The Audit and risk committee had received detailed assurance. A key part of demonstrating compliance with the additional licence conditions is the development of the new Code of conduct for governors which will be approved during Q1 2024/25 - A review has been completed on compliance with the Code of governance for NHS provider trusts. The Audit and risk committee have reviewed the outcome of this review in detail. The areas that the Trust will report minor non-compliance with the Code are Senior independent director and Chair of the Audit and risk committee being same person for a period during the year, succession planning development, policy for removal of a governor and remuneration for the Chair and Non-executive directors - The draft Scheme of delegation and reservation of powers is presented for approval following recommendation from the Audit and risk committee. These documents have been reviewed to ensure delegation for decision making and financial limits are appropriate - The draft terms of reference for the Strategic development committee and Audit and risk committee are presented with minor changes for approval following recommendation from the committees. PDR confirmed that the Scheme of delegation and reservation of powers has been reviewed in detail by the Audit and risk committee who support the proposed changes.

	In response to a question, LM confirmed that the Trust annually reviews national Non-executive director pay benchmarking analysis from NHS Providers to ensure that it is not an outlier in paying above the recommended amount. The Board: - **Noted** that the Trust has complied with its standard and additional Licence conditions during 2023/24 - **Noted** the areas of non-compliance with the Code of governance for NHS provider trusts as set out above - **Approved** the changes to the Scheme of delegation and reservation of power and the Standing financial instructions - **Approved** the Audit and risk committee and strategic development committee terms of reference
9-24	**NHS Sussex Committee in Common Terms of reference** JL presented the report, reporting that the committee in common is an important step in NHS Sussex becoming an integrated system. LM confirmed that at this stage, the Board is not being asked to delegate any of its decision making authority and that decisions will be made on the basis of delegated authority of the members of the committee. Any decisions required above this delegated authority will go through the Trust's usual governance processes. The primary function of the committee will be to deliver the Improving lives together strategy, but this is also a good opportunity to drive forward system risk oversight and management. The first meeting is arranged for 8 May 2024. The Board was asked to approve the establishment of the committee and its terms of reference The Board considered and discussed the proposal as follows: - The Board agreed the importance of keeping traction of the work of the committee and impact for patients, service users and their families to ensure effectiveness and JS confirmed that the Chairs are focussed on making a difference for patients - The Board agreed that the terms of reference are broad and encouraged members of the committee to remain focussed on what the committee will deliver. JS confirmed that the committee will consider eight priorities and focus on two or three things which will have a lasting impact on patient care - The Board acknowledged that this collaboration will be an important enabler to transform clinical services and develop relationships between organisations - JL concurred that this committee must deliver change to the health and care system and address health inequalities in a meaningful way The Board **approved** the establishment of the committee and common and its terms of reference.
10-24	**Board assurance framework (BAF) and corporate risk register (CRR)** LM presented the report to the Board, highlighting the executive summaries which were included for each BAF and changes from the last period visible in the BAF summary document. All scores remain the same with the exception of BAF 1 where the score has reduced from 15 to 10. The BAFs have been reviewed by the sub-committees during April. NR provided the Board with an update regarding ongoing work to refresh the Trust's approach to risk management and acknowledged that there is further work to do on the development of the BAF and CRR. The Trust has some support from an interim risk lead to operationalise and make the documents meaningful. NR stated that the strategic and corporate risks highlight current areas of concern for noting.

	The Board provided feedback on the development of these documents. A Board member expressed the view that the current approach is too focussed on scores and requested that the Board hears from management about the risk landscape for the organisation with evidence and assurance that high level risks are being effectively managed. The Board agreed that there is further work to do in refining the information presented. The Board asked about the timescale for the refreshed approach to risk management and refined reporting. NR acknowledged that changes within the executive team had made this work more complex. She confirmed that the refreshed approach to risk management and refined report should be in place by the autumn with the help from the interim risk lead. The Board invited the executive team to highlight any current areas of concern and KT confirmed that she is concerned about long waiting patients and the sustainability of some of the teams, including many interim appointments. The Board agreed the importance of the risk profile recognising and monitoring system risks. The Board **noted** the report.
11-24	**Audit and risk committee assurance** PDR presented the report to the Board, highlighting that the monitoring of the contract management improvement plan is a key area of focus for the committee. He reported that the Audit and risk committee will have an additional meeting to consider the revised risk management framework and that the committee is pushing to receive further updates on system risk management as this is a recognised gap for NHS Sussex. A Board member asked for PDR's view on when the committee will be assured that the contract management improvement plan is complete. In response, PDR confirmed that he expected the improvement plan to be complete and embedded within nine months. In response to a question, PDR confirmed that there is nothing that the committee is aware of that may affect the Trust's going concern rating within its Annual governance statement. The Board **noted** the contents of the report.
Key strategic objective 3: operational excellence	
12-24	**Financial, workforce and operational performance assurance** POD presented the report to the Board, highlighting that: - The committee notes that the Trust has not delivered on its 65 week wait RTT target and is expecting to meet it during September but there is challenge and risk related to this position - The committee is assured that the current estates team are aware of current issues and that they are bringing arising issues to the committee's attention. There is further work to do on disability compliance, RAAC and asbestos compliance. The committee is assured that good progress has been made on fire safety compliance but acknowledges challenges with meeting the agreed timeline for completion In response to a question regarding waiting time targets, POD confirmed that the committee did have some pre warning of this but the ability for the Trust to effectively forecast is a weakness and the committee is keen to see further improvements in this. A committee member confirmed that some opportunities had been missed to identify RAAC which had led to some questions about the confidence of the committee in the assessment of the estate. There are lessons to be learned from this.

	The Board acknowledged quality of appraisals as a long standing issue and urged that this issue is dealt with as a matter of priority. The Board **noted** the contents of the report.
13-24	**Operational performance report** KT presented report to the Board, reporting that QVH performs well in terms of operational performance. Her biggest concern is related to long waiting patients. She confirmed that QVH did not meet its target to eliminate patients waiting more than 78 weeks by year end, and there were nine patients remaining. She hopes that these will be eliminated by the end of June 2024. KT reported that to date the Local anaesthetic unit had seen 250 patients which would usually have been treated in the Trust's theatres. Theatre efficiency is good but more will be done to improve this. KT highlighted the importance of improved forecasting and confirmed that work is ongoing with the business intelligence team to make this happen. A Board member sought assurance that long waiting patients are not coming to clinical harm and urged this to be thought about in the widest sense, In response, TC confirmed that all patients are triaged upon booking and treated before the recommended date identified upon triage. The Board thanked KT for her patient centred approach to operational oversight and **noted** the contents of the report.
Key strategic objective 5: organisational excellence	
14-24	**Workforce performance report** HE presented the report to the Board and reported that the team are completing a deep dive on appraisal compliance and quality following the Finance and performance committee meeting. For those that have not had an appraisal, staff are being followed up with individually. HE reported that an ethnicity pay gap report is being drafted and confirmed that in recent months, the Trust's gender pay gap has been zero. A Board member asked about the increase in agency staff and whether there is cause for concern. HE confirmed that this is a concern but it is within target and will reduce for the new financial year. The Board **noted** the contents of the report.
Key strategic objective 4: financial sustainability	
15-24	**Financial performance report** MW presented the report, highlighting the Trust has a break even position for month 11, and for the 2023/24 financial year end. She reported challenges around capital spend ahead of year end and confirmed that the draft accounts have been submitted. MW provided the Board with an update on fire safety, reporting that good progress has been made, however, a survey has highlighted that the fire dampners are in a bad state of repair and more work is required than first thought. It is likely that this work will not be completed before the 3 June 2024 deadline. West Sussex Fire Service remain supportive of the Trust and work completed to date.

	The Board sought assurance that that learning related to fire safety issues has been embedded to ensure that similar situations will not arise in the future. MW confirmed that standard operating procedures have been established to ensure that checks and balances have been done and that a fire authorised engineer has been appointed. External assurance will be provided by ongoing checks by the fire service and the Finance and performance committee will continue to receive regular updates. A Board member asked if there are cultural issues within the estates and facilities team and a lack of curiosity. MW confirmed that in the past there have been cultural issues, but that staff are now coming forward to raise issues and have seen positive outcomes from raising issues. JL confirmed that estates work going forward should be completed to the required standard and that a missed opportunities audit is underway to establish route causes of issues and what needs to happen to ensure that they do not resurface. The Board acknowledged the Trust's positive financial position and **noted** the contents of the report.
Key strategic objectives 1 and 2: outstanding patient experience and world class clinical services	
16-24	**Quality and safety committee assurance** SOL presented the report to the Board and reported that there had been no serious incidents reported to the committee during the period. The committee had received assurance that the Trust continues to maintain its substantial compliance in relation to emergence planning, response and resilience (EPRR), but have urged for more planned training around this to ensure preparedness. He reported an improvement in antimicrobial stewardship. SOL confirmed that the learning from patient stories has been very varied and therefore it has been difficult for the committee to identify themes for continued monitoring. The Board **noted** the contents of the report.
17-24	**Annual review of learning from patient stories** NR presented the report to the Board, highlighting that complaints are often centred on communication issues which escalate. She expressed the view that an increased focus on culture will support positive patient experience. The Board considered and discussed the contents of the repot as follows: - Discussion was had regarding behavioural issues that the report identifies and the Board recognised cross over with workforce, culture and safety which will be picked up by NR and HE - JL recognised that there is further work required to develop this report in providing insight into route causes and culture. He emphasised this as a starting point with more work to be done. The integrated performance reporting will help with triangulation and the Board noted that a behavioural framework is being developed alongside the vision and values - The Board acknowledged the importance of valuable patient feedback and the need to embed learning from it which will feed into the Board's strategy and culture work The Board **noted** the contents of the report.
18-24	**Quality and safety report** NR presented the report to the Board, confirming that the Schwartz rounds had been positive for the Trust. She encouraged colleagues to attend. NR confirmed that the new freedom to speak up guardian service is in place and operating well. She agreed to invite the guardian to the July Board meeting to provide an update. **Action NR** The Board **noted** the contents of the report.

Meeting closure	
19-24	**Any other business (by application to the Chair)** There was none.
Members of public	
20-24	**Questions from members of the public** 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 There was a patient story last year from a patient who was scheduled onto a Saturday list and there was a lack of support services available. How can the Board be assured that if weekend services are increased, patient care is not compromised? Response HE confirmed that the executive team are considering what a six or seven day week looks like and workforce planning accordingly, including ensuring that the workforce are on board, with modelling to match activity. JL confirmed that all essential parts of services will continue to be covered during weekend activity. Question The BAF is difficult for a lay person to understand. Is the Board confident that it understands the Trust's risk profile from the information presented? Response JS acknowledged that risk reporting is not where it needs to be and that further assurance regarding the effective management of risks is required. The Board is aware of the key areas for concern and what is being done to manage them. Question Are there any worries about the Trust's financial position? Response MW confirmed that the Trust is reasonably comfortable with its revenue position but the system is in a difficult financial position. The ability to maintain the Trust's estate is a concern as well as meeting efficiency targets and achieving value for money without diminishing quality. Question What assurance can be taken from the Guardian of safe working report, specifically relating to supervision of plans? Response TC confirmed that assurance will be given to the Deanery by June that all sessions have been removed. Question Are the Non-executive directors assured that the Trust is on track with implementing the recommendations from the well led review? Response

	JS confirmed that the Non-executive directors are assured regarding the ongoing work around the development of integrated performance reporting and organisational restructure but remain concerned about risk and assurance. Question What are the risks to QVH with the development of provider collaboratives and committee in common? How do we ensure that our patients are still taken care of? Response JL confirmed that the Trust has a duty to collaborate under the Health and Social Care Act 2022, and support the needs of the public at large. The Trust is keen to support the system and patients and public at large whilst maintaining what is great about QVH.

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~~ July 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 April 2024: The Integrated assurance framework will be presented to the Board at its meeting in July 2024 July 2024: Integrated quality and performance report included on agenda	Closed
2	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~~ HE	~~April 2024~~ ~~July 2024~~ September 2024	January 2024: Deep dive being completed into gender pay gap and will be presented to the finance and performance committee April 2024: the Finance and performance committee received an update during April 2024. Other Trusts will be included in the annual report presented to the Board in July 2024. July 2024: Gender pay gap update to Board delayed until September due to pre-election period. The Finance and performance committee received the report at its meeting in June 2024.	Pending
3	May 2024	06-24	Schwartz rounds	Provide the Board with an update regarding learning and outcomes for patients and staff related to the Schwartz rounds	NR	1 September 2024	June 2024: Scheduled for the September 2024 Board meeting	Not yet due
4	May 2024	18-24	FTSU	Invite new Freedom to speak up guardian to July Board meeting	NR	4 July 2024	June 2024: New Freedom to speak up guardian attending July Board meeting to present report	Closed

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04/07/2024		**Agenda reference:**	**32-24**	
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	• There is work to do on the quality of papers with less data and more insight • All day governor development day held during May 2024 • Annual general meeting/ Annual members meeting being held on 16 September 2024 • Welcome to our four new public governors				
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:	32-24
Date of meeting:	2 May 2024
Report from:	Jackie Smith, Trust Chair
Report author:	Jackie Smith, Trust Chair
Date of report:	27 June 2024
Appendices:	None

Chair's report

Introduction

The papers for this Board meeting were published during the pre-election period, which means that they are limited to matters which require operational or financial oversight.

Service visits

Since the last Board meeting the non-executive directors have visited the risk, Charity and human resources and organisational development teams as well as theatres and plastics. I have continued visiting services with the lead and deputy lead governor. I have visited the library, dieticians, radiology and critical care.

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. I am pleased to say that governors have been invited to join the Non-executive directors on service visits to get to know more about the Trust and its services and to help in their role of holding the Non-executive directors to account for the performance of the Board.

Other activities

At its extraordinary meeting on 18 June 2024, the Board reviewed and approved the Annual report and accounts 2023/24. These will be shared with our governors and members at our Annual general meeting/ Annual members meeting which is being held at 6pm on 16 September 2024.

During the period, the Board completed the final part of its self-assessment of its own effectiveness through a survey which included questions about Quality of papers, Chairing and Board support, the Board's approach to partnerships, Board development and the annual cycle of business.

The responses to the survey indicate that although there has been some improvement to the quality of reports, there is still work to do to ensure that they are consistently of good quality with less data and more insight. The general feeling is that Board papers are too long. The new format for the Non-executive director's committee assurance reports to Board (alert, assure, advise) has been welcomed by the Board. There is agreement amongst the Board that the Board seminars have been valuable and that there are opportunities for further development and mutual learning. An action plan is being developed to address any areas identified for improvement.

Governors
During May, we held an all-day development and training for governors which was well received.

During June, governor working groups were held with the Finance and Performance and Quality and safety committee Chairs, executive leads and governors. An Informal Council of Governors meeting was held on 19 June 2024.

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

I am really pleased that we will welcome Antony, John, David and Richard to the Council of Governors as public governors from 5 August 2024.

Strategic development committee
A meeting was held during May, the assurance for which will be included in my next report following the end of the pre-election period.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04/07/2024		**Agenda reference:**	**33-24**	
Report title:	Chief Executive's report				
Sponsor:	James Lowell, Chief Executive Officer				
Author:	Michelle Baillie, acting Associate Director of Communications and Engagement				
Appendices:	N/A				
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	• QVH continues to excel in a number of our operational performance domains. For patients on a cancer pathway, we reported the highest performance on QVH record of 90.6% against the 75% Faster Diagnosis Standard in March 2024. • Our system focus remains on reducing long waiting patients to ensure that no patient waits in excess of 65 weeks by September 2024 • I am pleased to confirm that we broke even at the end of the last financial year • As Nicky Reeves, our Chief Nursing Officer, marks her 40 year anniversary of working in the NHS, she has announced that she will be retiring. Jane Dickson has joined us as Interim Chief Nursing Officer • As you will be aware we are now in the pre-election period in the lead up to the General Election on Thursday 4 July and are bound, like other trusts, by strict guidance on what can and cannot be done or said. This month and next we had a number of key meetings planned to progress the essential elements of our strategy development before the final strategy goes to Board for approval which unfortunately must now be postponed until after the General Election. This will lead to a short delay in the approval and launch of our new strategy • As I write this report, junior doctors across the NHS are preparing for their latest period of industrial action which begins at 7am tomorrow until 7am on Tuesday 2 July				
Recommendation:	It is recommended that the Board **notes** the contents of the report				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				

Report to:	Board Directors
Agenda item:	33-24
Date of meeting:	4 July 2024
Report from:	James Lowell, Chief Executive Officer
Report author:	Michelle Baillie, acting Associate Director of Communications and Engagement
Date of report:	26 June 2024

Chief Executive's report

Operational performance

QVH continues to excel in a number of our operational performance domains. For patients on a cancer pathway, we reported the highest performance on QVH record of 90.6% against the 75% Faster Diagnosis Standard in March 2024. We achieved 95% against the DM01 diagnostic waiting time target in May 2024 compared to a national average of 77%, and we continue to exceed the 95% 4 hour urgent care standard each month in our Minor Injuries Unit.

Our system focus remains on reducing long waiting patients to ensure that no patient waits in excess of 65 weeks by September 2024. It is important that patients have timely treatment and we are supporting other providers to enable equity of access where we can.

Financial performance

I am pleased to confirm that we broke even at the end of the last financial year which is thanks to the hard work of all of our colleagues. However we are aware of the economy in which we operate and the expectations of increasing efficiency savings next year to support the Sussex integrated care system and wider NHS. We will continue looking at making the best use of our resources and eliminating waste where we can whilst maintaining the delivery of high quality care to our patients.

Our Chief Nursing Officer

As Nicky Reeves, our Chief Nursing Officer, marks her 40 year anniversary of working in the NHS, she has announced that she will be retiring. Nicky joined QVH 18 years ago and during that time she has been Burns Centre manager, Deputy Director of Nursing, and since 2022 our Chief Nursing Officer. Throughout that time her passion for nursing and our patients has seen us receive some of the best patient feedback in the country, particularly in areas relating to nursing and care. She was also instrumental in QVH's COVID-19 response, ensuring our staff and patients were safe and we were able to support patients with Cancer from across Sussex, Surrey and Kent.

Jane Dickson has joined us as Interim Chief Nursing Officer and is busy meeting colleagues across the organisation and completing a comprehensive handover with Nicky. Jane brings a wealth of experience gained from holding a number of operational, strategic and transformational roles across a range of healthcare settings. She has been a Chief Nurse since 2018 and has worked across the NHS

including for East Kent Hospitals University NHS Foundation Trust, Surrey and Sussex Healthcare, and NHS Blood and Transplant.

On behalf of the Board I would like to thank Nicky for her service and commitment to QVH and for the support she is giving Jane to maintain strong leadership of our nursing teams.

NHS Providers come to QVH

We were delighted to welcome Sir Julian Harley, Chief Executive of NHS Providers in May to learn more about QVH. It was an opportunity for us to show how effective teamwork and collaboration are key to delivering high quality patient care, an approach we are particularly proud of. And it would not be a visit to QVH without showing how our heritage and passion to be at the forefront of innovation inspires us to continue delivering excellence.

Sir Julian is writing a blog about his visit to be shared through the NHS Providers Start the Week, so without wanting to spoil that, he had the opportunity to visit a number of our specialist teams including maxillofacial prosthetics (pictured), our sleep disorder centre, theatres, speech and language therapy, and facial palsy therapy.

There was even some audience participation when Professor Jag Dhanda, Consultant Maxillofacial/Head and Neck Surgeon, showed Sir Julian the technology he has developed, which gives live streaming and restreaming of cadaveric and live surgical techniques using virtual reality for medical education. Brian Bisase, Consultant Maxillofacial Surgeon, explained how we are supporting an increasing number of head and neck Cancer patients with cutting-edge surgery.

Thank you to everyone involved in this visit and we welcome the opportunity to show Sir Julian more next time.

Strategy update

As you will be aware we are now in the pre-election period in the lead up to the General Election on Thursday 4 July and are bound, like other trusts, by strict guidance on what can and cannot be done or said. This month and next we had a number of key meetings planned to progress the essential elements of our strategy development before the final strategy goes to Board for approval which unfortunately must now be postponed until after the General Election. This will lead to a short delay in the approval and launch of our new strategy.

A tremendous amount of work and effort has got us to this point and work is still very much taking place behind the scenes to develop our enabling strategies, clinical strategy and overarching strategy. I would like to personally thank everyone who has been involved so far – whilst the delay in approving the strategy is out of our control we are in a good place to take this for approval to our November Public Board.

Celebrating our staff

Since my last report, we have been fortunate to have had a number of opportunities for our whole organisation to celebrate the work of our colleagues. In May we had Nurses' Day and Operating Department Practitioner (ODP) days and our teams held a celebration of the work of their teams in our Education Centre. It was wonderful to see and very informative.

QVH is known for its love of cakes so I was particularly impressed by this creation by Karen and Rosie, two of our Heads of Nursing, who immortalised Nicky and myself in fondant icing! Thanks to our QVH Charity we also had an ice cream van visit us to treat our staff.

This month we marked Estates and Facilities Day. Having started my NHS career as a porter this day is especially poignant for me and I was honoured to join in the celebrations with the team. Our estates and facilities colleagues play an integral role in helping us support our patients and staff and although you may not always see them, the impact they have made is clear.

Thank you to everyone involved in arranging these important events.

Junior doctor industrial action

As I write this report, junior doctors across the NHS are preparing for their latest period of industrial action which begins at 7am tomorrow until 7am on Tuesday 2 July. Whilst we support colleagues to have the right to take industrial action, we do not underestimate the time and effort staff across our organisation have put in to help plan for this including rescheduling appointments and working to keep our patients safe. Thank you to everyone involved.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04/07/2024		**Agenda reference:**	**34-24**	
Report title:	Freedom to Speak Up Guardian Update				
Sponsor:	Jackie Doherty, Freedom to speak up guardian				
Author:	Nicky Reeves, Chief Nursing Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To update the board on the progress with the roll out of the new freedom to speak up guardian support				
Summary of key issues	3 Speak ups since 29th April 2024 – including 1 legacy Excellent engagement with the new service Clear escalation process for "speak ups"				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	Information	Discussion	Assurance	**Review**
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	Speak up has been logged on the BAF but will be closed following discussion				
Corporate risk register:	Was a Corporate Risk but will be rescored				
Regulation:	It is a requirement to have speak up provision				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	Board of Directors
Agenda item:	34-24
Date of meeting:	4 July 2024
Report from:	Jackie Doherty, Freedom to Speak Up Guardian
Report author:	Nicky Reeves, Chief Nursing Officer
Date of report:	20 June 2024
Appendices:	None

Report title: Freedom to Speak Up Guardian Report

Introduction
All organisations are required to provide a Freedom to Speak up guardian who is an visible advocate in protecting patient safety and the quality of care.

This paper is giving a very high level summary of the QVH approach to Speak up and the activities.

Executive summary
As the Board are aware, we have commissioned a new provider to deliver our freedom to speak up offer to the organisation rather than rely on a trust employed individual.

We have appointed “The Guardian Service” who are the number one Freedom to Speak Up provider in the UK, and they commenced working with us from 29th April 2024.

The team provide access for colleagues via Email and phone with a dedicated number and email address.

We have 24/7 access to the service, interactions can be face to face or virtual.

The Guardian Service have provided a detailed escalation framework and have met with colleagues to ensure there is clarity on how a “speak up” will be managed.

Situation
Since the Guardian Service started with us, they have received 2 new speak ups and 1 legacy speak up.

Due to small numbers so far, there are no themes or learning identified as yet.

We are confident the numbers will increase and there is a significant amount of effort being put in to meeting the teams and being visible in the non-clinical areas.

To date the speak up guardian has been to 12 team meetings, has a slot on the corporate inducting agenda and has carried out 3 drop in sessions.

The organisation has welcomed the speak up guardian and she has a list of teams she is intending to meet over the next few weeks.

The chief nurse meets with the speak up guardian on a bi weekly basis.

There will be more detailed reporting at future boards as the team begin to see increased activity and the report will be written by the speak up guardian as we move forwards.

Recommendation
The Board is asked to **NOTE** this report

Report cover-page					
References					
Meeting title:	Board of Directors				
04/07	04/07/2024		**Agenda reference:**	35-24	
Report title:	Board assurance framework (BAF)				
Sponsor:	Leonora May, Company secretary Nicky Reeves, Chief nursing officer				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one: Board assurance framework				
Executive summary					
Purpose of report:	To present the Board assurance framework (BAF) to the Board				
Summary of key issues	- We are working towards a revised approach to the production of the BAF both in terms of contents and presentation to improve its effectiveness using InPhase - Of the eight risks, three current scores remain the same and five current scores have reduced, meaning that the overall risk profile of the organisation has improved during the period - A number of actions delayed due to pre-election period rules for foundation trusts				
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 June 2024				
Next steps:	NA				

Report to:	Board Directors
Agenda item:	35-24
Date of meeting:	4 July 2024
Report from:	Leonora May, Company secretary Nicky Reeves, Chief nursing officer
Report author:	Leonora May, Company secretary
Date of report:	27 June 2024
Appendices:	Appendix one: Board assurance framework

Board assurance framework (BAF)

Board assurance framework (BAF)

Since the Board's last review, the BAF documents have been reviewed and updated including overall assurance ratings and scores. Assurance regarding committee assessments of the effectiveness of controls is included within the sub-committee assurance reports to the Board.

At its extraordinary meeting in June, the Audit and risk committee received an update on the development of the Trust's Risk management framework and the implementation of InPhase, a risk management tool to simplify the presentation of the BAF. We are working towards a revised approach to the production of the BAF both in terms of contents and presentation to improve its effectiveness. The format of this report has been refined for this meeting.

The Board will be asked to consider the revised Risk management framework and approach to risk appetite at its September meeting.

Summary of all strategic risks

The table below presents a summary of all eight strategic risks and the Trust's strategic risk profile, including the overall assurance ratings showing the level of confidence in the controls.

The trajectory arrows show changes to the current risk scores since the last review of the risks. Of the eight risks, three current scores remain the same and five current scores have reduced, meaning that the overall risk profile of the organisation has improved during the period.

REF	RISK TITLE	Principal Exec	RISK ASSESSMENT			TRAJECTORY		GOVERNANCE COMMITTEE	ASSURANCE RATING
			Inherent	Current	Target	Direction of travel/ Date to reach target score			
01	**Patient services**	Chief Nursing officer	25	10	5	⟷	Dec 24	Q&S	**AMBER**
02	**Workforce strategy**	Chief People Officer	20	9	6	↓	Mar 25	F&P	**AMBER**
03	**Physical infrastructure**	Chief Finance Officer	20	15	6	⟷	Apr 31	F&P	**AMBER**
04	**Long-term sustainability**	Chief Executive	25	8	6	↓	Nov 24	SDC	**GREEN**
05	**Compliance breach (non-clinical)**	Chief Executive	20	9	6	↓	Sep 24	F&P	**GREEN**
06	**Financial sustainability**	Chief Finance Officer	25	12	9	↓	Mar 25	F&P	**AMBER**
07	**Information assets**	Chief Finance Officer	25	12	8	⟷	Dec 24	F&P	**GREEN**
08	**Partner organisations**	Chief Executive	25	8	6	↓	Nov 24	SDC	**GREEN**

Executive summary BAF 1 (Patient services)

Risk profile

The current score remains at 10 with a consequence of 5. The consequence description has been updated to read 'avoidable' harm to people. The overall assurance RAG rating remains as amber demonstrating medium confidence which indicates that there are some issues to be monitored and addressed.

Key issues/ updates

- Progress against the clinical audit plan is off track
- No current mechanism for the triangulation of speak up mechanisms and identification of themes- new action added
- Clinical audit learning being rolled out is off track
- Review of national clinical standards and gap analysis off track
- Qnet search function review off track

Actions completed since last review

- Development of integrated assurance framework

Executive summary BAF 2 (workforce strategy)

Risk profile

The current score has been reduced to 9 on the basis that the consequence has reduced due to the completion of some key actions. The overall assurance RAG rating remains as amber demonstrating medium confidence which indicates that there are some issues to be monitored and addressed.

Key issues/ updates

- There has been some delay in the development of the People and culture strategy due to the general election and pre-election rules for foundation trusts
- Lack of resource to develop more preventative violence prevention reduction initiatives
- A need to embed EDI group and networks
- Lack of leadership and development framework

Actions completed since last review

- End to end recruitment task and finish group established
- Review of Trust values completed
- Local staff survey action planning completed
- Active management of non-compliance with MAST training completed as business as usual

Executive summary BAF3 (physical infrastructure)

Risk profile

The current score remains 15 and the overall assurance RAG rating remains as amber demonstrating medium confidence which indicates that there are some issues to be monitored and addressed. The target date has been moved to December 2031 as the risk will not meet its target score until the hospital rebuild.

Key issues/ updates

- Progress will be supported by the newly appointed Associate director of estates and facilities. A full estates work plan is underway
- Main focus area is on team structure and recruitment to ensure delivery of actions- an important enabler for delivery
- New critical suppliers procurement process in place
- Progress being made in developing a planned preventative maintenance plan
- Fire safety enforcement notice received and extended for eight months
- Asbestos re- inspections scheduled for June 2024
- RAAC present in one building
- EHO inspection identified issues

Actions completed since last review

- Five year backlog maintenance plan completed and reported to capital planning group
- Estates structure review completed
- Estates risk register reviewed and updated
- Permanent Associate Director of estates and facilities started 3 June 2024

Executive summary BAF4 (long term sustainability)

Risk profile

The current score has been reduced to 8 and the overall assurance RAG rating remains as green demonstrating high confidence indicating that there are no serious issues. The score has been reduced on the basis that completed actions and controls in place are working well and although the strategy is delayed due to the general election, positive discussions have taken place with key stakeholders. The likelihood has therefore been reduced. Further work scheduled to take place

regarding the development of the strategy following the pre-election period will mean that the consequence can be reduced to meet the risk target score.

Key issues/ updates

- Target date updated to November 2024 due to pre-election period

Actions completed since last review

- Review of resource requirements and updated plan
- Review of strategic options in March 2024
- Phase three engagement plans

Executive summary BAF5 (compliance breach)

Risk profile

The current score has been reduced to 9 on the basis that the consequence has reduced due to the completion of some key actions. The majority of assurances have been rated as green and the overall assurance RAG rating is green demonstrating high confidence indicating that there are no serious issues.

Key issues/ updates

- There has been some delay in the Code of conduct for governors being approved due to the general election and pre-election period rules for foundation trusts- this will be presented to governors at the CoG meeting in July
- Some non-compliance with the Code of governance for NHS provider trusts as explained in the Annual report 2023/24
- The action related to policies has been delayed due to ongoing work associated with the corporate governance review
- The action related to review of effectiveness of well led actions has been delayed due to awaiting the implementation of triumvirate working and the integrated quality and performance report
- External audit annual report shows no material governance or compliance concerns

Actions completed since last review

- Delivery and reporting of Trust wide programme of increased visibility of Board members
- Development of integrated assurance framework
- Fit and proper persons NHSE framework guidelines met

Executive summary BAF6 (financial sustainability)

Risk profile

The current score has been reduced to 12 on the basis of satisfactory financial performance and financial planning/ budget process. The overall assurance RAG rating remains as amber demonstrating medium confidence which indicates that there are some issues to be monitored and addressed.

Key issues/ updates

- Contract management and budget holder training to take place during 2024/25
- There is a need to review contract management processes including financial sue diligence of new suppliers to ensure they are robust

- The financial plan being linked to the Trust's strategy has been delayed due to the general election and pre-election rules for foundation trusts

Actions completed since last review

- Integrated assurance framework developed
- Executive provider collaboratives have been developed to drive productivity and efficiency

Executive summary BAF7 (information assets)

Risk profile

The current score remains at 12.

Key issues/ updates

- Cyber security profile of the organisation is good
- Legacy unsupported digital systems, creates potential for higher risks. Robust protection already in place, but further protective software to be implemented as part of the rollout of the 2024/25 business plan

Actions completed since last review

- SIEM tool included in business planning for 2024/25
- Cyber security Board training completed

Executive summary BAF8 (partner organisations)

Risk profile

The current score has been reduced to 8 and the overall assurance RAG rating remains as green demonstrating high confidence indicating that there are no serious issues. The score has been reduced on the basis that completed actions and controls in place are working well and system wide engagement is good. Although the strategy is delayed due to the general election, positive discussions have taken place with key stakeholders. The likelihood has therefore been reduced. Further work scheduled to take place regarding the development of the strategy following the pre-election period will mean that the consequence can be reduced to meet the risk target score.

Key issues/ updates

- Target date updated to November 2024 due to pre-election period
- Lack of QVH partnership plan and strategy (to be developed as enabling strategy- delayed due to pre-election period)

Actions completed since last review

- Consider opportunities for QVH executive directors to assume system leadership roles

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)

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1 – 23/24	Q2 – 23/24	Q3 – 23/24	Q4 – 23/24	Q1 – 24/25
✓.	✓.	✓.								

BAF 1

Risk Ref & Description: **01 – There is a risk that the Trust fails to deliver safe, effective, caring, responsive and well-led patient services**

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 avoidable harm to people, failing to meet regulatory performance targets, financial implications including losses, regulatory intervention, criminal prosecution, and reputational damage

Responsible committee	Quality and Safety committee	**Date Risk Added:**	September 2023		
Principal Exec – Risk Owner	Chief Nursing Officer	**Date Risk last reviewed:**	20 May 2024		
Risk Handler(s)	Chief Medical Officer Chief Operating Officer	**Date Risk last formally discussed:**	25 June 2024	**Group**	QSC

Inherent Score

Likelihood \ Consequence	1	2	3	4	5
5					25
4					
3					
2					
1					

Current Score

Likelihood \ Consequence	1	2	3	4	5
5					
4					
3					
2					10
1					

Target Score

Likelihood \ Consequence	1	2	3	4	5
5					
4					
3					
2					
1					5

Direction of travel since last review	⟷	**Target date**	December 2024
		Risk tolerance	To be added

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.	Process for staff checking for new policies and procedures and keeping up to date and introduction to policy locations at local induction Review of which networks we should be aligned with externally Not meeting some national standards for paediatrics, critical care and burns Not managing all third party contracts appropriately which leads to risk of service delivery Medical Devices Group clinical lead stepping down in May	1st line: Governance meetings for all services which do not meet national standards. Minutes available at Clinical Governance Group demonstrate risks, activity and audit reports are being reviewed and appropriate action taken (May 2024, Green) Approval Process of change of practice via Clinical Governance Group well embedded (April 2024 Green) Quarterly quality review meeting with ICS with external review of incidents and risks with no unmitigated issues identified (April 2024, Green)	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 Currently no overall MAST reporting to FPC and ELT for scrutiny

		Datix reporting of issues demonstrates awareness and management of issues (April 2024, Green) Review of new medical devices by medical devices group with no issues (April 2024, Green) 2nd line: Mandatory Training reports generated by Learning and Development Centre and shared to department heads show over 90% compliance (May 2024, Green) Out of date policy report seen at Audit and Risk Committee shows some policies are out of date and due review (December 2023, Amber)	
2. 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 (April 2024, Green)	None
3. CQC preparation and quality review visits utilising benchmarking and self assessment allows us to understand potential gaps and areas for development	Gap analysis against each quality statement under new framework	1st Line: CQC preparation self-assessment has been completed and is being reviewed- identifies some gaps (April 2024, Amber) 1st Line CQC preparation updates and feedback at ELT, Clinical Governance groups, Quality and Safety Committee, team and Nursing Quality Forum and Board seminar demonstrates staff understand what to expect (April 2024, Green)	None
4. 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, no issues identified (last tabled May 2024, Green) 3rd Line Quarterly quality review meeting with ICS with external review of incidents and risks with no unmitigated issues identified (April 2024, Green)	None
5. 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	2nd line: Q&S committee and Audit & Risk Committee (ARC) see the progress against clinical audit plan shows off track (February 2024, Red)	Clinical audit annual report to Audit and risk committee outlining assurance to be taken from the programme and outcome of clinical audits

6. New Freedom to Speak Up (F2SU) external provider now in place with additional resource to support the timely and effective remediation of staff concerns.	Triangulation of FTSU mechanisms and identification of themes	2nd line: Board receive quarterly freedom to speak up reports including updates on numbers of "speak ups", whistleblowing and "Tell Nicky demonstrates low number of speak ups (January 2024, Amber)	Assessment of the impact of the new speaking up arrangements Assurance from external FTSU provider

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Assess the impact of the new speaking up arrangements with external provider	July 2024	Chief Nurse	On track
2. ELT review of MAST data	July 2024	CPO	MAST data seen at directorate level
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	June 2024	CPO and Head of Risk	Not yet started
4. Identify governance routes for HLT and CD Meetings	April 2024	CMO and CS	Complete
5. Clinical audit learnings to be robustly rolled out via clinical governance group with assurance reporting to ARC	September 2024	CMO	Off track
6. Development of integrated assurance framework	April 2024	Chief strategy officer	Complete- to be presented at July Board meeting
7. Review of which external networks the Trust should be linked to	July 2024	CNO CMO	On track
8. Review national standards and gap analysis resulting in action plan to mitigate (linked to Corporate risk register number 3)	July 2024	CMO, CDs	Off track
9. Review QNet search function and consider alternative software provider	July 2024	Comms manager	Off track
10. Assessment of all Clinical SLAs to identify areas of concern	July 2024	CFO and CMO	Not yet started
11. Appointment of new medical devices lead clinician	September 2024	CMO	Off track- started
12. Gap analysis against each quality statement under new framework	July 2024	CNO	On track- completed for well led
13. Clinical audit annual report to Audit and risk committee outlining assurance to be taken from the programme and outcome of clinical audits	June 2024	CMO	On track
14. Triangulation of FTSU mechanisms and identification of themes	September 2024	CNO, CPO	Not yet started
15. Assessment of how many staff do not have an up to date job description	September 2024	CPO	Not yet started

Longer term actions (with indicative timeframe e.g. Q1 2024)	
Internal policy review group established (September 2024) Review to be completed by HR regarding completion and effectiveness of local and corporate inductions	
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

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1 – 23/24	Q2 – 23/24	Q3 – 23/24	Q4 – 23/24	Q1 – 24/25
✓	✓	✓	✓	✓						

BAF 2	**Risk Ref & Description:** 02 – There is a risk that the Trust's **workforce portfolio** 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

Responsible committee	Finance and Performance Committee	**Date Risk Added:**	December 2023		
Principal Exec – Risk Owner	Chief People Officer	**Date Risk last reviewed:**	12 June 2024		
Risk Handler(s)		**Date Risk last formally discussed:**	2 April 2024	**Group**	ELT

Inherent Score

Current Score

Target Score

Direction of travel since last review	
Target date	March 2025
Risk tolerance	To be added

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 Develop **behavioural framework** to enable culture and OD work Management of **temporary staffing** use and spend	1st Line: Monthly meeting between workforce and Freedom to Speak up Guardian (Green). JCNC & JLNC (bi-monthly, Green). Monthly Senior Leadership Team (SLT) and Service Performance Review monitoring of operational performance (Monthly, Green). Monthly service meetings / Local Faculty Group meetings with medical trainees / Educational Supervisors (3 times per year, Green). Local Induction is already a competency. LI checklist	New People and Culture Strategy to be reviewed through F&P and Board. EDI network / staff networks being promoted and embedded. New triumvirate teams in place from May 2024 – ongoing leadership development and coaching in place for senior leaders.

		contains narrative to advice of staff of the process to report completion (Green). 2nd Line: Bi-monthly exception reporting to F&P and Board on Trust performance (June 2024, Green). Bi-annual reporting of speak up concerns to Audit committee and Board (Mar 24, Green) 3rd line: Annual GMC Survey linked to action 4 (June 23, Green). Annual Staff Survey (Mar 2024, Green)	
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. Lack of timely and effective **review of national staff survey data** and implementation of local and Trust actions, reviewed on an annual cycle. Lack of **health and wellbeing framework** / strategy. Lack of resource to develop and implement more preventative **VPR** initiatives.	1st Line: Annual reporting of Staff Survey reports are analysed and issued to departments where available by the end of March (Mar 24, ongoing Green). Monthly meeting with OH service providers (Feb 24, Green). 2nd Line: Depts are provided with a timeframe to share results with staff and develop action plan and comms. HoD monthly meeting tracks completion against dept SS action plans (Apr 24, Green) Bi-monthly exception reporting for OH and Health and wellbeing through Health and Safety & Quality and Safety and onto Board (June 24, Green). Monthly reporting on VPR to ICB (June 24, Green)	Lack of monthly review of staff survey actions, health and wellbeing at SMT and PR's. ELT needs to ensure department follows through on SS action plans. Currently ICB assurance only covers a small number of projects, inc. VRP
3. Implementing our EDI objectives in order to be compassionate and inclusive, eliminate discrimination and **ensuring everyone feels that they belong**	**EDI Group and networks** to be embedded and promoted for greater visibility and purpose.	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 (June 2024, Green). Monthly reporting on EIA 6 HIA to ICB (Starting in Feb 24). 3rd line: Data submission to NHSE through ICB for EDI high-impact actions – monthly (Green)	Development of proxy EDI outcome metrics aligned to NHS requirements
Development and reform – working as one team and developing a multi-skilled workforce			
4. **Supporting all our staff in their education and development** for the workplace today and tomorrow through:	Failure to utilise the entire apprenticeship levy each year There is a need to develop long term workforce planning tools to support new roles and ways of organising work.	1st line: Ongoing communications and engagement strategy with HoD, staff and Trust (Green). Monthly MAST training reports for managers (June 24, Green).	

• **strategies to mitigate local skill and recruitment challenges** and respond to national shortages • Embedded **education and training programmes**, covering induction, NHSE and non-mandatory training / CPD funding, **work experience** and **apprenticeship** supported by bi-monthly Education and Development Group (EDG).	Lack of **leadership and development framework** covering talent and leadership (including cultural competence), **just culture, civility** and **high performance** team work and improvement. (Refer to longer term actions).	A draft leadership level framework is currently being produced in line with new triumvirate structure for publication in July (Jun 24, Green) 2nd line: Scoping and monitoring of available apprenticeships to ensure variety and maximisation of offerings (Green). Bi-monthly exception reporting in workforce performance report to Education and Development Group, F&P and Board (June 24, Green). Annual apprenticeship report (Sept 23, Green). 3rd line: Monthly data submission via ICB in relation to apprenticeship numbers and levy spend (Green)	

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not started)
1. Development of new People and Culture Strategy	November 2024	CPO	Linked to overall strategy, further work delayed due to pre-election requirements.
2. End to end recruitment task and finish group established	Sept 24	Head of Resourcing	Completed – group established
3. Establishment of new EDI Group and re-establish staff networks and ensure embedded	January 2025	CPO	On track – external consultants engaged to embed networks
4. Review of Trust values	May 24	CSO	Completed
5. Tendering of salary sacrifice and employee assistance programme	Sep 24	Deputy CPO	In progress – phased work underway
6. Focus on local staff survey action planning	Sep 24	Head of OD	Completed – paper to ELT
7. Design and implementation of health and wellbeing plan	Sep 24	Head of ER	On track – pending start date of Wellbeing and Inclusion Manager
8. VPR implementation in line with ICB plans / case for additional support as part of business planning	Mar 25	Deputy CPO	On track – pending start date of Wellbeing and Inclusion Manager
9. Design and implementation of Trust leadership and development framework	July 24	CPO/Head of OD	In progress – scheduled to go to ELT in July 2024. Target date amended
10. Succession planning for Exec team implemented	November 2024	CPO	In progress – as part of overall strategy
11. Actively manage underperformance of medical MAST training	Ongoing	Head of Med Ed	Complete - BAU
12. Development of workforce planning tools and training	September 2024	CPO/Head of OD	Work underway with Allocate

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

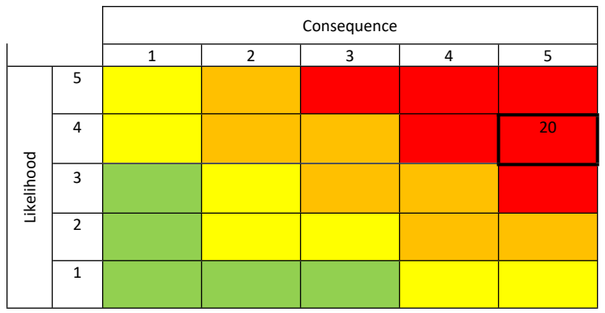
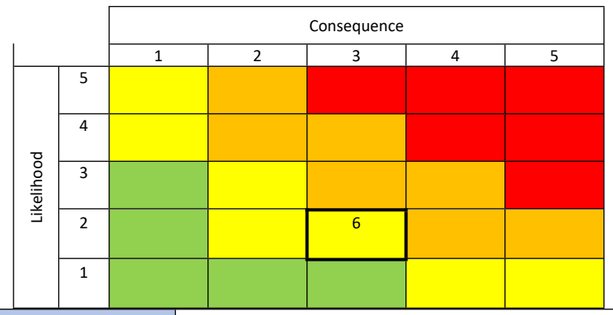
- Development of behavioural framework (September 2024)
- Development of sub-strategies within People Strategy, Inc.:
  - Resourcing
  - Wellbeing strategy
  - Talent Management and Succession planning
  - Systematic process to support staff development, and career progression (Talent Management)
  - Education strategy
- Embedded processes for medium and long term workforce planning with links to transformation

Links to Corporate Risk Register	

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1 – 23/24	Q2 – 23/24	Q3 – 23/24	Q4 – 23/24	Q1 – 24/25
✓	✓	✓	✓	✓						

BAF 3	**Risk Description: - There is a risk that the Trust's physical infrastructure (i.e. buildings and services) is not fit for purpose to support an effective, efficient and safe environment for operational delivery** **Causes:** Ageing infrastructure, lack of financial investment resulting in back log of maintenance / repairs, ineffective governance, inadequate resources, failure of critical third-party suppliers **Consequences:** Potential harm to individuals, disruption to / inefficiencies within clinical and support services, damage to physical infrastructure (i.e. the buildings and the services e.g. heating systems, electrical infrastructure, cooling and ventilation systems), financial loss, regulatory intervention, reputational damage, negative impact on staff morale

Responsible committee	Finance and Performance Committee	**Date Risk Added:**	12 October 2023		
Principal Exec – Risk Owner	Chief Finance Officer	**Date Risk last reviewed:**	13 June 2024		
Risk Handler(s)	Associate Director of Estates and Facilities	**Date Risk last formally discussed:**	2 April 2024	**Group**	ELT

Inherent Score	Current Score	Target Score
		
	Direction of travel since last review 	**Target date** April 2031 **Risk tolerance** To be added

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)		1st line: Draft 5 year plan has been produced and being reviewed. Will be reviewed monthly (Green) 2nd line: Backlog maintenance schedule for 24/25 will be reviewed with Finance monthly to track progress and spend (Green) Summarised backlog maintenance reporting to capital programme group (CPG) monthly (Amber)	

		Estates and facilities reporting to F&P (quarterly) covers a status update on the backlog maintenance plan progress (Amber) 3rd line: Independent six facet survey which gives a complete assessment of the status risk of entire estate (not due until 2028 per NHS Estates guidance)	
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 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 to raise / update the departmental risk register	AE's must be appointed in writing and perform an annual audit of the site with recommendations for improvement. 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.	2nd line: 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. 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 (due June 2024, Amber) There has not been a plan in place to remove asbestos other than when area is developed.	Estates team to create a spreadsheet to show service, name of AE, contract period and reporting arrangements (refer to action 6) 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 (Action 3) Training for staff on SOPs (Action 3)	1st line: Internal review of effectiveness of standard operating procedures (Long term action once the SOPS have been updated) (Amber) 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)	
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)	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

	Trust wide testing of business continuity plans (refer to longer term actions)		
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) New critical suppliers' procurement process on-going	Estates team to create schedule for quarterly service review meetings in 2024
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)	Asset register is currently being undertaken by external company. Micad CAFM system has been purchased
7. Premises Assurance Model (PAM) annual submission to NHSE by September showing the 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		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		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	June 2024	Interim associate director of estates and facilities (IADEF)	In progress – being completed, target date amended to end June 2024
2. Produce a 5 year back log Maintenance Plan	29 February 2024	IADEF	Completed
3. SOP review and development of training programme for 2024 for estates team	October 2024	IADEF	Ongoing – target date amended to October 2024
4. Formal report to CPG outlining the detail of the maintenance plan	30 November 2023	IADEF	Completed
5. Improve quality and detail of report to F&P	29 February 2024	IADEF	Completed
6. Estates team to create a spreadsheet to show service, name of AE, contract period and reporting arrangements	September 2024	IADEF	New list being completed – target date amended to September 2024
7. Estates to provide a summary report to F&P to highlight any exceptions arising from the AE annual reports	September 2024	IADEF	AE process not managed and reports not completed. New AE's being appointed. Target date amended
8. Estates structure, including roles and responsibilities, require review and updating	30 April 2024	IADEF	Completed. Review completed, with ELT for approval

9. Commence summarised reporting of PAM results to F&P	October 2024	IADEF	New PAM to be developed for October 2024 deadline
10. Review and update estates risk register	31 March 2024	IADEF	Complete
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	Complete
12. Create comprehensive list of critical suppliers with support from procurement team	December 2024	IADEF	Not yet completed, ongoing work
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 – on target first draft completed. Review again in December to align with clinical strategy - Rebuild the Hospital Site – New hospital Programme – Estimated timeline 1st April 2031. No update - Purchase and launch new CAFM system with SFG20 software to support planned preventative maintenance – May 2024 - system purchased, awaiting compliance manager to be able to launch - Estates team to consider assurance mechanisms once asset register and updated PPM are in place – May 2024 – compliance manager to be recruited - Establish robust contract management processes and improve compliance with procurement regulations – May 2024 – compliance manager to be recruited - BCP review and development of training / testing programme for 2024 – May 2024 - not completed/started - Reporting on the status of BCP reviews / tests to the monthly estates and facilities steering group and Emergency Planning Lead – May 2024 – not completed/started - Estates team to create schedule for quarterly service review meetings in 2024, with all suppliers to have had initial meeting by May 2024 – compliance manager recruitment - Internal review of effectiveness of standard operating procedures – May 2024 – ongoing to be reviewed in line with policies			
Links to Corporate Risk Register	6 - Major incident		

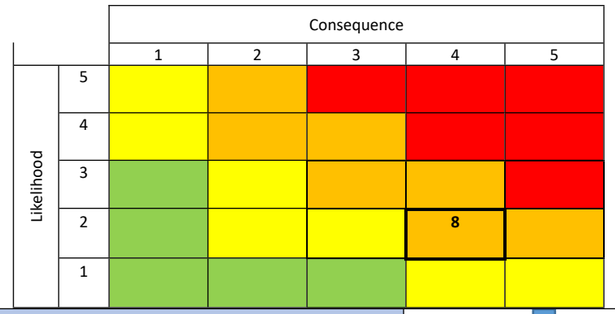
KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1 – 23/24	Q2 – 23/24	Q3 – 23/24	Q4 – 23/24	Q1 – 24/25
✓	✓	✓	✓	✓						

BAF 4	**There is a risk that the Trust fails to secure its long-term sustainability leading to closure of services and /or the site** **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

Responsible committee	Strategic Development Committee	**Date Risk Added:**	September 2023		
Principal Exec – Risk Owner	Chief Executive Officer	**Date Risk last reviewed:**	13 June 2024		
Risk Handler(s)	Chief Strategy Officer	**Date Risk last formally discussed:**	2 April 2024	**Group**	ELT

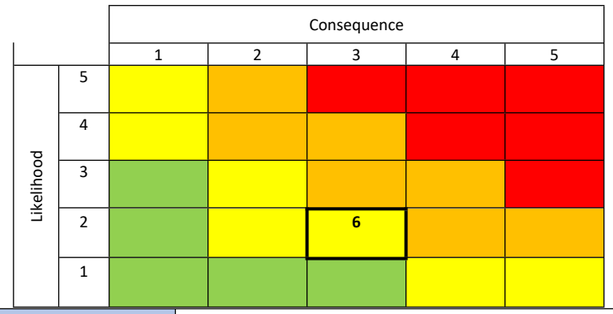
Inherent Score

Current Score



Direction of travel since last review	

Target Score



Target date	November 2024
Risk tolerance	To be agreed

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	2nd line: Strategy updates provided to hospital management team on a monthly basis (commenced Nov 23 ongoing, Green) Update provided to Board seminar (last time Feb 24, Green) 3rd line:	None

		High level options board paper share with ICB who reported being supportive of the approach (Jan 24, Green)	
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	Clinical Options review to take place (Action 6) Full strategy to be approved (Action 7)	2nd line: Milestone roadmap updates to SDC monthly, with papers at ELT (June, Green) Framework and milestone update provided to Board seminar (Feb 24, Green)	None
3. Clear and robust internal governance arrangements for decision making aligned to strategy objectives have been agreed by Chief Executive Officer / Board Chair and documented. This includes the initiation of the Strategic Development Committee (SDC) to oversee strategic development / implementation and provide assurance and advice to the Board	None	2nd line: 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)	None
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		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.

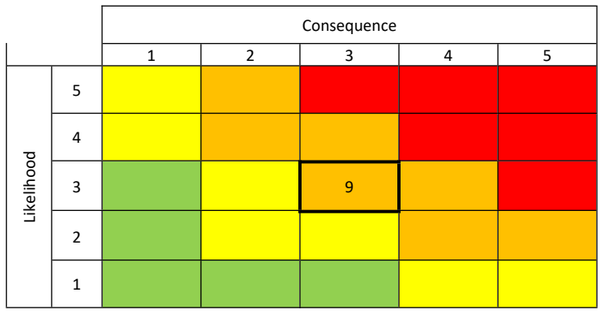
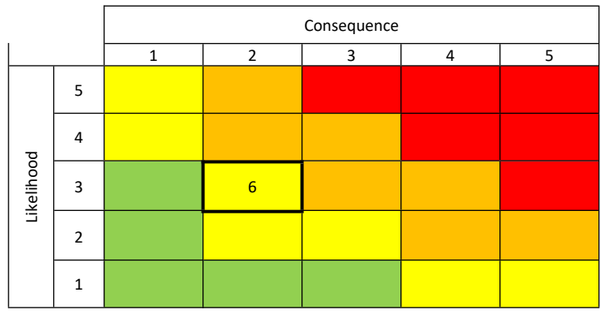
Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Strategy framework and milestone plan to be updated / shared at ELT on a fortnightly basis	19/10/23	CSO	Complete
2. Decision making framework for discussion at board seminar and subsequent development	12/10/23	CSO	Complete
3. Review of resource requirements and updated plan	In progress	CSO	Complete
4. Review of strategic options – January 2024 - March 2024 Board – January Board paper complete and March complete	Complete	CSO	Complete
5. Phase 3 engagement plans	Complete	CSO	Complete
6. Clinical options review	September 2024	CSO	Delayed due to pre-election requirements – target date amended
7. Full strategy for approval	November 2024	CSO	Delayed due to pre-election requirements – target date amended
Longer term actions (with indicative timeframe e.g. Q1 2024/25)			

Links to Corporate Risk Register	None

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1 – 23/24	Q2 – 23/24	Q3 – 23/24	Q4 – 23/24	Q1 – 24/25
	✓	✓	✓	✓						

BAF 5	**Risk Ref & Description:** **<u>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

Responsible committee	Finance and Performance Committee	**Date Risk Added:**	September 2023		
Principal Exec – Risk Owner	Chief Executive Officer	**Date Risk last reviewed:**	28 March 2024		
Risk Handler(s)	Company Secretary	**Date Risk last formally discussed:**	2 April 2024	**Group**	ELT

Initial Score	Current Score	Target Score
		
	Direction of travel since last review 	**Target date** September 2024 **Risk tolerance** To be added

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 Training for budget holders regarding standing financial instructions and scheme of delegation 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")	<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) (March 2024, 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) Reporting to ARC on compliance with licence conditions and code of governance shows some non-compliance with the Code of governance (March 2024, Amber) 3rd Line: External audit annual report shows no material governance or compliance concerns (June 2024, Green)	
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 - 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) - Fit and proper person record for Board members and self-attestation forms completed		2nd line: Internal reporting of MAST training compliance to executive leadership team, general managers, heads of departments and line managers once per month shows 90% compliance (May 2024, Green) Integrated assurance framework being developed to be reported to July Board (July 2024, Green) Report to ARC and Board- Review of Annual governance statement annually demonstrates a sound system of internal control and highlights issues (June 2024, Green) Self-certification of compliance with Trust licence conditions reported to the Board shows compliance (May 2024, Green)	Assurance that workforce compliance checks and local inductions have been completed and are effective
3. CQC preparation action plan for the well-led domain	Continuous improvement framework	2nd line: Gap analysis against CQC well led quality statements completed and reported to ELT shows work completed to address actions from previous inspections. QI framework being procured (April 2024, Green)	Reporting on effectiveness of actions completed to address recommendations from the well-led review Reporting of effectiveness of continuous improvement framework
4. External counter fraud support provided by external specialist provider who delivers an annual work programme to meet compliance requirements		3rd Line: Assurance reporting to ARC from local counter fraud specialist (RSM) quarterly shows no material concerns (March 2024, Green)	
5. External Freedom to Speak Up guardian in place		2nd line:	

		Board receive quarterly freedom to speak up reports including updates on numbers of “speak ups”, whistleblowing and “Tell Nicky” - first report due from external provider in July 2024 (Board January 2024, Amber)		
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		April 2024	CNO and CS	Complete
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		July 2024	CFO and CS	Training for budget holders regarding SFI detailed within action on BAF6 (target March 2025). Scheme of delegation communications produced ready to be shared
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		May 2024	CPO and HoR	Policy actions contained within BAF1. Off track – delayed due to ongoing work associated with policies and governance framework
4. Development of integrated assurance framework		May 2024	CSO	Complete – presented at July board meeting
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	Complete
6. Reporting on effectiveness of actions completed to address recommendations from the well led review		September 2024	CS	Off track – date adjusted to September
7. Implement continuous improvement framework		September 2024	CSO	On track
8. Code of conduct for governors to be updated		July 2024	CS	Off track – due to purdah rules around policy. Scheduled for July COG meeting. Date changes to July.
9. Review of Trust wide Corporate Governance and implementation of new framework		September 2024	CS	On track
10. Review of effectiveness of exec/board increased visibility visits		September 2024	CS	On track
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			

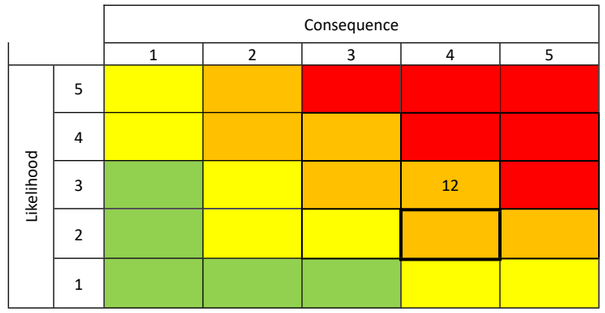
KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1 – 23/24	Q2 – 23/24	Q3 – 23/24	Q4 – 23/24	Q1 – 24/25
✓	✓	✓	✓	✓						

BAF 6	**Risk Ref & Description: <u>There is a risk that the Trust is unable to deliver medium to long term financial sustainability</u>** **Causes:** increasing demand outstrips resources available, impact of investment requirements and inflation, failure to deliver operational efficiencies and /or realise investment programme benefits, potential for unplanned costs (e.g., cyber-attack), lack of available workforce increasing agency spend, Ineffective management of multiple Integrated Care Systems financial transformational risks, impact of political changes and national directives **Consequences:** possible loss of operational capacity and failure to provide timely treatment to patients, failure to generate funding for investments, potential for workforce restructuring, and /or reputational damage with loss of confidence from stakeholders (e.g., ICB)

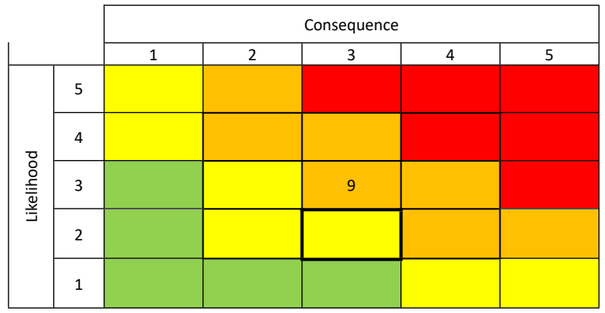
Responsible committee	Finance and Performance Committee	**Date Risk Added:**	September 2023		
Principal Exec – Risk Owner	Chief Finance Officer	**Date Risk last reviewed:**	12 June 2024		
Risk Handler(s)	Deputy Chief Finance Officer	**Date Risk last formally discussed:**	2 April 2024	**Group**	ELT

Inherent Score

Current Score



Target Score



Direction of travel since last review		**Target date**	March 2025
		Risk tolerance	To be added

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.		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 (refer to action 9)
2. Monthly financial reporting scrutinised by finance team, ELT, F&P and Board		2nd Line: IAF reporting (Amber) 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		1st and 2nd line: Monthly triumvirate meetings provide assurance that budget holder meetings have occurred, and the financial position is understood. Not yet fully embedded sufficiently (Amber)	
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. Triangulated via Intregrated Assurance Framework		1st and 2nd line: Reporting to ELT & F&P committees (Amber)	
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		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 (Green)	No formal feedback loop to QVH Board to share outcomes of ICS review (Action 5)
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 (Action 2)	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 (Green)	None identified

7. Staff training - Training for budget holders on the management of budgets, understanding of financial planning, financial governance.	Budget holder training not yet started. Reporting of budget holder training completed to ELT on compliance. Budget Holder Training pack was left by previous employee for implementation, this needs further work. A roll out plan in place and agreed with ARC (Action 2)	2nd line: Updated budget holder training being developed and review of budget holders and training completion rates by finance team (Amber)	
8. Supplier management processes including elements of due diligence	A need to review contract management processes including financial due diligence of new suppliers to ensure they are robust (refer to action 1)	2nd line: Internal audit report on contract management. Only partial assurance (Amber)	Audit committee Action plan is needed to improve contract management processes (refer to action 1)
9. 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		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 (Green)	

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 2025	Chief Finance Officer	Progressing to target, plan agreed by ARC
2. Rollout of formal Budget holder training, including governance	March 2025	Chief Finance Officer	On track, programme paper to be presented to ARC June 2024
3. Rollout of Risk Management Training	July 2024	Interim Risk Project Lead	On track, framework agreed at ARC June 2024
4. Integrated Assurance Framework development and reporting produced	June 2024	ELT	Complete
5. Work with the system to develop provider collaboratives to drive productivity and efficiency	March 2024	ELT	Collaborative work underway. Complete
6. Triangulation and validation of assumptions in financial plan	May 2024	Chief Finance Officer	Complete
7. Financial plan to be linked to new trust strategy	November 2024	CFO	Delayed due to pre-election requirements

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

- Introduce focused Programme Delivery for all efficiencies identified through business planning (Q2 2024/25) - ongoing
- Identify opportunities for income growth as part of system collaboration - opportunities for 2025/26 to be identified (Q4 2024/2025)

Links to Corporate Risk Register	Risks 4 – Procurement, 6 - Major Incident, 10 – Financial Plan

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1 – 23/24	Q2 – 23/24	Q3 – 23/24	Q4 – 23/24	Q1 – 24/25
✓	✓	✓	✓	✓						

BAF 7	**Risk Description: <u>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.

Responsible committee	Finance and Performance Committee	**Date Risk Added:**	September 2023		
Principal Exec – Risk Owner	Chief Finance Officer	**Date Risk last reviewed:**	12 June 2024		
Risk Handler(s)		**Date Risk last formally discussed:**	13 February 2024	**Group**	ELT

Inherent Score	Current Score	Target Score
		
	Direction of travel since last review 	**Target date** July 2024 **Risk tolerance**

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 (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)	2nd line: 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 (June 24, Green) DSPT submission is presented to the IGG and Audit Committee (May / Jun 24, Green) 3rd line: Internal audit review a sub-set of the DSPT submission (Apr 24, Green)	None
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) IT and the Comms team are in the process of developing a communication plan, to include quarterly cyber security advice, annual cyber security campaign in-line with National Cyber Security Awareness Month (October). Adhoc Comms in the event of any heightened cyber threats
6. Ongoing security updates, reactive vulnerability scanning and penetration testing – remediation plans monitored through IMT group and SIRO	Enhanced proactive monitoring tools to be installed in 2024/25 (refer to action 3)	2nd line Reporting to IMT as required with associated work plans to address remediation plans (Green) Monthly reports for vulnerabilities KPIs provided to IMT. Meetings are minuted (Green) and digital steering group 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 tabletop digital business continuity exercise with feedback report provided to CDIO with IMT having oversight of	None

		remediation plans. Completed 5/6, Amber as results still be presented to IMT (Amber). Results of the exercise are reported as part of the DSPT	
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 (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 (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 will be reviewed and amended, if necessary, following the approval of the clinical strategy.	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)	Final strategy to be approved following approval of the Trust Clinical Strategy (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	Comms plan completed. **New Cyber Security Comms plan will be ready by the end of July 2024**
3. Include a SIEM tool into business planning for 24/25	January - March 2024	Head of IT	Completed
4. Development of digital strategy with Board support	June 2024	CDIO / CFO	Complete. Board Approve Feb 2024. Further iterations maybe needed following finalisation of Clinical Strategy. **Further reviews underway with CCIO / CDIO / CNIO along with other key stakeholders. Expected to be approved at Nov 2024 Board.**
5. Reconciliation of all digital programmes and reporting to digital steering committee	April 2024	CDIO/CFO/ICS	In progress as part of wider governance review in **July 2024.**
6. Board development dates for cyber security training	February 2024	CFO / CDIO	Completed
7. Management of programmes and project governance to be considered within trust wide governance review	April 2024	CFO / CDIO	In progress
8. Implementation of SIEM tool	December 2024	Head of IT	Awaiting board approval
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) • 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

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1 – 23/24	Q2 – 23/24	Q3 – 23/24	Q4 – 23/24	Q1 – 24/25
✓	✓	✓								

BAF 8

Risk Description: **There is a risk that the Trust does not develop and maintain collaborative relationships with partner organisations built on shared objectives and mutual trust that may impact adversely on the ability to deliver a sustainable future and trust strategy and improve the health of the populations we serve**
Causes: the Trust and /or system partners do not effectively engage with the system framework or direct arrangements, ineffective communication, absence of shared goals
Consequences: failure to achieve system and Trust objectives, negative impact on patient outcomes and experience

Responsible committee	Strategic Development Committee	**Date Risk Added:**	September 2023		
Principal Exec – Risk Owner	Chief Executive Officer	**Date Risk last reviewed:**	13 June 2024		
Risk Handler(s)	Chief Strategy Officer	**Date Risk last formally discussed:**	2 April 2024	**Group**	ELT

Inherent Score

Current Score

Target Score

Direction of travel since last review		**Target date**	November 2024
		Risk tolerance	To be agreed

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.		1st line: Engagement tracker in place to report progress against plan; this is reviewed weekly by the strategy team (Green) 2nd line: 3 phase engagement plan on track. Revised comms and engagement plan to SDC. Verbal engagement updates to continue to be reported to SDC on a monthly basis. (Green) Engagement update reported to Governors (quarterly), JLNC (quarterly), HMT (monthly) and Board (at seminars) with respective meeting minutes evidencing the discussions held on	None identified

		progress reported. Revised engagement plan shared (Green) 3rd line: 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) Independant review of patient engagement feedback via focus groups and survey. Positive assurance received (Green)	
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 (Action 5)	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 (Green) Quarterly Provider Assurance meetings with ICB and NHSE in place (Green)	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. Strategic commissioning meeting in place to align commissioning intentions across 3 ICBs and NHSE specialist commissioning Senior representation in place at Cancer Alliance meetings and CEO and Chief Strategy Officer connections across providers		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 (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

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	Complete - Engagement in system partnerships in place. Action to be ongoing to maintain relationships
5. Develop partnership strategy	November 2024	CSO	Delayed due to pre-election requirements and delay to overall strategy
Longer term actions (with indicative timeframe e.g. Q1 2024)			
Links to Corporate Risk Register	Risk 13 – partnership and commissioner risk		

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04/07/2024	**Agenda reference:**	**36-24**		
Report title:	Business Plan 2024/25				
Sponsor:	Maria Wheeler, Chief Finance Officer				
Author:	Jonathan Wharton Deputy Chief Finance Officer				
Appendices:	Appendix one: Business plan 2024/25				
Executive summary					
Purpose of report:	To provide an overview of the final 2024/25 Business Plan for ratification				

Summary of key issues	• The final plan for 2024/25 was submitted to NHSE on 12 June 2024 following an extraordinary Trust Board meeting which approved the final business plan.
	• The business plan addresses the Key Strategic Objectives:
	  • Outstanding Patient Care
	  • World Class Clinical Services
	  • Operational Excellence
	  • Financial Sustainability
	  • Organisational Excellence
	• The overall plan is for a break even position for 2024/25.
	• We are planning to hit the 65WW by Sept 2024.
	• The Trust ERF is to increase to 121% in 2024/25
	• Pay award of 2.1% has been included in the business plan as per NHSE guidance.
	• Efficiencies have been included with a value of £6.7m (6.3%) which includes the £1.4m stretch target.
	• The Capital programme is £6.0m, in addition there are centrally funded schemes (EPR & CDC) which add an additional £11.5m.				

Recommendation:	The Board is asked to ratify the business plan for 2024/25.				
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:	Contributes to understanding financial sustainability (BAF6) and operational delivery requirements for 2024/25				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Trust Board				
	Date:	06/06/2024	Decision:	Approved	

Queen Victoria Hospital
NHS Foundation Trust

QVH Business Plan 2024/25

June 2024

Contents

Queen Victoria Hospital
NHS Foundation Trust

- Business Plan Highlights
- Strategic Priorities 2024/25
- 5-year Capital plan
- Performance Indicators & Expected targets
- Finance Plan

Business Plan Highlights

Queen Victoria Hospital
NHS Foundation Trust

- The final plan for 2024/25 was submitted on the 12 June following an extraordinary Trust Board meeting on the 6 June which approved the plan for submission. The current numbers are the latest version which was submitted. In addition a further efficiency stretch target was required in order to support the ICS (£0.2m).
- The overall plan is for a break even position for 2024/25
- We are planning to hit the 65WW by Sept 2024.
- The projection is for ERF to increase 121% in 2024/25
- Pay costs have been increased by a provision of 2.1% inflation in line with planning guidance.
- Efficiencies have been included with a value of £6.7m (6.3%) in 2024/25.
- The Capital programme is £6.0m, in addition there are centrally funded schemes (EPR & CDC) which add an additional £11.5m.

Priorities for 2024/25

Queen Victoria Hospital
NHS Foundation Trust

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

5 Year Capital Plan

Queen Victoria Hospital
NHS Foundation Trust

	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000
Property Land & Buildings	11,387	2,564	2,464	2,364	2,717
Plant & Equipment	600	500	500	500	500
IT	5,497	700	800	900	900
Gross Capital Expenditure	**17,484**	**3,764**	**3,764**	**3,764**	**4,117**
Self Financed	6,769	3,764	3,764	3,764	4,117
Capital Loan repayment	(778)				
CDC	6,706				
EPR	4,787				
Net CDEL	**17,484**	**3,764**	**3,764**	**3,764**	**4,117**

Performance Indicators & Expected Targets

Queen Victoria Hospital
NHS Foundation Trust

- A&E waiting times improved to minimum of 78% seen within 4 hours in March 2025
- Eliminate waits of over 65 weeks asap and by Sep 2024 at latest – except where patients choose to wait longer or in certain specialties
- Deliver or exceed system specific activity targets - 109% for Sussex
- Increase proportion of new and outpatient procedures across all outpatient attendances to 46% across 24/25
- Improve performance against headline 62-day cancer standard to 70% by March 2025
- Improve performance against 28-day FDS to 77% by March 2025 and 80% by March 2026
- Increase % of cancer diagnosed at Stages 1 and 2 in line with 75% early diagnosis ambition by 2028
- Increase % of patients receiving a diagnostic test within 6 weeks in line with 95% ambition by 2025

Income & Expenditure

Queen Victoria Hospital
NHS Foundation Trust

	FOT 2023/24 M10	Financial Plan 2024/25
NHS Clinical Income	95,700,000	101,746,178
Other Operating Income	3,183,000	2,696,000
Non-NHS Clinical Income		
Total Income	**98,883,000**	**104,442,178**
Pay 2.1% uplift	(64,646,000)	(70,891,718)
Non-Pay	(24,694,301)	(23,179,934)
Drugs - 0.6% uplift	(1,494,674)	(1,702,449)
Utilities - Electricity - 5% uplift	(1,064,836)	(1,118,078)
Utilities - Gas - 5% uplift	(476,189)	(499,998)
Total Expenditure	**(92,376,000)**	**(97,392,177)**
EBITDA	6,507,000	7,050,001
Financing & Capital Charges	(6,785,000)	(7,328,000)
Surplus/(Deficit)	(278,000)	(278,000)
Donated Assets Adjustments	278,000	278,000
Adjusted Surplus/(Deficit)	**-**	**-**

Updated for the two Trust efficiency stretch targets to support the ICS (£1.2m and £0.2m)

Activity & Performance

Queen Victoria Hospital
NHS Foundation Trust

Type	POD Grouping	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total	VWA %
Fixed	Non Elective	529	570	558	574	559	502	588	584	502	591	523	561	6640	
	Follow Up	7864	8474	8292	8530	8308	7455	8741	8682	7455	8791	7773	8332	98696	
Block		**8393**	**9044**	**8850**	**9104**	**8867**	**7956**	**9329**	**9266**	**7956**	**9382**	**8296**	**8892**	**105336**	
ERF Variable	Day Case	914	818	982	966	988	955	882	1015	994	882	1009	910	11316	
	Elective	250	250	270	264	271	264	237	278	276	237	280	247	3125	
	First Outpatients	3224	3224	3570	3494	3594	3501	3141	3683	3658	3141	3704	3275	41208	
	Outpatient Procedures	2676	2676	2916	2854	2936	2859	2565	3008	2988	2565	3025	2675	33742	
Sleep	Outsourcing - Outpatients Procedures	50	50	50	50	50	50	50	50	50	50	50	50	600	
Baseline Total		**7114**	**7018**	**7789**	**7628**	**7839**	**7629**	**6875**	**8034**	**7965**	**6876**	**8068**	**7157**	**89990**	**115.2%**
LAU Backfill		26	26	26	26	26	26	26	26	26	26	26	26	312	
Theatre Efficiency		43	43	43	43	43	43	43	43	43	43	43	43	516	
Outpatient Efficiency		152	152	152	152	152	152	152	152	152	152	152	152	1824	
Efficiencies Total		**221**	**221**	**221**	**221**	**221**	**221**	**221**	**221**	**221**	**221**	**221**	**221**	**2652**	**6.3%**
Total Activity Plan 24/25															**121.5%**

Workforce Plan (People in Post)

Queen Victoria Hospital
NHS Foundation Trust

	Baseline Staff in post outturn Year End (31-Mar-24)	Plan Year End (31-Mar-25)	Movement	Outturn to M12 Change
Substantive Workforce	Total WTE	Total WTE		
Registered Nursing, Midwifery and Health visiting staff	191.1	198.57	7.47	4%
Allied Health Professionals	78.2	80.32	2.12	3%
Other Scientific, Therapeutic and Technical Staff	46.1	45.31	-0.79	-2%
Registered/Qualified Healthcare Scientists	33.5	33.9	0.4	1%
Support to clinical staff	159.4	170.08	10.68	6%
NHS Infrastructure Support	335.4	355.6	20.2	6%
Any Other Staff	6	6	0	0%
Medical & Dental	173.5	174.01	0.51	0%
All Consultant	84	85.61	1.61	2%
All Non-Consultant Career Grades	21.3	23.73	2.43	10%
All Trainees (excluding Foundation Trainees)	68.2	64.67	-3.53	-5%
All Foundation Trainees	0	0	0	-
Total	1023.2	1063.79	40.59	4%

WTE Movements from March 2024 to March 2025

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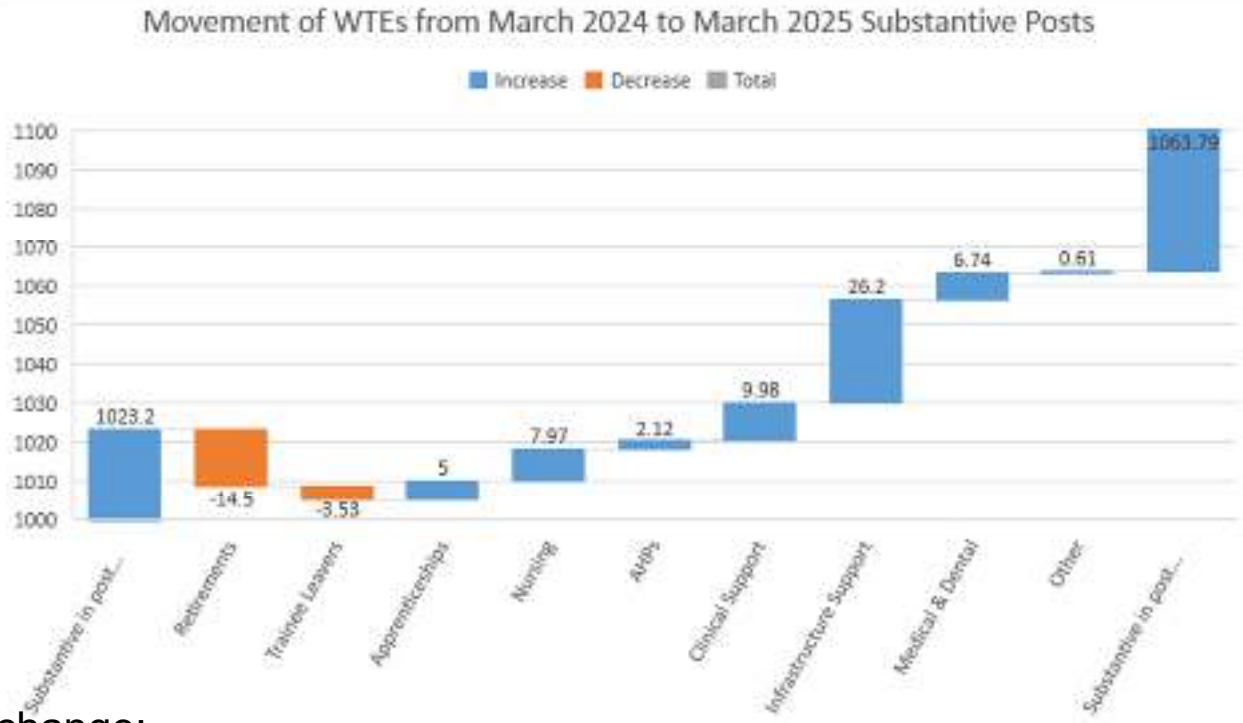

Drivers of change:

- Administration: additional 6 staff in strategy team

Estates: additional 7 staff to support physical infrastructure due to aging estate

- Support: additional 13 staff to support delivery of additional activity
- Clinical, nursing, medical & Dental: additional 15 staff increase to support increased activity

Efficiencies

Queen Victoria Hospital
NHS Foundation Trust

Area	Value £'000
LAU benefit	2,200
ERF additional activity	2,250
Reduction in agency costs	250
Procurement opportunity	200
Drugs	50
Other Directorate efficiencies	350
Stretch efficiency target	1,400
Total	6,700

The current efficiencies deliver against the target set on the Trust by the ICS planning requirements, additional savings are being developed.
In 2024/25 there will be a focus on further efficiencies both in 2024/25 and beyond using GIRFT focus, benchmarking and collaborative working within the system.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04/07/2024	**Agenda reference:**	**37-24**		
Report title:	Integrated Quality and Performance Report				
Sponsor:	Kirsten Timmins, Chief Operating Officer				
Author:	Executive team				
Appendices:	Appendix one: Integrated Quality and Performance Report M1				
Executive summary					
Purpose of report:	To provide oversight and assurance of the trust's performance in an integrated report on quality, operational performance, workforce and finance for Month 1 (April) 2024/25) and a narrative update on Month 2 (May 2024/25).				
Summary of key issues	KSO 1 – no areas of concern noted KSO 2 – further work to identify Patient Related Outcome Measures (PROMs) at directorate level KSO 3 – risk to delivery of >65 week wait RTT target by September 2024 although Month 2 position is better than trajectory. Increasing size of the waiting list will add to the challenges for meeting RTT targets KSO 4 – finance position on plan at Month 2 achieving a break-even position KSO 5 – establishment numbers are being rebased to reflect 2024-25 business planning and the new structures Highlight reports are included for each of the five major projects for 2024/25 and no significant concerns are reported.				
Recommendation:	The Board is asked to note the Integrated Quality and Performance 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:	Supports the Board Assurance Framework as set out in the IQ&PR attached				
Corporate risk register:	Supports the Corporate Risk Register				
Regulation:	ICS, NHS England and Care Quality Commission (CQC)				
Legal:	None				
Resources:	External support to develop the new reporting format.				
Assurance route					
Previously considered by:	ELT, Finance and Performance Committee, Quality and Safety Committee				
	Date:	04/06/24, 24/06/24, 25/06/24	Decision:	N/A	
Next steps:	Embed new monthly reporting processes				

Report to:	Board of Directors
Agenda item:	37-24
Date of meeting:	04/07/2024
Report from:	Kirsten Timmins, Chief Operating Officer
Report author:	Executive team
Date of report:	27/06/24
Appendices:	Integrated Quality and Performance Report (IQ&PR)

Integrated Quality and Performance Report

Introduction

In line with the Integrated Assurance Framework, the Integrated Quality and Performance Report (IQ&PR) has been introduced to bring together the different aspects of the trust's performance into one report to support triangulation of the information. The IQ&PR provides oversight and assurance of the trust's position against agreed standards and priorities. For those metrics not being met, further information is provided on the issues and the actions being taken.

This paper highlights the key areas from within the Month 1 report updated for the Month 2 position where relevant.

Background

The IQ&PR will be produced each month and used for internal reporting through the sub committees of the Board prior to presentation at the Trust Board meetings throughout the year. This report will be replicated at business unit level and directorate level to provide ward/service level reporting through to the board.

The IQ&PR is based on the current strategic aims of the trust (to be updated following the agreement of the new strategy later this year), and the agreement of five annual goals and five major projects to be delivered in 2024/25.

A summary of the key points within the report including the major projects and a scorecard for the annual goals and major projects is included at the front of the IQ&PR. For each Key Strategic Objective (KSO), there is a reference page followed by a summary narrative page and a scorecard. Behind these there is additional detailed information by metric. A highlight report for each of the major projects is included in the relevant KSO.

This is the first iteration of the report, and it is recognised that there is further work required to develop and refine the report and its contents. Processes are being introduced to automate the production of the report as far as possible with current systems and it will be developed further during the year.

April/May 2024 Performance

This paper highlights the key areas from within the Month 1 report updated for the Month 2 position where relevant. Further detailed information is included in the attached Month 1 report.

KSO 1 Outstanding Patient Experience

There are no areas of concern being raised in Month 1 or Month 2 with no never events or serious patient safety incidents reported.

KSO 2 World Class Clinical Services
Whilst the recommendation rate for Friends and Family Test (FFT) is being used as an available metric to report patient feedback, directorate teams are exploring how to evidence clinical quality through patient related outcome measures and national benchmarking standards. Further data and information will be included as plans are developed.

FFT recommendation rate is at 95% for Month 2 against a target of 90%.
Work continues to ensure clinical engagement with antimicrobial stewardship and an antimicrobial pharmacist has been appointed.

KSO 3 Operational Excellence
RTT - The national target is to eliminate >65 week waits by September 2024 and the trust has 51 reported at Month 2 against a target of 101. However, this continues to be an area of risk to delivery. >78 week waits continue to reduce with just 4 reported at Month 2.

Whilst the waiting list performance for RTT continues to improve and is reported at 63% for Month 2, the increase in the numbers on the waiting list is an area of concern.

Cancer – (reported a month in arrears). Faster Diagnosis Standard continues to meet the target. >31 days and >62 days targets continue to not be met at Month 1.
There are a number of challenges to delivery of the cancer targets including the numbers waiting >62 days; the numbers for >104 days fell to 6 for Month 2 although this is above the internal trajectory.

Diagnostics (DM01) – the target of 95% was met for the first time since February 2021 in Month 2, mainly due to the sustained improvement within sleep services to 90%.

Outpatient Productivity – a new target for 2024/25 is to increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46%. Current performance at Month 2 is at 43% and this will be an area of focus in the coming months.

Theatre Productivity – performance against the capped target of 85% is at 83% for Month 2 and remains below the target. However, a work programme is being established to address utilisation and patient flow to improve productivity.

KSO 4 Financial Sustainability
For Month 2 the trust remained at breakeven. NHS England has confirmed that external reporting for trusts will commence from Month 3.

KSO 5 Organisational Excellence
The trust's establishment is being rebased to reflect the 2024-25 business planning and the new structures. Resourcing processes are being improved and this should improve the time to hire.

Appraisal rates have fallen to 81% in Month 2 against a target of 90% and this is being followed up with managers.

A Wellbeing and Inclusion Manager has been appointed to commence in June 2024 to support the delivery of health and wellbeing and equality, diversity and inclusion plans.

Major Projects 2024/25

KSO 2 World Class Clinical Services
To implement and optimise an on-site Local Anaesthetic Unit – Phase 2 has been paused and being re-assessed

KSO 3 Operational Excellence
To deliver the Community Diagnostic Centre programme – work is progressing with the ICS with regards to system demand that will inform the final design of the building

To deliver the Sussex Pathology Network Programme – this is a programme for multiple projects being implemented simultaneously and QVH is a member organisation. The Laboratory Information System (LIMS) project is now behind plan

To deliver Year 1 of the Electronic Patient Record – following the approval of the business case this programme is being established with the formal start of the programme in June 2024. It does however carry significant risk for delivery given the scale of the programme and the trust's digital maturity

KSO 5 Organisational Excellence
To design and implement a systematic quality improvement approach across the organisation - the procurement process has been concluded and a preferred provider has been identified.

Recommendation
The trust board is asked to **note** the Month 1 Integrated Quality and Performance Report and the updated position at Month 2.

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Integrated Assurance Report

Month 1 - April 2024

QVH

www.qvh.nhs.uk

Integrated Assurance Report - Overview

Queen Victoria Hospital
NHS Foundation Trust

April 2024

KSO 1 Outstanding Patient Experience

There are no areas of concern being raised for Month 1 of 2024/25. Further work is required to review and define the annual goals of ethnicity recording - to ensure that the base data is being put in place to provide appropriate platform to improve health equality across ethnic groups; and for smoking status - to ensure that the focus is on improving patient health. Nationally the focus is on the implementation of the Patient Safety Incident Response Framework (PSIRF) and the reporting for this by the trust will be developed through the year.

KSO 2 World Class Clinical Services

The reporting of the recommendation rate for Friends and Family Test as the annual goal is being used as a currently available metric to report patient feedback whilst further work is undertaken to develop Patient Related Outcome Measures (PROM) that can be reported for the trust. It should be noted that the specialist nature of the services provided by the trust make it difficult to use national data and draw comparisons to other providers.

KSO 3 Operational Excellence

The targets for operational performance have been updated in line with the national requirements for 2024/25. The annual goal is to eliminate waits of over 65 weeks for elective care by September 2024. A trajectory has been developed and the trust is ahead of plan at Month 1. However, the increasing size of the waiting list presents a concern for future capacity and delivery.

KSO 4 Financial Sustainability

The trust has a plan to deliver a break-even position for the year after the delivery of efficiencies of £5.3m (5% of income) and plans are in place to achieve this outturn. Summary data for Month 1 shows the trust on plan. Further information will be included at Month 2.

KSO 5 Organisational Excellence

Workforce metrics highlight further work taking place to improve time to hire and appraisal rates whilst staff turnover is showing an improving trend. Additional narrative has been provided on the cultural work taking place within the trust where it is difficult to use metrics to demonstrate progress on a monthly basis. However, these should impact in the longer term on staff survey results and on recruitment and retention.

Integrated Assurance Report - Overview

Queen Victoria Hospital
NHS Foundation Trust

April 2024

Major Projects

KSO 2 World Class Clinical Services

To implement and optimise an on-site Local Anaesthetic Unit – Phase 2 underway to review the viability of the next stage of development

KSO 3 Operational Excellence

To deliver the Community Diagnostic Centre programme – planning application has been submitted with likely build to take place in 2025/26. Project team in place which will allow increased pace on implementation

To deliver the Sussex Pathology Network Programme – this is a programme for multiple projects being implemented simultaneously and QVH is a member organisation

To deliver Year 1 of the Electronic Patient Record – following the approval of the business case this programme is being established. It does however carry significant risk for delivery given the scale of the programme and the trust's digital maturity

KSO 5 Organisational Excellence

To design and implement a systematic quality improvement approach across the organisation - a procurement process is in progress to identify a partner to work with the trust to design, implement and embed a systematic approach to quality improvement

Integrated Assurance Report - Scorecard

Queen Victoria Hospital
NHS Foundation Trust

Annual Goals

Metric	Latest month	Target	Variation	Assurance	Actual	Previous month	Mean	LCL	UCL	Summary
Ethnicity Recording	Apr-24	90%	-	-	78%	-	-	-	-	Below target
Smoking Status Recording	Apr-24	95%	-	-	99%	-	-	-	-	Exceeding target
PROM - FFT	Apr-24	90%		P	96%	95%	96%	94%	98%	Normal variation - will consistently meet the target
No waits >65 weeks	Apr-24	0		F	45	64	69	42	96	Normal variation - ahead of trajectory for Month 1
Break-even position	Apr-24	£0	-	-	£0	-	-	-	-	Month 1 on plan

Major Projects

Project	Latest month	Overall status	Previous month	Summary
Local Anaesthetic Unit	Apr-24	Feasibility of plan	-	Phase 2 underway to review viability of proposal
Community Diagnostic Centre	Apr-24	Off track but mitigations in place	-	Planning application submitted
Sussex Pathology Network Programme	Apr-24	Off track but mitigations in place	-	A number of projects combined managed at system level
Year 1 Electronic Patient Record	Apr-24	Risk to delivery of plan	-	Signficant change programme required
Quality Improvement	Apr-24	On track	-	Procurement process in progress to identify partner provider

Integrated Assurance Report

Queen Victoria Hospital
NHS Foundation Trust

KSO1 Outstanding Patient Experience

Ambition

We will deliver safe and compassionate care for our patients

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

2024/25 Annual Objectives

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)*

2024/25 Annual goals

1. 90% ethnicity recording
2. 95% smoking status recording

KSO1 Outstanding Patient Care - Summary

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Overview

QVH continues to deliver high quality safe effective care.

- No Never events or serious harm reported during April
- No incidents with moderate or major harm reported during April
- Two Patient Safety Incident Investigations taking place.
  1. Cardiac arrest - Report has been to May 2024 CCG, action plan to return to CCG in June 2024. Learning from the investigation included emergency buzzers not ringing across the whole department. This is on the risk register and being followed up with estates.
  2. Possible wrong site surgery – report in progress
- New Freedom to Speak Up (F2SU) provider “The guardian service” in place and working well throughout the trust
- Continue to see positive patient feedback via Care Opinion and in direct contact with QVH
- Wound Care strategy Group has commenced to ensure best practice is being adhered to with regards to wound management
- PLACE Task and Finish group continues to address gaps following the inspection in autumn 2023 with good progress against the dementia and disability standards.
- Oliver McGowan training continues to be encouraged and currently 88% have attended – aspiration is for 100% compliance
- Infection control training continues to sit on the lower control limit for last three months
- Flu Campaign completed – 73% staff vaccinated or opted out.
- Martha's Law (Call for Concern) rolled out and audit in progress

Positive Assurance/Improvements	Challenges	Mitigations and Actions
1.9 falls per 1000 bed days No hospital acquired pressure ulcers in month No reportable infections in month	Bathrooms on C-Wing have inadequate ventilation which leads to very hot and humid conditions	On risk register Estates are aware and awaiting update

KSO1 Outstanding Patient Care – Scorecard

NHS
Queen Victoria Hospital
NHS Foundation Trust

Metric	Latest month	Target	Variation	Assurance	Actual	Previous month	Mean	LCL	UCL	Rule	Summary
Ethnicity Recording	**Apr-24**	**90%**	**-**	**-**	**78%**	**not reported**	-	-	-		*Below target*
Smoking Cessation	**Apr-24**	**95%**	**-**	**-**	**99%**	**not reported**	-	-	-		*Exceeding target*
Infection prevention and control training compliance (all staff)	Mar-24	90%	L	P	90%	90%	92%	90%	93%		*Special cause deterioration - will consistently meet target*
Falls per 1,000 occupied bed days	Apr-24	-		-	1.9	0	3.0	-3.9	9.8		*Normal variation*
Hospital acquired PU per 1,000 occupied bed days	Apr-24	-		-	2	0	0.8	-2.6	4.2		*Normal variation*
Number of formal Complaints received	Apr-24	0		?	12	2	5	-2	13		*Normal variation - will hit and miss the target*
Safer staffing compliance	Apr-24	99%		?	99%	99%	99%	97%	101%		*Normal variation - will hit and miss the target*
Number of patient safety incidents with no harm near miss	Apr-24	-		-	31	24	38	12	63		*Normal variation*

KPI Description	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
No. of patient safety incidents with moderate harm	0	0	1	0	0	0	1	1	0	1	1	0	0
No. of patient safety incidents with severe harm or death	0	0	0	0	0	0	0	0	0	0	0	0	0
No. of CDI, MRSA, E.Coli, MSSA (Trust acquired)	0	0	0	1	1	0	0	0	0	1	0	0	0
Oliver McGowan Training												83%	88%

KSO1 Outstanding Patient Care -2024/25 Annual Goal

Queen Victoria Hospital NHS Foundation Trust

Ethnicity Recording

Reporting Month: Apr-24

Executive Lead: CNO

1. Historic trend data

Historical data unavailable for 2023/24 due to change in reporting methodology for annual goals, trend data will be available moving forward.

Definition:

Denominator is Outpatient Attendances, Minor Injuries Unit (MIU) attendances and admissions in mor
Numerator will be those that have an ethnicity recorded (which is excluding those recorded as 'not stated').

Actual	Internal Target	Variance/ Assurance
78%	90%	-12% Below target

2. Stratified data

Month	Not stated	Not yet collected	Recorded	Grand Total	
MIU	9	4	1387	1400	99.07%
OP attendances	698	2968	12029	15695	76.64%
IP admissions	44	405	1324	1773	74.68%
Total	751	3377	14740	18868	78.12%

3. Top contributors

MIU appear to have robust recording methodology in place. To be audited to enable shared learning

Inpatient and Outpatient activity needs improvement to collection methodology

4. Action Plan

Actions	Target date
Replicate MIU best practice across other areas to ensure improved compliance	September 2024

KSO1 Outstanding Patient Care -2024/25 Annual Goal

Queen Victoria Hospital NHS Foundation Trust

Smoking Status

Reporting Month: Apr-24

Executive Lead: CNO

1. Historic trend data

Historical data unavailable for 2023/24 due to change in reporting methodology for annual goals. Trend data will be available moving forward.

Definition:
All patients added to the Waiting List who have been recorded and referred in previous month

Actual	Internal Target	Variance/ Assurance
99%	95%	+4% Exceeding target

2. Stratified data

Must Stop pre Op	21	1.97%
Non Smoker	1020	95.60%
Not known	8	0.75%
Stopping not required	18	1.69%
Grand Total	**1067**	

3. Top contributors

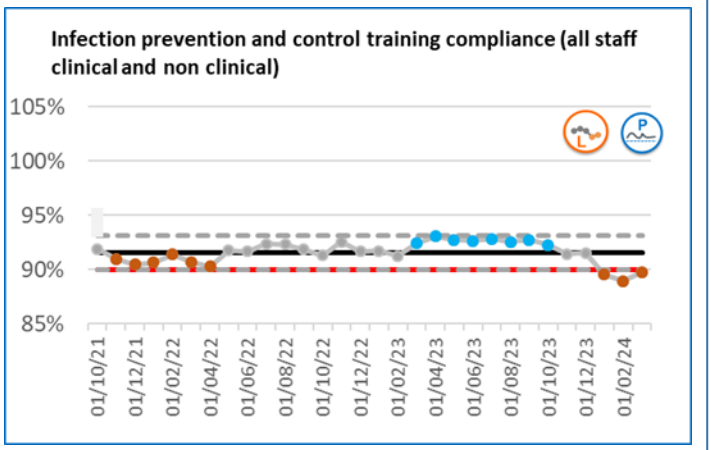
Addition to wait list forms have a mandatory field which must be completed before a patient can be added to the waiting list. This ensures high compliance with recording smoking status. This also automatically emails the smoking cessation nurse who will contact any smoker to offer support and advice.

Consideration of starting to report numbers of patient who quit smoking having accessed our service may be more relevant.

4. Action Plan

Actions	Target date
Monitor data moving forwards to understand potential gaps in assurance and areas for improvement	July 2024
Consider adjusting measure over time depending on compliance	Sept 2024

KSO1 Outstanding Patient Care

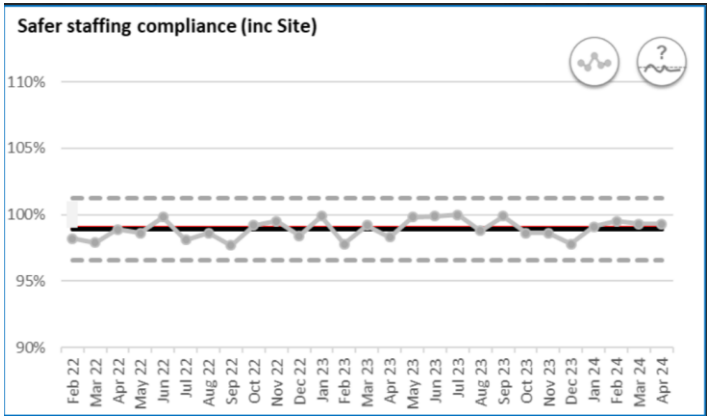


Actual
90%
Internal Target
90%
National Target
-
Variance/ Assurance
Special cause deterioration – will not consistently meet the target

Current Position	Issues	Actions and Timescales
1. Decreased compliance with infection control training in past three months.		IPACT team to review areas of lower compliance and target resources

KSO1 Outstanding Patient Care – Safer Staffing

Queen Victoria Hospital NHS Foundation Trust



Apr 24
99%
Internal Target
95%
National Target
95%
Variance/ Assurance
Normal variation – will hit and miss the target +4%

Combined Staffing exc. Site

Target 95%

Apr-24

	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
DAY	5399	391	2772	5330	391	2749	*Total Hrs Planned and Actual*
				98.7%	100.0%	99%	*% Planned Hrs Met*
			8562			8470	*Total Hrs Planned & Actual - Combined reg & support*
						98.9%	*% Planned Hrs Met - Combined reg & support*

	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA
NIGHT	4221	115	1426	4209	115	1426
				99.7%	100.0%	100.0%
			5762			5750
						99.8%

Current Position	Issues	Actions and Timescales
Evidence demonstrates compliance with internal target however, to achieve this there has been use of agency and bank staff	Long term sickness, time to recruit and dependency of patients and high use of RMN's is contributing	

Integrated Assurance Report

Queen Victoria Hospital
NHS Foundation Trust

KSO2 World Class Clinical Services

Ambition

We will deliver excellent clinical and patient outcomes

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
05 Compliance breach
06 Financial sustainability
07 Information assets
08 Partner organisations

2024/25 Annual Objectives

To deliver a Patient Related Outcome Measure (PROM) in every business unit so that we have consistent patient outcome information available for our clinical services.

2024/25 Annual goals

1. Patient Related Outcome Measure (PROM)

2024/25 Major Projects

1. To implement and optimise an on-site Local Anaesthetic Unit *(Executive Lead: CNO)*

KSO2 World Class Clinical Services - Summary

Queen Victoria Hospital NHS Foundation Trust

Overview. Teams continue to deliver high quality care and have been able to articulate this as part of the clinical strategy stocktake. However, providing the strong evidence of clinical quality in the form of patient reported outcomes and national benchmarked standards is not always easy and the Directorates are now considering with all the business units to see how we can better assess our performance.

Work to be able to report PROMs

Directorate Triumvirates are working with the business units/subspecialty teams to identify outcome measures currently in use and consider how these can be developed where needed.

Antimicrobial QP and CQUIN

Antimicrobial stewardship is improving. Bi-weekly Microbiology ward rounds on TEAMs are proving highly effective with good attendance and preparation. The NICE guidance has been reviewed and the Microguide App and QNET are being updated with a new consultant microbiologist. A new antimicrobial pharmacist has been appointed and antimicrobial champions identified. Successful completion of the national CQUIN on intravenous antibiotic switching to oral. The audit is planned for prescribing habits and choice of drug as separate entities as they represent separate issues in antimicrobial stewardship.

Review how to report returns to theatres – planned/unplanned

Unplanned Returns to Theatre and the need for an out of hours operation are currently manually extracted and cases reviewed by the theatre manager. In the future this review process should happen in the business units to pick up any trends and mapped to best practice. Theatre and Medical Education teams will still need to overwatch to ensure that out of hours activity is appropriate including the case mix and supervision levels.

Positive Assurance/Improvements	Challenges	Mitigations and Actions
Good Outcomes – evidenced in well in some subspecialties – peer reviewed publications and registry data. Formal reporting metrics to be identified	Not all subspecialties have obvious benchmarking opportunities / patient reported outcome measures so teams will need to be inventive and develop metrics	Directorate teams to consider outcome measures and develop an action plan to work towards these.
Better clinical engagement with Antimicrobial Stewardship from QVH teams and Microbiologist. Appointment of antimicrobial pharmacist. Updated prescribing app to reflect QVH caseload	Documentation of decision making and discussions with microbiologist	New more detailed audit planned to separate prescribing habits, documentation and choice of drug

KSO2 World Class Clinical Services - Scorecard

Queen Victoria Hospital NHS Foundation Trust

Metric	Latest month	Target	Variation	Assurance	Actual	Previous month	Mean	LCL	UCL	Rule	Summary
PROM - Overall FFT % recommendation rate	**Apr-24**	**90%**		P	**96%**	**95%**	**96%**	**94%**	**98%**		***Normal variation - will consistently meet the target***
FFT response rate - Inpatient Adult	Apr-24	25%		?	40%	51%	43%	24%	63%		*Normal variation - will hit and miss the target*
FFT response rate - Inpatient Children	Apr-24	25%		?	7%	8%	29%	7%	52%		*Normal cause variation - will hit and miss the target*
FFT response rate - MIU	Apr-24	25%		?	22%	19%	22%	15%	30%		*Normal cause variation - will hit and miss the target*
FFT response rate - Outpatients	Apr-24	25%		F	17%	16%	18%	13%	22%		*Failing process and will not meet the target*
Overall FFT response rate	Apr-24	25%		?	20%	19%	22%	14%	30%		*Normal variation - will hit and miss the target*
Returns to theatre	Apr-24										*Data under review*
Re-admissions <30 days	Apr-24	2%		?	1.3%	3.2%	2%	1%	4%		*Normal variation - will hit and miss the target*
Anti microbial stewardship audits	Apr-24										*Reporting to be agreed*

KSO2 World Class Clinical Services – 2024/25 Annual Goal

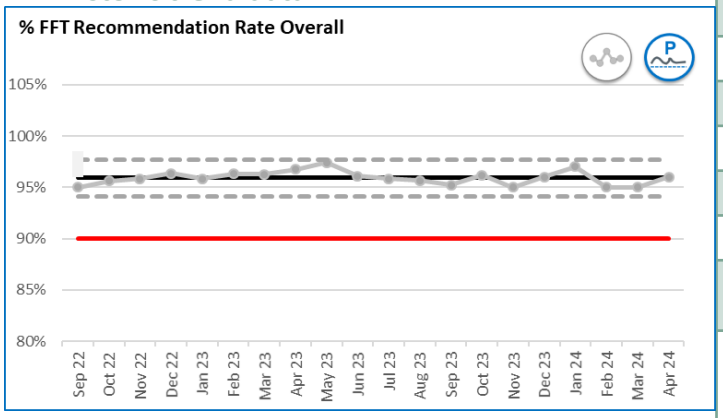
Queen Victoria Hospital NHS Foundation Trust

PROM – Friends and Family Test

Reporting Month: Apr-24

Executive Lead: CNO

1. Historic trend data



Actual
96%
Internal Target
90%
National Target
-
Variance/ Assurance
Normal variation – will consistently meet the target

2. Stratified data

	Recommendation						
	Inpatient Adult	Inpatient Children	DSU	Sleep	MIU	OPD	Overall
Jan-24	100%	100%	100%	100%	94%	97%	97%
Feb-24	100%	96%	97%	94%	92%	95%	95%
Mar-24	100%	100%	97%	95%	86%	95%	95%
Apr-24	100%	100%	97%	92%	94%	95%	96%

3. Top contributors

Friends and Family metrics are collected in Inpatient and Outpatient settings with good results.

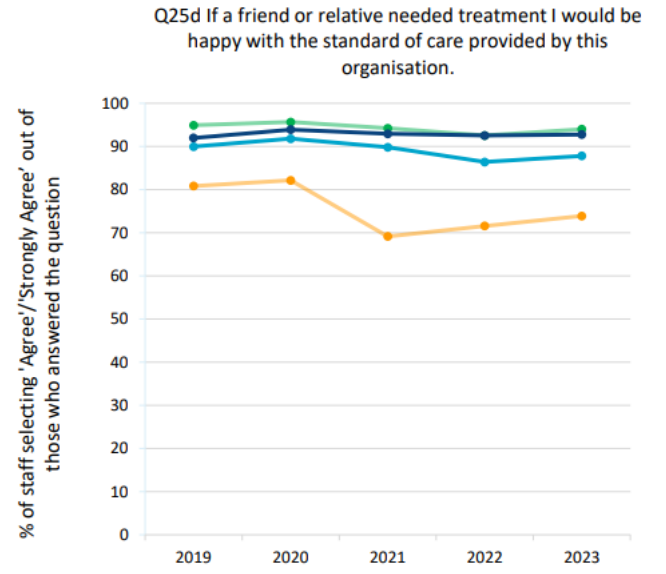
4. Action Plan

Actions	Target date
However, the numbers of patients that complete the survey is low so there may be opportunity to improve this. It would be interesting to know why patients do not choose to complete the FFT are we getting a skewed sample?	

KSO2 World Class Clinical Services

Queen Victoria Hospital
NHS Foundation Trust

NHS Staff Survey 2023



	2019	2020	2021	2022	2023
Your org	91.96%	93.91%	92.96%	92.56%	92.77%
Best result	94.95%	95.67%	94.25%	92.56%	94.02%
Average result	89.98%	91.82%	89.84%	86.42%	87.82%
Worst result	80.84%	82.15%	69.16%	71.58%	73.88%
Responses	572	594	637	605	653

Current Position	Issues	Actions and timescales
NHS Staff Survey 2023 – recently published results show the Trust continues to show above average within its peer group for staff happy with the standard of care provided by the Trust for a friend or relative needing treatment		

KSO2 World Class Clinical Services – 2024/25 Major Projects

Queen Victoria Hospital NHS Foundation Trust

Local Anaesthetic Unit	Exec Lead: CNO Lead: CMO	Reporting Month: Apr-24	Overall Status:

Summary **2024/25 budget:** TBC

Phase 1 – delivered March 2024. The Local Anaesthetic Unit (LAU) is located within Location 56 (old EBAC). There are two procedure rooms to manage Local Anaesthetic (LA) skin non-complex patients during the working week, Monday to Friday, 8-6pm, scheduled for procedures of sixty minutes or less, instead of in the main theatre complex or other providers. There are two rooms each with allocated procedures. Admission criteria apply to ensure patients are suitable for admission.
Phase 2 – to carry out a feasibility study to review the old A Wing Theatre (currently Health Records) as to whether this could be repurposed as a LA suite. This would allow the incorporation of LA Eye surgery as well as Plastics and MaxFac.
Phase 3 – dependent on the outcome of Phase 2 – to develop a business case for the redevelopment of the space to a LA Suite.

Milestones	Planned date	Actual/Forecast date	Commentary
Review delivery of Phase 1	Mid-April 2024	April 2024	Post implementation review carried out. Learning incorporated in future plans.
Phase 2 – feasibility study • Architect plans delivered • Project Team established	 Early Apr Late Apr	 April 2024 May 2024	To review viability of the proposal by bringing together all interested parties and to recommend next steps
Phase 3 – build business case to redevelop the space	Oct 24		If successful, the likely build date would be 2025/26

Risk/Issue	Description	Mitigating Action
Feasibility	If the feasibility study suggests that this is not an appropriate solution, this would impact capacity plans for the delivery of activity	Alternative sites to be considered in line with the estate's strategy
Slippage on feasibility	If the feasibility study slips this could impact the development of the business case and the ability to fund the project in 2025/26	Architect work commenced; slippage due to need for additional information required
Affordability	The cost of the project may exceed available funding	
Estates strategy	The project needs to fit within the trust's overall estates strategy	
Link to strategic change	Confirmation required that the development of LA services is a key strand within the trust's new strategy	

Integrated Assurance Report

Queen Victoria Hospital
NHS Foundation Trust

KSO3 Operational Excellence

Ambition

We will deliver timely and efficient care for our patients.

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
05 Compliance breach
06 Financial sustainability
07 Information assets
08 Partner organisations

2024/25 Annual Objectives

To deliver constitutional standards relating to access to care including cancer, diagnostics, referral to treatment (RTT) and urgent care in line with national requirements (**SDP**)

2024/25 Annual goals

1. No patient waits >65 weeks for first definitive treatment by September 2024

2024/25 Major Projects

1. To deliver the Community Diagnostic Centre programme *(Exec Lead: CFO)*
2. To deliver Sussex Pathology Network programme *(Exec Lead: CMO)*
3. To deliver Year 1 of the Electronic Patient Record *(Exec Lead: COO)*

KSO3 Operational Excellence - Summary

Queen Victoria Hospital NHS Foundation Trust

Overview

RTT performance: RTT performance remains challenged due to capacity shortfalls, anaesthetic workforce availability and late referrals, however longest waiting patients over 65 and 78 weeks are reducing. Efforts to eliminate patients waiting over 65 weeks by M6 continue, with M1 position significantly ahead of internal trajectory.

Cancer performance: performance against all three Cancer Waiting Times standards improved in M12; Faster Diagnosis Standard (FDS), 62-day performance and 31-day performance. The backlog of patients waiting over 62 days saw a slight increase in M1 from 37 to 43 patients due to late referrals and capacity challenges.

Diagnostics (DMO1): Overall Trust position continues to improve, reporting 94% in M1 against the 95% target. Radiology performance remains high. Whilst Sleep is challenged by capacity issues and fluctuating referral demand, performance has maintained improvement through outsourcing, reporting 86% in M1 with the lowest number of patients breaching 6 weeks since 2021/22.

Outpatient productivity: Performing well against the new outpatient target to increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46%. M1 reporting 43%; further work required to increase internal data visibility and understand areas of opportunity.

Theatre productivity: Utilisation calculation changed to capped (total touch time within the start and end time of the planned session, in proportion to planned theatre session/list duration. Excluding overruns / unplanned session extensions). Performance has an improving trend, however, remains below the national target of 85% due to challenges with cancellations on the day and underutilised lists.

Positive Assurance/Improvements

- Cancer FDS reporting **90.6%** in M12 which is the highest rate on QVH record
- Cancer 62-day performance **89.0%**; increased from 75.4% previous month
- Cancer 31-day performance **93.5%**; increased from 90.4% previous month
- RTT waits over 78 weeks reduced by 55% and waits over 65 weeks reduced by 30% compared to previous month
- DMO1 performance continues to improve reporting **94%** in M1 against the 95% target
- M1 elective activity performance against plan was 111%

Challenges

- Anaesthetic workforce challenges are starting to impact long waiting RTT position due to limited GA capacity
- Cancer >62-day backlog challenged by late tertiary referrals (making up 56% of the backlog) and medically complex pathways
- Breast cohort (RTT and cancer) challenged by complexity and workforce capacity; also experiencing an increase in breast cancer referrals from M2
- Large seasonal increase in urgent suspected skin cancer referrals from M2; approx. 70% increase against average weekly referral rate from previous month.

Mitigations and Actions

- Anaesthetic challenges: close monitoring of anaesthetic rota against theatre lists; converting GA capacity to LA where there are shortfalls in cover; awaiting pay discussions to conclude.
- Negotiating with late referring providers regarding breach reporting
- Capacity prioritised for cancer patients over elective RTT
- Continued close monitoring of performance against trajectories
- Recruitment of Skin registrar to increase capacity, start date M4
- Working with IS providers to provide additional Skin capacity

KSO3 Operational Excellence - Scorecard

NHS
Queen Victoria Hospital
NHS Foundation Trust

Metric	Latest month	Actual	Target	Variation	Assurance	Previous month	Mean	LCL	UCL	Summary
RTT 65	**Apr 24**	**45**	**0**			**64**	**69**	**42**	**96**	***Normal variation. Ahead of trajectory for M1***
RTT Waiting List Size	Apr 24	17965	-			17863	16474	15850	17097	*Special cause worsening. Eleven months above UCL*
RTT 78	Apr 24	5	0			11	8	-3	20	*Normal variation. 55% reduction from previous month*
RTT 52	Apr 24	437	358			489	358	303	413	*Special cause worsening. Eight months above UCL, but 10% decrease in month*
Elective Activity against 24/25 plan	Apr 24	111%	100%			-	111%	#N/A	#N/A	*Metric starts from M1 2024/25. Shadow reporting not available*
Cancer Faster Diagnosis Standard	Mar 24	90.6%	75.0%			89.8%	84.7%	77.0%	92.4%	*Highest performance on record. Consistently meeting target*
Cancer 62 day performance	Mar 24	89.0%	85.0%			75.4%	79.0%	54.4%	103.6%	*Passing target, significantly above M1 trajectory*
Cancer 31 day performance	Mar 24	93.5%	96.0%			90.4%	84.4%	69.9%	98.8%	*Normal variation, significantly improved. Two months above mean.*
Cancer >62 day backlog	Apr 24	43	-			37	43	22	65	*Includes >104 day cohort and patients referred by con. upgrade or screening*
Diagnostic tests <6 weeks	Apr 24	94%	95%			92%	78%	67%	90%	*Special cause improving; significant recovery efforts continue. Failing target.*
Theatre Elective Utilisation - QVH site (capped)	Apr 24	80.2%	85.0%			80.0%	79.6%	74.8%	84.3%	*Special cause improving; failing target. Seven months above the mean*
Outpatient % of firsts and procedures	Apr 24	43%	46%			-	43%	#N/A	#N/A	*New metric for 2024/25. Shadow reporting not yet available*
MIU seen <4 hours	Apr 24	99.6%	95.0%			99.0%	99.6%	98.7%	100.5%	*Normal variation. Continues to meet target*
Bed occupancy			-			-				*Further work required to understand the scope of this metric*
Length of stay (elective & non-elective)			-			-				*Further work required to understand the scope of this metric*

KSO3 Operational Excellence – 2024/25 Annual Goal

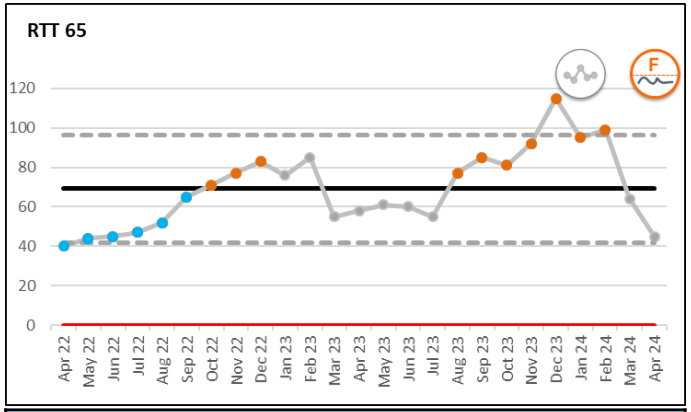
Queen Victoria Hospital NHS Foundation Trust

No patient waiting >65 weeks by 30 September 2024

Reporting Month: Apr-24

Executive Lead: COO

1. Historic trend data

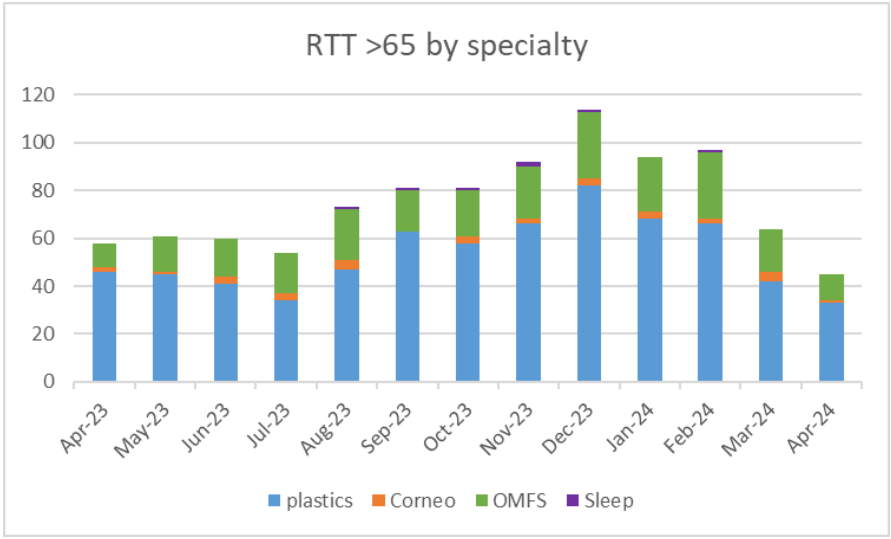


Apr-24
45
Internal Trajectory M1
71
National target
0 by Sep-24
SPC
Normal variation.

BENCHMARK: >65ww as % of the RTT PTL *(look back M12)*

National:	Sussex ICB:	QVH:
0.7%	1.4%	0.4%

2. Stratified data



3. Top contributors

Maxillofacial (OMFS), Breast and Mohs (Skin) identified as at-risk areas
1. Capacity shortfalls
2. Anaesthetic workforce availability
3. Late referrals from other providers, particularly affecting breast and skin
4. Patient choice delays
5. OMFS spoke site pathway data quality

4. Action Plan

Actions	Target date
1. Plans to increase complex Mohs capacity through the local anaesthetic unit, pending estates revisions to procedure rooms and co-located lab	Sept-24 (M6)
2. Daily close monitoring of anaesthetic rota against theatre lists. Also converting GA capacity to LA capacity where there are shortfalls in anaesthetic cover, with list cancellation as a last resort	ongoing
3. Plastics - individual monitoring of late referrals to expedite appointments where possible, and engaging with clinicians to determine provisional treatment plans to pre-emptively protect surgical capacity where required	ongoing
4. Applying active monitoring codes where appropriate	ongoing
5. Recruitment underway for a dedicated RTT spoke site validator to allow greater process control; expected to be in post by M5	Aug-24 (M5)
New digital PTL tool in place to support services with daily proactive management of long waiting patients	ongoing

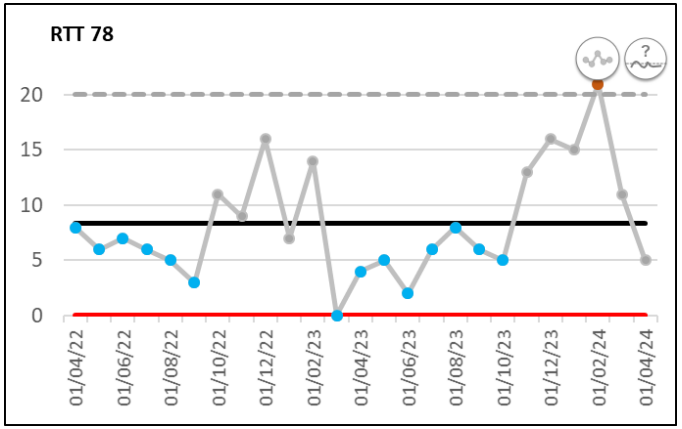
KSO3 Operational Excellence – RTT 78 weeks

Queen Victoria Hospital NHS Foundation Trust

No patient waiting >78 weeks

Reporting Month: Apr-24 | **Executive Lead:** COO

1. Historic trend data



Apr-24
5
National target
0
SPC
Normal variation. Will hit and miss target

BENCHMARK: >78ww as % of the RTT PTL *(look back M12)*

National:	Sussex ICB:	QVH:
0.07%	0.13%	0.06%

2. Stratified data

FORWARD LOOK* M2

QVH: 3 patients

May forward look* – breach details

Specialty	Delay details	Treatment plan
Plastics (Breast)	Capacity issues	Treatment date booked in June
Plastics (Skin – Mohs)	Patient choice	Treatment date booked in June
Maxillofacial	Medically complex	Pending outcome of haematology pathway at secondary provider; provisional treatment date booked in June

**Forward looks are unvalidated and are subject to change*

3. Top contributors

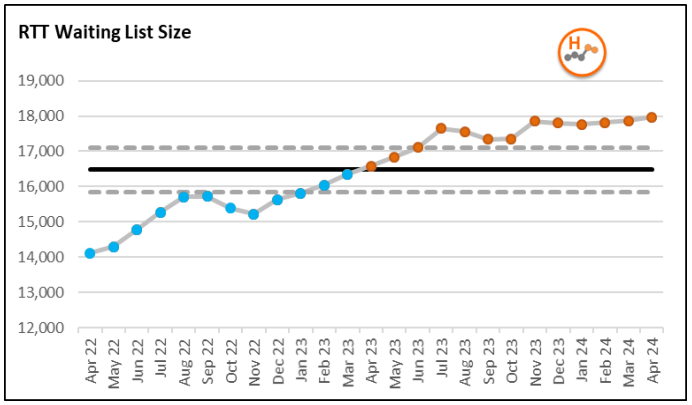
1. Breast cohort: patient complexity; patient choice; capacity where lists require more than one consultant; long waiting mutual aid patients; increase in breast cancer referrals (M2) impacting capacity available for RTT breast patients
2. Late referrals from other providers affecting all services
3. Medically complex pathways
4. Capacity challenges

4. Action Plan

Actions	Target date
1. Proactive monitoring of breast consultant rota against theatre capacity. Offering breast patients to change consultant, limited by patient choice. Negotiating with other providers to manage reporting of mutual aid patients.	Ongoing
2. Highlighting late referrals on PTL to enable proactive management of pathway challenges	Ongoing
3. Patients tracked individually at service level daily and prioritised where clinically appropriate	Ongoing
4. Continued close monitoring of demand and capacity at service level against revised trajectories. Exploring all scheduling opportunities	Ongoing
Patients waiting over 78 weeks are reported weekly with assurance provided to both the Chief Operating Officer and the Sussex ICB	Ongoing

KSO3 Operational Excellence – RTT

Queen Victoria Hospital NHS Foundation Trust



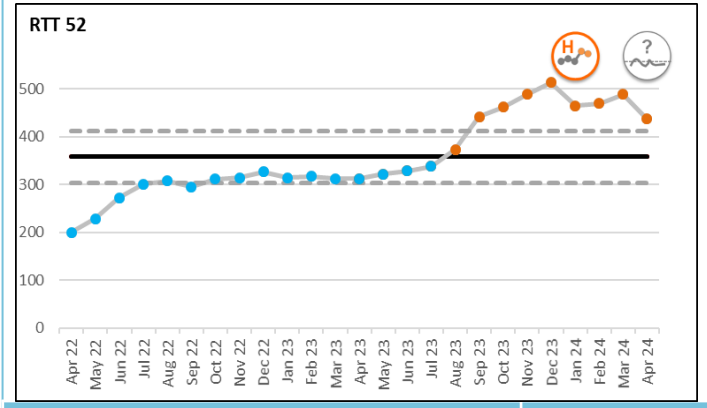
Apr-24
17965
SPC
Special cause worsening

RTT 18WW BENCHMARK: *(look back M12)*

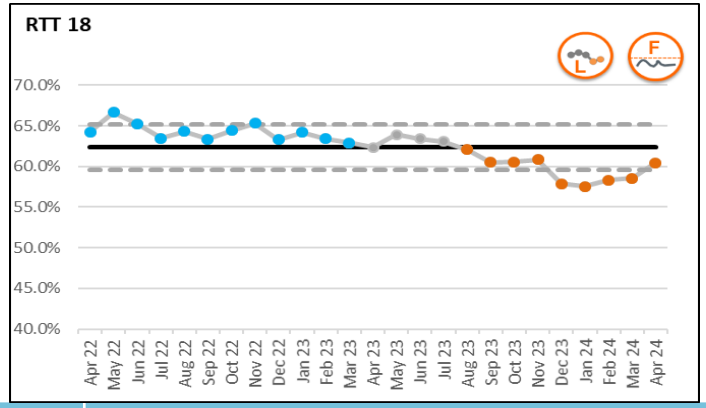
National:	Sussex ICB:	QVH:
57.2%	50.2%	58.5%

RTT 52WW BENCHMARK: *(look back M12)*

National:	Sussex ICB:	QVH:
4.1%	7.3%	2.7%



Apr-24
437
M1 trajectory
457
SPC
Special cause Worsening
Will hit/miss target

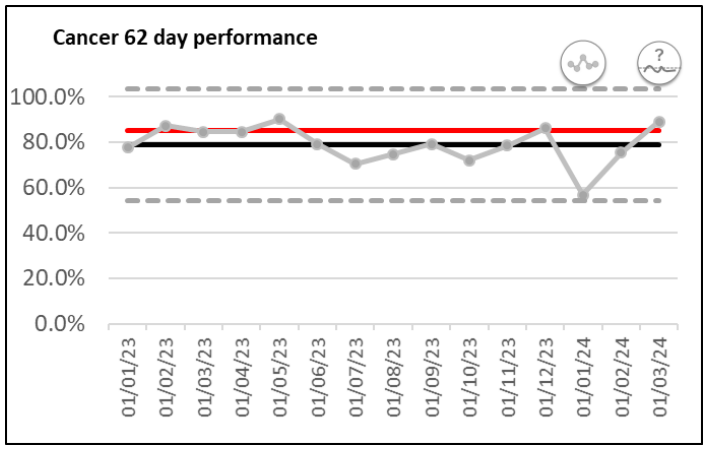


Apr-24
60.4%
National target
92%
SPC
Special cause worsening
Failing target

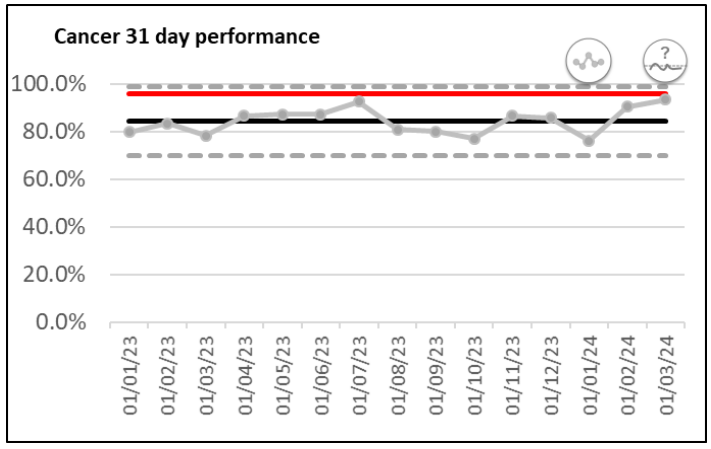
Current Position	Issues	Actions and timescales
Total WL size continues to increase Patients >52 weeks have reduced by 10% from previous month RTT18 performance improved in month but remains challenged Recovery efforts continue from long term impact of sustained industrial action Most challenged area continues to be plastics	Breast workforce skill mix and capacity	Consider increasing workforce capacity through extending current Locum contract beyond the initial 6-month cover period, as well as recruiting an additional micro-fellow to release consultant capacity
	Limited Mohs capacity	Increased existing QVH Mohs outpatient capacity at the Sussex Community Dermatology service from M12
	Routine Skin outpatient capacity causing pathway delays	GM and clinical lead to review demand and capacity to redesign the current service
	Routine Skin patients (P3) breaching optimal surgical wait times due to prioritisation of oncology and longer waiting RTT patients	Plans to utilise Independent Sector provider for routine P3 patients from Month 3 to release QVH capacity for oncology and long waiting RTT patients

KSO3 Operational Excellence – Cancer 62 day & 31 day

Queen Victoria Hospital NHS Foundation Trust



Mar-24 (M12)
89.0%
National Target
85%
SPC
Normal Variation. Will hit and miss target



Mar-24 (M12)
93.5%
National Target
96%
SPC
Normal Variation. Will hit and miss target

BENCHMARK 62D PERFORMANCE: M12

National:	Sussex ICB:
68.7%	66.9%

BENCHMARK 31D PERFORMANCE: M12

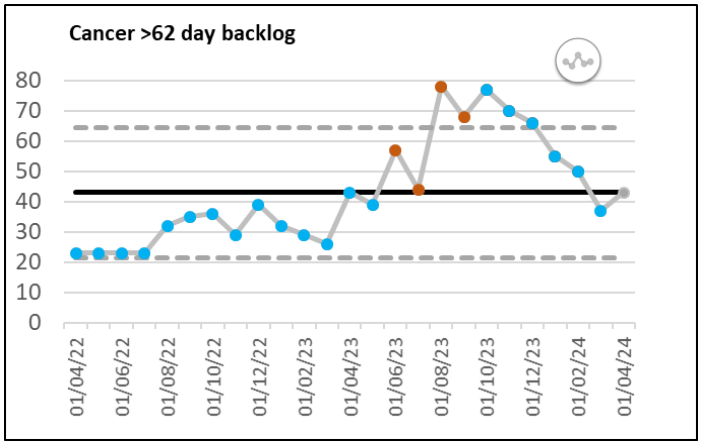
National:	Sussex ICB:
91.0%	86.3%

Current Position	Issues	Actions and timescales
62-day performance Significant improvement in month reporting 89.0% Skin reported 96.7%; positively impacted by a temporary reduction in urgent suspected cancer referrals Performance dip expected in M1 but still predicting to achieve internal trajectory; trajectories reflect anticipated challenges with skin outpatient capacity and the impact of treating a number of complex H&N cancer patients where two consultants are required for one list.	Complex pathways, late referrals and patient choice	Regular meetings with Kent Integrated Dermatology Service to monitor and address late referrals, accurate pathway administration, and referral of patients awaiting further tests before treatment can start.
	Increase in breast cancer referrals seen in M2	Capacity prioritised for cancer patients over elective RTT
	Workforce capacity shortfalls in H&N	Recruitment of substantive consultant to fill vacancy shortfall; in post from mid M2

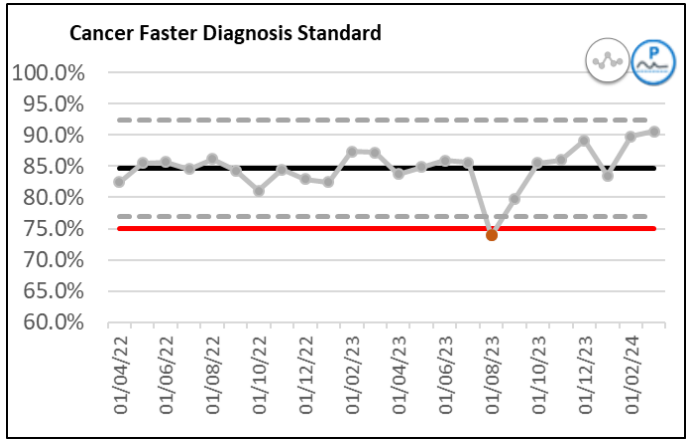
Current Position	Issues	Actions and timescales
31-day performance Underperformance in M12 reporting 93.5%, however this was an improvement from previous month Specialty performance; Skin 93.5%, Head & Neck 100% and Breast 83.3%.	Sentinel Lymph Node Biopsy (SLNB) capacity and pathway challenges	Working with IS providers to provide additional SLNB capacity, although challenged by patient choice delays
	Staff capacity and skill mix	Skin: moving less complex patients to alternative lists to protect capacity of consultants able to see more complex patients

KSO3 Operational Excellence – Cancer backlog and FDS

Queen Victoria Hospital NHS Foundation Trust



Apr-24 (M1)
43 (7.5% of PTL)
PTL Target
6%
SPC
Normal variation



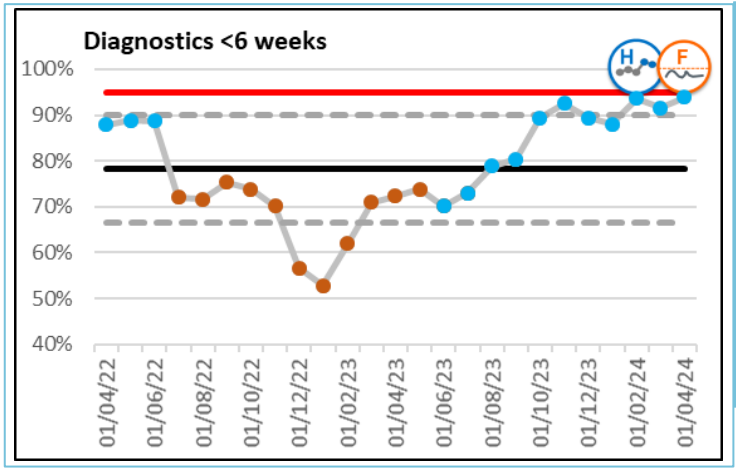
Mar-24 (M12)
90.6%
National Target
75%
ICB Target
80%
SPC
Normal Variation. Achieving target

Current Position	Issues	Actions and timescales
62-day backlog Reporting 43 patients in M1; increased by 6 from M12 Reporting a small increase in the number of patients waiting over 62 Days as a proportion of the PTL to 7.5% from 7.2% Specialty performance: Skin (32), Head & Neck (7), Breast (4). Skin remains the most challenged specialty with regards to its backlog. Patients waiting over 104 days are included in the 62-day backlog; in M1 there were 9 patients over 104 days.	Late tertiary referrals (>38 days) make up 56% of the backlog Skin: outpatient capacity and large seasonal increase in referrals from M2 High volume of complex pathways with patients having inpatient stays at other hospitals or being too unwell to accept a treatment date	Ongoing conversations with referring providers where late referrals are a challenge Recruitment of registrar to increase capacity, start date M4. In the interim, recruiting agency staff until end of M3 to minimise impact on further delays to cancer pathways and 62-day performance. Continued focus on patients over 62 days at twice weekly patient tracking meetings where patients are discussed at an individual level to monitor pathway progression

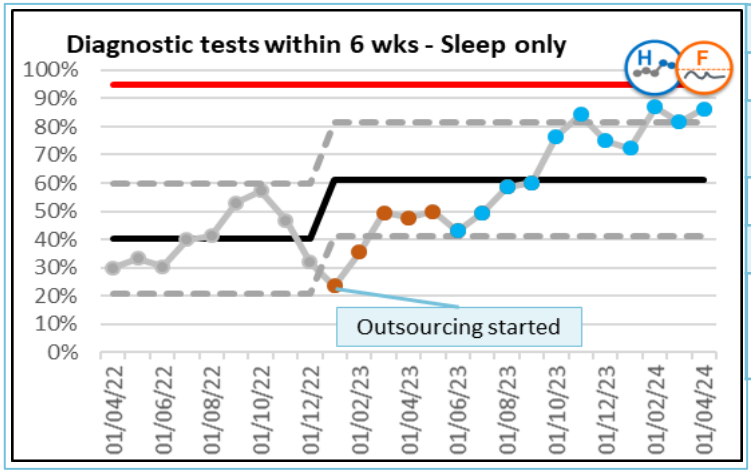
Current Position	Issues	Actions and timescales	Benchmark M12
Faster Diagnosis Standard (FDS) The Trust continues to meet the Faster Diagnosis Standard with a performance of 90.6% in March. **This is the highest performance on QVH record** Specialty performance: Skin 93.4%, Head & Neck 86.5% Unvalidated M1 position remains compliant with the national and ICB targets.	The most common causes of FDS breaches in M12 were Outpatient Capacity (14), Administrative Delay (11) and Delay to Diagnostic Test by Health Care Provider (9)	Closely monitoring FDS at specialty meetings to enable proactive pathway management	**National:** 77.3% **Sussex ICB:** 74.9%

KSO3 Operational Excellence – DM01 Diagnostics

Queen Victoria Hospital NHS Foundation Trust



Apr-24
94%
National Target
95%
SPC
Special cause improving. Failing target.



Apr-24
86%
National Target
95%
SPC
Special cause improving. Failing target.

Service	DMO1	6 wk breaches
Radiology	99%	13
Echocardiography	88%	3
Sleep Studies	86%	104

DMO1 NATIONAL BENCHMARK – Total and Sleep only: (look back M12)

National DMO1:	QVH DMO1:	National Sleep DMO1:	QVH Sleep DMO1:
78.2%	92%	64%	82%

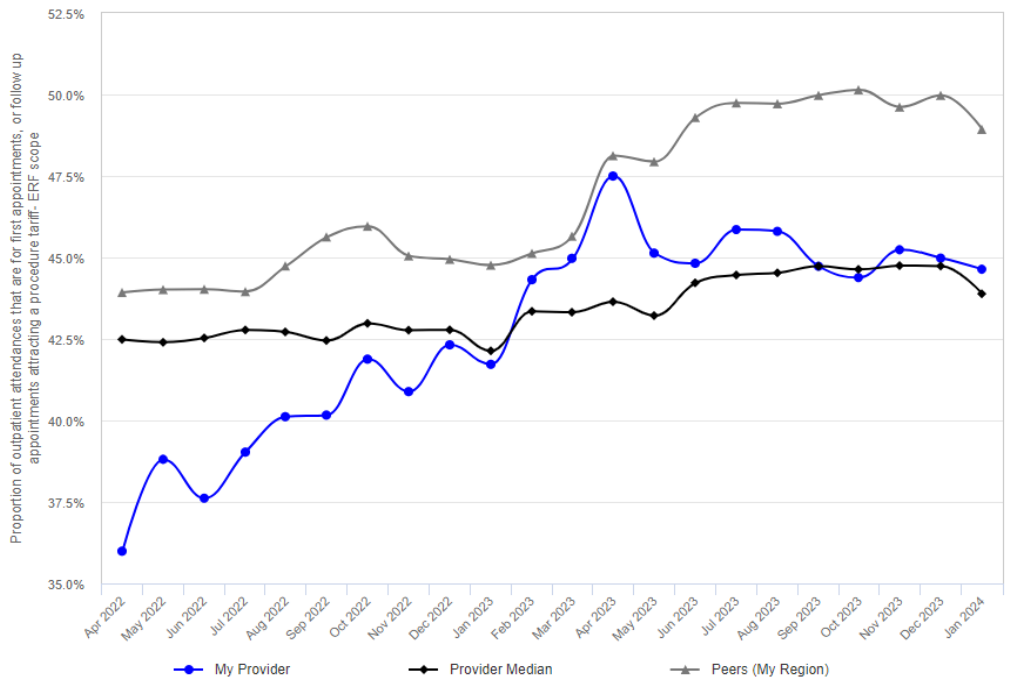
Reported DMO1 positions are a snapshot of the position at the end of the reported month, not a reflection of whole month average performance

Current Position	Issues	Actions and timescales
Trust position continues to improve, reporting 94% in M1 against 95% target Radiology DMO1 performance remains high reporting 99% Sleep DMO1 performance sustained improvement reporting 86% with 104 breaches; the lowest number of DMO1 breaches within Sleep since 2021/22 Sleep patients waiting over 6 weeks for diagnostics continues to reduce Internal DMO1 trajectories for 2024/25 have been agreed, predicting compliance with target by M6	Sleep - lack of consultant clinic capacity to identify patients requiring a DMO1 test, contributing to inconsistent DMO1 waiting list figures	Continuing to schedule additional clinics subject to consultant availability. Recruitment underway for 2 new consultants; one appointed pending start date in M6
	Radiology - National shortage of sonographers; likely to cause DMO1 breaches within the next few months. Estates issue with one of the US rooms	Substantive recruitment ongoing; posts equivalent to 1.3WTE have been offered. Also seeking agency staff. Bank sonographer identified and contract in negotiation. Estates have agreed to find alternative space, tbc.
	Sleep - Fluctuating referral rates, with a trend of 600+ per month	Continued monitoring of referral levels to assess demand and capacity – to be reviewed
	Sleep - Staffing to support additional admin requirements	Continued use of bank staff, although challenged by availability – process to be reviewed
	Sleep - Majority of breaches are WatchPATs due to lack of internal capacity	Needing to maintain third party outsourcing. Outsourcing increased from M1 2024/25

KSO3 Operational Excellence – Outpatient Productivity

Queen Victoria Hospital NHS Foundation Trust

Proportion of outpatient attendances that are for first appointments, or follow up appointments attracting a procedure tariff – ERF scope



Apr-24
43%
National Target
46%
SPC
Insufficient data Pending shadow reporting

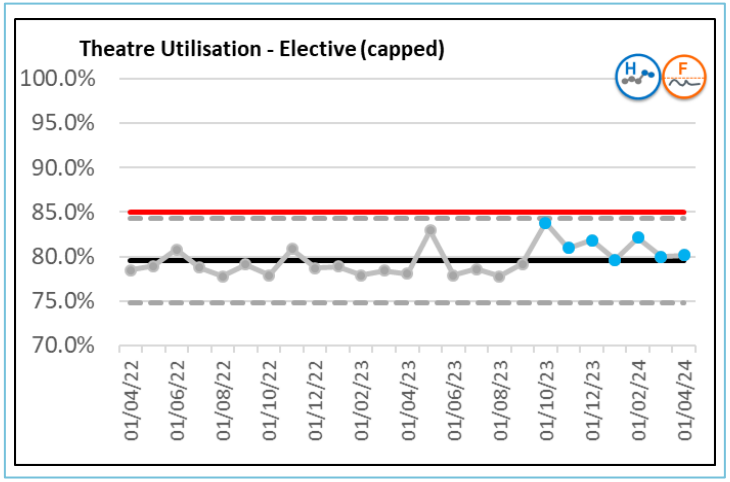
BENCHMARK: (*look back Jan 24)*

National:	**Sussex ICB:**
43.9%	47.7%

Current Position	Issues	Actions and timescales
The above graph is taken from NHS Model Hospital showing data from Apr-22 to Jan-24, pending finalisation of internal reporting mechanisms to plot current data.	Understanding current position at specialty level to identify areas of opportunity	Finalise internal reporting mechanisms and increase data visibility by end of M3
New national target for 2024/25: ***Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff (OPPROC) to 46%*** Currently performing at 43% in M1	Loss of activity post 2023/24 which had contributed towards first/OPPROC position; community ENT and increased Sleep outsourcing	Review if any further appointment types should be coded as OPPROC; work started in M2

KSO3 Operational Excellence – Theatre Utilisation

Queen Victoria Hospital NHS Foundation Trust



Apr-24
80.2%
National Target
85%
SPC
Improving special cause
Failing target

KPIs - Theatres	Latest month	Current Performance	Target	Variation	Assurance
Theatre Utilisation - Elective (capped)	Apr 24	80.2%	85.0%		
Theatre Utilisation - Elective (uncapped)	Apr 24	87.3%	85.0%		
Elective Late Starts Average (Mins)	Apr 24	14	15		
Elective Early Finish Average (mins)	Apr 24	25	30		
Cancellations on the day - % of all elective activity	Apr 24	3.9%	5.0%		

UTILISATION BENCHMARK (capped) - week snapshot as at 21.04.24

National:	Sussex ICB:
78.5%	76.7%

Current Position	Issues	Actions and timescales
M1 saw the second highest number of patients treated in QVH theatres on record (1094) Utilisation remains on an improving trajectory, reporting 80.2% (capped) and 87.3% (uncapped) against the 85% capped GIRFT target. There was particular improvement in Skin list utilisation which reported 84% in M1 compared to 76% in previous month; positively impacted by LAU processes being refined and embedded as BAU Recognising that capped utilisation is consistently below target, the areas of opportunity for improvement are Skin, OMFS, Eyes and late filled ENT oncology lists which depend on MDT outcomes The theatre productivity group is being relaunched in M3 with a focus on utilisation and patient flow QVH activity has been repatriated from TMC and Uckfield from M1	Continued anaesthetic staffing challenges affecting general anaesthetic activity delivery	Daily close monitoring of anaesthetic rota against theatre lists Converting GA capacity to LA capacity or cancelling where there are shortfalls in anaesthetic cover, and where appropriate
	Cancellations on the day (COTD), majority due to "operation not needed" within Skin	Regular monitoring with service leads in the monthly COTD meeting Skin service leads are reviewing their processes in M2 to increase touch points where patients are asked whether their lesion is still present, which could trigger a consultant review
	OMFS - underutilised lists for specific surgeons	Detailed data on these lists provided to service leads in M2 to understand the estimated and actual variance; requiring clinical engagement to produce an action plan
	Challenges to timely discharge of patients due to limited discharge space	Space identified for a second stage recovery and discharge area. Awaiting estates input for costs and timeframe

KSO3 Operational Excellence – 2024/25 Major Projects

NHS Queen Victoria Hospital NHS Foundation Trust

Community Diagnostic Centre (CDC)	**Exec Lead:** CFO **Lead:**	**Reporting Month:** Apr-24	**Overall Status:**

Summary	**Total capital budget** - £8.5m				

The QVH CDC programme is progressing. Appointment of new programme team will increase pace around the programme and advance the demand and capacity model, the business case and the planning application. Work ongoing with ICS in terms of system demand which will inform the final design of the building.

Milestones	Planned date	Actual/Forecast date	Commentary
Estates new build	March 24	June 24	Planning application submitted. New programme team appointed. Start date for building commencement estimated Q4 2024/25.
Increase referrals and activity demand – demand and capacity model to be completed	Aug-24		
Develop additional Clinical pathways	On-going		To further develop clinical pathways for Patients to access.

Risk/Issue	Description	Mitigating Action
R002	Delay implementing a digital solution	Procurement process timescales are in place and a value for money review is required by the Trust
R004	Threat to viability of overall programme through insufficient demand in activity.	Engagement with primary care and ICB to increase demand and awareness of QVH shorter waiting times Onboard more practices for an increase in opportunity for referrals.
R006	Risk of delay of new build timescales.	Put in place new programme team to support delivery and developing relationships with ICS to support develop of business case.

KSO3 Operational Excellence – 2024/25 Major Projects

NHS Queen Victoria Hospital NHS Foundation Trust

Pathology network (including Digital Pathology)	**Exec Lead:** CMO **Lead:** Project Manager - RR	**Reporting Month:** Apr-24	**Overall Status:**

Summary **2024/25 budget:** TBC

The Sussex Pathology Network (SPN) Programme has multiple projects progressing concurrently with QVH as member organisation:
LIMS - LIMS currently in the low-level design phase which will continue into the summer, QVH implementation is scheduled for Feb 2025
Managed Services Contract (MSC) - The outline business case has been approved. Procurement's second round began 10th April 2024.
SPN (S7) Target Operating Model (TOM) – Work continues to review options and to gain further understanding of each individual Trust's strategies and align to a network-wide TOM. The programme team aim to have an outline business case (OBC) autumn 2024
Quality Workstream – A strategic outline case for a single quality management information system is planned for standardisation.
Digital Pathology – QVH are currently working to progress an internal business case to align with SPN for a single approach to digital histopathology across the region which will facilitate easier access and sharing of digitised slides leading to improved outcomes
Order Comms - CliniSys ICE has been procured as a new enterprise order communications system for SPN. Planning for implementation has already started, with an aim to have three phased go-lives throughout Spring/Summer 2025.

Milestones	Planned date	Actual/Forecast date	Commentary
MSC: Bidder submissions for procurement Round 2	May 2024	As per plan	Bidder packs must be distributed by April 2024
LIMS: Test and Connect POST devices to Trust PAS systems	May 2024	As per plan	
Quality: Complete plan for procurement of a single quality reporting system	June 2024	As per plan	

Risk/Issue	Description	Mitigating Action
Risk	MSC Full Business Case (FBC) not submitted in time	Project Plan for FBC completion to be drafted
Issue	LIMS integration high level design not signed off	SPN working with third party suppliers to resolve
Risk	Competing priorities on resources for multiple workstreams	SPN completing network-wide review if resources supported by Pathology leads

KSO3 Operational Excellence – 2024/25 Major Projects

NHS Queen Victoria Hospital NHS Foundation Trust

Electronic Patient Record	Exec Lead: COO Lead: JC	Reporting Month: Apr-24	Overall Status:

Summary	2024/25 budget: £4.787m	FOT: £4.787m	YTD budget: £105k	YTD spend: £105k	YTD Variance: £0

In March 2024, the Trust Board approved the business case to implement a fully functional modern system to enhance our patient care through an electronic patient record system. This is a significant, multi-year programme which is a key part of our digital and organisational strategy. The scale of the programme, the engagement of teams, and the improvements required to the trust's digital maturity underpin the amber scoring of the programme in terms of risk.

Milestones	Planned date	Actual/Forecast date	Commentary
OIP stakeholder engagement events	17 April 2024	17 April 2024	Took place as planned, good engagement
OIP to be signed off by EPR Programme Board	8 May 2024	8 May 2024	EPR Programme Board approved
Infrastructure workstream kick off meeting	31 May 2024		Define hosted environment requirements and draft delivery plan
Detailed finance report against budget	31 May 2024		Budget setting completed with finance
As-is workflow mapping across trust departments	31 May 2024		To review with Altera
Formal Programme Kick-off workshop	12 June 2024		Formal start of the programme
Integration workstream kick off meeting	14 June 2024		Define scope & associated plan to align to Outline Implementation Plan (OIP)
Creation of Project Initiation Document (PID)	31 July 2024		Joint document with Altera

Risk/Issue	Description	Mitigating Action
R032	Risk that data quality on existing PAS records requires significant work prior to migrations impacting time and increase resources/costs	Ongoing task in lead up to go live(s), with all departments. Data Migration strategy (in PID) to define data to be migrated, resolve quality issues prior to migration, this is to be resourced & planned.
R003	Risk around release of internal resources required to assist with project, and potential problems linked with backfilling positions	Ensure that all programme activities are planned, and dates allow time for clinical engagement. Advise departments when staff required to assist in programme. Determine backfill need and plan into programme budget.
R022	Risk of clinical staff not having sufficient time to engage during EPR implementation.	Recruitment process for EPR clinical lead is underway to lead on clinical engagement strategy and deliver with support from wider EPR programme resources and trust staff.

Integrated Assurance Report

Queen Victoria Hospital
NHS Foundation Trust

KSO4 Financial Sustainability

Ambition

We will maximise the use of our resources to deliver best value and treat the maximum number of patients

Board Assurance Framework

02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
05 Compliance breach
06 Financial sustainability
07 Information assets

2024/25 Annual Objectives

- To achieve financial sustainability for the organisation and a break-even position

2024/25 Annual goals

1. Break even position
2. Remain within the Capital Resource Limit

KSO4 Financial Sustainability - Summary

Queen Victoria Hospital
NHS Foundation Trust

Overview

- NHSE has informed Trusts that external reporting for the ICS starts at Month 2 with national reporting for Trusts starting in Month 3. there is therefore reduced information is available for Month 1.
- At the close of April 2024, the Trust was delivering its breakeven plan and had a cash balance of £5.4m. The Forecast is for the achievement of the Trust breakeven plan.
    - A 2.1% pay award has been included in the accounts as an estimation as per NHS planning guidance. This will be updated as pay awards are agreed and confirmed.
    - Activity levels have been good however patient income is £0.4m below plan.
    - The reduced level of patient income has been offset by lower costs across the Trust.
- Efficiency plans of £5.3m are required by the Trust, this equates to 5% against Trust income. £5.7m of initial plans have been pulled together. A new programme group to monitor and challenge efficiencies is being put in place.
- The Trust capital plan for the year is £17.5m and includes capital spend associated with the receipts from the sale of land.
- An updated plan is be submitted to reflect the final agreements with the ICS and NHSE. This will include an update to the Trust phasing of its plans.

Positive Assurance/Improvements	Challenges/Risks	Mitigations and Actions

KSO4 Financial Sustainability - Scorecard

Queen Victoria Hospital NHS Foundation Trust

Metric	Latest month	Target	Variation	Assurance	Actual	Previous month	Mean	LCL	UCL	Rule	Summary
Breakeven YTD	**Apr-24**	**£0**	**-**	**-**	**£0**	**-**	**-**	**-**	**-**		
Cash at bank YTD	Apr-24	TBC	-	-	£5.4m	£12.8m	-	-	-		*M12 saw PDC receipts of £8m with payments in M1 resulting in reduced cash*
Capital spend YTD	Apr-24	£1.3m	-	-	TBC	-	-	-	-		*To be updated following M2 reporting*
Efficiencies YTD	Apr-24	£0.4m	-	-	TBC	-	-	-	-		*To be updated following M2 reporting*
BPPC (NHS & Non NHS) - volume	Apr-24	95%	-	-	93.1%	-	-	-	-		*Just below target*
BPPC (NHS & Non NHS) - value	Apr-24	95%	-	-	97.0%	-	-	-	-		*Just above target*
Agency spend <3.2% total pay bill	Apr-24	£0.1m	-	-	£0.2m	-	-	-	-		*Above plan in M1 with work to reduce future agency spend*

Sussex System Financial Summary

NHS Reporting starts at Month 3 for Trusts and for the ICS in Month 2, therefore sector numbers are not available for Month 1

KSO4 Financial Sustainability – 2024/25 Annual Goal

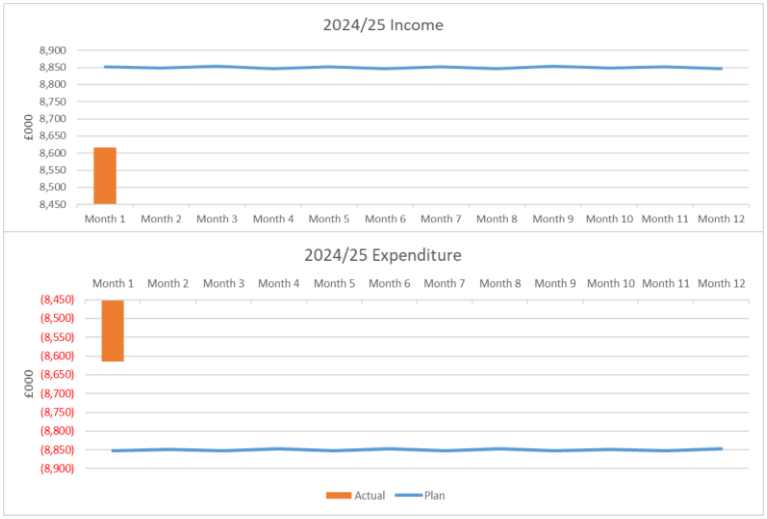
Queen Victoria Hospital NHS Foundation Trust

Break Even

Reporting Month: Apr-24

Executive Lead: CFO

1. Historic trend data



2. Stratified data

	Annual Target	Forecast Outturn
Income & Expenditure	£0	£0
Cash at bank	£14.3m	£14.3m
Capital Spend	£17.5m	£17.5m
Efficiencies	£5.3m	£5.3m
BPPC (NHS & Non-NHS)		
- Volume	95%	95%
- Value	95%	95%

3. Top contributors

Value Weighted Activity achievement in Month 1 is 120%.

4. Action Plan

Actions	Target date
Set up efficiencies programme group to monitor and deliver the Trust Forecast	June 24
Finalise plan with NHSE and the ICS following	June 24

KSO4 Financial Sustainability

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 1 2025
Income and Expenditure

	In Month £'000				Year to Date £'000				Forecast Outturn £,000		
	23/24	Plan	Actual	Variance	23/24	Plan	Actual	Variance	Plan	Forecast	Variance
Income											
Patient Activity Income	8,153	8,630	8,180	(450)	8,153	8,630	8,180	(450)	103,546	103,546	0
Other Operating Income	313	222	436	214	313	222	436	214	2,654	2,654	0
Total Income	**8,467**	**8,852**	**8,616**	**(236)**	**8,467**	**8,852**	**8,616**	**(236)**	**106,200**	**106,200**	**0**
Pay											
Substantive	(4,522)	(5,462)	(4,963)	499	(4,522)	(5,462)	(4,963)	499	(65,526)	(65,526)	0
Bank	(392)	(331)	(413)	(82)	(392)	(331)	(413)	(82)	(3,950)	(3,950)	0
Agency	(149)	(107)	(227)	(120)	(149)	(107)	(227)	(120)	(1,275)	(1,275)	0
Total Pay	**(5,063)**	**(5,900)**	**(5,603)**	**297**	**(5,063)**	**(5,900)**	**(5,603)**	**297**	**(70,751)**	**(70,751)**	**0**
Total Non Pay	**(2,939)**	**(2,380)**	**(2,484)**	**(104)**	**(2,939)**	**(2,380)**	**(2,484)**	**(104)**	**(28,575)**	**(28,575)**	**0**
Total Non Operational Expenditure	**(485)**	**(595)**	**(551)**	**44**	**(485)**	**(595)**	**(551)**	**44**	**(7,151)**	**(7,151)**	**0**
Total Expenditure	**(8,487)**	**(8,875)**	**(8,638)**	**237**	**(8,487)**	**(8,875)**	**(8,638)**	**237**	**(106,477)**	**(106,477)**	**0**
Surplus / (Deficit)	**(20)**	**(23)**	**(23)**	**0**	**(20)**	**(23)**	**(23)**	**0**	**(277)**	**(277)**	**0**
TechnicalAdjustments	20	23	23	0	20	23	23	0	277	277	0
Adjusted Surplus / (Deficit)	**(0)**	**(0)**	**(0)**	**0**	**(0)**	**(0)**	**(0)**	**0**	**0**	**0**	**0**

Current Position	Issues	Actions and timescales
The trust has submitted a 2024/25 plan for breakeven. The Trust is forecast to achieve this plan.	Planning discussions ongoing with the sector and NHSE	Complete the discussions with NHSE and adjust the Trust plan.
Income has performed well although with the stretching plan has underperformed £0.2m at Month 1. Pay is underspent although agency spend has remained high.	High level of agency spend due to number of vacancies that need cover	Recruitment to substantive roles to reduce agency figures later in the year

KSO4 Financial Sustainability

Queen Victoria Hospital NHS Foundation Trust

Efficiency plan for 2024/25 with actuals to be updated following Month 2 reporting

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Non-Pay - NHS subcontracted	188	187	188	187	188	187	188	187	188	187	188	187	**2,250**
Non-Pay - non-NHS subcontracted	183	183	183	183	183	183	183	183	184	184	184	184	**2,200**
Pay - Agency	21	21	21	20	21	21	21	20	21	21	21	21	**250**
Non-Pay - Procurement (excl drugs)	22	22	22	22	22	22	22	22	22	22	20	20	**260**
Pay - Establishment reviews	31	29	29	29	29	29	29	29	29	29	29	29	**350**
Total	**445**	**442**	**443**	**441**	**443**	**442**	**443**	**441**	**444**	**443**	**442**	**441**	**5,310**

Non pay efficiencies to be delivered through a combination of non-pay reductions, changes in contracts and increased activity leading to increased income contribution net of costs.

Current Position	Issues	Actions and timescales
The Trust has an efficiency programme of £5.3m in order to deliver the breakeven position	In order to deliver the ICS target the Trust may need to deliver a higher level of efficiencies	Review the required efficiency programme following discussions in the ICS and resubmission of the plan.
Efficiency programme has been developed and a new governance process is being developed to support delivery and deliver assurance.	Governance process is required to provide assurance and support delivery	Finalise the efficiency governance process

KSO4 Financial Sustainability

Queen Victoria Hospital
NHS Foundation Trust

Capital Spend 2024/25

Plan for 2024/25. Actuals to be updated in Month 2

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
IT - Hardware	59	59	59	59	59	59	59	59	59	59	59	61	**710**
Equipment - clinical Other	50	50	50	50	50	50	50	50	50	50	50	50	**600**
Backlog Maintenance	120	120	120	120	120	120	120	120	120	120	120	117	**1,437**
New Build - Wards	83	83	83	83	83	83	83	83	83	83	83	81	**994**
IT - Hardware	399	399	399	399	399	399	399	399	399	399	399	398	**4,787**
New Build - Diagnostics	559	559	559	559	559	559	559	559	559	559	559	557	**6,706**
Equipment - clinical Other							375	375	375	375	375	375	**2,250**
Total	**1,270**	**1,270**	**1,270**	**1,270**	**1,270**	**1,270**	**1,645**	**1,645**	**1,645**	**1,645**	**1,645**	**1,639**	**17,484**

Current Position	Issues	Actions and timescales
Plan has been submitted to NHSE for £17.5m. This is £15.2m of CDEL and £2.3m from receipts associated with the sale of land.		

Integrated Assurance Report

Queen Victoria Hospital
NHS Foundation Trust

KSO5 Organisational Excellence

Ambition

We will support an engaged and motivated workforce as a well led organisation and excellent partner

Board Assurance Framework

02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
05 Compliance breach
06 Financial sustainability
07 Information assets

2024/25 Annual Objectives

- To implement the trust's 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

2024/25 Major Projects

1. Design and implementation of a systematic quality improvement approach across the organisation (**QP**) (**SDP**) *(Exec Lead: CSO)*

KSO5 Organisational Excellence - Summary

Queen Victoria Hospital NHS Foundation Trust

Overview

Time to Hire a project has commenced to look at the process from raising a vacancy on TRAC through to starting in post for the new employee, all aspects where we have control are subject to a redesign to take more tasks into the resourcing team to allow appointing managers more time for their day-to-day role. **Occupational Health (OH)** pre-employment checks are also being reviewed with a discussion taking place on risk based OH clearances with Cordell, allowing candidates to self-clear based on a set risk assessment template of duties for some roles.

Employee Relations: aside from sickness absence caseload, there were 22 new / ongoing cases in April 2024. 2 new informal investigations and 1 ongoing formal investigation; 6 ongoing conduct management cases and 1 informal performance management case; an additional informal grievance alongside 3 ongoing formal cases; 2 new informal and 1 new formal dignity & respect cases; 1 ongoing probation management; 2 informal change management consultations/engagements; 1 new formal redeployment case; 2 ongoing mediation interventions.

Temporary Staffing: Admin and Clerical had the highest bank usage at 30.58WTE in May with 5.75 in Sleep and 4.81 in Plastic Surgery. Nursing and Midwifery had the highest agency usage at 15.61WTE with Burns at 8.28 and Theatres at 4.72 as the highest users.

Fire Marshal training is being delivered to ensure sufficient marshals are available in all areas across QVH

Mandatory and Statutory Training (MAST): NHS England are leading a programme of work to optimise, nationalise and reform MAST training which aligns to the Core Skills Training Framework (CSTF). QVH is aligned to the current framework and is working with subject matter experts to ensure training standards meet requirements

Apprenticeship Levy spend increased from 62% to 70% in 2023/24. There are 52 apprenticeships running in 23/24, of which 28 are clinical, 11 non-clinical and 13 are management. There are currently an additional 15 apprenticeships planned for autumn starts 24/25 of which 13 are clinical and 2 are non-clinical

Corporate Induction: task and finish group established to improve programme, with the revised corporate induction starting June 24

Medical Education: LEEP 4 – the final session of the first leadership training cohort – was delivered in April. A new cohort starts in May and is fully subscribed. Feedback from the first cohort has been excellent. An excellent multidisciplinary OMFS TMJ teaching day was delivered on 16 April.

Positive Assurance/Improvements	Challenges	Mitigations and Actions
• All permanent staff **MAST compliance** remains above 90% target (92.55%) • Redesigning of **Resourcing** process by utilising MSForms to take heavy process away from appointing managers. • Excellent feedback from April trainee doctors' **induction** • Improvements in place to assure **supervision** for trainee doctors in plastic surgery. • No trainee doctor **exception reports** received in April.	• Gender pay gap remains above 30% for 23/24 • Bullying and harassment has been detailed in the Workforce Race Equality Standard and the Workforce Disability Equality Standard for 23/24 • Engagement by staff with staff networks remains low • Time to hire is within the KPI but remains higher than neighbouring trusts • Bank use remains high in some areas • Vacant Wellbeing and Inclusion post has meant a reduction in promotion of wellbeing initiatives	• Reviewing recent years recruitment to establish if there have been improvements • Gender pay gap action plan in place • Working with an EDI partner and ICB EDI lead to support staff network engagement and improvements of experience for staff from under-represented groups • Time to hire / recruitment process is under review • Workforce modelling to be undertaken to review staffing levels / activity • Recruited to a Wellbeing and Inclusion Manager role

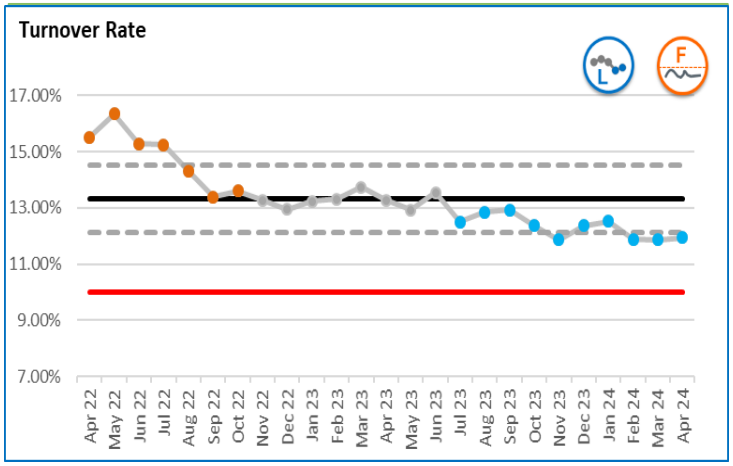
KSO5 Organisational Excellence - Scorecard

Queen Victoria Hospital
NHS Foundation Trust

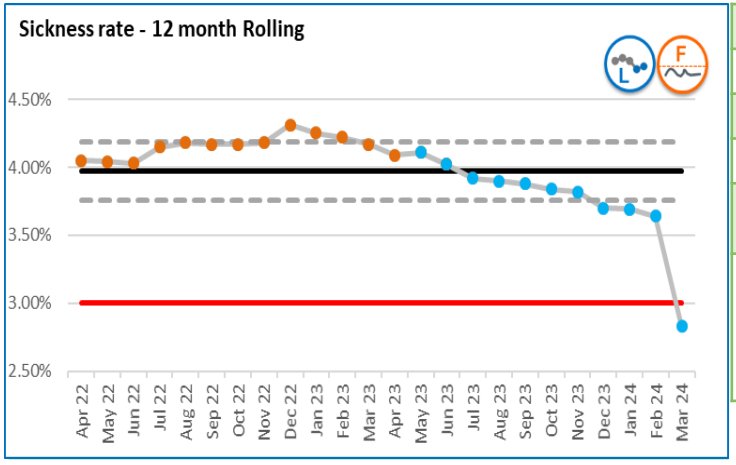
Metric	Latest month	Target	Variation	Assurance	Actual	Previous month	Mean	LCL	UCL	Rule	Summary
Vacancies - staff in post	Apr-24	8%	L	P	2.83%	2.87%	5.44%	3.69%	7.20%		*Special cause Improvement - will consistently meet target*
Vacancies - incl bank & agency	Apr-24	8%	L	P	-4.10%	-6.32%	0.60%	-2.36%	3.56%		*While this is below target trust bank and Agency usage exceeds vacancy WTE so therefore over budgeted establishment*
Time to hire - days	Apr-24	70	H	?	59.24	52.40	50.19	23.20	77.18		*Special cause deterioration. Meeting Target*
Turnover - rolling 12 months	Apr-24	10%	L	F	11.93%	11.87%	13.32%	12.13%	14.51%		*Special cause improvement. Failing process and will not meet the target*
Sickness - rolling 12 months	Mar-24	3%	L	F	2.83%	3.64%	3.97%	3.76%	4.19%		*Special cause improvement. Failing process and will not meet the target*
Appraisal	Apr-24	90%		F	82.16%	82.78%	83.85%	81.13%	86.57%		*Normal variation. Failing process and will not meet the target*
Statutory & mandatory training	Apr-24	85%		P	92.55%	91.80%	92.21%	90.84%	93.59%		*Normal variation - will consistently meet target*
Agency usage in month WTE	Apr-24	N/A	H	-	23.28	26.16	13.6	8.49	18.7		*Special cause deterioration No Target*
Bank usage in month WTE	Apr-24	N/A		-	82.97	104.61	78.18	60.46	95.91		*Normal variation usage remains high. No Target*

KSO5 Organisational Excellence

Queen Victoria Hospital
NHS Foundation Trust



Actual
11.93%
Internal Target
10%
Variance/ Assurance
Special cause improvement. Failing process and will not meet the target

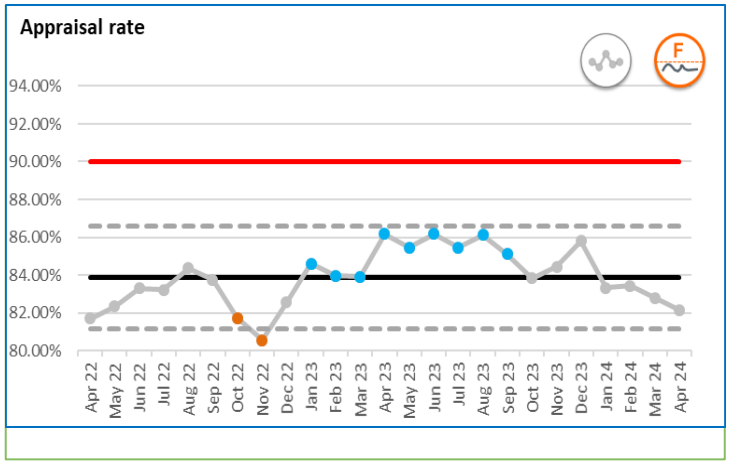


Actual
2.83%
Internal Target
3%
Variance/ Assurance
Special cause improvement. Failing process and will not meet the target

Current Position	Issues	Actions and timescales
Staff Turnover - Our 12-month turnover rate has reduced by 1.35% compared to April 2023 with the last 3 months showing at under 12%.	During April the highest turnover was within Eyes at 36.60%, Finance at 26.46%, Corporate and Clinical Support at over 15%. The highest turnover staff group was AHP's at 14.25%, Admin & Clerical at 13.75% Estates & Ancillary at 13.15%. (Medical and Dental was also high at 13.96% however this is due to the number of fixed term contracts for Specialty Doctors).	To improve a candidate's experience on initially joining the trust we are doing a deep dive review into the full recruitment process to speed up the on-boarding and to work with managers to look at the first few weeks in post to ensure all starters are made to feel welcome, included and valued from the start. A People Promise Manager starts at QVH in June, with a focus on retention across the Trust.
Sickness - The 12-month rolling sickness rate saw a significant drop in Mar-24 to 2.83% (from 3.64% in Feb24) driven by a reduction in short term absences		Employee Relations team continue to advise managers in line with the Supporting Health in the Workplace Policy as appropriate

KSO5 Organisational Excellence

Queen Victoria Hospital
NHS Foundation Trust



Actual
82.16%
Internal Target
90%
Variance/ Assurance
Normal variation. Failing process and will not meet target

Current Position	Issues	Actions and timescales
Overall appraisal rate is below 90% KPI (82.16%) and compliance has never exceeded 87%.	Non-clinical compliance is lower than both clinical and medical and dental compliance (72% vs 89%).	Engage with managers regarding non-clinical appraisal compliance to scope reasons for non-compliance. 24 members of staff are recorded as over 9 months overdue for an appraisal, of which 7 are either long term sick or recently returned from maternity leave. The 16 remaining are admin and clerical staff, who are being followed up to with managers.
Number of appraisals expired more than 3-months ago has increased to 88 (up from 78 in Mar 24)	As a rolling consequence, as appraisals get completed, others drop off and fall into the expired more than 3-month category. Managers are failing to complete appraisals in a timely manner. Raised at business unit managers meetings for escalation and oversight.	Monthly report is produced highlighting all appraisals that expired more than 3 months ago which is shared with HoD and discussed at Business Unit (BU) meetings. HoD must check o/s appraisals and schedule within the next month. This is monitored through BU meetings and will be escalated to support completion.
Appraisal action plan is ongoing. New forms and training is now offered to managers and staff on effective appraisals. Appraisal experience survey has been launched in May 2024. Feedback is presently being collated. Implementation of revised appraisal documentation, training programmes and evaluation survey are live. Process review and feedback to be monitored, with lessons learned and development where needed.	Appraisal form requires some adjustments to make it more user friendly.	Introduce ESR Manager and ESR Self Service through ESR will enable managers to oversee compliance levels, complete appraisal documentation online and log compliance in real time.

KSO5 Organisational Excellence

Queen Victoria Hospital NHS Foundation Trust

Culture

Health and Wellbeing
We have appointed a Wellbeing and inclusion Manager to lead the work on staff experience, engagement and inclusion. Barclays Bank has been providing financial clinics for staff. We have agreed to implement Wagestream to support staff with more regular and flexible access to their salary. We are reviewing our salary sacrifice offer, with cycle to work limits being removed.

Violence Prevention Reduction (VPR)
QVH has improved their compliance against national standards by 32%, with work ongoing to achieve full compliance by March 2025. QVH is engaged with system partners to work collaboratively on agreed communications, sexual safety charter and the EDI High Impact Action 6.

Equality, Diversity and Inclusion
We are working with 'Absolute Diversity' and with ICB colleagues to support embedding of staff networks, identification of network chairs and their ongoing support. Workforce Race Equality Standard and the Workforce Disability Equality Standard are being reported for 23/24 with the reports going to the Finance and Performance Committee in June 2024 and to Board in July 2024. The Gender Pay Gap report and Ethnicity Pay Gap report are being reported for 23/24 with the reports going to the Finance and Performance Committee in June 2024 and to Board in July 2024.

Coaching
Organisational Development and Learning (OD&L) are developing a coaching programme for managers to support the creation of a coaching culture at QVH. Sessions will commence in August 24. The senior triumvirate leadership team in the 4 directorates are having a development session as they form their new teams, with ongoing coaching as part of the development programme.

National Quarterly Pulse Survey (Staff Friends and Family Test)
Overall Employee Engagement score: 7.4 (out of 10)
Advocacy: 8.1 Involvement: 6.8 Motivation: 7.4 All results are within the top 25% quartile nationally

Staff Survey
All departments where a report has been received have been asked to share the results with staff and produce an action plan to address any areas of concern. Departments have been asked to share an update and a copy of their action plans with OD&L to enable oversight of the work being done and to support team development and interventions where required.

KSO5 Organisational Excellence – 2024/25 Major Projects

Queen Victoria Hospital NHS Foundation Trust

Quality Improvement	Exec Lead: CSO Lead: Deputy CSO - KB	Reporting Month: Apr-24	Overall Status:

Summary **2024/25 budget:** TBC

- ❑ QVH has undertaken a procurement process to identify a partner to design, implement and embed a systematic approach to Quality Improvement across QVH. As part of this process 'A Request for Information' exercise was undertaken to initially test the market.
- ❑ In March 2024, due to the size, complexity, resource availability and ambition of the organisation, a mini-competition commenced with 20 companies on the Workforce Alliance Framework Agreement for Management Consultancy Framework Three (MCF3), RM6187 Lot 5. This mini-competition closed in late March 2024, where two companies submitted their formal bids and associated documentation
- ❑ Next steps are outlined below
- ❑ Formal procurement process to be completed which will identify the preferred partner provider
- ❑ A Head of Improvement substantive post is being recruited to ensure leadership capacity for the programme of work

Milestones	Planned date	Actual/Forecast date	Commentary
Potential partner presentations (two companies) to multi-disciplinary group	19 April 2024	19 April 2024	Complete
Scoring to be completed by identified panel	23 April 2024	23 April 2024	Complete
Scoring alignment	25 April 2024	25 April 2024	Procurement to align scoring of all involved ahead of moderation session
Moderation session	26 April 2024	26 April 2024	Complete
Financial assessment	09 May 2024		
Award recommendation and offer			

Risk/Issue	Description	Mitigating Action
Lack of preferred provider	Following the scoring and moderation process there is no preferred partner	Two bids have been submitted and are deemed as reputable QI providers

Interpretation of Summary Icons for Statistical Process Charts

Queen Victoria Hospital NHS Foundation Trust

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	**Excellent** **Celebrate and Learn** • This metric is improving • Your aim is high numbers, and you have some • You are consistently achieving the target because the current range of performance is above the target	**Good** **Celebrate and Learn** • This metric is improving • Your aim is high numbers, and you have some • Your target lies within the process limits so we know that the target may or may not be achieved	**Concerning** **Celebrate but Take Action** • This metric is improving • Your aim is high numbers, and you have some • HOWEVER, your target lies above the current process limits so we know that the target may or may not be achieved without change	**Excellent** **Celebrate** • This metric is improving • Your aim is high numbers, and you have some • There is currently no target set for this metric
L	**Excellent** **Celebrate and Learn** • This metric is improving • Your aim is low numbers, and you have some • You are consistently achieving the target because the current range of performance is below the target	**Good** **Celebrate and Learn** • This metric is improving • Your aim is low numbers, and you have some • Your target lies within the process limits so we know that the target may or may not be achieved	**Concerning** **Celebrate but Take Action** • This metric is improving • Your aim is low numbers, and you have some • HOWEVER, your target lies below the current process limits so we know that the target may or may not be achieved without change	**Excellent** **Celebrate** • This metric is improving • Your aim is low numbers, and you have some • There is currently no target set for this metric
○	**Good** **Celebrate and Understand** • This metric is currently not changing significantly • It shows the level of natural variation you can expect to see • HOWEVER, you are consistently achieving the target because the current range of performance exceeds the target	**Average** **Investigate and Understand** • This metric is currently not changing significantly • It shows the level of natural variation you can expect to see • Your target lies within the process limits so we know that the target may or may not be achieved	**Concerning** **Investigate and Take Action** • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • Your target lies below the current process limits so we know that the target will not be achieved without change	**Average** **Understand** • This metric is currently not changing significantly • It shows the level of natural variation you can expect to see • There is currently no target set for this metric
H	**Concerning** **Investigate and Understand** • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • HOWEVER, you are consistently achieving the target because the current range of performance is below the targe	**Concerning** **Investigate and Take Action** • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • Your target lies within the process limits so we know that the target may or may not be achieved	**Very Concerning** **Investigate and Take Action** • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** **Investigate** • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • There is currently no target set for this metric
L	**Concerning** **Investigate and Understand** • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • HOWEVER, you are consistently achieving the target because the current range of performance is above the target	**Concerning** **Investigate and Take Action** • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • Your target lies within the process limits so we know that the target may or may not be achieved	**Very Concerning** **Investigate and Take Action** • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** **Investigate** • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • There is currently no target set for this metric

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04/07/2024	**Agenda reference:**	**38-24**		
Report title:	Audit & risk committee assurance report				
Sponsor:	Paul Dillon-Robinson, committee Chair				
Author:	Ellie Simpkin, governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last two committee meetings (held on 4 and 18 June).				
Summary of key issues	*Due to the restrictions which apply during the pre-election period this report is limited to matters which require operational or financial oversight.* - Head of Internal Audit Opinion 2023/24 confirmed the Trust has adequate and effective framework for risk management, governance and internal control, with some room for further enhancements. - External auditors anticipate issuing an unmodified audit opinion for 2023/24 - Trust Annual Report, including the Annual Governance Statement, for 2023/24 reviewed and recommended to Board for approval - The committee will be receiving regular updates on the Tactical Measures Programme as work progresses - The committee supported the revised risk management framework and implementation plan at its extra meeting on 4 June				
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:	No specific BAFs covered, but role of committee is to assure the complete assurance framework. Individual BAFs allocated to other committees.				
Corporate risk register:	None				
Regulation:	Compliance with financial reporting, NHS E and NHS Sussex requirements.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	38-24
Date of meeting:	4 July 2024
Report from:	Paul Dillon-Robinson, committee Chair
Report author:	Ellie Simpkin, governance officer
Date of report:	20 June 2024
Appendices:	None

Sub-committee assurance report
Audit & risk committee - 4 June 2024 and 18 June 2024

Due to the restrictions which apply during the pre-election period this report is limited to matters which require operational or financial oversight.

Key agenda items

- **Risk management framework**
- **Internal audit & LCFS contract**
- **Clinical audit annual report**
- **Financial assurance**
- **Grip & control - Tactical Measures Programme**
- **Local counter fraud progress report and annual report 2023/24**
- **Internal audit progress report and annual report 2023/24 (including the Head of Internal Audit Opinion)**
- **Trust Annual Report, including the Annual Governance Statement 2023/24**
- **Trust audited annual accounts and financial statements and external audit opinion 2023/24**

Alert

A summary report of the **clinical audit** quality and compliance work undertaken in 2023/24 was discussed by the committee. There are a number of audits which demonstrate good compliance with national standards, however, there are a small number of audits where there are gaps in assurance. There is further work to do on aligning the clinical audit strategy with the Board Assurance Framework and to develop the assurance which the committee receives from the Quality & safety committee on the quality and patient safety aspects of the clinical audit programme.

RSM reported on two **internal audit** reviews which have reported a 'reasonable' level of assurance. The committee challenged the time being taken to implement some management actions and noted that staff resourcing has been a limiting factor. The Head of Procurement will be attending the next committee meeting to provide a further update on the progress being made on the actions arising from the review of contract management. Work has commenced on the delivery of the initial internal audit plan 2024/25.

The committee received assurance on the Trust's **compliance with Standing Financial Instructions**. The committee has asked that future reporting provides further assurance that value for money is being considered when approving contract waivers.

Work has commenced on the **Tactical Measures Programme** which aims to reinvigorate the culture with respect to compliance with financial control and

established governance arrangements. The committee will be receiving regular updates as the programme progresses.

Assure
The Head of Internal Audit Opinion 2023/24 has confirmed that '*The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.'* The committee concurs with this assessment. The area of most concern, previously noted, was in contract management

The committee reviewed and recommended the Annual Report, including the Annual Governance Statement, for 2023/24 to the Board for approval, noting that some areas were still subject to final review.

The external auditors, Azets, presented their annual audit findings for year ending 31 March 2024. **Subject to** the satisfactory resolution of a few remaining matters, they anticipate issuing an unmodified audit opinion. The committee was pleased to note that the audit process has been positive for both the Trust and Azets. The draft Value for Money assessment has not identified any significant weaknesses in the Trust's arrangements for 2023/24, whilst recognising the significant progress made in addressing previous issues.

Advise
The Counter Fraud Functional Standards Return 2023/24 has been submitted. All requirements except one have been assessed as green, indicating full compliance. Access to and completion of training remains as 'amber'. The Local Counter Fraud Service will be introducing an e-learning package and reviewing onsite training opportunities for staff to address this requirement.

A recommendation was made to the Board on the award of the internal audit and local counter fraud service contract.

Risks discussed and new risks identified
At its meeting on 4 June 2024 the committee supported the revised risk management framework and implementation plan which the Board will be asked to consider in the autumn.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04/07/2024		**Agenda reference:**	**39-24**	
Report title:	Quality & safety committee assurance report				
Sponsor:	Shaun O'Leary, Committee Chair				
Author:	Ellie Simpkin, Governance officer				
Appendices:	Appendix one - Safeguarding annual report 2023/24 Appendix two - Infection, prevention and control annual report 2023/24 Appendix three - Emergency preparedness, resilience and response (EPRR) annual report 2023/24 Appendix four - Research and innovation annual report 2023/24 Appendix five - Professional standards: framework for quality assurance and improvement - Annual Report 2023-2024				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	*Due to the restrictions which apply during the pre-election period this report is limited to matters which require operational or financial oversight.* - the Quality Account for 2023/24 highlights the significant achievements of the Trust, acknowledging the areas for improvement - further work is due to be undertaken in 2024/25 on the auditing and monitoring of compliance with antimicrobial prescribing guidelines - the committee welcomes the approach which is being taken to development of the Integrated quality & performance report - the following annual reports have been reviewed by the committee and are presented to the Board for assurance given its specific oversight responsibilities in these areas: o Safeguarding annual report 2023/24 o Infection, prevention and control annual report 2023/24 o EPRR annual report 2023/24 o Research and innovation annual report 2023/24 - The committee reviewed the Professional standards: framework for quality assurance and improvement annual report 2023/2024. The committee is satisfied that the Trust is compliant and recommends that the Board ratifies the report.				
Recommendation:	The Board is asked to **note** the contents of the report, **note** the contents of the annual reports presented for assurance and **ratify** the Professional standards: framework for quality assurance and improvement (FAQI) Annual Report 2023-2024, confirming that Trust is compliant with the regulations.				
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 committee maintains oversight of BAF 01 patient services.				
Corporate risk register:	None				
Regulation:	None				
Legal:	The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'				
Resources:	None				
Assurance route					

Previously considered by:	Quality & safety committee			
	Date:	25 June 2024	Decision:	
Next steps:	Professional standards: framework for quality assurance and improvement - Annual Report 2023-2024 will be shared with South East Higher Level Responsible Officer			

Report to:	Board Directors
Agenda item:	39-24
Date of meeting:	4 July 2024
Report from:	Shaun O'Leary, Committee Chair
Report author:	Ellie Simpkin, Governance officer
Date of report:	26 June 2024
Appendices:	Appendix one - Safeguarding annual report 2023/24 Appendix two - Infection, prevention and control annual report 2023/24 Appendix three - Emergency preparedness, resilience and response (EPRR) annual report 2023/24 Appendix four - Research and innovation annual report 2023/24 Appendix five - Professional standards: framework for quality assurance and improvement - Annual Report 2023-2024

Sub-committee assurance report
Quality & safety committee – 25 June 2024

Due to the restrictions which apply during the pre-election period this report is limited to matters which require operational or financial oversight.

Key agenda items

- **Quality Account 2023/24**
- **Integrated quality performance report**
- **Board assurance framework**
- **Patient safety incident investigation briefing**
- **Patient experience report**
- **Annual reports 2023/24**

Alert

- During the period of April 2024 and May 2024 the Trust received 18 formal complaints. Trends (which include an alleged lack of/poor communication and treatment delay) are being monitored.
- Progress is being made on improving antimicrobial stewardship, however, further work is due to be undertaken in 2024/25 on the auditing and monitoring of compliance with guidelines.

Assure

- The committee reviewed and agreed the Quality Account for 2023/24 which highlights the significant achievements of the Trust, acknowledging the areas for improvement. The committee extended its thanks to all staff for their hard work and dedication.
- There have been no new Patient Safety Incident Investigations since the committee's last meeting.
- The Trust maintains an overall inpatient Friends & Family test recommendation rate of 96% against a target of 90%.
- The committee received assurance from the following annual reports:

  Patient safety annual report 2023/24: The patient safety agenda was maintained throughout the year and the Trust has successfully implemented the new Patient Safety Investigation Response Framework. The review of Clinical Harm Review process and policy will be an area of focus for QVH in 2024/25.

  Clinical audit annual report 2023/24: There were a number of positive project outcomes in 2023/24. The team will be working with directorate triumvirates on

developing the clinical audit programme for the 2024/25. The committee commented on the importance of ensuring that the programme provides the required assurance, linking to those areas identified in the Board Assurance Framework.

Guardian of safe working annual report 2023/24: The Guardian of Safe Working has provided assurance that rotas are safe and being monitored. There have been no immediate recent rota safety concerns. Consultant level supervision for plastic surgery junior doctors on theatre lists and in clinics is improving and is being monitored by the Surgical Tutor and at Deanery level.

- The following annual reports are also presented to the Board for assurance given the Boards specific oversight responsibilities in these areas:

  Safeguarding annual report 2023/24: The committee was pleased to note that additional staff have joined the safeguarding team. A named doctor for safeguarding children is now in post via a Service Level Agreement with University Hospitals Sussex NHS Foundation Trust and is having a positive impact on training delivery. Compliance with the Mental Capacity Act remains a challenge; rota planning is important to allow staff to attend training.

  Infection, prevention and control annual report 2023/24: Assurance is received from the audits undertaken, training compliance and low infection rates. The Trust is benchmarking well against national standards. Ventilation continues to be an area of concern, however, the Lead infection control Nurse has informed the committee that there is now support from the Estates team to implement the improvements needed.

  Emergency preparedness, resilience and response (EPRR) annual report 2023/24: QVH achieved substantial compliance against the NHS England EPRR Core Standards. Business continuity plans are in place. Periods of industrial action have been successful managed. A training needs analysis is being undertaken to inform the work plan for 2024/25.

  Research and innovation annual report 2023/24: it was a successful year for the research team with recruitment to portfolio studies resulting in an increase in activity of 126% since 2020. It was noted that development of the Trust's non-portfolio studies will be part of the research strategy which is currently being developed.

Advise

- The committee welcomes the corporate approach which is being taken to develop the Integrated quality performance report, noting that it is an iterative process. The report will support the Board Assurance Framework and provide monitoring of the delivery of the Key Strategic Objectives, helping to ensure that the organisation is strategical focused but operationally informed.
- The committee reviewed the consultant appraisal & revalidation **Professional standards: framework for quality assurance and improvement annual report 2023/2024**. An electronic appraisal system has been successfully implemented, assisting with compliance monitoring. Clinical engagement with appraisals has improved, however, appraiser numbers remains a challenge. The committee is satisfied that the Trust is compliant and recommends that the Board ratifies the report.
- Following the meeting, Non-executive directors met with the Governor working group for the committee.

Risks discussed and new risks identified

- The committee reviewed the Board Assurance Framework 01 patient services. The current score remains at 10 with a consequence of 5. The overall assurance RAG rating remains as ‘amber’ demonstrating medium confidence. Actions are currently on track to deliver the target score of five by December 2024.

Recommendation

The Board is asked to **note** the contents of the report, **note** the contents of the annual reports presented for assurance and **ratify** the Professional standards: framework for quality assurance and improvement (FAQI) Annual Report 2023-2024, confirming that Trust is compliant with the regulations.

Report cover-page					
References					
Meeting title:	Quality and Safety Committee				
Meeting date:	25/06/2024		**Agenda reference:**	**167-24**	
Report title:	Safeguarding Annual Report 2023/24				
Sponsor:	Nicky Reeves, Chief Nursing Officer				
Author:	Katy Fowler, Paediatric Safeguarding Lead Nurse Ian Cruickshank, Adult Safeguarding Lead Nurse and MCA Lead				
Appendices:	None				
Executive summary					
Purpose of report:	Assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.				
Summary of key issues	**Current Challenges:** • Compliance with MCA. • Audit programme is currently delayed. • There are a range of safeguarding protocols to support staff however, due to workload some of these are currently out of date • Managing safeguarding concerns is made more difficult by the lack of electronic patient records. **Current Achievements:** • Addition of a new staff members to the safeguarding team. • Named Doctor for Safeguarding Children now in Post via an SLA with University Hospital Sussex (UHSx). • Improved compliance for level 3 mandatory training. • Bespoke training has been rolled out to specific teams • There has been an increased awareness of domestic violence and abuse across the trust. • The New MCA policy has been approved and rolled out across the trust to support staff to comply with the MCA. • The safeguarding QNet page has been updated with links to local authority referral forms. • The safeguarding team have secured a regular slot at Joint Hospital Governance Group (JHGG) meeting.				
Recommendation:	The committee is asked to receive the Safeguarding Annual 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:	Applicable to KSO 1,2,3,5				
Corporate risk register:	One current corporate risk- MCA risk rating 16				
Regulation:	All Boards must publish an annual safeguarding report and demonstrate to regulators that appropriate safeguards are in place to protect vulnerable adults and all children.				
Legal:	All health care providers are required to meet safeguarding criteria for adults- Care Act 2014. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to safeguard and promote the welfare of children.				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report cover-page					
References					
Meeting title:	Quality and Safety Committee				
Meeting date:	25/06/2024		**Agenda reference:**	**167-24**	
Report title:	Safeguarding Annual Report 2023/24				
Sponsor:	Nicky Reeves, Chief Nursing Officer				
Author:	Katy Fowler, Paediatric Safeguarding Lead Nurse Ian Cruickshank, Adult Safeguarding Lead Nurse and MCA Lead				
Appendices:	None				
Executive summary					
Purpose of report:	Assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.				
Summary of key issues	**Current Challenges:** • Compliance with MCA. • Audit programme is currently delayed. • There are a range of safeguarding protocols to support staff however, due to workload some of these are currently out of date • Managing safeguarding concerns is made more difficult by the lack of electronic patient records. **Current Achievements:** • Addition of a new staff members to the safeguarding team. • Named Doctor for Safeguarding Children now in Post via an SLA with University Hospital Sussex (UHSx). • Improved compliance for level 3 mandatory training. • Bespoke training has been rolled out to specific teams • There has been an increased awareness of domestic violence and abuse across the trust. • The New MCA policy has been approved and rolled out across the trust to support staff to comply with the MCA. • The safeguarding QNet page has been updated with links to local authority referral forms. • The safeguarding team have secured a regular slot at Joint Hospital Governance Group (JHGG) meeting.				
Recommendation:	The committee is asked to receive the Safeguarding Annual 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:	Applicable to KSO 1,2,3,5				
Corporate risk register:	One current corporate risk- MCA risk rating 16				
Regulation:	All Boards must publish an annual safeguarding report and demonstrate to regulators that appropriate safeguards are in place to protect vulnerable adults and all children.				
Legal:	All health care providers are required to meet safeguarding criteria for adults- Care Act 2014. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to safeguard and promote the welfare of children.				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Safeguarding

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2023 to March 2024

Executive Sponsor: **Nicky Reeves, Chief Nurse**

Authors:
Katy Fowler, Named Nurse for Safeguarding and Looked After Children
Ian Cruickshank, Named Nurse for Safeguarding Adults and MCA lead

April 2024

Executive Summary:

This annual report provides a summary of activity, progress and multi-agency participation in relation to adults and children safeguarding and Mental Capacity Act (MCA) during 2023/ 24.

The Chief Nurse has executive leadership for safeguarding.

Safeguarding systems at QVH are well established.

The current workload, which includes significant time undertaking assurance, is very challenging for a small team to manage albeit within a small trust. The trust has recognised this during the year and have responded positively with additional resource.

Current Challenges:

- Compliance with MCA. There are three strands to consider with improving MCA compliance: patient pathway, audit and staff training. The MCA audit has provided the evidence and recommendations for next steps have been considered as part of this.
- Audit programme is currently delayed due to workload – this should improve with the introduction of the new safeguarding specialist nurses.
- There are a range of safeguarding protocols to support staff however, due to workload some of these are currently out of date
- Managing safeguarding concerns is made more challenging by the lack of electronic patient records. Paper records and several distinct IT systems are an obstacle to sharing information internally, supervision and audit of safeguarding practice.

Current Achievements:

- Addition of a new staff members to the safeguarding team.
- Named Doctor for Safeguarding Children now in Post via an SLA with University Hospital Sussex (UHSx).
- Improved compliance for level 3 mandatory training.
- Bespoke training has been rolled out to specific teams including Max Fax, Anaesthetics, Pre-assessment and community therapies.
- There has been an increased awareness of domestic violence and abuse across the trust.
- The New MCA policy has been approved and rolled out across the trust to support staff to comply with the MCA.
- The safeguarding QNet page has been updated with links to local authority referral forms.
- The safeguarding team have secured a regular slot at Joint Hospital Governance Group (JHGG) meeting. These meetings reach a wide range of clinical staff and will serve as an opportunity to discuss important safeguarding topics with clinicians.

Introduction:

Each year a safeguarding report is produced for the QVH Board to provide assurance that the trust is undertaking its safeguarding responsibilities safely and effectively.

Effective safeguarding arrangements must be in place to safeguard children and adults who are at risk of abuse or neglect. These arrangements include:

- safe recruitment
- effective training for staff
- effective supervision arrangements
- working in partnership with other agencies
- Identification of a Named Doctor and Named Nurse for safeguarding children, plus a Named Nurse for adult safeguarding and Mental Capacity Act lead.

The named professionals have a key role in promoting good practice within QVH, supporting local safeguarding systems and processes, providing advice and expertise, and ensuring safeguarding training is in place, which is of a suitable quality. They are expected to work closely with QVH Chief Nurse, Sussex Designated Professionals, West Sussex Safeguarding Children Partnership (WSSCP) and West Sussex Safeguarding Adults Board (WSSAB).

Safeguarding Adults:

"All staff within the health service have a responsibility for the safety and well-being of patients and colleagues. Living a life that is free from harm and abuse is a fundamental human right and an essential requirement for health and wellbeing. Safeguarding adult is about the safety and well-being of all patients but providing additional support to those least able to protect themselves from harm and abuse". NHS England

The Care Act provides the legislative basis for Adult Safeguarding. The local authority, who are the lead agency will, use safeguarding procedures in the following circumstances:

- The patient has care and support needs
- They are less able to protect themselves due to their care and support needs
- They are experiencing or at risk of abuse or neglect

The NHS responsibilities for providing support are wider than this, most obviously for those experiencing domestic abuse; other patients may not meet the threshold for local authority safeguarding procedures but be at significant risk from abuse or neglect.

The Trust sees patients who have suffered domestic abuse. Following on from last year's training sessions by a Specialist provider, the safeguarding adult lead has worked to raise the profile of domestic abuse within the trust. Additional sessions have been run on the practical aspects of managing situations that may involve domestic abuse, as well as bespoke sessions with clinical teams and case scenarios in training. See page 10 for data.

In order to safeguard patients it is necessary for QVH staff to

- Recognise the signs of possible abuse and neglect

- To be professionally curious and provide challenge
- To adhere to making safeguarding personal guidance
- Record and share information appropriately
- Make referrals and liaise with outside agencies
- Agree and action safety/protection plans
- Participate in safeguarding enquiries
- Have systems in place to learn from incidents

In addition to the policies, procedures, training and supervision in these areas immediate guidance, where a possible safeguarding concern is raised, is provided by the Named Nurse for Adult Safeguarding, The Chief Nurse, The Site Practitioners and the Medical Director.

QVH adheres to the Sussex Safeguarding Policies and Procedures which provides an over- arching framework to coordinate safeguarding within the Trust.

Safeguarding Children:

A child is anyone who has not yet reached their 18th birthday

'*The welfare of the child is paramount'* is a principal that was enshrined in the Children Act 1989 and remains at the core of safeguarding children practice nationally.

Section 11 of the Children Act 2004 places a statutory duty on all NHS organisations to ensure that services are designed to safeguarding and promote the welfare of children. The Section 11 self-assessment audit is completed bi-annually and is due to be completed this year.

QVH has a duty to ensure a culture exists where safeguarding is everybody's business. There have been occasions when medical staff have not engaged with the safeguarding process in a robust and meaningful way. The medical leadership team and the safeguarding team have continued to work together to encourage and sense of ownership, confidence and collaboration. The addition of Leonie Perera (Paediatrician) in the role of Safeguarding Children Named Doctor (1 pa per week, via SLA with University Hospital Sussex UHSx) has meant that moving forward the medical leadership in safeguarding is strengthened. Leonie comes to QVH with many years' experience of working as a Paediatric Consultant in the Emergency Department as well as previously holding the post of Safeguarding Children Named Doctor for UHSx.

Looked after Children:

Looked after Children or Children in Care are a group of young people who are cared for and accommodated by the Local Authority. This cohort of children may have increased health risks and significant emotional and physical health needs. Although QVH does not have a specially commissioned service for Looked After Children, there is a role in promoting recovery, resilience and well-being for this cohort

There is ongoing work in the trust with teams around parental responsibility and consent. This is covered in all training at all levels.

The Named Nurse has established good links with the Designated Professionals within the ICB for Looked After Children and has utilised these links, particularly in relation to Unaccompanied Asylum Seeking Children (UASC).

Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS):

The Mental Capacity Act is important legislation that provides safeguards and protections for patients who may be unable to make their own decisions and thus consent to their proposed care and treatment.

All QVH staff are required to understand their legal responsibilities under the Mental Capacity Act including undertaking mental capacity assessment, best interest decision making processes and when to complete a DOLs application. MCA activity data is no longer captured on the Datix system as this fails to give an accurate reflection of the total number of mental capacity assessments and best interest's decisions being taken across the Trust. A quarterly audit cycle, will instead, be used to provide assurance of the Trust's compliance with the MCA by focussing on the quality of the completed orange MCA forms.

Adherence to the Mental Capacity Act is important to ensure that the provision of health services is provided with shared decision making and lawful consent. A deep dive audit was undertaken in early 2024, which indicated ongoing challenges with adherence to the Mental Capacity Act. This follows the 2022 audit.

The results will be presented at the Clinical Governance Group for their awareness as well as to agree actions to improve compliance.

There are particular challenges for QVH in complying with the MCA:

- A significant proportion of our patients are older and therefore more likely to have mental capacity issues i.e. those treated for skin cancer
- Patients on the cancer pathway need to be treated in a timely way as per the Cancer pathway targets
- We do not have Electronic Patient records-this is a barrier to internal communication, this means colleagues in Pre-Assessment won't be able to confirm if a Mental Capacity assessment has been completed.
- Much of the surgery undertaken is high volume- low complexity. The emphasis from NHS England is to improve theatres productivity, cutting out unnecessary appointments, however this does need to be balanced by the need to ensure equality of access to support an elderly population.
- We have patients from across the region so it is not so easy for them to travel for repeated appointments

Recommendations:

There is a need to review the mental capacity training that is currently incorporated into level 2 and level 3 safeguarding training as there is insufficient time to cover this topic adequately. Similarly there is a need to review the training requirements of new staff.

There is a need to review processes to ensure that patient who may lack mental capacity are identified on receipt of the referral and that procedures are agreed to manage these patients. This would include face to face appointments with support identified and arranged. Adequate time to complete assessments and the best

interest process, where this is indicated, and/or liaising with the Lasting Power of Attorney.

A further audit will be required to monitor progess.

The safeguarding adult and MCA lead has updated the new Mental Capacity Policy which has been approved and published. Further quick guides and flow charts will be produced to support staff as well as examples of good capacity assessments and best interest decisions on the MCA page on QNet.

A new mental capacity and best interest form has been produced which is more user friendly and is awaiting approval by the Patient Documentation Group.
Electronic patient records will aid compliance with the Mental Capacity Act.

Further work is required to ensure where patients are deprived of their liberty that this is completed lawfully with requests for authorisation of DOLs submitted to the local authority.

The implementation of the Liberty Protection Safeguards, the replacement of DOLs have now been delayed until at least the next Parliament.

In addition to the Datix system that records safeguarding concerns the Named Nurse has introduced a spreadsheet to provide improved recording of data for both safeguarding concerns and patients where that are Mental Capacity Act issues.

Prevent

Prevent is part of the governments counter terrorism strategy with its aim to reduce the risk to the UK and its overseas interest from terrorism.

NHS providers are mandated to contribute to the Prevent agenda. Within QVH the Prevent lead role is shared between the Safeguarding Named Nurses. Currently, the level 3 Prevent training is delivered via the national e-learning package. Compliance for Prevent training at level 3 is 93%.

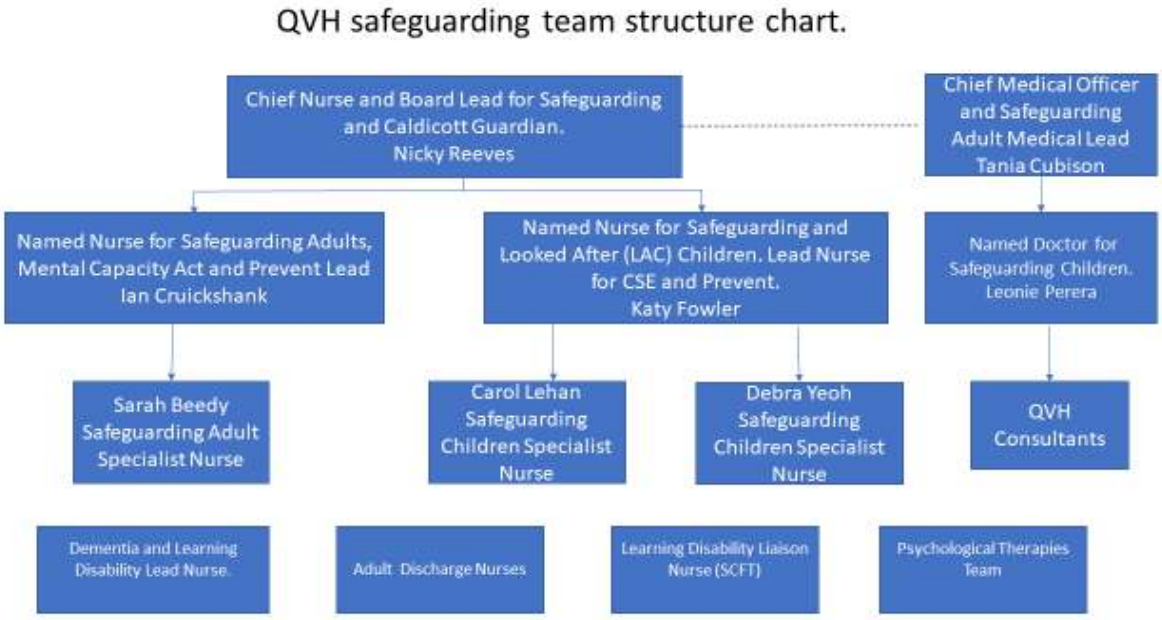
The prevent delivery plan was updated in July 2023. One of the Safeguarding leads attended the Prevent leads meeting chaired by the ICB.

No Prevent referrals were made during the year 2023-24.

Sussex Safeguarding Standards.

These are 9 standards that enable all parties to identify key benchmarks to ensure an effective auditable approach to safeguarding of all patients.

STANDARD 1: Strategic leadership:



The strategic safeguarding group is to oversee the development and implementation of adult and children safeguarding, as well as oversight of Looked After Children, Mental Capacity Act practices, Prevent, and Learning Disability and Dementia strategy throughout the organisation. It provides summary updates to the Quality & Governance Committee.

During summer 2023, the safeguarding team met with the board to enable them to scrutinise the safeguarding arrangements for the trust and to ensure members understood their responsibilities as well as an overview of the achievements and challenges the safeguarding team face. This was undertaken in line with the intercollegiate documents.

The safeguarding team links with the ICB Sussex Designated Nurses and wider Sussex network, including the WSSCP and WSSAB via regular meetings to ensure that QVH is updated on the rapidly changing local safeguarding picture and disseminate relevant information to staff in a timely way.

Across QVH there is a network of link champions from service areas who attend a quarterly safeguarding steering group to discuss clinical issues, review learning from Safeguarding Practice Reviews and Safeguarding Adult Reviews as well as case studies from QVH and share practice improvement across the organisation. The safeguarding team are working to improve active participation in this forum.

QVH have a 3 year safeguarding strategy that will be reviewed in 2024, Priorities are updated every three year and will align, where appropriate, with WSSAB and WSSCP objectives, they will also take into account PREVENT and Looked after Children priorities.

QVH uses Datix system to report safeguarding incidents as well as any shortfall that may impact on the ability of QVH to meet safeguarding responsibilities. These are

highlighted to the board and are discussed during the strategic safeguarding meetings.
Safeguarding open risks:

There is currently one safeguarding corporate risk.

- Not able to demonstrate full compliance with implementation of the MCA (risk rating 16) Nursing and Quality department. The Quality and Safety Committee and Strategic Safeguarding Group monitor this corporate risk.

There are one safeguarding departmental risk:

- Minor Injuries Unit (MIU) risk (Risk rating 9) relating to access to previous information held in the trust about patients re-attending. Staff in MIU do not access the full records of patients when they attend, this poses a risk in terms of safeguarding. Work is underway to mitigate the risks including health records now amalgamating individuals MIU records from January 2021. The trust has procured an electronic patient record system (EPR) which will be rolled out across the trust including to MIU. This risk is monitored at the Strategic Safeguarding Group.

STANDARD 2: Lead effectively to reduce the potential of abuse

QVH has policies and procedures in place to support staff to manage safeguarding concerns they may have for patients and others using QVH services, these are available on QNet. Staff have access to safeguarding prompt cards; these cover a variety of safeguarding topics and signpost staff where they can access support – these require updating.

The Datix system is used as a data collection system and captures 'safeguarding incidents'. This is used to generate safeguarding data that is reported into the Clinical Governance Group meeting as well as for case discussion and learning.

The safeguarding team have a number of patient information leaflets and posters around the trust – these are updated periodically.

STANDARD 3: Responding Effectively to Allegations of Abuse

QVH currently use an electronic document management system (EVOLVE). There is a safeguarding section available for all patients, as required. This section highlights where there are concerns flagged about a patient in terms of safeguarding or mental capacity.

The safeguarding section has a locked box, staff can access this section by using a drop down box to select the reason they want to access the information and provides an audit trail. The safeguarding team discuss access to the safeguarding section during training; however, feedback from staff is that many do not feel they can access the safeguarding section. The safeguarding team are looking to remove this feature to empower staff to check what safeguarding information is known about a patient that they are dealing with.

Child Protection Information systems (CP-IS) is used by Minor Injuries Unit and Peanut Ward to check whether unscheduled children or young people have a child

protection plan or are looked after by a local authority. The safeguarding team are looking into how this can be used in other trauma areas across the trust where children are seen.

Allegations against staff.
Allegations against staff can be varied and not all relate to safeguarding. The Chief Nurse and HR will share any allegations against staff of a safeguarding nature with the safeguarding team who may need to be involved in an investigation or seek advice from external sources such as the Local Authority Designated Officer (LADO). Information is kept securely, relevant issues are reported to the ICB in the quarterly exception reports.

STANDARD 4: Safeguarding Practice and Procedures

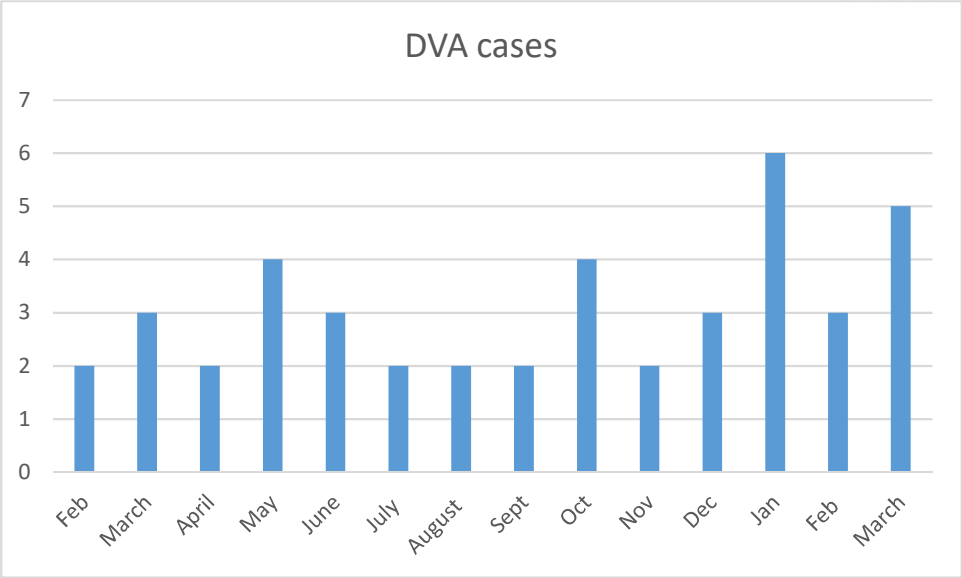
The Safeguarding Team develop a wide range of documents for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. These are available on the Website or QNet.

The safeguarding team have updated the safeguarding page with links to local authority referral forms to make it easier for staff to make safeguarding referrals. The QNet safeguarding and MCA pages have been improved during the year but need further updating in the year ahead.

Restrictive interventions:

When a patient is identified as needing any form of control, restraint or therapeutic holding staff need to follow hospital policy. The policy has been launched this year and has coincided with training for security staff and de-escalation training for key staff members across the trust. It is likely that other staff members would benefit from de-escalation training, this is being looked into by the trust.
The children's therapeutic holding policy was launched at the same time.

Domestic violence and abuse (DVA)
Managing risks, keeping individuals safe and seeking the right specialist advice are all important aspects of patient care when DVA is being considered a possibility or has been confirmed. Raising awareness of and managing DVA situations is included in all levels of safeguarding training.
Staff awareness of this safeguarding concern has increased, particularly in relation to cases where there are children involved.



Domestic Abuse Stalking Honour (DASH) risk assessments are used by staff to help inform next steps to protect patients. Worth DVA specialist services and the police can provide advice and support to staff at QVH.

Domestic abuse has been a topic discussed during bespoke safeguarding sessions with several staff groups.

Safeguarding Audit

The Safeguarding children team undertook an audit of the safeguarding section on the Electronic Discharge Notification (EDN), which found that safeguarding sections are not consistently being completed accurately therefore missing opportunities for information sharing with GP's. This has been fed back in various forums.

The MCA audit was completed during the Q4 and built on the previous audit (see MCA section on page 5)

Reports and action plans are reviewed and monitored either in the QVH strategic safeguarding group or on of the QVH safeguarding steering groups.

The safeguarding audit programme has been delayed due to workload; this should improve in the coming year due to recruitment of the band 6 safeguarding specialist nurses.

The safeguarding team inputs to the WSSCP and WSSAB multi-agency audits as required. The Safeguarding children Named Nurse is a member of the WSSCP improvement and assurance subgroup.

Child Sexual Exploitation and Criminal Exploitation.
Recognition of Child Sexual Exploitation (CSE) or Child Sexual Abuse (CSA) requires careful assessment and consideration when concerns arise. The Safeguarding Children Named Nurse is the CSE lead for QVH and supports staff to access specialist support if required.

Staff within MIU have a 4 question-screening tool available to them when they have a concern about sexual exploitation, it may be useful to consider these for use on Peanut ward.

Modern Slavery

The Procurement Team work with the NHS Terms and Conditions, which require suppliers to comply with relevant legislation. Procurement frameworks are also largely used in the Trust to procure goods and services, under which suppliers such as Crown Commercial Services and NHS Supply Chain adhere to a code of conduct on forced labour. Relevant pass/fail criteria has also been introduced on Procurement led tenders and quotations not conducted via framework.
The Trust has not been informed of any incidents of slavery or human trafficking during the year.

In the event of a patient possibly experiencing slavery or human trafficking staff need to carefully assess the situation using translation services, where required, and seeing the patient alone. Data relating to these aspects of safeguarding are collected by the safeguarding team. There is a Modern Slavery Protocol is available on QNet and is referenced in training and the QVH prompt cards. This will require update in Q1 and 2 of 24/25.

STANDARD 5: Staff Competence

Driving improvement in all aspects of safeguarding practice is a continuous process and as such has to be reviewed, evaluated, developed and adapted over time. Level 1 and 2 safeguarding training incorporates both adult safeguarding, child safeguarding and MCA into a single 'think family' approach to allow staff to be updated on all safeguarding issues as it is important to recognise the complexities and interconnected nature of safeguarding.

QVH safeguarding team continue to offer level 3 Adult and Child Safeguarding sessions separately for consultants and those members of staff who require this additional level of training. These sessions are now offered four times a year, increasing from two last year. Staff needing to meet the training requirements outlined in the intercollegiate documents, of 8 hours training over 3 years, have the opportunity to access other level 3 training off site, as part of their personal development. Staff training logs can be used to record additional training and will be self-certified as being completed during their annual appraisal.

Level 4 training is required by the safeguarding Named Nurses and Doctors a record of training attended is kept in a log to demonstrate their competence.

Safeguarding Learning and development Strategy

QVH Safeguarding learning and development strategy is in need of updating for 2024. This document is aligned with the core skills framework document and with national guidance from the NHS England regarding roles and competences for health care staff – from 4 intercollegiate documents (Prevent, LAC, Adults and Children).

Safeguarding responsibilities remain integral to everyone's job description; this is reiterated during safeguarding training.

STANDARD 6: Safer Recruitment

QVH work to ensure that those working or who are in contact with children, young people and adults are safely recruited and Human Resource processes take account of the need to safeguard and promote the welfare of all. Making sure that QVH do everything we can to prevent appointing people who pose a risk to vulnerable people is an essential part of safeguarding practice and QVH recruit staff and volunteers following safer recruitment procedures.

All staff at the Trust are employed in accordance with the NHS Employers safe recruitment pre-employment check standards.

As part of their induction, new employees, including volunteers are expected to undertake mandatory training in safeguarding at either level 1, 2 or 3 or be able to provide evidence that this has been completed at another trust within the last 3 years.

Building on the changes made last year whereby HR are rolling out enhanced Disclosure and Barring Service (DBS) checks to all clinical staff given that children are seen across the trust and not just in designated areas. There has been some consideration given to DBS checking other non-clinical members of staff as many have access to areas across the trust where vulnerable people are being treated; estates staff are an example of this and work is in progress to take this forwards

STANDARD 7: Learning from incidents

Statutory Safeguarding Reviews:
Safeguarding Adult Reviews (SAR)
Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

QVH were not directly involved in any SAR during 2023-24. Learning from SARS outside of QVH is shared at safeguarding groups if relevant for care delivery.

Local Child Safeguarding Practice Reviews (LCSPR's).
When a child dies or is seriously harmed, including death by suspected suicide, and abuse or neglect is known or suspected to be a factor in the death, WSSCP is required to conduct a Local Safeguarding Practice Review into the involvement of organisations and professionals in the lives of the child and the family.

QVH were not directly involved in any Child Safeguarding Practice Reviews during 2023-24. QVH have contributed to safeguarding children rapid reviews where required.

Child Death Reviews.
QVH has not contributed to any child death reviews this year.

STANDARD 8: Commissioning

The Integrated Care Board (ICB) are the commissioners of local health services, as such they need to be assured that provider organisations have effective safeguarding arrangements in place.

The ICB combined exception reports are completed and submitted quarterly.

Sussex Safeguarding Standards Assurance Return was completed in summer 2023, this is a self-assessment audit required by NHS Sussex to ensure commissioned services have safe and effective safeguarding arrangements in place. The safeguarding team have been working with the ICB on areas that are challenging. For QVH MCA has been identified as an area where improved compliance is desirable.

In early 2024, QVH had a site visit from representatives from NHS Sussex as part of their ongoing assurance work. They were given the opportunity to visit various clinical areas and talk with staff as well as having specific time with the safeguarding leads. There were no areas of concern in relation to quality or safety.

A self-assessment tool is completed bi-annually for adult safeguarding for submission to the West Sussex Safeguarding Adults Board (WSSAB) and a similar section 11 (Children Act 2004) self-assessment audit, submitted to the West Sussex Safeguarding Children Partnership (WSSCP). The section 11 is due to be completed during this year.

The WSSCP requests that QVH, and all other partner organisations, submit information to be included into their annual report to provide transparency about the safeguarding activities that have been carried out over the previous 12 months and how effective these have been.

External regulation and inspection
QVH CQC re-inspection during February 2019 overall the Trust sustained a ‘good’ rating and also an ‘outstanding’ for care. There was no concerns raised regarding safeguarding.

There have been no safeguarding enquiries raised against QVH in the year 2022-23.

STANDARD 9: Safeguarding Data Requested by Department of Health

Female Genital Mutilation (FGM).
QVH submit FGM returns to NHS England.
There have been no FGM risk assessments during this year.

Prevent Returns
QVH submits quarterly reports to the regional co-ordinator and the ICB.

Recommendations from last year:

- **Continued work with the medical teams to ensure engagement and collaboration in safeguarding and MCA cases with the support of the Safeguarding Medical Director.**
  Safeguarding Children Named Doctor; this will enhance the links between the safeguarding team and the medical staff. The safeguarding team have also

attended governance meetings to discuss case studies relevant to their speciality. The team have had slots in the Max Fax, Anaesthetics and Hands and discuss either adults or children's safeguarding issues due to the short slots that are allocated. Future meetings are planned with the plastics team and it is intended to be repeated annually.

Other teams non-medical have also had input from the safeguarding team, including Pre-assessment, therapies and MIU.

- **Secure additional safeguarding resource.**
  Two band 6 safeguarding specialist nurses are in post (1WTE) to support the safeguarding agenda across the hospital.

- **To get the audit programme on track.**
  The safeguarding specialist nurses came into post at the end of the financial year, we are yet to see the impact of this on workload. This recommendation will be rolled over to 2024 /25
  However, The MCA audit and EDN children audit have now been completed.

- **Changes to the steering group.**
  A poll has gone out asking staff what their preference would be to improve engagement. Staff expressed they would benefit having shorter meetings every other month rather than quarterly. This will be actioned later on in the year. The group wanted to maintain the meetings online rather than in person, this can limit participation.
  The Safeguarding Named Nurses have brought a case study to the group for learning to be discussed which has worked well.

- **Improve compliance with the MCA as measured by audit.**
  The audit has been completed an action plan has been recommended and will be discussed in CCG May 2024. An action plan is being drawn up.

Recommendations for this year:

- Improve compliance with the MCA following the MCA audit
- To roll out the use of adult safeguarding paperwork across the trust. This will ensure that any safeguarding concerns are highlighted to staff on Evolve.
- To continue with the safeguarding audit programme.
- Child was not brought (WNB) to appointments protocol is being revamped and relaunched during the year to provide clearer guidance to staff and template letters to improve information sharing.

NHS
Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Quality & Safety Committee				
Meeting date:	25/06/2024		**Agenda reference:**	**166-24**	
Report title:	Infection Prevention and Control Annual report 2023/24				
Sponsor:	Nicky Reeves, Chief Nursing Officer				
Author:	Sarah Prevett, Lead infection control Nurse				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the Committee and all relevant stakeholders with a comprehensive overview and assurance around the infection prevention and control processes across the Trust in 2023/24				
Summary of key issues	The report demonstrates assurance from evidence based practice in terms of audits, training compliance and low infection numbers The committee should note the small resources allocated to IPACT 1.8 WTE in total Lack of AP for ventilation is noted several times in the report. This should be resolved in June 2024 when the new Director of Estates starts in role				
Recommendation:	The committee is asked to not the assurance given in 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:	Not a specific challenge but impacts on safety and experience in KSO1				
Corporate risk register:	Risks regarding Ventilation are recorded on local registers				
Regulation:	CQC take a keen interest in IPACT				
Legal:	As above				
Resources:	This report was compiled using existing resources within the team				
Assurance route					
Previously considered by:	N/A				
Next steps:					

Report cover-page					
References					
Meeting title:	Quality & Safety Committee				
Meeting date:	25/06/2024		**Agenda reference:**	**166-24**	
Report title:	Infection Prevention and Control Annual report 2023/24				
Sponsor:	Nicky Reeves, Chief Nursing Officer				
Author:	Sarah Prevett, Lead infection control Nurse				
Appendices:	None				
Executive summary					
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Recommendation:	The committee is asked to not the assurance given in 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:	Not a specific challenge but impacts on safety and experience in KSO1				
Corporate risk register:	Risks regarding Ventilation are recorded on local registers				
Regulation:	CQC take a keen interest in IPACT				
Legal:	As above				
Resources:	This report was compiled using existing resources within the team				
Assurance route					
Previously considered by:	N/A				
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

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Infection Prevention and Control

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2023 to March 2024

Document Control: committees and groups who have approved this report
Executive sponsor: Chief Nurse and DIPC

Authors: Lead Infection Control Nurse

Date: 04/05/2023

Type: Annual Report
Version: 1
Pages: 30
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1.	Executive Summary
	The purpose of this report is to inform and provide assurance to the Trust Board, patients, public and staff of the processes in place at The Queen Victoria NHS Foundation Trust (QVH) to prevent and control healthcare associated infections (HCAI). The trust has a statutory responsibility to comply with the Health and Social Care Act: Code of Practice for the prevention and control of Healthcare-Associated Infection 2008 (DH 2015). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control (DIPC). This report provides an overview of infection prevention and control activity at QVH for the reporting period from 1st April 2022 to 31st March 2023 and demonstrates compliance with the Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare related guidance. The key findings of the report are: • The Trust has maintained compliance with Care Quality Commission (CQC) regulations relating to Infection Prevention and Control despite resources being stretched due to the additional pressures put on the team from the Covid-19 pandemic • Overall incidence of Healthcare Associated Infection remains low with zero cases of methicillin resistant staphylococcus (MRSA) bacteraemia, one case of methicillin Sensitive Staphylococcus (MSSA) bacteraemia, one case of Escherichia coli (E.coli) bacteraemia and one case of Clostridium Difficile (CDI) infections, although reportable this was not attributed to the QVH as sample taken within 48 hour of admission. With each of the positive results a Root cause analysis was undertaken (RCA) with actions implemented at the time and learning needs taken forward where applicable. • Infection Control Auditing that has been undertaken with actions and learning needs identified

2.	Introduction
	The Trust recognises that the effective prevention and control of Health Care Associated Infections (HCAIs) is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained. This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. The purpose of this report is to provide the Board with information on trust performance and provide assurance that suitable processes are being employed to prevent and control infections. This paper provides the board with an overview of work completed during the previous year and goals for the continuing programme of infection prevention and control for the upcoming financial year. The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008, at the heart of this law there are two principles: • to deliver continuous improvements of care • it meets the need of the patient With this in mind, patient safety remains the number one priority for the Trust. Infection prevention strategy and a consistent approach are key elements to ensuring the QVH has a safe environment and practices. Infection prevention and control is the responsibility of everyone in the healthcare and is only truly successful when everyone works together. In order to achieve this the IPACT continued to work on the ‘Back to Basics’ strategy that was launched on the financial year

2022-2023, which utilises alternative teaching and engagement strategies to re-engage staff with infection control measures including hand hygiene, compliance with PPE, antimicrobial stewardship and cleanliness. Taking the time to reinforce these basic principles of infection control and the importance of adhering to them.

2.1 The Infection Prevention and Control Team (Appendix A)

The infection control service is delivered and facilitated by an infection control team which consists of:

- Director of Infection Prevention and Control
- Infection Lead Nurse. (full time, 37.5 hours/week)
- Infection Control Nurse. (part time 22.5 hours/week)
- Administration assistant. – retired in May 2023, this post was filled for 2 months Sept-Dec 2023 but the new member of staff left the Trust. This role is now to be reviewed as to assess how best to meet the needs of the service rather than just replacing in the same format.
- Antimicrobial pharmacist. This role has been filled sporadically throughout this financial year with gaps in coverage. The role has been out to advert with a new starter coming early 2024-2025
- The microbiology and virology laboratory services are provided by University Hospitals Sussex (UHS). As part of this service UHS provide QVH with a Consultant Microbiologist, The Trust has had no onsite presence from the Consultant Microbiologist since February 2020 this has been a attributed to lack of resources in UHS who have now successfully appointed more Consultant Microbiologists. The SLA is due for review to assess whether the Trusts support requirements are reflective of need and being met. The Trust has continued to be supported remotely by the Consultant Microbiologists who provide a 24 hour advice service via telephone or email to support safe provision of infection control services, and with remote attendance at ward rounds, MDT meetings and assurance groups

2.2 The Director of Infection Prevention and Control (DIPC)

The Infection Control Team reports directly to the DIPC, who is the trust's Chief Nurse. The DIPC is directly accountable to the Chief Executive and has an overarching responsibility for the strategy, policies, implementation and performance relating to infection prevention and control. The DIPC attends the trust board and other meetings as planned or required, including the quarterly infection control group meeting.

3. Service aim, objectives and expected outcomes

All NHS organisations must ensure that they have effective systems in place to control healthcare associated infections (see Table 1). The prevention and control of infection is part of the Trusts overall risk management strategy. Evolving clinical practice presents new challenges in infection prevention and control, which need continuous review.

Table 1: The requirements of the Health and Social Care Act (2008) updated in this report in line with revised guidance issued December 2022.

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of

	service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

The Trust's infection control policies set out a framework of compliance to these criteria and are published in the trust policy section of Qnet. These documents are reviewed and updated as a minimum every 3 years or more often if changes to national guidance by the infection control nurses (ICN's) and relevant clinicians before being ratified by the Infection prevention and Control Group (IPCG).

Internal assurance processes and board accountability.

QVH has an infection prevention and control structure and processes in place which are led and supported by a team of specialist infection prevention and control clinicians. (See Appendix A for QVH infection prevention and control structure chart).

As an organisation QVH is committed to the prevention of HCAI for patients, staff and visitors whilst on the premises or in the care of the hospital. This is done through a robust infection prevention and control programme which involves:

- Policies and procedures for staff to follow which conform to current best practice guidance
- An audit programme to ensure compliance against the policies
- Education programme designed to each staff group
- Guidance and advice to all staff and patients on infection control available by phone, email or in person from the dedicated Infection Control Nurses
- Mandatory surveillance of reportable infections
- Robust quality assurance process through updates at meetings, quarterly reports to board and an annual report of all activities

The IPCG is a multidisciplinary group which meets quarterly.

The committee is chaired by the DIPC. Membership of the IPCG includes representation from key service areas:
Facilities, Estates, Pharmacy, Theatre, Infection Control Nurses, Microbiology Consultants, Heads of Nursing, Risk and Safety, Decontamination Lead, Representation from the UK Health Security Agency (UKHSA), and the Integrated care board (ICB). Other trust staff may be invited to attend as required.

The Quality and Safety Committee (QSC) receives a quarterly infection control report on each of the key elements of infection control management. In addition, the DIPC also provides updates to the Clinical Governance Group, Hospital Management Team, Executive Management Team and to the Trust Board. There is also oversight of antimicrobial issues at this group via attendance of the trust antimicrobial pharmacist (this post is currently vacant with an invitation to the meeting being sent to the Lead Pharmacists in the interim).

Members of the IPACT share infection control information and learning with a number of groups and committees which include:

- Quality & Safety Committee
- Health and Safety Group
- Antimicrobial steering group
- Estates and Facilities Group
- Medicines Management Optimisation Governance Group (MMOGG) attendance is by the Consultant Microbiologists
- Patient Led Assessment of the Care Environment (PLACE)
- Pathology Meeting
- Nursing and Quality Forum
- Ventilation Steering Group
- Space Utilisation Group (SUG)
- Specific task and finish groups that are initiated for specific projects

IPACT continue to remind all clinical teams, including Estates and Facilities and Hotel Services of the importance of engagement to ensure that infection prevention and control is included in the planning stages of every new project and development or refurbishments.

Infection Prevention and Control microbiology activity

All the trust microbiology specimens are processed in accredited laboratories, with accreditation being monitored and audited by UHS pathology/microbiology providers. Assurance is given to the Trust for the SLA contract management and through the quarterly pathology meetings.
The results of all microbiology samples including blood specimens and swabs are checked, by the ICN's for positive colonisation or infection that may have the potential to spread and cause harm. Although labour intensive this scrutiny provides oversight and assurance that every specimen taken from QVH is monitored for infection and ensures that information and clinical advice is then given to the relevant ward/clinical staff. This process allows the ICN to monitor patterns in infection rates, identify samples that are multi-drug resistant (MDR) and identify clusters of positive results that are showing a pattern through either department or organism type. Significant, reportable or unexpected results are also relayed to the IPACT or the ward via the on-call microbiologist. Due to staffing and equipment issues experienced by UHS we have noticed a delay in our samples being checked into the laboratories and results being reported. This concern has been escalated to the Business Unit manager who oversees the SLA with UHS and to the lead for Microbiology at UHS. All wards and departments have been asked to ensure excellent compliance with standard infection control precautions especially while waiting for patient results. Delays peaked during quarter 3 with some progress on reporting times being seen in quarter 4. The ICN's continue to monitor the situation closely and submit Datix's where necessary.

Infection prevention and control link persons (ICLP)

Infection prevention and control remains central to the maintenance and promotion of high standards throughout QVH. The ICLP Group aims to meet every quarter. Its purpose is to provide a link between the IPACT and ward/departmental staff in all clinical and non-clinical areas in order to facilitate the dissemination of information and to promote compliance with infection control policies and the Health & Social Care Act (2015). Every meeting aims to include an educational element. The ICLP members are reviewed annually or more frequently if staff changes occur, by the Departmental leads. The link staff conduct monthly infection control audits and champion good

infection control practices within their teams/departments.

External Meetings

Infection control remains high on the national agenda. The ICN participates in local and national webinars and virtual meetings to ensure robust links with other infection control teams across the South East area, utilising the opportunity to share learning and resources and ensure all practices in the Trust are in line with current national guidance and best practice. The implementation of these networking meetings has ensured the QVH has become integral in local policy making and participating in forming recommendations for the South East Coast as a group that are sent to the national system in relation to both the implementation of Covid guidance and ways to tackle HCAI's with associated policy/guidance changes.

Mandatory Surveillance

Mandatory surveillance data is required to be submitted to UK health security agency (UKHSA) for the following alert organisms:

- Staphylococcus aureus (S. aureus) bacteraemia – both Methicillin Resistant Staphylococcus aureus (MRSA) and Methicillin sensitive Staphylococcus aureus, (MSSA)
- Clostridium difficile infection (CDI)
- Escherichia coli (E. coli) bacteraemia
- Pseudamonas aeruginosa bacteraemia

Carbapenemase-producing enterobacteriaceae (CPE), Glycopeptide Resistant Enterococci bacteraemia (GRE) and Vancomycin Resistant Enterococcus bacteraemia (VRE) are reported to the Commissioners as required and to UK Health Security Agency (UKHSA) on a quarterly basis.

IPACT also monitor Urinary Tract Infection (UTI), Acinetobacter, Pseudomonas, Klebsiella spp and any other Multi Drug Resistant (MDR) organisms.

Target thresholds are set by the UKHSA for each Trust every financial year.

Root Cause Analysis (RCA)

The Trust continues with the protocol for RCA review for all reportable infections and, for all MRSA bacteraemia the Post Infection Review (PIR) process.

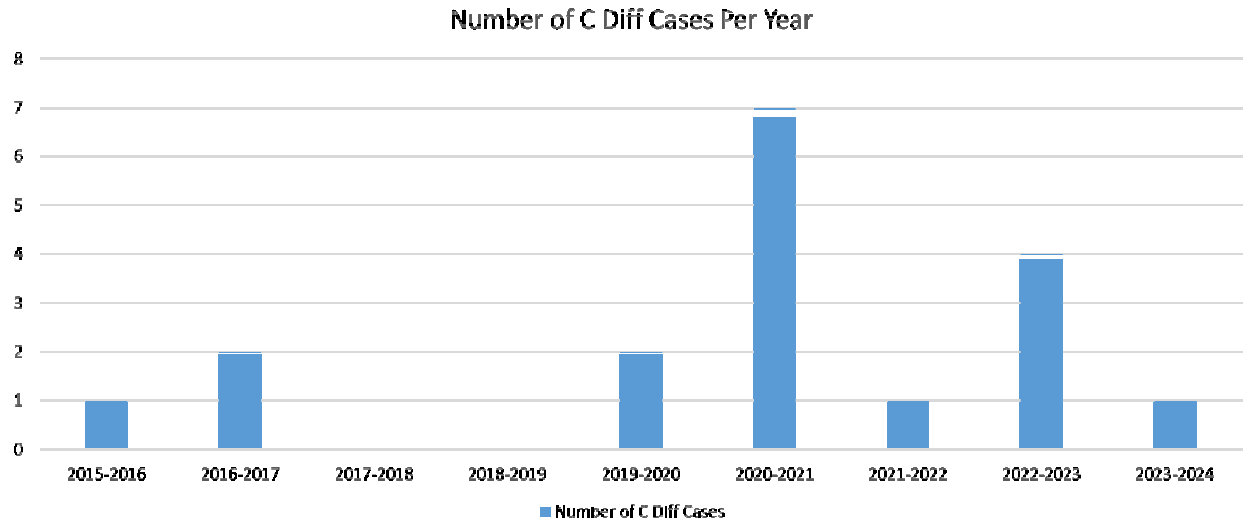
MRSA Bacteraemia

QVH have a target of zero cases of avoidable MRSA bacteraemia every year – the trust achieved this during the 2023/2024. There has not yet been a revision of this target for 2024/25.

***Clostridium difficile* infection (CDI)**

The CDI lapse in care objective target for QVH for 2023/2024 was set at three, a significant decrease on the previous year's target of eight. The Trust has however met this target with zero cases of CDI attributable to the QVH. There was one case of CDI isolated in a Burns patient that was reportable to the UKHSA however this CDI was sent from a sample obtained on the day of the patient's admission to the unit from another NHS Trust meaning that the result was attributable to them rather than the QVH. A streamlined RCA was completed and it identified that all the correct actions had been taken by the staff, there were no secondary cases and no learning identified.

Figure 1



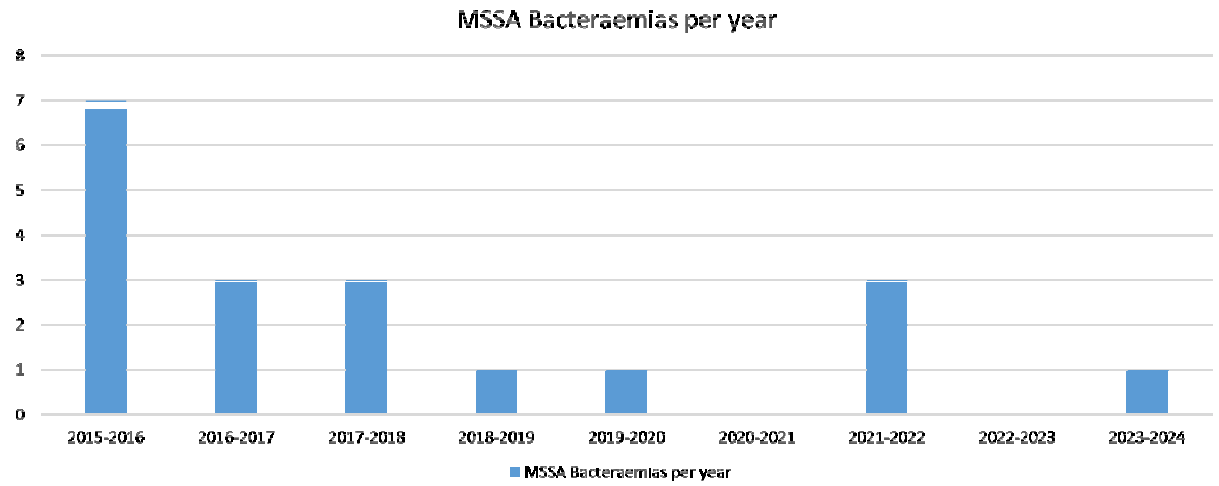
Trusts are required under the NHS Standard Contract 2022/23 to minimise rates of both CDI and of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England and Improvement.

MSSA bacteraemia

No target has been set for MSSA bacteraemia to date although every effort should be taken to prevent all healthcare associated infections. QVH had one MSSA bacteraemia case in 2023/2024.An RCA was completed which showed the patient was a long term Burns patient who had multiple extensive wounds and was often non-compliant with care including refusing line flushes and wound dressing changes. This is the likely cause of the bacteraemia which was treated successfully with antibiotics following guidance from the consultant microbiologist. There was no secondary cases.

Figure 2 shows the year on year numbers of MSSA bacteraemia.

Figure 2

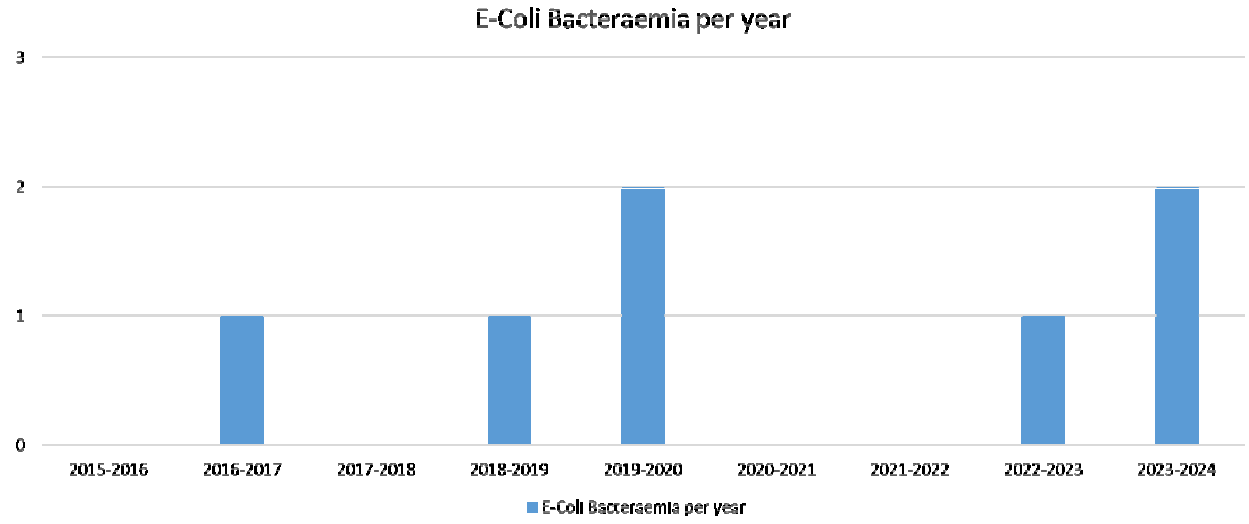


E. Coli bacteraemia

QVH had two reportable *E.coli* bacteraemia's in 2023/24, both cases of E.coli bacteraemia were identified in the same Burns patient with the cultures sent 2 weeks apart. An RCA completed showing patient admitted from Medway NHS Trust for treatment of necrotising fasciitis to buttocks and perineum. Patient had a urinary catheter insitu on admission with the patient showing signs of a urinary tract infection. Samples showed E.coli in the urine and catheter changed but this is the likely source of the infection. Patient treated successfully with antibiotics. It is unclear why a second sample was sent 2 weeks post treatment as patient was well with no further signs of infection. There were no secondary cases.

Figure 3 shows the year on year numbers of reportable *E.coli* bacteraemia

Figure 3



Glycopeptide resistant enterococci bacteraemia (GRE)

No reportable GRE's or VRE's have been identified at the QVH. No target has been set by NHS England to date. There have been no Trust acquired GRE infections in the last 10 years.

MRSA positive patients April 2023 to March 2024 (Infected and colonised)

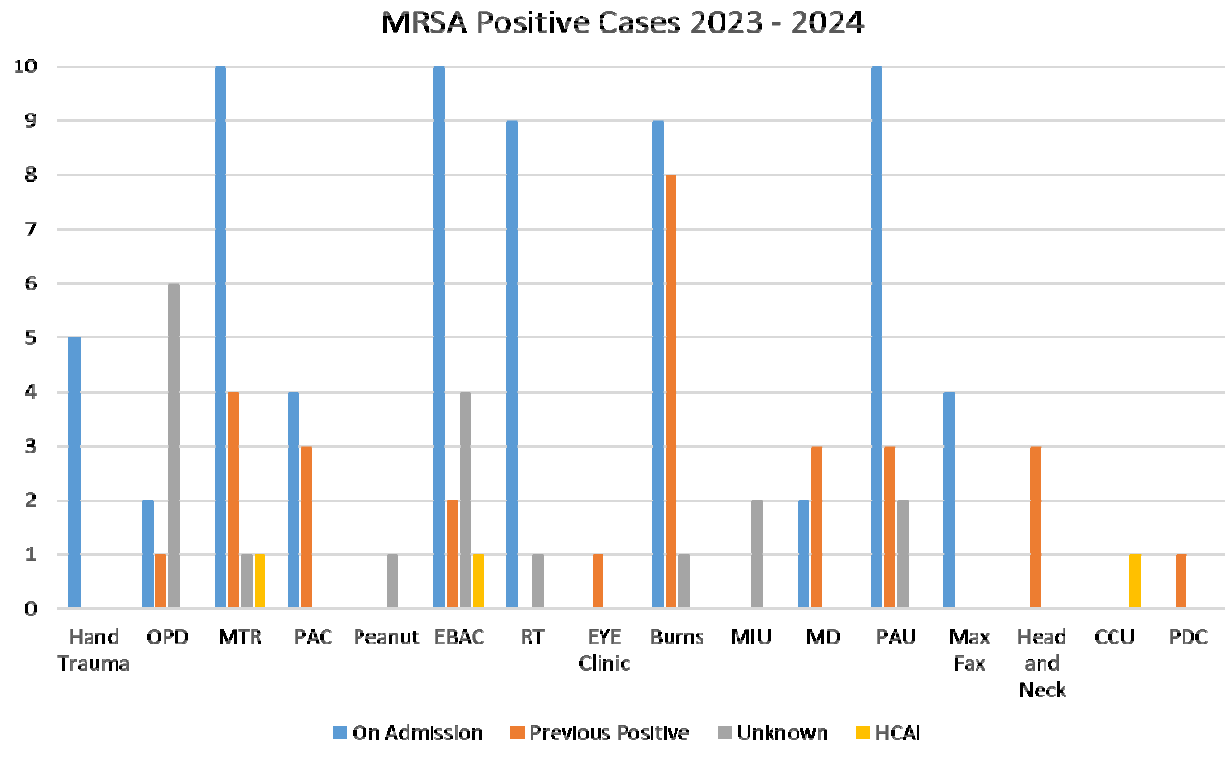
During the period of 2023/2024 there were 129 confirmed cases of MRSA either colonisation or infection. This is an increase from the previous financial year where 88 were reported – this can

be partially explained by the fact that the paediatric unit has started screening their patients in accordance with the policy where in previous years the unit had previously felt the paediatric patients were exempt from screening, the unit has also seen an increase in patients being admitted from overseas and asylum camps. It was identified that these patients were not being screened correctly; the IPACT did additional training and education with the paediatric staff on MRSA screening, increasing compliance and as a result identifying more positive results. Additional training was done with the Burns team to increase compliance with screening wounds on admission or first attendance which has also increased the amount of positive cases identified. None of these positive results were acquired from blood cultures (bacteraemia) but from either surface swabs (such as nose and groin) or from wound swabs. Of these, 3 were classed as HCAI, 79 were identified from admission or pre-admission swabs (O/A), 29 were from patients known to be previously positive (PP) and 18 patients it was difficult to determine the source of acquisition. The Trust's MRSA policy, which is in line with National MRSA screening guidance, focuses on screening only high risk patients, therefore, we may not always have a baseline admission swab for MRSA if the patient was deemed to be low risk on admission. Without an admission swab to provide this baseline data, we are unable to ascertain if the MRSA was acquired in the hospital setting or in the community either before or after admission.

All cases of MRSA both colonisation and infection are recorded and monitored to look for any emerging patterns such as an increase in cases of a particular surgical group or a rise in MRSA cases with the same resistance pattern as this could indicate an outbreak or hospital transmission. None were identified during this time period.

Figure 4 shows the MRSA positive cases broken down by department sending the swab and type of MRSA identified e.g. on admission or previous positive.

Figure 4



4.	Activity analysis/ achievement

External regulation and inspection by Care Quality Commission (CQC), NHSI and commissioners

The CQC did not conduct any inspections in between April 2023 to March 2024 relating to Infection Prevention and Control. The Trust continues to monitor compliance set out in the Health and Social Care Act (2008) through a robust audit plan and assurance process.

The Trust Board

The Trust Board has responsibility for overseeing infection control arrangements and has been kept informed by the DIPC providing exception reporting and quarterly reports at the Quality and Governance Committee through the quarterly reports produced by the lead ICN.

Key Performance Indicators (KPIs)

KPI's set for the IPACT include monitoring hand hygiene compliance, MRSA screening compliance and trust acquired reportable infections. Results for these are all included within the document. Ensuring policies are in line with national guidance and within date, a list of all updated policies is included in this document, and that regular audits are completed to monitor compliance against the policies. Completed audits are included in the audit section of this report. The remaining KPI's are ensuring all members of the IPACT are attending mandatory training and are undertaking an annual appraisal. All members of the IPACT achieved this during the year April 2023 to March 2024.

Complaints

When necessary the IPACT will liaise with the Patient Experience Manager to assist with the investigation of complaints associated with infection prevention and control. The outcomes of these are reported back at the quarterly committee meetings. During this year the IPACT has not being involved in any formal complaints or claims. Although the following complaint was received: Telephone call received from a patient who had surgery in May 23 for removal of skin lesions. She was then found to be MRSA positive in her surgical site post operatively at a GP wound review. Information passed to the Patient Experience manager along with the following assurance: "I have received and reviewed the microbiology report of the MRSA result from the patients GP and can say that the strain of MRSA she had identified is not the same as any known cases within any of our patient groups within the last year.". We have robust infection control precautions in place such as strict guidance on hand hygiene, PPE, skin prep pre-operatively, surgical scrub policy, cleaning checks and audits in place in all areas which have not showed any areas of major non-compliance or concern. We have one of the lowest rates of reportable infections in the country and continually strive to maintain and improve on this.
The patient appears satisfied with the response and no further information was required.

Infection Prevention and Control Learning and Development

Infection Prevention and Control is part of the Trust's mandatory training programme. Face to face training sessions were greatly reduced during the Covid-19 pandemic and have not been increased since the reduction in nationally required precautions. In person training has considered for induction and Junior Doctor training, bespoke departmental training and 1:1 sessions. All other clinical and non-clinical mandatory training sessions were completed using E-learning. Induction training days have been held monthly for all categories of staff, with separate sessions for new Doctors' Induction and Volunteers Training. Training is carried out by the ICN's. The ICN has raised that there has been issues with compliance with basic standards of infection control such as cleaning, uniform compliance and bare below the elbows across the site and has

theorised that this may be down, in part, to the lack of face to face updates for staff which offer the opportunity for the education to be tailored to the Trust, give real time examples and updates, provide an opportunity for discussion and questions and maintain open communication and links between staff and the infection control team. In order to address this the ICN has requested that face to face/classroom sessions be restarted firstly for clinical staff and then extended to non-clinical teams. This programme has met with some challenges including a national and local push to use more electronic training therefore a trial education session timetable is to be re-started in the 2024/2025 year with a limited number of sessions being held to see if staff attend and if there is an increase in IPC standards.

Awareness Day

In March the IPACT held an infection control interactive awareness day. This was to build on the success of the previous years Infection Control 'Back to Basics' drive but increased to capture more staff groups. Three scenario areas were created including, a ward based scenario room that included multiple 'errors' such as dirty equipment left out, the patient having incorrect identifiers on them, incorrectly prescribed antibiotics, a non-clinical office space that had dirty notes, cluttered desk, used PPE and an operating theatre which had sharps left out, 'blood' on equipment, staff belongings and dirty PPE left in there. Staff were encouraged to identify the mistakes and highlight what should have been done.
There were also FIT testers available on the day, hand hygiene practice, resources on infection control and lots of cake. All staff were invited to drop in and have a go at identify all the 'errors' pick up some educational resources, get FIT tested and meet the team. Staff who attended and attempted one of the scenarios were able to complete the requirement for their annual infection control training.

World Hand Hygiene Day

As part of World hand hygiene day, to promote the importance of effective hand hygiene, the ICN's roamed the hospital with the UV light torches and the UV gel representing the germs and encouraged clinical staff to take part in handwashing roadshow. The response was excellent with lots of clinical staff getting involved and a prize was given to the department who showed the most enthusiasm as well as displaying excellent hand washing skills. All clinical staff seemed to enjoy the interactive roadshow and were given pens, hand gels and creams as provided by the Trust's hand hygiene supplier.

Figure 5 shows the training compliance figures

Figure 5

	Required	Achieved	Compliance %
Quarter 1	1294	1200	92.74%
Quarter 2	1277	1185	92.80%
Quarter 3	1345	1233	91.67%
Quarter 4	1346	1207	89.67%

Where compliance in specific staff groups is low the leads for these areas have been contacted and reminded of the importance of staff attending/undertaking their mandatory training to ensure they are kept abreast of the required standards of infection control, any chances to guidance and reinforcing best practice. If they have any concerns or issues accessing the training they should contact the infection prevention and control team to arrange an alternative training method.
The main area showing the lowest levels of compliance was within the non-permanent staff group (bank staff), the bank co-ordinator has been contacted to follow up with individuals who have not undertaken their training and with the new face to face up date session re-starting this

will increase the ways staff can access this training requirement.

Infection Prevention and Control audit

Clinical audit is a fundamental component of clinical governance and underpins the assurance process for a high-quality service (CQC, 2010). The IPACT maintained an audit timetable that is monitored to ensure compliance with national recommendations for assurance. The following audits have been undertaken in the period April 2023 to March 2024.

Antibiotic CQUIN.

One of the CQUIN's assigned to the Trust for this financial year is the auditing of compliance with use of IV antibiotics specifically that where IV antibiotics are being used that they are switched to oral antibiotics as soon as clinically able. The audit targets are to include 100 patients, per quarter, who are on IV antibiotics, prophylaxis antibiotics and oral antibiotics are excluded from the audit. Each of these patients are then assessed to establish the reason for the IV antibiotics, patients ability to take oral medication, infection markers and microbiology data and from this whether they have been left on IV antibiotics longer than is necessary. For quarter 1 we reviewed 100 patients and achieved a compliance rate of 83% meaning 17% of patients audited were still receiving IV antibiotics past the point they met the switching criteria. The main area for improvement was noted as bloods not being sent for patients on IV antibiotics – the deputy medical director was actioning the learning needs for this. During Q1 the infection control nurses reviewed the drug charts and collected the data but advised that it would be more appropriate and beneficial for the Doctors to collect this data and review each patient on the ward rounds as it was proving to be a good opportunity to review all antibiotics and assess for compliance with policy. This was agreed by the Deputy Chief Medical Officer (DCMO) and all Doctors asked to complete. Unfortunately we had minimal support from medical colleagues, . As a result the Infection control nurses took back the audit in September meaning we did not reach 100 patients during the audit period .For quarter 2 we reviewed 73 patients and achieved a compliance rate of 88% meaning 12% of patients audited were still receiving IV antibiotics past the point they met the switching criteria. The main area for improvement was noted as again being bloods not being sent for patients on IV antibiotics – the DCMO is actioning the learning needs for this. For quarter 3 97 patients' drug charts were reviewed and a compliance rate of 85% was achieved. Therefore 15% of patients audited were still receiving IV antibiotics past the point where they had met the switching criteria. The main area for improvement was noted as again being bloods not being sent for patients on IV antibiotics – this is the same action identified in both Q1 and Q2. The DCMO is actioning the learning needs for this. For quarter 4 97 patients' drug charts were reviewed and a compliance rate of 89% was achieved. Therefore 11% of patients audited were still receiving IV antibiotics past the point where they had met the switching criteria. This number could potentially be much higher as again it was noted that patients are not having bloods taken whilst on IV antibiotics to confirm that the WBC and CRP count is decreasing, without this data the audit states they do not meet the criteria for switching to oral. The main area for improvement was again bloods not being sent for patients on IV antibiotics – this is the same action identified in Q1, Q2 and Q3.

Isolation Room Audit

Isolation room snapshot audit was completed by the Infection Control team in July. Audit showed that on the day the audit was completed, all isolation rooms were being used appropriately for infection control reasons. Audit also demonstrated that no patients were being nursed in open bays who required isolation rooms due to infection control requirements. Recommendations were made to remind staff about use of isolation room signs and to continue auditing isolation room usage in line with Trust policy.
Whilst this audit is completed as a 1-day annual snapshot audit, continuous assurance is met by the infection control team having oversight of patient placement both in wards as well as in outpatient settings. The clinical staff regularly contact the IPACT when advice is needed on

patient placement. The IPACT also inform the wards and outpatient areas of any patient with a specific alert organism that may require isolation and additional infection control precautions.

Sharps box Audit

This audit was conducted by the Infection control team and representative from our Sharps box providers, Daniels. The Infection control team will do further training on the correct usage of Sharps boxes and look to re-audit in 6 months. The individual department results and associated actions are displayed below:

The main issues continue to be:
- The temporary closure not in use when boxes left unattended or whilst being moved
- Sharps containers containing significant inappropriate contents

Not ensuring the temporary closure is in place presents a huge health, safety and infection control risks to all colleagues and patients. Inappropriate contents fill sharps containers more quickly and therefore increases costs for the Trust.
Other issues noted include:
- Containers not correctly assembled
- Containers unlabelled
- Containers overfilled to above the fill line

Table 1

No.	AREA	Number of sharps / speciality containers inspected	POSSIBLE SCORE	NUMBER OF NON COMPLIANCES	ACTUAL SCORE	PERCENT COMPLIANT
1	Theatres, Inc. Recovery, Pre-Op	37	296	22	274	92.57%
2	Head & Neck	8	64	6	58	90.63%
3	Critical Care	5	40	5	35	87.50%
4	Ross Tilly	8	64	7	57	89.06%
5	Margaret Duncombe	5	40	0	40	100.00%
6	Peanut Ward	6	48	2	46	95.83%
7	Sleep	3	24	1	23	95.83%
8	Minor Injuries	5	40	3	37	92.50%
9	Main Outpatients	16	128	11	117	91.41%
10	Outpatients -Trauma	3	24	3	21	87.50%

The IPACT continue to provide education and training on sharps box management in induction and clinical training sessions. Sharps box compliance will be re-audited in 12 months.

Surgical Site Infection Audit (SSI)

For this financial year the SSI audit was being conducted in two parts, with both looking specifically at breast surgery patients. For the first part of the audit, all breast surgery patients who were admitted from November – December 2023. This involved collecting baseline data for

all eligible patients which included date of admission, surgery performed, ward, theatre used and staff involved. These patients were all then written to and asked to complete a questionnaire 30 days post-surgery detailing if they had any problems post operatively including whether the wound healed without problems, if not did they see anyone about the concerns, were they given antibiotics and were they re-admitted to any hospital for these concerns or did their wounds heal without issues. For this phase of the audit, 27 patients were admitted for breast surgery. Of the 27 participants, responses were received from 15, a 55% return. Of the 15 responses, 5 answered 'No' to "Did your surgical wounds heal without problems". Of these 5 responses, all were deemed to have an SSI, giving a SSI rate of 33%, none were readmitted for IV antibiotic treatment. Although 1 of the 5 occurred outside of the 30 day window, this patient had also had a haematoma (which was aspirated) on the same day. There was no correlation to surgical team, theatre used or surgery date. The second part of this audit involves auditing the same surgical cohort of patients with the difference that these patients were asked to use a skin and nasal decolonisation in the 5 days leading up to their date of surgery. This was done by patients being given a prescription for the decolonisation at pre-assessment along with information on the audit and the post-op questionnaire for them to complete 30 days post surgery. This was done for all patients admitted from January – March 2024 unfortunately we only received 1 response from these group which we believe is likely due to patients forgetting about the questionnaire as it was given so far in advance. As a result, the infection control team has had to extend this audit period and has re-written to all identified patients asking them to complete a new audit questionnaire. Once this data collection period is complete we aim to compare both audit results to see if there is a decrease in post-operative SSI rates when decolonisation is used.

Gloves Off Campaign

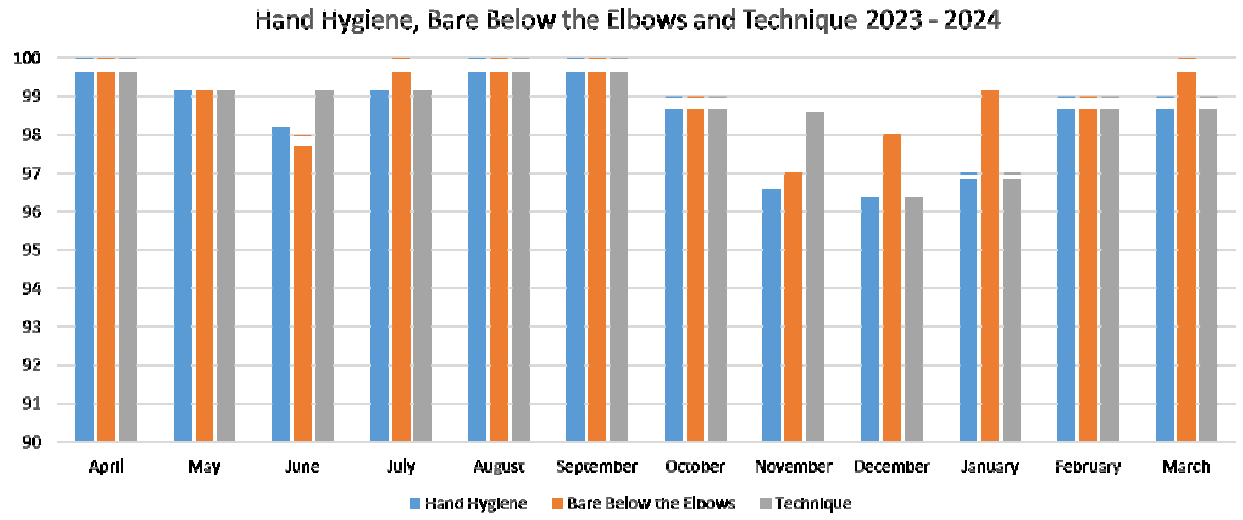
This campaign has been launched Trust wide with the aim of this project being to reduce unnecessary glove usage (see methodology below for measurement tools), in turn reducing procurement and waste costs. A reduction in these will have a positive impact on our carbon footprint by reducing the carbon emissions associated with the production, packaging, transportation and disposal of SUP's. This is in line with the Trusts Green plan 2022 'working towards a 57% reduction in our NHS carbon footprint'.

In addition, this project aims to empower staffs understanding of appropriate glove use through education posters and a risk assessment tool that will enable a quick assessment whether gloves are required or not. This will be supported by the trusts Green ambassadors.

Aseptic technique audit

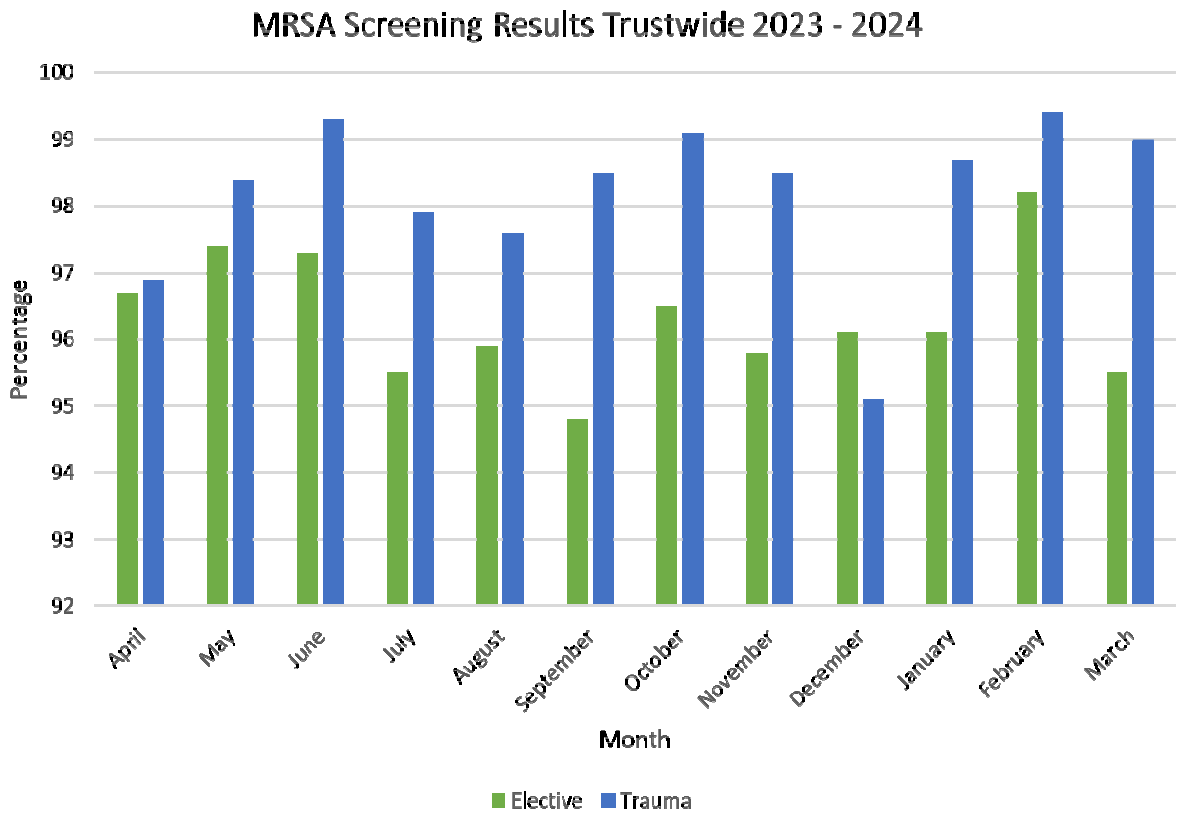
This annual audit is conducted by the senior nurses in each clinical department. They are asked to observe 10 dressing changes being undertaken and mark down compliance with the procedural guidelines as laid out on clinicalskills.net. Unfortunately despite being given a month to complete this observations multiple departments did not return any audit forms (only 3 of the 9 areas asked to participate completed the audit) The results received from these 3 departments showed good compliance across all areas of the audit. However, the amount of forms received did not give enough data to be a true reflection of practice across all departments. Therefore, the infection control team will extend this audit period into April with additional support being offered to the clinical areas to complete the required amount of forms.

Hand Hygiene Audits



Monthly hand hygiene and bare below the elbows compliance audits have continued and are conducted by the Infection Control Link staff in their own areas. Overall compliance has fluctuated throughout the year although compliance has remained at or above 95% in all areas. All staff are reminded at mandatory training sessions of the hand hygiene, bare below the elbows and uniform policy and any staff seen not complying is spoken with by the department lead. The audit tool focuses on the key requirements: hand hygiene at the point of care, ensuring staff are bare below the elbows and making the audit personal by including staff names and details. This has resulted in a positive improvement in compliance in all areas.

MRSA screening



Monthly audits are undertaken to ascertain the level of compliance with Trust policy for the

mandatory screening of all elective and trauma patients. The Trust policy for MRSA screening requires all patients to be risk assessed as to whether they are high risk. High risk is defined as: previous MRSA positive, current MRSA positive diagnosis, transfer from another healthcare provider, patients who are resident of a communal living facility e.g. prison or nursing home, and healthcare workers. The Trust has included all admissions to the Burns unit and CCU as being high risk. All patients identified as being high risk must be screened for MRSA either in the 7 days before admission or within 48 hours of admission day. This is to include all patients including in-patients, day cases and paediatric admissions. There had been a significant decrease in compliance with MRSA screening particularly in elective screening. Our lowest compliance is with those patient who have been admitted in the previous 12 months and with wounds not always being swabbed. Training has been given to staff and results fed back through various meetings. This has been highlighted as an area for increased scrutiny, training and review for the next financial as there is no obvious cause or rational for this level of compliance.

Infection prevention and control policies, procedures and guidance for QVH staff and patients

IPACT have developed guidance for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. All documents are placed on Qnet. All documents have been systematically reviewed and updated in collaboration with relevant services and governance groups (see Appendix C).

Local peer review and assurance processes

QVH has a case peer review system in place in the Burns Unit. Meetings to discuss cases occur every Monday (except Bank Holidays). These meetings review injury mechanism and explanation, treatment, risk assess, discuss any Infection Prevention and Control issues and agree actions required.

The purpose of these groups is to strengthen communication and dissemination of infection prevention and control information and practice across the organisation. The meeting has been attended remotely by the Consultant Microbiologist.

The ICN has continued to attend local and regional Infection Control Network meetings. These have proved to provide a supportive environment to share learning, knowledge, tools and resources with our neighbouring Trusts.

Influenza arrangements

During 2023/24 support has again been given to the management of influenza (flu), with the ICN's encouraging vaccination of staff within the annual flu vaccination programme. Flu vaccination update is reported through the emergency planning reporting system.
The Infection Control Team co-ordinate the FIT testing programme for clinical staff to ensure safe practice is delivered, the monitoring of FIT tests has now been incorporated into the staff formal education records as clinical staff are required to be FIT tested annually.

Untoward Incidents including Outbreaks

This is a summary of events with further details having been included in the Infection Control quarterly reports.

<u>April 2023 to June 2023</u>
Current issues.

- Limited compliance with antibiotic prescribing identified. Antimicrobial steering group in place and chaired by the DCMO. Risk reviewed monthly. Lead Intensivist steering progress in antimicrobial stewardship. Further challenges due to the fact that the

Antimicrobial pharmacist left the Trust with currently no one able to fill the position.

- Lack of ventilation Authorised Person (AP) – there is no ventilation lead or AP onsite; there is an external AE in ventilation with an SLA in place for support although as there is no AP for ventilation this SLA is not being overseen. Estates asked to raise a risk assessment.
- Severe delays in the University Hospital Sussex East (UHS E) laboratory checking in, processing and reporting microbiological results for QVH samples. Some samples taking over 2 weeks to be reported causing delays in implementing IPC measures, starting treatment and informing patients and clinicians. Issue raised to UHS through business unit manager, at the quarterly pathology review meeting and through Datix of individual cases. The infection control team continue to monitor the results of all samples and assurance has been sought from UHS although there was no microbiology representative in attendance at the last pathology review meeting.

Outbreaks/significant infections

- The National requirements for PPE and screening, relating to the Pandemic Coronavirus (Covid-19) have been lowered to return to pre-pandemic levels. With the guidance focusing now on patients with symptoms of respiratory infections or those classed as extremely vulnerable. The Trusts SOP has been re-written and made available to all staff reflecting these changes. The IPACT has also reviewed all the Covid information available on the intranet, internet to ensure it is up to date, and all patients' letters reflect the current guidance.

All cases within the Trust and case numbers within the local community are monitored closely to ensure our current precautions are providing robust protection to our patients and staff. Processes and SOPs remain in place and have been reviewed and updated to ensure they remain functional, in-line with national guidance and continue to provide a safe and effective admission process for both patients and staff.

- Strep A cases continue to be higher than in the same quarter in previous years with 26 cases reported in Q1 22/23 compared to 9 this time last year. There are no obvious links although the majority of cases appear to be in Paediatric patients, suggesting this is not an outbreak but rather a reflection of a national increase in Strep A. This was confirmed by the Consultant Microbiologist, who reported that this is a national phenomenon. IPACT will continue to monitor cases.
- 1 case of Creutzfeldt-Jakob Disease (CJD). The IPC team were notified by another healthcare provider that a patient who had had recent surgery at the QVH had been admitted to them with suspected CJD. UKHSA notified and advised on actions, which included tracing and quarantining all surgical instruments that had been used to operate on this patient for every admission, this was three surgical episodes. Full details of all the patients' admissions and surgical procedures performed sent to the UKHSA for consideration of level of risk with the surgical equipment quarantined. The patient passed away and CJD was confirmed following this the UKHSA advised that the surgical equipment that was being held in quarantine was safe to be decontaminated and brought back into circulation as the surgical procedures performed on the affected patient was low risk for cross contamination

<u>July 2023 to September 2023</u>

Current Issues.

- Limited compliance with antibiotic prescribing identified. Antimicrobial steering group in place and chaired by the DCMO. Risk reviewed monthly. Lead Intensivist steering progress in antimicrobial stewardship. The ICN's continues to teach on antibiotic prescribing and awareness at all training sessions and is conducting quarterly audits. Further challenges faced due to the fact that the position of Antimicrobial pharmacist remains unfilled.

- Lack of ventilation Authorised Person (AP) – there is no ventilation lead or AP onsite; there is an external AE in ventilation with an SLA in place for support although as there is no AP for ventilation this SLA is not being overseen. This is still not raised as a risk on the risk register.
- Severe delays in the University Hospital Sussex East (UHS E) laboratory checking in, processing and reporting microbiological results for QVH samples. Some samples taking over 2 weeks to be reported causing delays in implementing IPC measures, starting treatment and informing patients and clinicians. Issue raised to UHS through business unit manager, at the quarterly pathology review meeting and through Datix of individual cases. The infection control team continue to monitor the results of all samples and assurance has been sought from UHS although there was no microbiology representative in attendance at the last pathology review meeting. Business Unit manager asked to raise as a risk on the risk register.

Outbreaks/significant infections.

- Strep A cases appear to be slowing down with 19 cases identified during Q2 compared to Q1 where 26 were identified. There are no obvious links although the majority of cases appear to be in Paediatric patients, suggesting this is not an outbreak but rather a reflection of a national increase in Strep A. IPACT will continue to monitor cases.
- 1 case of Invasive group A (IGAS) identified in a Burns patient. Patient had sustained a Burn to her hand which she had then not sought medically assistance for 5 days due to have no feeling in her extremities due to an underlying medical issue. Infection identified from a tissue sample that was sent on admission. UKHSA aware and satisfied with all actions taken.
- 2 cases of E.coli bacteraemia identified, 1 in July and 1 in August although both from the same patient. Patient had been transferred to the Burns unit from Medway for necrotising fasciitis. She had a urinary catheter insitu on admission with urine samples showing E.coli. RCA completed which showed poor compliance with catheter maintenance but also with PVC maintenance with 3 PVC's being inserted and all of them having incomplete care plans and 2 of them being left in for longer than the recommended 72 hours. Source of E.coli could be related to either the urinary catheter or the PVC. Improvement needed in the management of urinary catheters, PVC's and documentation.
- 1 CPE positive case identified in a Burns patient. Patient admitted from Medway with Fourniers Gangrene. Initial result returned from a wound swab that was sent on admission. Advice on patient management, PPE precautions and cleaning given to the ward staff and EBAC staff to minimise the chances of spread. Further swabbing done which confirmed a CPE positive rectal swab. Samples sent for typing to UKHSA laboratory, Collindale and further information requested from Medway on previous swab results and courses of antibiotics given whilst patient was with them.
- Vancomycin-resistant enterococci identified in a wound swab for a Burns patient. Patient had been transferred to Medway for further rehabilitation, swab results phoned through the Medway IPACT. Patient colonised but no signs of infection and no secondary cases.

<u>October 2023 to December 2023</u>

Current issues

- Limited compliance with antibiotic prescribing continues. Antimicrobial steering group in place and chaired by the DCMO. Risk reviewed monthly. The DCMO is steering progress in antimicrobial stewardship. The ICN's continues to teach on antibiotic prescribing and awareness at all training sessions and is conducting compliance audits. Further challenges faced due to the fact that the position of Antimicrobial pharmacist remains unfilled.
- Head of Estates has now undertaken the course to assume the role of Authorised Person (AP) – once formally appointed in writing by the CEO once the external AE has completed his verification, this was raised as a matter of urgency in the Ventilation Steering group, the Trust will have a ventilation lead/AP onsite; there is an external AE in ventilation with an SLA in place for support. Work then required to provide a complete

and robust asset register of all ventilation and air handling units including portable units throughout the Trust with accompanying evidence and assurance that all are serviced and maintained in the nationally agreed format and timescale. This will be estates led.

- The severe delays in the University Hospital Sussex East (UHS E) laboratory checking in, processing and reporting microbiological results for QVH samples has eased over the last quarter with 3 samples known to have taken over 2 weeks compared to 9 in the previous quarter. The infection control team continue to monitor the results of all samples and will escalate if further issues identified.

Outbreaks/significant infections

- Strep A cases appear to be remaining stable with 19 cases identified during Q3 which is the same as Q2 and a decrease when compared to Q1 where 26 were identified. There are no obvious links between the cases, although the majority appear to be in Paediatric patients, suggesting this is not an outbreak but rather a reflection of a national increase in Strep A. IPACT will continue to monitor cases.
- Patient with a multi-drug resistant organism that had previously been identified on the Burns unit organism became fully resistant with no antibiotic treatment options left. Patient remains isolated with strict infection control precautions in place. Burns staff and Consultant informed of the result and guidance given on management. No further cases identified.
- 2 Covid Clusters identified in staff in 2 separate departments. No cases identified in patient groups. Increased precautions implemented including re-introducing mask wearing for all staff while working, social distancing in staff rest areas and increased awareness of staff symptoms. Situation resolved in both areas within 2 weeks of implementing precautions.
- No reportable infections or outbreaks during this quarter.

<u>January 2024 to March 2024</u>

Current Issues.

- Antimicrobial steering group in place and chaired by the DCMO. Risk reviewed monthly (risk number 1221) The Deputy Medical Director is steering progress in antimicrobial stewardship. The ICN's continues to teach on antibiotic prescribing and awareness at all training sessions and is conducting compliance audits. Antimicrobial pharmacist commences April 2024, although a new starter has been appointed and is due to commence in the new financial year. Targeted approach to compliance agreed and is to focus on staff completing all relevant sections on the drug chart when prescribing, including duration and indication. This will then allow us to audit appropriate usage with greater accuracy in the future. Antimicrobial ward rounds commenced on CCU, Head and Neck and Canadian Wing with surgeons and Microbiologists.
- There is now oversight of all relevant ventilation/air handling units within the Trust with assurance available of maintenance and servicing of these systems. Head of Estates has undertaken the training for the role of Authorised Person Ventilation (APV) and will be assessed by the external Authorising Engineer for Ventilation. This was raised as a matter of urgency in the Ventilation Steering group in Q3. The Authorising Engineer (AE) for ventilation is currently in place to provide the Trust expertise and support. An asset register of all specialist ventilation and air handling units will be compiled. Evidence of Theatre verifications are now in place and the specialist systems are under a 3 year contract for servicing and maintenance.

Outbreaks/significant infections

- 1 patient identified as being positive to C.diff. Patient admitted to the Burns unit from QEQM for treatment following necrotising fasciitis, patient had active loose

stools on admission and sample sent on the day. His sample returned positive so whilst reportable is not attributable to the QVH. IPACT at QEQM informed of the result and asked for further information regarding the patient's bowel habits and antibiotic usage pre-transfer. Patient had loose stools before transfer and had had repeated courses of antibiotics. Patient isolated with full precautions on admission with no further cases identified.

- 1 patient had a reportable MSSA bacteraemia. Patient was a long-term Burns patient who was often non-compliant with many aspects of their care making dressing changes more complicated and delaying wound healing. Patient had become systemically unwell and blood cultures were taken as part of the septic screen. MSSA confirmed and patient treated under Micro advise with no secondary cases.

5. Involvement and Engagement

Antimicrobial report
This report is compiled and published by the antimicrobial pharmacist as a separate document.

Decontamination and disinfection report
Routine decontamination of nasendoscopes and specific theatre equipment continues through the Wassenburg (endoscope washer disinfector). Routine water testing and servicing of the Wassenburg has been performed minor fluctuations in the levels within the water were rectified using approved processes such as thermal cleans and disinfections. Repeat samples following positive results have all returned negative and no positive cases required the closure of the decontamination service. The Trust continues to have an external Authorised Engineer who conducts the annual audit and ensures compliance with national guidance. The Wassenburg had reached the end of its usable life span and following a business case application a new machine was installed in March 2024.

Steris continue to provide the Trust with sterile services for all reusable equipment that cannot be processed through the Wassenburg machine. They are an accredited company licensed to perform sterilisation for healthcare premises in line with national guidance and requirement.

Monthly meetings are held with Steris to ensure compliance with national sterilisation guidance and to monitor the contract.

All decontamination reports and audit results are taken to the quarterly infection control group meeting.

Facilities report

Cleaning audits are undertaken by the Domestic Supervisors weekly, each clinical area is audited every week and non-clinical areas 3 monthly. Where issues or concerns related to cleaning are noted these addressed and resolved within 48 hours with a repeated audit conducted within 7 days.
Deep cleaning programme has continued with all areas deep cleaned in line with the

National Standards of Cleanliness with both clinical areas and non-clinical areas done annually.

Facilities produce a quarterly report of all actions undertaken including audit results that is presented at various meetings including the quarterly Infection Prevention and Control group.

Estates report

IPACT continues to work closely with the Estates department and are consulted on infection control issues as well as project works. An Estates quarterly report is produced by the Head of Estates which is reviewed in various forums including the Infection Prevention and Control group.

The ICNs has raised concerns throughout the year around the assurance and processes in place relating to ventilation. There has been no appointed AP for ventilation for over two years, there is no robust asset list of all air handling devices within the Trust, including full ventilation systems, portable air conditioning, split air conditioning or ceiling cassette air units and as a result there is no assurance provided on service and maintenance of these systems. ICN requested this be raised as a Trust risk but this has not yet happened. An AE is in place but provided by an external company, ventilation steering group re-started and requests for assurance and key staff in position documented through this group. Ventilation policy was due for review January 2023 which remains outstanding.

Water Safety

The Trust continues to take monthly water sample (Approximately 25 tests per month) for the monitoring of legionella Pneumophila bacteria within the domestic water supplies. This work is undertaken by TSS and their attendance and performance continues to meet expectations.

All outlets are inspected for the presence of flexi pipes / dead legs / blind ends. Any defects identified are rectified e.g. flexi pipes removed & replaced with copper hard piping. Dead Legs / blind ends to be removed as far as practically feasible.

All Legionella sampling is monitored by the Trusts RP of water safety, with actions taken when required.

Pseudomonas samples are taken every six months within augmented areas (CCU, Head & Neck and Burns unit). Results are presented in the Estates quarterly reports including any positive results and associated remedial actions.

Infection Control Risks and incidents.

The ICN's receive notification of any suspected/confirmed Infection Prevention and Control incidents via the Datix reporting system. The ICN's respond to each Datix report. The response may be in the form of advice or it may trigger further investigation. This activity allows the lead ICN to maintain oversight of all Infection Prevention and Control incidences. A list of all incidents relating to infection control reported through is taking to the quarterly infection control group meeting for review and to look for any similarities or patterns that may require further investigation, training or service review.

There are no Infection Control Risks on the corporate risk register. This is discussed at the quarterly infection prevention and control group each quarter to provide assurance

there are no areas that require a risk entry. There are 2 corporate risks that relate to, although not owned by the infection control team, these are:

- Poor compliance with antimicrobial prescribing – this risk is overseen and managed by the Chief medical Officer and Chief pharmacist

Contract monitoring -Sussex ICB Infection Prevention and Control Standards

ICB's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective Infection Prevention and Control arrangements in place. An annual self-assessment tool titled a Board Assurance Framework (BAF) is completed annually detailing compliance with national standards relating to infection control. This BAF highlights any areas that are falling below compliance and provides assurance and evidence of risk mitigating factors in place or actions to complete compliance.
Members of the ICB are invited to all the IPCG meetings that are held quarterly, they are sent copies of any RCA's completed and involved when needed in any outbreak management meetings (this has not been required this financial year as no outbreaks experienced).

6.	**Learning from Experience**

2023/2024 continued to be a challenging year for the Trust as a whole and the IPACT specifically with the global pandemic of Covid-19 and the drive to move back to pre-covid ways of working.
The IPACT has maintained its close working relationships with the estates team, facilities team, clinical leads, emergency plan lead and Covid-19 groups set up to review national guidance, PPE requirements, patient pathways and flow through the Trust, estates and infrastructure, ventilation requirement, screening requirements for both patients and staff. During the year there been further decreases in Covid-19 precautions for both staff and patients with changes to screening and PPE, the IPACT has worked to ensure that this guidance was read and then implemented in a way that ensured the continuing low numbers of Covid-19 in both patients and staff whilst not impeding hospital admissions or disrupting services.

Despite the pressure on the IPACT we have continued to ensure high standards of infection control have been maintained for all patients to prevent a rise in HCAI, this is evident through our continuing low numbers of reportable HCAI and low numbers of Covid positive cases, MRSA positive numbers and outbreaks. The Trust continues to strive to improve compliance with all aspects of Infection Control in order to safeguard the patients, service users and staff through a robust programme of education, audit and reporting. The rates of both reportable and non-reportable infections remained low however there is still improvement to be made. The main area that have been shown through the auditing process for this year as requiring improvement is engagement with the infection control team and basic standards such as bare below the elbows and dress code, compliance with antibiotic prescribing and compliance with MRSA screening

Support from the Consultant Microbiologists has remained virtual, with no onsite presence since the start of 2020, they have increased attendance at the IPC quarterly meetings and commenced antimicrobial virtual ward rounds on CCU.
There have been significant delays in reporting of swab results, with some wound swabs taking 2 weeks to process and report. Issue raised to UHS through business unit manager, at the quarterly pathology review meeting and through Datix of individual cases. The infection control team continue to monitor the results of all samples and assurance has been sought from UHS.

	The infection control team will continue to champion and promote the implementation of infection control to all staff in all departments with the emphasis on 2024/2025 programme being reinforcing compliance with infection control and ensuring the basics are done consistently to a high standard. Further scrutiny is required on the environment to ensure it is clean and safe with the ICN's looking to implement an environmental screening programme. The infection control team has increased departmental based inspections, to provide real time education and training and greater opportunities for staff to ask questions or raise concerns. Further work is required to improve the audit programme to ensure that audits are being used to improve services and deliver meaningful data, and target areas of concern. An electronic auditing programme is being reviewed to see if this will assist with reporting and monitoring of audit actions. Further work has been done to change the way the infection control education is delivered to ensure we are engaging with as many staff as possible in as many ways as we can. We have requested the return of face to face training rather than all mandatory sessions being done via eLearning in order to make the training more QVH focused and again allow staff the opportunity to engage with the IPACT, raise concerns or ask questions. We again did an interactive IPC awareness day that involved education, and training in a variety of formats including hand hygiene training, games, subject experts, posters, education resources, sharps safety and three scenarios for staff to identify infection control errors, 1 ward based, 1 office based and 1 theatre based.

7.	**Recommendations**
	The evidence in the form of audit results, low numbers of infections, meeting minutes and patient feedback has shown that overall, compliance with National guidance, Trust policy and National targets is good although there is still some improvement required. This report has evidenced the challenges faced by the trust's IPACT through this financial year. Looking forward, using the experiences and knowledge gained throughout the last financial year, further targeted work could be undertaken to improve compliance with antimicrobial prescribing, and MRSA screening Priorities for this year have been identified as continuing to build on the Back to Basics groundwork reinforcing the importance of compliance with all aspects of infection control. Improving the audit programme by looking at new ways of auditing. Further work will also be undertaking to ensure the care environment is clean, safe and compliant where possible with national recommendations.

8.	**Future Plans and Targets**
	The infection control team will work alongside the staff to ensure infection control standards are implemented by all staff in all situations, that auditing is robust and targeted, that the education being delivered is meaningful and accessible and that the basic standards of infection control are implemented and understood with the aim of achieving zero preventable infections. The IPACT aim to strengthen to working relationship with the estates and facilities teams to providing a clean, compliant environment for both staff and patients.

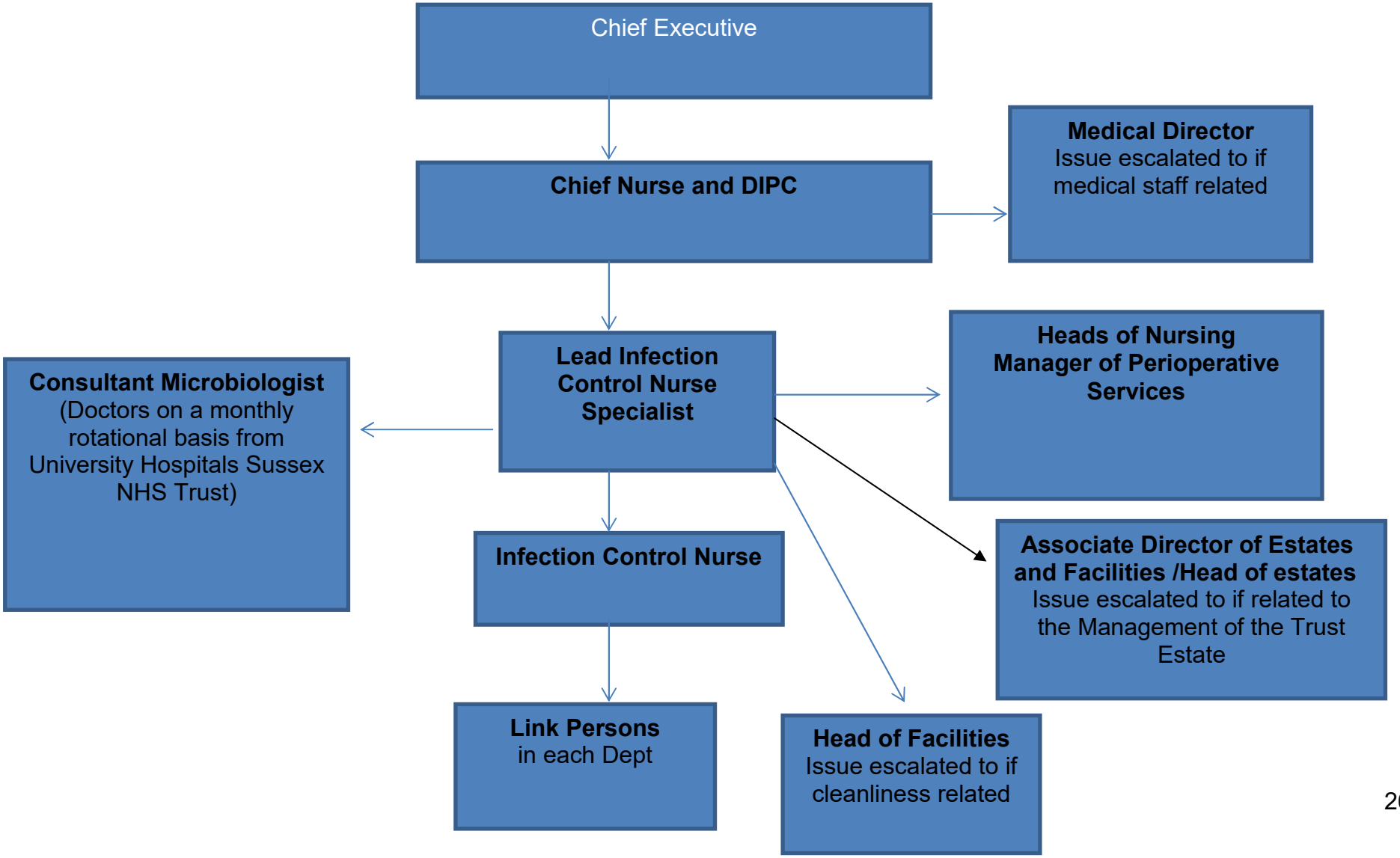
9.	**Conclusions and assurance**

	This report demonstrates the systems and processes in place to ensure that the trust meets the requirements of the Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare related guidance. The completion of the infection control audit programme, teaching and alert organism surveillance is a proven method of achieving high standards across the trust and it is the ICN's implementation of this that ensures assurance processes are focused on patient, visitor and staff safety as a priority. This is done through the writing and implementing of policies in line with best practice guidance, a robust audit process and programme of education and staff engagement which has been detailed in this report. This has assisted in maintaining the Trusts low rate of healthcare associated infections across all departments. QVH has a range of internal assurance processes in place. An overview of Infection Prevention and Control activities in QVH are in place. The ICN's also works closely with the ICB ICN to provide reassurance on processes and practice within the trust. QVH has an overview of all relevant Infection Prevention and Control information and documents, which are systematically developed, reviewed and/or updated. QVH has local external regulation undertaken by the ICBs. Monitor ensures QVH are registered with the CQC. Local Infection Prevention and Control peer review and assurance processes are in place. IPACT are well supported by the Chief Nurse/ DIPC. QVH staff are guided and supported by the specialist Infection Prevention and Control Nurses. The QVH Infection Prevention and Control team present this report to provide assurance to the Board that the Infection Prevention and Control agenda is robustly overseen and managed within the trust and with partners. To conclude, the Infection Control Team believes this annual report accurately reflects the commitment and achievements of the infection prevention and control service in the trust.

10.	**Report approval and governance**
	The Board is asked to consider the contents of this report and raise any issues of concern or outline any specific action they request.

11. Appendices

APPENDIX A **Infection Prevention and Control Structure Chart 2023/2024**



Appendix B

Infection Control Annual Programme Objectives for 2024/25

Infection prevention and control continues to be a top priority at both National and local level. The IPACT, under the direction of the DIPC and with the full support of the Board of Directors and Governors, will continue to ensure that the highest possible standards in infection prevention and control are applied and achieved at the QVH.

This action plan contains new areas of activity and a number of on-going areas of particular importance. A large amount of activity is on-going and not included in the action plan.

Department	Section	Action	Frequency
Microbiology	Management	Continued review of pathology provider to ensure safe and efficient service delivered	On-going
Microbiology	Management	Continued review of pathology provider IT systems, e.g., the provision of electronic reporting in a useable, reliable format and request for regular list of blood cultures taken	On-going
Microbiology	Management	Continued review of antimicrobial prescribing	On-going
IC	Management	Maintain input into Clinical Audit Meetings and Consultant mandatory training	Quarterly
IC	Management	Maintain input into the review of any new Estates project from start to finish	On-going
IC	Management	Continue to review the Board Assurance Framework related to the Health and Social Care Act (2010)	Annually
IC	Management	Quarterly IPACT report for Board	Quarterly
Theatres	Management	Decontamination Lead to continue monitoring of decontamination of equipment in conjunction with the decontamination staff within Theatres	Ongoing
IC	Management	Review policies in line with DoH and NICE National guidance and Trust timescale	As required
IC	Management	Continued attendance at external meetings and Infection Prevention Society annual conference	On-going
IC	Surveillance	Continue mandatory surveillance and reporting in line with DH requirements including MRSA, MSSA, *C. difficile* and *E. Coli*	Monthly
IC	Surveillance	Enhanced surveillance (RCA/PIR) of *C. difficile*, MRSA, MSSA and *E. coli* bacteraemia	When new case identified
IC	Surveillance	Continue speciality specific surgical site infection audit	Annual
IC	Audit	Audit sharps policy compliance	Trust wide annual

IC	Audit	Continue hand hygiene audit and compliance	Monthly
IC	Audit	Audit compliance with MRSA policy Audit compliance with MRSA screening	Monthly
IC	Education	Updates for Clinical Practice Educators / Department Managers / departments	As required
IC	Education	Mandatory training: Clinical Non-clinical Induction Junior doctors Consultants	X2 month X1 month X1 month X6 year X2 year Available through e-learning
IC	Education	Link person training	quarterly
IC	Education	Deliver training to staff on current issues and attend department meetings on request	As required
Estates	Management	Involvement in the Capital Programme	As required
Estates	Management	Review of estates policy and new guidance	As required
Estates	Management	Involvement in reviewing water sampling and ventilation results	As required
Estates	Management	Involvement in the prioritising of general refurbishment works within the Trust	As required
Facilities	Audit	Waste facility	Annual
Decontamination	Management	Review of decontamination and disinfection policy	As required
Decontamination	Management	Update for ICG	Quarterly

Appendix C

IC Policies Ratified April 2023 – March 2024

- **Protocol for Animals in Hospital**
- **Policy for the screening of patients for Methicillin resistant staphylococcus aureus (MRSA) and treatment and management of MRSA positive patients**
- **Carbapenemase Producing Enterobacterales (CPE) Policy**
- **Personal Protective Equipment (PPE) Policy**
- **Screening of patients for MRSA and Treatment and Management of Positive Patients**
- **Hand Hygiene Policy**
- **Guidelines for the Control of Varicella Zoster Virus Infection (Chickenpox and Shingles)**
- **Policy for the Prevention of Healthcare Associated Infections in Short and Long Term Urinary Catheterisation in Acute Care**
- **Standard Operating Procedure (SOP) – QVH COVID Screening SOP for Patients and Staff**

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Report cover-page					
References					
Meeting title:	Quality and Safety Committee				
Meeting date:	25/06/2024		**Agenda reference:**	**168-24**	
Report title:	Emergency planning, resilience and response (EPRR) annual report				
Sponsor:	Nicky Reeves, Chief Nursing Officer				
Author:	Liz Blackburn, Deputy Chief Nursing Officer				
Appendices:	QVH CS assurance letter 2023/24				
Executive summary					
Purpose of report:	Annual report on the Trust's preparedness for emergencies in 2023/24				
Summary of key issues	• EPRR 2023 workplan achievements • Industrial action, policy updates • Training and exercising • Business continuity • Assurance process • Practice exercises and risk				
Recommendation:	To note the progress made in planning for emergencies and approve 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:	KSO1&3				
Corporate risk register:	Local Risk register entries 1348,1155 and 1156				
Regulation:	National requirement working with NHSE and Sussex ICB				
Legal:	Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response Framework (EPRR) 2022				
Resources:	None				
Assurance route					
Previously considered by:	ELT				
	Date:		Decision:		
Next steps:					

Report cover-page					
References					
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Resources:	None				
Assurance route					
Previously considered by:	ELT				
	Date:		Decision:		
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Emergency Planning, Resilience and Response

Annual Report

Report covering the period from
April 2023 to March 2024

Document Control:
Executive sponsor: Nicky Reeves. Chief Nurse

Authors: Liz Blackburn. Deputy Chief Nurse

Date: 15th May 2024

Type: Annual Report
Version: Draft
Pages:
Status: Public. Written and prepared for the Trust Board
Circulation: Quality and Safety committee

Contents List

1.	Executive Summary
	This paper provides a report on the Trust's preparedness for emergencies in 2023/24. It highlights the planning process, the training and exercising programme and the instances in which the Trust has had to respond to incidents. The 2023/24 NHS England annual assurance review process was carried out in full. The review was undertaken in conjunction with EPRR leads from the ICB and the trust has been assessed as substantially compliant. (Appendix 1).

2.	Introduction
	The Trust's emergency preparedness must meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response Framework (EPRR) 2022. The Civil Contingencies Act 2004 divides local responders into two categories, imposing a different set of duties on each. QVH is defined as a category one responder which include the following responsibilities: • to carry out a risk assessment of our operational areas for contingency planning • to have emergency plans • to have business continuity plans • to warn, inform and advise the public in the event of an emergency • to share information with other local responders • to cooperate with other responders through a Local Resilience Forum During 2023/24, the Accountable Executive Officer for EPRR and Business Continuity is held by the Chief Nurse who represented the organisation at the Local Health Resilience Partnership Executive Group (LHRP),which continued to be held virtually. The Deputy Chief Nurse attended the Sussex Health Resilience Group (SHRG).

3.	Service aim, objectives and expected outcomes
	QVH is expected to deliver the requirements of a category one responder for the purposes of EPRR. The EPRR lead has co-ordinated activities which demonstrate the trust has met its responsibilities as a category one responder the key outcomes being: • Refreshed and tested plans related to emergency plans • Collaborative working with LHRP • Establishing QVH in the wider EPRR health economy and utilising expertise within this network • Resilience test of business continuity EPRR work plan 2023 achievements: • Evacuation and shelter plans reviewed and approved • Business impact assessments completed in critical areas • Internal audit of business continuity plan • Monthly linking reports submitted to SHRG • Updated 'Management of Outbreaks' plan We did not achieve departmental fire drills due to long term absence in fire team. However, regular fire alarm testing takes place weekly, and there have been two fire incidents over the past year, which have tested our evacuation plan. Departmental

	Fire Drills have been added to the Training and Exercising Schedule to ensure that this gets tested regularly.

4.	Activity analysis/ achievement

Industrial Action

During this period QVH were affected by fourteen episodes of industrial action from Nursing, junior Doctors, Consultants and radiography, regular industrial action planning meetings and debriefs were held throughout these periods of disruption. Although these have been impactful on activity, the hospital has maintained the safety of our patients and core services.

Policy

Emergency preparedness plans are held centrally on the Trust intranet pages accessed via a 'tile' within the Policies section; for ease they are divided into sections to reflect specific guidance.

The following plans had a full review:

- Emergency Plan Section 9 - Heatwave Plan
- Emergency Plan Section 7 - Plan for Chemical, Biological, Radiological or Nuclear and HazMat Incidents
- Emergency Plan Section 13 - Hospital Evacuation Plan
- Emergency Plan Section 6a – Lockdown Process

Minor amendments and additions were made to:

- Emergency Plan Section 11a - Departmental Business Impact Assessments & Service Level Plans
- Emergency Plan Section 2 - Switchboard & Co-ordination Team Action Cards

All EPRR sections are currently in date or have plans to take through the governance routes at QVH.

Winter Planning

There were a number of minor impacts from wet weather particularly with flooding and minor roof leaks across the site, all managed without disruption to services.

Seasonal Flu

The 2023/24 flu vaccination programme concluded in March 2024 with all data submissions to IMMFORM uploaded successfully. Reasons for refusal remain mixed with no themes being noted. The vaccination and opt out data is reported below.

As at the end of March 2024

Staff Group	Vaccinated	Unknown/Not Recorded	Formal Decline Recorded	Total Staff	% Vaccinated	%Vaccinated or recorded as Opted out
All Doctors	78	91	23	190	40.00%	52.11%
All other Professional Qualified	96	40	33	169	56.80%	76.33%
Qualified Nurses	132	59	59	242	54.55%	77.27%
Support to Clinical staff	381	157	112	690	60.46%	76.25%
Grand Total All Staff	**685**	**323**	**223**	**1231**	**55.65%**	**73.76%**

Training

Emergency planning and preparedness is presented on induction to all new employees

There has been a small increase in both clinical (0.11%) in non-clinical (1.67%) compliance during this year.

EPRR compliance as at the 31 March 2024

Staff Group	Assignment count	Required	Achieved	Compliance %
Clincial	715	715	653	91.33%
Non-clinical	427	427	406	95.08%
Grand Total All Staff	**1142**	**1142**	**1059**	**92.73%**

Other training and exercises

- Principles in Health Command - e-learning is required to be completed by all on call managers, and the site practitioner team
- Loggist training - plan has been introduced by the ICB
- Hazmat and Chemical, biological, radiological and nuclear (CBRN) - training is completed by all staff working in our Minor Injures Unit (MIU)
- Exercise Hiertan – attendance of the south east exercise of the evacuation of a single large site and the support of individual organisations with their own preparedness
- Live EX 2023 – attendance of a regional exercise to test the operational and strategic response to severe weather event resulting in coastal, river and surface water flooding

Business Continuity

Maintaining the effective continuity of our business operations is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management capability in line with BS 25999 Business Continuity Management. This includes the development of business continuity plans for core business activity.

All business continuity plans can be accessed by the on call managers and site practitioner team via folders on the “N” drive and hard copies of the emergency plan area available in the incident control room in the event of a power or IT failure and all departmental leads have a copy of their individual plans.

Other activity undertaken over the year:

- Bi monthly meeting for on-call managers
- Attendance at the Sussex Health Resilience Group
- Attendance at the Local Health Resilience Partnership Executive Group
- Additional administration support with EPRR function
- All Business Impact Assessments completed in ‘critical’ service areas

5.	**Involvement & Engagement**
	Assurance process *Internally:* Bi-monthly on-call manager and EPRR meetings, attendance includes all managers and directors who undertake on call duties and a representative from the site practitioner team. On-call log and incidents are reviewed and learning shared and actioned.

	New managers receive an induction session from the EPRR lead to facilitate the transition into their role. Each new on-call manager is offered a 'buddy' to support them through their first series of on-calls. Non-clinical on-call managers without an operational remit have access to the contact details of a manager with a clinical background to call for advice as required. EPRR updates and the Annual report are discussed at Quality and Safety Committee. *Externally:* All NHS Trusts who are category one and two responders (Civil Contingencies Act 2004) are required to complete a self-assessment and submit a statement of readiness to NHS England stating compliance against the national requirements of EPRR. The 2023/24 assurance process was formally completed with virtual meetings and assessments by the ICB EPRR team. In October 2023 QVH were assessed as **substantially** compliant against the NHSE EPRR Core Standards. We were fully compliant with 56 of the total 59 standards assessed, and partially compliant with three. The confirmation letter and areas for improvement are in Appendix 1.

6.	**Learning from Experience**
	Practice Exercises and Live Events During 2023/24 QVH has tested its emergency planning resilience during a number of "live" incidents as identified below. The learning from these incidents is utilised to ensure the emergency plan remains up to date and is reviewed in the light of any recommendations as a result of these scenarios. Debriefing following incidents is now embedded in the organisation. **Incidents** There have been 11 emergency planning and business continuity incidents, with the following being most significant: • April 2023 - total loss of internet activity for one hour • June 2023 – lockdown following a patient being observed with a hammer • August 2023 – repeated power failures in main theatres • September 2023 – lack of heating in four theatres • November 2023 – fire alarm and partial evacuation due to smoke coming from a vending machine • January 2024 – lack of heating on Burns Unit resulting in the moving of patients to an alternative ward In all cases, datixes have been completed, learning points identified and any actions are monitored via the local governance groups. **Risks** There are currently 33 risks related to EPRR or Business Continuity issues, with the highest number of risks sitting within IT.

7.	Recommendations
	The core standards assurance review for 24/25 will commence in September 2024. The actions from last year will be completed prior to the review. Training and exercising will continue over the next year, with a work plan in place and full engagement with the ICB EPRR plan. All incidents will continue to be monitored and learning shared.

8.	Future plans and targets
	The EPRR lead has reviewed the actions highlighted in the 2023/24 EPRR assurance document to ensure the organisation has satisfactory arrangements in place to meet the requirements of the EPRR function. The assurance process for 2024/25 will commence in September 2024 and QVH will endeavour to achieve full compliance with the standards. The Accountable Executive Officer for EPRR is to move to the Chief Operating Officer during 2024/25.

9.	Conclusions and assurance
	The Trust has policies and procedures in place that are monitored and up to date for the effective management of any EPRR event and business continuity incident. It meets the requirements of the category one responder as evidenced in retaining substantial assurance during the external review of core standards.

10.	Appendices
	QVH CS assurance letter 2023/24

11.	Report approval and governance
	Executive Leadership Team Quality and Safety Committee Board

Nicky Reeves
Interim Director of Nursing
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West Sussex
RH19 3DZ

NHS Sussex Integrated Care Board
Wicker House
High Street
Worthing
BN11 1DJ
sxicb.eprr@nhs.net
https://www.sussex.ics.nhs.uk/

29 January 2024

Dear Nicky

Re: NHS England EPRR Core Standards Assurance Process 2023 - Queen Victoria Hospital NHS Trust

Firstly, can I thank you and your team for all your hard work and close collaboration with the ICB's Emergency Preparedness, Resilience and Response (EPRR) team during the assurance process last year.

Following the review of Queen Victoria Hospitals (QVH's) self-assessment against the 2023 NHS England (NHSE) EPRR Core Standards at the Local Health Resilience Partnership Executive Group on 13 December 2023, and the approval from NHSE of the ICS's overall submission in December 2023, we are writing now to formally confirm the outcome of the process.

Outcome of the assessment process

As discussed at the final meeting in October 2023 QVH have been assessed as substantially compliant against the NHSE EPRR Core Standards.

QVH were fully compliant with 56 of the total 59 standards assessed, and partially compliant with three.

NHS England define substantially compliant as:

Compliance Level	Evaluation and Testing Conclusion
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.

The rationale for the assessment is contained in the table below for those standards that were assessed to be partially or non-compliant (please note the deep dive standards do not form part of the overall assessment of compliance). We have also included recommendations for further improvements in fully compliant core standard i.e. advisories - which if not completed may have an impact on next year's ratings:

Ref	Core Standard	2023 rating	Rationale
22	Training and Exercising - EPRR training	Partially compliant	No evidence of Training Needs Analysis or training records for staff in their response role.
24	Training and Exercising - Responder training	Partially compliant	No evidence of Training Needs Analysis or training records for staff in their response role.
64	Hazmat/CBRN training resource	Partially compliant	Hazmat/CBRN training records provided. TNA / minimum training standards for organisation not available at present.
Deep Dive 2023			
DD1	Training Needs Analysis	Partially compliant	As 22,24,64 above, further work is required around training needs analysis and aligning this with the MOS and training records. To note, following the meetings work has commenced on taking this area forward and Senior Leaders are undertaking 1:1 training and are booking onto PHIC.
DD2	National Minimum Occupational Standards (MOS)	Partially compliant	
DD4	Senior Leadership Training	Partially compliant	
DD6	Training data	Partially compliant	
DD8	JESIP doctrine	Partially compliant	
Further advisories, not impacting on the overall compliance rating			
• Work plan is currently based on recommendations from last year- this could be amalgamated into one document to include all domains in core standards, e.g. training and exercising (CS4). • Key lessons identified from debrief reports to continue to be shared wider than at organisation level i.e., through the Sussex Health Responders Group (SHRG) monthly report (CS6). • New and significantly reviewed policies could be shared via the Sussex Health Responders Group (SHRG) for consultation purposes and shared understanding with partners (CS9). • Amalgamate cold and hot weather plans into one Adverse Weather Plan for next year (CS11).		

Next steps

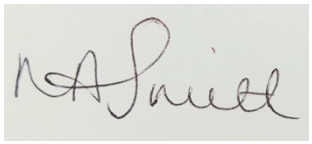
Please check this letter and the final core standards spreadsheet sent with it to ensure it matches your understanding of the final outcome of this process and let us know, via the EPRR inbox, (sxicb.eprr@nhs.net), if anything does not correlate.

It would also be helpful if you could confirm to us when you will be taking the outcome of the core standards assurance process to your Board for review.
The ICB EPRR team will be working with your EPRR team to agree a SMART action plan to address the comments noted in the table above by the end of February 2024.

The action plan will then be reviewed on a bi-monthly basis to help facilitate significant improvements by the time the core standards assurance process for 2024 begins.

On behalf of the Sussex ICB, our thanks for your help and assistance in completing this year's annual EPRR assurance process.

Yours faithfully,



Nicki Smith
Director of EPRR

Claudia Griffith
Chief Delivery Officer
Accountable Emergency Officer

On behalf of Sussex NHS Commissioners

Cc: EPRR team

Report cover-page					
References					
Meeting title:	Quality & Safety committee				
Meeting date:	25/06/2024		**Agenda reference:**	**173-24**	
Report title:	Research & Innovation Annual Report 2023-24				
Sponsor:	Tania Cubison, Chief Medical Officer				
Author:	Sarah Dawe, Head of Research				
Appendices:	None				
Executive summary					
Purpose of report:	To present the R&I annual report for 2023/24				
Summary of key issues	Research has had another good year, having sustained its strong performance from last year, despite staff shortages. Participant recruitment remained robust. On key metrics, QVH Research demonstrated value for money equivalent to much bigger local Trusts. We increased the number of commercial studies we undertake, and successfully brought in almost enough funding to cover the entire costs of running the department for the year. The anonymous National Research Participant Survey showed that patients were overwhelmingly pleased with the support they received during research studies. Further expansion of Research at QVH is limited by consultant engagement, which remains low.				
Recommendation:	To **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	R&I Governance Group				
	Date:	03/06/24	Decision:	Approved with minor amendments	
Next steps:	To submit to Board.				

Report cover-page					
References					
Meeting title:	Quality & Safety committee				
Meeting date:	25/06/2024		**Agenda reference:**	**173-24**	
Report title:	Research & Innovation Annual Report 2023-24				
Sponsor:	Tania Cubison, Chief Medical Officer				
Author:	Sarah Dawe, Head of Research				
Appendices:	None				
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Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	R&I Governance Group				
	Date:	03/06/24	Decision:	Approved with minor amendments	
Next steps:	To submit to Board.				

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust
Research & Innovation Annual Report

Report covering the period from
April 2023 to March 2024

Document Control: Q&S Committee, R&I Governance Group
Executive sponsor: Tania Cubison

Author: Sarah Dawe

Date: May 2024

Type: Annual Report
Version: 1
Pages: 12
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1. Executive Summary

- Research has had another fantastic year, with **743** participants having been recruited to National Portfolio studies. The National Portfolio is the UK gold standard for high quality clinical research. This represents an increase in activity of **126%** since 2020, reflecting our focus on widening participation in research, making research available to as many of our patients as possible.

- Efficiency and value for money is important to us, and we are pleased to report that Research brought in enough funding to cover almost all its costs in 2023-24, with the Trust only needing to contribute £9K.

- The key objective by which the CRN (Clinical Research Network) measures our performance is a 'Value For Money' (VFM) measure, which is broadly the amount of CRN funding we are awarded divided by the number of research participants we recruit. This year, our cost-per-weighted-recruit was **£61** – a level which is very competitive and demonstrates that we are functioning as a lean, agile and effective team. It compares very favourably with much bigger Trusts in KSS, which are able to better benefit from the economies of scale.

- We have increased the number of commercial studies that we undertake. This is a key CRN goal nationally, and helps to brings in more funding to the Trust.

- We are proud that one of our clinicians acted as a Chief Investigator on a National Portfolio study (Baljit Dheansa). .

- We took part in the national anonymous Participant in Research Experience Survey, with 84 respondents. **93**% felt they had received the right information about the study; **93%** of people felt that their participation was valued; **97%** felt that research staff always treated them with courtesy and respect; and encouragingly, **94%** said that they would consider taking part in research again. Respondents commented on the friendliness and professionalism of research staff, and of the benefits of taking part - both for themselves and for future generations.

- We faced some challenges with under-staffing during the year, but were still able to continue to support a full programme of research activities.

2. Introduction

As the Director of Research & Innovation, it gives me great pleasure to introduce the annual Research and Innovation Report for 2023/2024. It has been 18 months since I started in this important and exciting role and I am delighted to present this detailed highlight which reflects the hard work of The Research and Innovation Team in Queen Victoria Hospital NHSFT.

Over the past year the team has worked hard and have managed to accrue the highest ever number of participants to National Portfolio studies; this is a further improvement over 2022/2023, which at the time was our record year for recruitment. This was achieved despite staff shortages and sickness. We have maintained our positive financial position.

As always my thanks and gratitude go to the whole Research & Innovation team and the researchers for their work, and all the members of the Research Governance Group for their continuous support for the research we run at the Queen Victoria Hospital NHSFT. It is important to highlight the support I always receive from the Head of Research & Innovation, Sarah Dawe and our Chief Medical Officer, Tania Cubison.

Mohamed Elalfy

3.	Service aim, objectives and expected outcomes
	Research & Innovation improves outcomes for patients both at QVH and in the wider NHS. This is achieved through a research programme which focuses on quality, transparency and value for money. R&I at QVH is performance-monitored by our local CRN and by the R&I Governance Group. Research activity is tracked regularly by the CRN via an interactive online system (EDGE), as well as via regular meetings, presentations, and reports. One key objective by which the CRN measures our performance is a 'Value For Money' (VFM) measure. This year, our cost-per-weighted-recruit was **£61** – a level which is extremely competitive and shows we are functioning as a lean, agile and effective team. It compares very favourably with much bigger Trusts in KSS, which are able to better benefit from the economies of scale. This strong performance will help to guarantee our future CRN funding.

1

4.	Activity analysis/ achievement

Research Activity

The number of patients receiving NHS services provided or sub-contracted by the Queen Victoria Hospital NHS Foundation Trust in 2022-23 that were recruited during that period to participate in research approved by the Health Research Authority was **743,** all of which were recruits to prestigious National Portfolio studies. This represents a **126%** increase in activity since 2020.

Participation in clinical research demonstrates QVH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes. In 2023-24, QVH staff were involved in **93** publications, helping to disseminate the knowledge gained from their work.

QVH took part in conducting **17** clinical research studies in 2023-24, of which **16** were National Portfolio studies, and one was non-Portfolio, as per the table below.

Project short title	Start date	Principle Investigator	National Portfolio study	Recruit-ment in 2023-24
POPPY	15/01/24	Fiona Ramsden	Yes	24

1

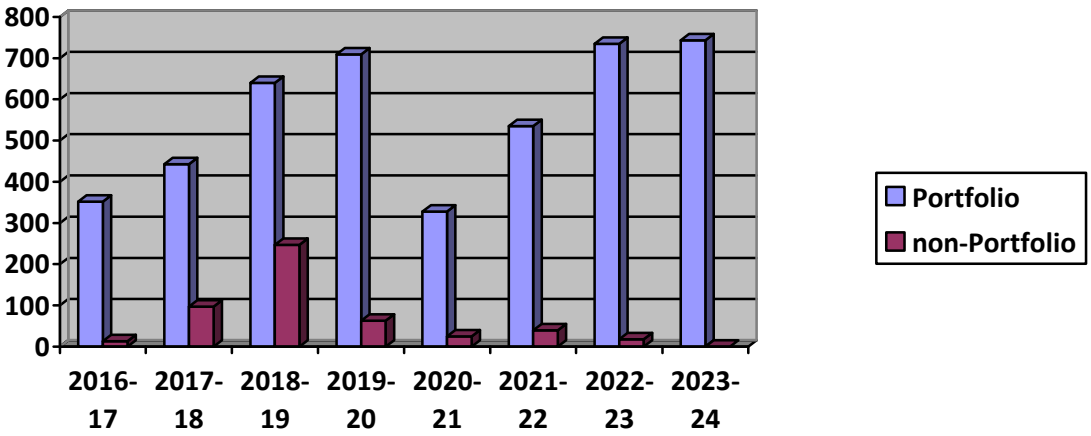
		NAMinG – vitamin B for glaucoma	12/12/23	Gok Ratnarajan	Yes	1
		Biatain Fiber on partial thickness burns	12/10/23	Baljit Dheansa	Yes	5
		STAR V	31/07/23	Gok Ratnarajan	Yes	7
		MyDress	14/07/23	Baljit Dheansa	Yes	12
		RAPTOR - treatment of mandibular osteoradionecrosis following curative treatment of H&N cancer with radiotherapy	17/03/23	Jag Dhanda	Yes	0
		SILVER I alginate dressings for donor sites	10/03/23	Baljit Dheansa	Yes	19
		Flexor tendon repairs - FIRST Study	17/10/2022	Asit Khandwala	Yes	5
		SQUEEZE	21/09/2022	Julian Giles	Yes	9
		PETS	20/09/2022	Simon Booth	Yes	137
		MIDI (MR Imaging abnormality Deep learning Identification)	04/10/2021	Bruce Smith	Yes	288

SAVER	29/10/2021	Zaid Sadiq	Yes	0
Perioperative Quality Improvement Programme: Patient Study	03/05/2017	Ida Forro	Yes	166
Investigation of Potential Biomarkers in the Role of Scar Formation	16/03/2016	Baljit Dheansa	Yes	9
Molecular basis of chronic inflammatory and degenerative diseases	30/11/2015	Asit Khandwala	Yes	61
Clinical Characterisation Protocol for Severe Emerging Infection	03/02/2021	N/A	Yes	0
Is MGI or upper marginal entropion a contributing factor in the development of SLK	25/02/21	Raman Malhotra	No	0

Our work on NIHR Portfolio studies

Recruitment to NIHR National Portfolio studies is recorded and monitored via a national interactive database, and the level of CRN funding received by the Trust is partly determined by these accrual figures. In the past eight years, the number of Portfolio participants recruited has greatly exceeded the number of non-Portfolio recruits, reflecting a successful strategic push to increase the proportion of Portfolio studies we undertake. Activity was considerably impacted during the COVID19 pandemic, but we have now exceeded our pre-pandemic recruitment, with **743** recruits in 2023-24.

QVH Research Participant Recruitment 2016-2024



External Funding

Core funding

The CRN awarded the Trust **£195,166** core funding in 2023-24, and £10K Recovery and Reset funding. Our strong performance the previous year also meant we were awarded £25K national Research Capability Funding. The CRN determines its level of funding partly using an algorithm based on the number of patients recruited to Portfolio studies over the previous two years. This activity-based funding formula is a key driver for how research work is prioritized at QVH.

Core funding was allocated according to CRN guidelines in the following way:

Resource	Allocation
Head of Research	39,637
Lead Research Nurse	35,250
Senior Research Nurse	10,807
Research Nurses	95,812
Research Practitioner	18,893
Office/IT/consumables/training	2169
Overheads	13,011

The R&I Budget has been managed carefully, and achieved a near cost-neutral position in 2023-24, with the Trust only needing to contribute £9K.

5.	Involvement & Engagement

Patient and Public Involvement and Engagement

QVH continues to work to find meaningful ways to involve patients and members of the public in its research activity. We are fortunate to have on our R&I Governance Group two very involved patient representatives, who take an active role in advising on and monitoring the research activities of the Trust. Patients are also sometimes involved in the early stages of research projects via focus groups, which feed into protocol development.

QVH participated in the national anonymous PRES (Participant in Research Experience Survey) questionnaire, and this year we have sent out (by post and email) 239 questionnaires). We received back 84 completed forms, which is a return rate of 35% and well above the target of 29 surveys required by our CRN.

Data from PRES is reviewed regularly throughout the year and helps us better understand the experience of research participants and how we might improve their experience. The results are shared both internally and with our CRN.

Overall, the PRES survey paints a positive picture of people's experiences of taking part in research. Respondents comment on the friendliness and professionalism of research staff, and of the benefits of taking part, both for themselves and for future generations. **93**% felt they had received the right information about the study; **93%** of people felt that their participation was valued; **97%** felt that research staff always treated them with courtesy and respect; encouragingly, **94%** said that they would consider taking part in research again. These figures represent an improvement on last year's figures, which were in themselves already good.

Here are some comments from research participants:

'*It is good to feel like I am giving something back, having had such brilliant treatment by the NHS'*

'The staff were lovely and caring and no stone was left unturned'

'Friendly staff, felt included and that my participation was worthy. The lady I have spoken to was lovely! She explained everything so well, was considerate of what I was going through and seemed so caring and happy'

'Clear communication of the process throughout with kindly words and genuinely appreciative emails'

'Info pack was fully detailed and staff were great'

'Researcher was very polite and courteous'

Clinical Research Network (CRN)

The Trust is a member of the Kent, Surrey, and Sussex Clinical Research Network (CRN). We work with the CRN to maximize opportunities for Portfolio studies, identify new studies the Trust may participate in, and implement new national systems and structures. The CRN distributes R&I resources amongst its members according to an activity-based algorithm. The CEO sits on the CRN Partnership Board, and the Head of Research and the Director of Research & Innovation regularly attend CRN finance and performance meetings, working closely with the CRN Link Manager and her team. During the year, the CRN began transitioning to a new RRDN structure. Meeting CRN targets is a priority area for the Trust.

Our people

Clinical Research Staff

We are proud that one of our clinicians acted as Chief Investigator on a National Portfolio research study in 2023-24 (Baljit Dheansa).

In 2023-24, the Trust supported one Lead Research Nurse (0.6WTE), three Research Nurses (2.61WTE), one Research Practitioner (1WTE) and one Research Assistant (0.1WTE).

Some clinical departments have their own arrangements for Research Fellows. These are funded by the departments themselves and are not managed by the R&I Department. In addition, we have identified nurses within different clinical areas who have been trained up to support research in their own department.

Research Management and Governance

The R&I Department presently consists of one Director of Research & Innovation (0.04WTE), one Head of Research (0.6WTE) one Research Governance Officer (0.3WTE), and one Research Assistant (0.1WTE).

Funding was received from the Clinical Research Network (CRN) to support research management and governance. Other income to support the R&I infrastructure comes from commercial studies, which in addition to paying general Trust overheads, contribute a fee for R&I Department services in assessing applications, setting up contracts, and implementing and monitoring studies.

Intellectual property and Innovation

The Trust has engaged the services of NHS Innovations South East to assist with commercializing and developing its intellectual property.

Training and Development

One physiotherapist is currently undertaking the national Associate PI training scheme.

It is a legal requirement that all staff involved in clinical trials complete Good Clinical Practice (GCP) training, and the Trust has facilitated this for staff – either by enabling access to off-site courses at other Trusts, or by paying for staff to do an individual online course. Commercial companies also regularly run refresher GCP courses for staff involved in the clinical trials they run at the Trust.

This year our research staff also attended training on the principles of plastic surgery, ophthalmology, mental health awareness, dyslexia education, coaching, and leadership.

CRN training
The Trust also has access to training provided by the CRN for any studies which are accepted onto the National Portfolio. A wide range of courses are offered, including GCP training.

Research Support Service
The NIHR Research Support Service (RSS) replaced the former Research Design Service South East in 2023-24. The new service continues to offer academic support to staff making grant applications. In the past, they have provided us with invaluable advice on study design, methodology, and statistics.

Governance

R&I at the Trust is overseen by a Research & Innovation Governance Group. Its members include: Director of Research & Innovation, Head of Research, Pharmacy Representative, Anaesthetics Lead, Burns Lead, Corneoplastics Lead, Hand Surgery Lead, Maxillofacial Lead, Chief Nurse, Oncoplastics Lead, Healthcare Science Lead, Orthodontics Lead, Lead Research Nurse, Finance Department Representative, and the Designated Individual with Responsibility for Human Tissue Authority License. The Group also has two very active patient representatives who play a valuable role in advising on new projects.

The R&I Governance Group reports to the Quality and Safety Committee.

The Chief Nurse acts as the Trust's Nominated Consultee for research participants unable to consent.

***Trust policies which cover R&D*:** Adverse Event Reporting Policy, Research Fraud Policy, Code of Practice for Researchers, Pharmacy policy for Clinical Trials, Intellectual Property Policy.

Sponsorship status

Some research carried out at QVH is investigator-led ie designed and conducted by our own staff, and these require the Trust to provide structures to support pre-protocol work and peer-review, as well as the subsequent indemnity and management of active studies. We currently have one Chief Investigator at the Trust who has initiated a QVH-Sponsored National Portfolio study (Baljit Dheansa), as well as one Chief Investigator for a non-Portfolio study.

No research study may begin in the NHS without a Sponsor being identified. The Trust continues to offer its researchers the benefits of providing Sponsor status for single-site non-CTIMP studies, although nationally there is no funding currently to undertake this work.

Monitoring research

All research that is externally sponsored is closely monitored to ICH-GCP standards by the Sponsor, who usually employs a dedicated Clinical Research Organisation or Clinical Trials Unit to undertake this work. Monitoring is performed via onsite visits, remote visits, and regular reporting. QVH adheres to the specific SOPs provided for each individual research study, and to the terms of the contract. In 2023-24, zero issues were raised by sponsor monitors.

The Trust also monitors the few research projects that it Sponsors internally, according to the guidelines laid down in the UK Policy Framework for Health and Social Care Research. Again, no governance issues were identified in 2023-24. We use the Edge online interactive system to manage and monitor research here at QVH.

6.	Learning from Experience
	Supporting small, QVH-initiated, non-Portfolio studies takes up a disproportionate amount of time for work which is not funded nationally.

7.	Recommendations
	We need to continue to focus on supporting and developing high quality Portfolio studies.

8.	Future plans and targets
	Specific targets for 2024-25: • Continue to increase the number of Portfolio studies that we undertake • Develop feasibility review process to improve reliability and accuracy Progress towards these targets will be monitored by the CRN and by the R&I Governance Group.

9.	Conclusions and assurance
	Research has had another good year, with QVH punching well above its weight for a small Trust. R&I maintained robust finances and achieved a near cost-neutral position at year end.

10.	Appendices
	None

11.	Report approval and governance
	This annual report has been reviewed by our R&I Governance Group, as well as by the Quality and Safety Committee.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04/07/2024	**Agenda reference:**	**39-24.5**		
Report title:	Appraisal & Revalidation Annual Report 2023/24				
Sponsor:	Tania Cubison, Chief Medical Officer				
Author:	Tania Cubison, Chief Medical Officer				
Appendices:	Appendix one: Professional standards: framework for quality assurance and improvement (FAQI) – Annual Report 2023-2024				
Executive summary					
Purpose of report:	To provide assurance regarding compliance of the Responsible Officer's (RO) statutory functions, report on performance in relation to those functions; to update on the progress since 2022/23 annual report; to highlight current and future issues and to present action plans to mitigate potential risks. This report forms part of the Chief Medical Officer's duties as Responsible Officer (RO).				
Summary of key issues	**Achievements** •Successful procurement and implement of electronic appraisal system L2P •Clinical engagement with appraisals has improved •Increased appraisers engagement with improved competencies **Challenges** •Appraiser number constraints •Monitoring of inequality and behaviours				
Recommendation:	The Board notes and signs Statement of Compliance, Annex A, Section 4 Statement of Compliance confirming is compliant with the regulations as recommended by the Quality and safety committee at its meeting in June.				
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:	KS02				
Corporate risk register:	None				
Regulation:	The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'				
Legal:	As above				
Resources:	This annual report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and safety committee				
	Date:	25/06/2024	Decision:	Recommend to Board	
Next steps:					

Report to:	Board of Directors
Agenda item:	39-24.5
Date of meeting:	4 July 2024
Report from:	Tania Cubison, Chief Medical Officer
Report author:	Tania Cubison, Chief Medical Officer
Date of report:	30 May 2025
Appendices:	Appendix one: Professional standards: framework for quality assurance and improvement (FAQI) – Annual Report 2023-2024

Appraisal & Revalidation Annual Report 2023/24

Introduction

To provide assurance regarding compliance of the Responsible Officer's (RO) statutory functions, report on performance in relation to those functions; to update on the progress since 2022/23 annual report; to highlight current and future issues and to present action plans to mitigate potential risks. This report forms part of the Chief Medical Officer's duties as Responsible Officer (RO).

Summary

Strong year for appraisal and revalidation with completion of all actions. The input and support from Lay Representative has been invaluable. The Trust continues to develop its strategy for the future and the organisational culture is a vital part of this. Delivering clinical excellence in a safe environment requires a continued focus on performance and personal development, appraisal and revalidation as well as the behaviour framework are key to this.

Achievements

- Successful procurement and implement of electronic appraisal system L2P
- Improved Clinical engagement with appraisals
- Increased appraisers engagement and increased competencies compliance

Challenges

- Appraiser number constraints
- Monitoring of inequality and behaviours

Recommendation

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Appraisal & Revalidation Annual Report 2023/24

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- Improved Clinical engagement with appraisals
- Increased appraisers engagement and increased competencies compliance

Challenges

- Appraiser number constraints
- Monitoring of inequality and behaviours

Recommendation

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Annex A

Professional standards: framework for quality assurance and improvement (FAQI) – Annual Report 2023-2024

Previously titled
A Framework of Quality Assurance (FAQ) for Responsible Officers and Revalidation – Annual Board Report and Annual Statement of Compliance

Covering reporting period
1 April 2023 – 31 March 2024

This framework will help responsible officers and organisations to provide assurance that their professional standards processes meet the relevant statutory requirements and support quality improvement.

This report sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metric
Section 3 – Summary and conclusion
Section 4 – Statement of compliance

Section 1: Qualitative/narrative

1A – General

The board of Queen Victoria Hospital NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Continuation of Responsible Officer (RO), Tania Cubison GMC No. 3539163, GMC registered professional with licence to practice.
Comments:	The Chief Medical Officer (CMO) fulfills RO duties within fixed term post. The RO leads on strengthened medical appraisal and ensures systems and processes are in place to fulfil the requirements of the GMC according to the legislation. The current RO's tenure expires January 2025. During this year, the Trust approved the appointment of a permanent CMO to ensure longevity as part of this organisational rewiring.
Action for next year:	RO responsibilities are included within scope of CMO role, recruitment and selection process planned for Q1 2024.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	Implementation and roll out of e appraisal system during 2023/2024.
Comments:	During the year, Q3, L2P an e appraisal system was implemented, increasing visibility of the appraisals process and supporting the RO and doctors in delivering compliant, efficient, and effective appraisals for the revalidation. The system provided an integrated 360-degree multisource feedback module, which reduced manual workload requirements. Various Workforce teams provide additional systems and procedural expertise; employee relations and employment law advice, resources for case management and case investigations and training and induction when required.
Action for next year:	Optimise L2P's reporting functionality maximising efficiency. Continue collaborating with L2P tailoring a system fit for QVH needs.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Continue using GMC portal as an accurate record of all licensed medical practitioners with a connection to QVH.
Comments:	The GMC Connect portal is used to securely record doctor details both into and out of QVH. Frequent monitoring of starter and leavers reports ensure accuracy is maintained
Action for next year:	Continue using GMC portal; maintain current process for updating of starter and leavers to ensure accuracy.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Complete policy revision for ratification by Local Negotiation Committee (LNC).
Comments:	The LNC ratified the Medical Appraisal, Revalidation and Remediation Policy, approved and published on 4 January 2024. Changes included L2P electronic system and Medical Appraisal Guide 2022 (AoMRC).
Action for next year:	Timetabled for next renewal date January 2027.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	None – awaiting further guidance from South East Higher Level Responsible Officer Team, NHS England – South East following postponement in 2020.
Comments:	NHS England advises a peer review in every 5-year revalidation cycle by commissioned audits, regulators, peers or Higher Level RO team. Awaiting further guidance from South East Higher Level Responsible Team, NHS England – South East having cancelled last review due to the pandemic.
Action for next year:	Scoping options to conduct peer review by April 2025.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Improve current process; agree next appraisal date within 6 weeks of start date at QVH.
Comments:	The medical workforce administrator agrees with doctors appraisal dates 1 month from start date. Doctors with an established appraisal month will have an appraisal due date 12 months from their last appraisal. Individuals with no previous appraisal have an appraisal due date set within 6 months of start date. The medical education team support with induction, mandatory training and provides CPD opportunities for all doctors at QVH.
Action for next year	Revise process ensuring appraisal date is booked 2 months prior to appraisal due date. RO to monitor appraisal completion data for short-term staff at quarterly meetings.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Procurement and roll out of e appraisal system by end of Q4 2024.
Comments:	From 1/12/24, all doctors use L2P for medical appraisals. The e system ensures full scope of work, information about complaints; significant events and outlying clinical outcomes are included. An annual appraisal input and output audit was completed in Q1 24/25; outcome demonstrated high compliance scoring an

	average 18.9 out of 20 overall for quality of documentation and highlighted areas of improvement.
Action for next year:	Revise L2P guidance mandating documents for uploading to L2P i.e. complaints, significant events, datix reports, MPITs.

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	Continue monitor and scrutiny of appraisals.
Comments:	L2P has improved visibility of missed appraisals enabling improved monitoring of the reasons and appropriate actions. There was a deduction in the number of appraisals missed by more than 6 months. The majority of missed appraisals (41%) were due to lack of medical appraisers. 3 new appraiser were recruited during the year. The traditional process of assigning appraisers firstly to consultants then junior doctors is no longer effective. It increases the risk of short-term placement doctors not having a timely appraisal. The risk increases when doctors come from non-NHS backgrounds without an established appraisal month. Although there are still a small number of doctors whose appraisals are overdue, the majority of these are new starters. During the year, overdue appraisals by more than 6 months were completed.
Action for next year:	Complete missed appraisals by end of Q1 24/25. As part of new organisational rewiring Business Units will be responsible for appraisal performance and provide additional support to doctors arriving without a previous appraisal.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Revision will incorporate changes to the allocation process and forms used.
Comments:	The Joint Local Negotiating Committee approved the Medical Appraisal, Revalidation and Remediation Policy, ratified by the Finance & Performance Committee and published in January 2024. Changes incorporated use of electronic sytem and reference to Medical Appraisal Guide (AoMRC) 2022. The electronic system has streamlined the allocation of appraiser process.
Action for next year:	Continue with current process. Policy renewal date January 2027

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Recruit two appraisers due to upcoming retirement x 1 and relinquishment of role x 1.
Comments:	The Trust successfully recruited three new appraisers late in the year. Two appraisers may relinquish role in coming year due to new management responsibilities. Two further appraisers will be required to ensure no more than 7 appraisals are completed within 12 months as per

	current policy.
Action for next year:	Recruit additional 2 appraisers, expressions of interest from SAS, selected senior managers, and consultants with more than 1 year in role. Seek to attract individuals with recent experience of the training pathway and reflective practice.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	Formalise/structure the Appraiser Update sessions with aims and objectives, guest speakers i.e. GMC Liaison Officer, Representative from Academy of Medical Royal Colleges.
Comments:	During the year, appraiser representatives contributed to the stakeholders' process selecting L2P as the preferred e appraisal system. 90% of appraisers attended in house update session, including presentations from L2P and Miad Healthcare. Miad provided a bespoke training session on improving medical appraisal inputs/outputs and quality assurances supporting revalidation evidence.
Action for next year:	Additional presentations planned for 2024/25 including GMC on Good Medical Practice 2024 update. RO to review additional leadership support of a named clinical appraisal lead. Evaluate post appraisal data and identify development, training needs.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	22/23 action carried over, the procurement of a digitalised solution will facilitate quality assurance process
Comments:	Using the PROGRESS audit tool 10% sample reviewed. High scores achieved 18.9 out of 20 average score. Benchmarked against external sample of 45 of which scored 15.4 out of 20.
Action for next year:	Planned correlation of post appraisal data with PROGRESS audit outcomes. Share outcomes with individual appraisers. Complete annual PROGRESS audit sampling appraisals from each appraiser.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Continue with monthly meetings during 2023/2024 to ensure timely recommendations.
Comments:	Meetings held throughout the year, revalidation portfolios reviewed by RO and Lay Representative with the majority of recommendations made on time. L2P has increased visibility of upcoming revalidations with reminders sent to doctors in line with expected timescales. Any delays recorded on L2P. L2P has replaced a manual process with an efficient system whilst maintaining quality.
Action for next year:	Ensure revalidation portfolios are completed at least 1 month before revalidation due date.

1C(ii)GMC recommendations are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	Maintain current process.
Comments:	All doctors received confirmation of the revalidation recommendation on the day. Confirmation of either a positive recommendation or deferral due to insufficient evidence sent from the medical workforce. In exceptional circumstances, when a deferral is mandated the RO will discuss with individual.
Action for next year:	Continue with confirmation on same day and RO to discuss with individual if deferral is mandated.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	We will continue to work with teams to share information on compliments, complaints, involvement in incidents and similar items for the medical appraisal process.
Comments:	There is good sharing of information including cascade from patient experience manager and Risk team supporting doctors' appraisal discussions and professional development.
Action for next year:	Ensure the effective sharing of clinical governance to business units continues during organisational rewiring.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Maintain current process.
Comments:	Effective systems are in place, clinical leads and clinical directors are responsible for initiating the Maintaining High Professional Standards (MHPS) managing conduct and performance within the organisation. The CMO will be case investigator for all formal MHPS process. Clinical Directors lead on MHPS for non-consultant grade doctors.
Action for next year:	Continue with current process and as part of the organisation's rewiring, strengthen and support clinical leads and clinical directors MHPS knowledge and skills. Review training needs and data capture process.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	None specified, new statement
Comments:	Information from various sources is readily accessible, provided in convenient formats and easily uploaded to L2P. This information is available on request from patient experience manager, risk and learning and development teams. To improve the consistency, the RO is considering providing doctors with an annual appraisal data pack containing governance, statutory and mandatory compliance data.
Action for next year:	Collaborate with patient experience manager, risk and medical education teams to scope providing an annual data pack to doctors.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Continue to follow our agreed policies and procedures.
Comments:	The Trust's process for responding to concerns is set out in its policies and based on the national 'Maintaining High Professional Standards (MHPS)' and GMC guidance.
Action for next year:	Continue to follow agreed policies

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Continue with current procedures.
Comments:	The Chief People Officer supports the CMO in responding to concerns. Issues are discussed with the GMC Employment Liaison Officer and if required PPA (NCAS) - NHS Resolution. Regular meetings with GMC Employment Liaison Officer take place at least 3 times per year. A non-executive board member oversees any investigation. Numbers and type of complaints reported to the Board.
Action for next year:	Continue with current procedures and ensure analysis of protected characteristics and country of primary medical qualification are included.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Continue with current process and monitor compliance.
Comments:	The Trust's process for transferring information and concern meet with NHS England's Information flows to support medical governance and responsible officer statutory function guidance, commonly known as MPIT or RO references. Requests are actioned within 10 days.
Action for next year:	Continue with current procedures

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	Continue to follow agreed policies and procedures
Comments:	Raising Concerns (Whistle Blowing) Policy, Freedom to speak up service and the Disciplinary policy for medical and dental staff continues to adhere to national MHPS and GMC / NHSE guidance on managing concerns. The CMO manages concerns supported by Chief People Office, and theEmployee Relation team ensures free from bias and discrimination.
Action for next year:	Continue to follow agreed policies and procedures

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Action from last year:	None specified; new statement
Comments:	Systems are in place to capture development requirements and opportunities in relations to governance from the wider system. Medical Education and Learning & Development teams support the RO to integrate these into policies and procedures. During the year, in response to national sexual harassment reports the Trust planned the roll out of an Active Bystander training program for 2024. The Oliver McGowan (OMMT) training on Learning Disability and Autism was incorporated in the statutory and mandatory training program for all staff. As at 31 March 2024, compliance rate for doctors was 67%. In addition, the GMC's Employers Liaison Team provided GMC Good Medical 2024 update.
Action for next year:	Improve OMMT compliance rate. Roll out Active Bystander training sessions in 2024.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	None specified; new statement
Comments:	The Trust offered leadership training to all professional groups. As part of the organisational rewiring, the Trust is committed to providing clinical leaders with the right leadership culture and behaviours ensuring fairer and more inclusive leaders.
Action for next year:	Consider a process to ensure middle level leadership receive appropriate management training. Cross-referenced training needs to job plans. Review clinical directors appraisals ensuring PDPs consistently reflect the needs of the role.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Continue to current processes and monitor compliance
Comments:	All doctors employed by QVH including the medical and dental Bank are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, via Trac recruitment system ensuring visibility and consistency. During the year, identity document validation technology (IDVT) was implemented; digital checks to documents providing an extra layer of clarity on individual documentation. At interviews, in addition to the standard clinically based questions; questions based on the Trust's values are included. Providing assurance successful applicants are able to converse and understand medical terminology at an appropriate level in English. Employment references follow a set format and include past employer and most recent Responsible Officer declaration. The Trust adheres to the National Health Service (Appointment of Consultants) Regulations: Good Practice Guidance 2005 when appointing consultants ensuring assurance.
Action for next year:	Continue current processes and monitor compliance.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	None; new statement in report template.
Comments:	The organisation's vision and values support a culture whereby clinical care flourishes and is continually enhanced. The Trust's Freedom to Speak up Guardian Service enables staff to discuss matters relating to patient care and safety, whistleblowing, bullying and harassment, and work grievances. Processes ensure immediate escalation of any issues relating to patient or employee safety to a member of the Trust's board. In Q1 2024, the Trust launched an external guardian service offering information and emotional support in a strictly confidential, non-judgmental manner. The Trust has now procured a formal Quality and Improvement system incorporating a new behavioural framework.
Acton for next year:	Embed Freedom to Speak Up Service and QI methodology to drive improvement.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	None; new statement in report template.
Comments:	The Learning & Development and Medical Education teams support the Trust in delivering training to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels. Introducing the Oliver McGowan mandatory training to support people with a learning disability or autism to access effective support and safe, compassionate and informed care. Active Bystanders training will be rolled out during 2024 to empower staff to challenge poor behaviours, bringing about change through the reinforcement of messages defining the boundaries of unacceptable behaviour. As at 31 March 2023, 67% of doctors have completed Oliver McGowan training. The Trust has completed a visions and values refresh and will be finalising the behaviours framework in the Autumn 24
Action for next year:	Implementation of Trust's behavioral framework.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	None specified; new statement
Comments:	Patient Safety Incident Response Framework (PSIRF) Lead, Tell Nicky and external Freedom to Speak Up Guardian processes support the Trust to ensure an openness and a continuously learning culture exist.
Action for next year:	Embed behavioural framework, identify training needs to support doctors make positive change.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	None; 2023-2024 report new statement
Comments:	The Dignity and Respect at Work Policy and Procedure, Maintaining High Professional Standards in the Modern NHS (MHPS) and Handling Complaints & Concerns Policy procedures exits and enable feedback about the Trust's professional standards processes. During the year, an active claim demonstrated this process is active.
Action for next year:	Continue with policies and processes. Review case outcomes.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	None specified; 2023-2024 report new statement.
Comments:	The Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) report assesses the overall parity by protected characteristics for staff however not reported by staff group. For disciplinary processes, we ensure the equality when dealing with concerns and our policies are clear about this.
Action for next year:	The Trust's does not record primary medical qualification and will investigate how this can be captured going forward for assessing level of parity.

1G – Calibration and networking
1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher- level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	None specified; 2023-2024 report new statement.
Comments:	To ensure the Trust's professional standards processes are consistent with other organisations the RO attends regular South East region Responsible Officer & Appraisal Lead Network meetings, engages with military RO colleagues sharing experience and best practices. Attendance at the Royal College of Physicians invited event (Kirkup).
Action for next year:	Continue with process and networking opportunities

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 to 31 March 2024.
All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2024	122

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	110
Total number of appraisals approved missed	11
Total number of unapproved missed	1

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	31
Total number of late recommendations	5
Total number of positive recommendations	22
Total number of deferrals made	8
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	1

2D* – Governance –

Total number of trained case investigators	
Total number of trained case managers	
Total number of new concerns registered	
Total number of concerns processes completed	
Longest duration of concerns process of those open on 31 March	
Median duration of concerns processes closed	
Total number of doctors excluded/suspended	
Total number of doctors referred to GMC	

**Unknown at this time, review of training needs and data capture process required.*

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	16
Number of new employment checks completed before commencement of employment	13

2F – Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	1
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Strong year for appraisal and revalidation with completion of all actions. The input and support from Lay Representative has been invaluable. **Achievements** • Successful procurement and implement of electronic appraisal system L2P • Clinical engagement with appraisals has improved • Increased appraisers engagement with improved competencies **Challenges** • Appraiser number constraints
Actions still outstanding:
None
Current issues
• Ongoing recruitment of medical appraisers • Monitoring of inequality and behaviours

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
1A(i) Recruitment permanent CMO post Q1 2024. 1A(ii) Optimise L2P reporting functionality maximising efficiency. Continue collaborating with L2P to tailor system fit for QVH needs. 1A(iii) Continue using GMC portal; maintain current process for updating of new starter and leavers to ensure accuracy. 1A(iv) Policy renewal due January 2027. 1A(v) Scoping options to conduct peer review by April 2025. 1A(vi) Revise process ensuring appraisal date is booked 2 months prior to appraisal due date. RO to monitor appraisal completion data for short-term staff at quarterly meetings. 1B(i) Revise L2P guidance mandating documents for uploading to L2P i.e. complaints, significant events, datix reports, MPITs. 1B(ii) Complete missed appraisals by end of Q1 24/25. As part of new organisational rewiring Business Units will be responsible for appraisal performance and provide additional support to doctors arriving without a previous appraisal. 1B(iii) Continue with current process. Policy renewal date January 2027. 1B(iv) Recruit additional 2 appraisers, expressions of interest from SAS, selected senior managers, and consultants with more than 1 year in role. Seek to attract individuals with recent experience of the training pathway and reflective practice. 1B(v) Additional presentations planned for 2024/25 including GMC on Good Medical Practice 2024 update. RO to review additional leadership support from a named clinical appraisal lead. Evaluate post appraisal data and identify development, training needs. 1B(vi) Planned correlation of post appraisal data with PROGRESS audit outcomes. Share outcomes with individual appraisers. Complete annual PROGRESS audit with sample appraisals from each appraiser. 1C(i) Ensure revalidation portfolios are ready for review by RO at least 1 month before revalidation due date. 1C(ii) Continue with confirmation on same day. RO to discuss with individuals if deferral is mandated procedures. 1D(i) Ensure the effective sharing of clinical governance to business units continues during organisational rewiring. 1D(ii) Continue with current process and as part of the organisation's rewiring, strengthen and support clinical leads and clinical directors MHPS knowledge and skills. 1D(iii) Collaborate with patient experience manager, risk and medical education teams to scope proactively providing an annual data pack to doctors 1D(iv) Continue to follow agreed policies. 1D(v) Continue with current procedures and ensure analysis of protected characteristics and country of primary medical qualification are included. 1D(vi) Continue with current procedures 1D(vii) Continue to follow agreed policies and procedures 1D(viii) Improve OMMT compliance rate. Roll out Active Bystander training sessions 1D(ix) Consider a process to ensure middle level leadership receive appropriate management training. Cross-referenced training needs to job plans. Review clinical directors appraisals ensuring PDPs consistently reflect the needs of the role. 1E(i) Continue current processes and monitor compliance. 1F(i) Embed QI methodology to drive improvement. 1F(ii) Monitor and improve compliance. 1F(iii) Embed behavioural framework, identify training needs to support doctors make positive change 1F(iv) Continue with policies and processes Review case outcomes 1F(v) The Trust's does not record primary medical qualification and will investigate how this can be captured going forward for reporting purposes. 1G(i) Continue with process and networking

Overall concluding comments:
Delivering clinical excellence in a safe environment requires a continued focus on performance and personal development, appraisal and revalidation as well as the behavior framework are key to this.

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	Queen Victoria Hospital NHS Foundation Trust
Name:	James Lowell
Role:	Chief Executive Officer
Signed:	
Date:	

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	04/07/2024		**Agenda reference:**	**40-24**	
Report title:	Finance & performance committee assurance report				
Sponsor:	Peter O'Donnell, Non-executive director & committee Chair				
Author:	Peter O'Donnell, Non-executive director & committee Chair Riya Jose, Governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	*Due to the restrictions which apply during the pre-election period this report is limited to matters which require operational or financial oversight.* - The new IQPR report was reviewed in detail. It was recognised as a major first step in developing a cohesive, clear and comprehensive set of management information. Feedback was given the report to enhance its clarity and to ensure key issues and analysis was transparent. - Good progress on meeting key operational targets & finance performance is tracking plan. The financial plan for this year has been updated/stretched again as the Sussex ICB continue to be challenged.to improve performance. - There was discussion and concern expressed on the growth in waiting lists in the month and the committee is seeking more assurance on key drivers and that the clinical oversight and prioritisation is robust. - Some progress has been made in increasing the representation of BAME staff and reducing incidents of bullying and harassment although the levels reported remain elevated. - Addressing the Fire safety enforcement notice requirements is proving more challenging than originally anticipated and taking longer. There was a discussion on what learnings the organisation could take from this issue and the committee will continue to probe this. - Significant progress has been made in updating the Board Assurance Framework (BAF) and the summary on progress is clearer. The committee continuing to discuss what level of risk is acceptable on the current estate and the timing of achieving this goal when agreed. - The key strategic projects have had slow starts as appropriate resources and detailed implementation plans are put in place. It is expected that progress will accelerate over the next couple of months. - Updates on information governance incidents confirm compliance with legal guidelines for Freedom of Information (FOI) requests.				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	None.				
Corporate risk register:	None.				

Regulation:	None.			
Legal:	None.			
Resources:	None.			
Assurance route				
Previously considered by:				
	Date:		Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 40-24
Date of meeting: 4 July 2024
Report from: Peter O'Donnell, Non-executive director & committee Chair
Report author: Peter O'Donnell, Non-executive director & committee Chair
Riya Jose, Governance officer
Date of report: 25 June 2024
Appendices: None

Sub-committee assurance report
Finance & performance committee, 24 June 2024

Key agenda items

- **Integrated Quality and Performance Report**
- **Workforce Disability Equality Standard and Workforce Race Equality Standard annual reports 2023/24**
- **Gender Pay Gap report 2023/24**
- **Ethnicity Pay Gap report 2023/24**
- **Equality, diversity & inclusion annual report 2022/23**
- **Estates update**
- **Strategic objectives 2024/25 - major projects update**
- **Review of Board Assurance Framework**
- **IGG and FOI update**
- **IM&T update**
- **Policies for ratification**

Alert

- Addressing the Fire safety enforcement notice requirements is proving more challenging than originally anticipated and taking longer. There was a discussion on what learnings the organisation could take from this issue and the committee will continue to probe this. Issues with past contractors and procurement practices have been identified, highlighting the need for improved value-for-money measures and rigorous auditing.
- There was discussion and concern expressed on the growth in waiting lists in the month and the committee is seeking more assurance on key drivers and that the clinical oversight and prioritisation is robust.
- Good progress on meeting key operational targets & finance performance is tracking plan. The financial plan for this year has been updated/stretched again as the Sussex ICB continue to be challenged to improve performance.
- The key strategic projects have had slow starts as appropriate resources and detailed implementation plans are put in place. It is expected that progress will accelerate over the next couple of months.

Assure

- The new IQPR report was reviewed in detail. It was recognised as a major first step in developing a cohesive, clear and comprehensive set of management information. Feedback was given the report to enhance its clarity and to ensure key issues and analysis was transparent.
- The organisation has not been affected by any recent cyber-attacks, and tests revealed no high-risk vulnerabilities. This assures that current cybersecurity measures are effective and that the organisation is well-protected against potential threats.
- Updates on information governance incidents have been noted, confirming that the organisation is compliant with legal guidelines for Freedom of Information (FOI) requests. This ensures transparency and adherence to legal requirements.
- The technical aspects of the Electronic Patient Record (EPR) programme are satisfactory, with ongoing improvements. This indicates a solid foundation for the programme, providing confidence in its current trajectory. The programme is technically sound, although operational enhancements are ongoing.
- Some progress has been made in increasing the representation of BAME staff and reducing incidents of bullying and harassment although the levels reported remain elevated.
- Significant progress has been made in updating the Board Assurance Framework (BAF) and the summary on progress is clearer. The committee is continuing to discuss what level of risk is acceptable on the current estate and the timing of achieving this goal when agreed.

Advise

- Focus should be placed on making recruitment processes more inclusive and specific actions should be targeted towards understanding and mitigating barriers to fair recruitment.
- Addressing the underlying causes of bullying and harassment is crucial for ensuring a sustainable and inclusive workplace environment. Continued efforts in this area are essential.
- Each amber and red risk in the BAF should include summary comments explaining the current status and actions being taken. This will enhance understanding and transparency of the risk management process.
- Setting realistic targets for physical infrastructure improvements is essential. The committee should ensure timely progress and manage expectations effectively to avoid long-term delays.

Risks discussed and new risks identified

- There is a potential risk of delays in achieving satisfactory physical infrastructure improvements. This requires management attention and realistic target setting to ensure timely progress and resource allocation.
- The EPR and CDC programmes are currently rated Amber due to the need for further team alignment, detailed plans and operational improvements. This highlights the importance of focused effort and adequate resource allocation to address these areas.
- Disparities in the appointment of BAME staff and levels of bullying and harassment present significant risks. These issues require targeted actions.

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