Bundle Public Board 12 September 2024

Agenda attachments

- A - Front cover PUBLIC
- B - Membership
- C - Register
- D - Agenda public-12 September 2024 FINAL

43.24 Welcome, apologies and declarations of interest
Jackie Smith, Trust Chair

44.24 Draft minutes of the public meeting held on 4 July 2024
Jackie Smith, Trust Chair
Approval

- 44-24 Minutes- PUBLIC Board meeting- 4 July 2024 DRAFT V1

45.24 Matters arising and actions pending from previous meeting
Jackie Smith, Trust Chair
Review

- 45-24 PUBLIC Matters arising

46.24 Patient story
Jane Dickson, interim Chief Nursing Officer
Discussion

47.24 Chair's report
Jackie Smith, Trust Chair
Assurance

- 47-24 Chair's report

48.24 Chief Executive's report
James Lowell, Chief Executive Officer
Assurance / approval

- 48-24 CEO report
- 48-24.1 SDP Public Y2 v7

49.24 Learning from deaths annual report 2023/24
Tania Cubison, Chief Medical Officer
Assurance

- 49-24 (FC) Learning from Deaths
- 49-24.1 Learning from deaths Apr 2023 to Mar 2024

50.24 Workforce annual reports
Equality, diversity and inclusion annual report 2022/23
WRES and WDES annual reports 2023/24
Gender pay gap report as at 31 March 2024
Ethnicity pay gap report as at 31 March 2024
Helen Edmunds, Chief People Officer
Approval

- 50-24.1 EDI Summary Annual Report 2022 -2023
- 50-24.2 WRES and WDES Annual Report 2023 - 2024
- 50-24.2a Appendix 1 - WRES 2023-2024 Report
- 50-24.2b Appendix 2 - WDES 2023-2024 Report
- 50-24.2c Appendix 3 - NHS Staff Survey Additional Information Q13 and 14 Issues
- 50-24.3 Gender Pay Gap Report as at 31 March 2024 V3
- 50-24.4 Ethnicity Pay Gap Report as at 31 March 2024

51.24 Risk management framework and risk appetite
Leonora May, Company Secretary
James Lowell, Chief Executive Officer
Approval

- 51-24 Risk Management Framework and risk appetite Board report
- 51-24.1 QVH Risk Management Framework DRAFT

52.24 Board assurance framework
Leonora May, Company Secretary
All executive directors
Assurance

- 52-24 BAF report
- 52-24.1 BAF1 V8

52-24.2 BAF2 V5
52-24.3 BAF3 V5
52-24.4 BAF4 V5
52-24.5 BAF5 V5
52-24.6 BAF6 V5
52-24.7 BAF7 V5
52-24.8 BAF8 V5

53.24 Assessment of Estate risks and issues
Maria Wheeler, Chief Finance Officer
Assurance
53-24 Estates and facilities update V2

54.24 Trust Constitution updates
Leonora May, Company Secretary
Approval
54-24 Trust Constitution updates
54-24.1 V11 Trust Constitution DRAFT V5

55.24 Vision and values and Key strategic objectives
Abigail Jago, Chief Strategy Officer
Approval
55-24 Vision values and key strategic objectives Sep 2024

56.24 Integrated quality and performance report
Kirsten Timmins, Chief Operating Officer
Assurance
56-24 M4 IQPR Board 09 2024
56-24.1 M3 IQPRv3

57.24 Audit and risk committee assurance
Paul Dillon-Robinson, Non-executive Director and committee Chair
Assurance
57-24 ARC assurance report to Board Sept 2024 FINAL

58.24 Quality and safety committee assurance
Shaun O'Leary, Non-executive director and committee Chair
Assurance
58-24 QSC assurance report to Board Sept 2024 FINAL
58-24.1 Bi Annual Safe Staffing and Nursing Workforce Reviewv5 HE

59.24 Financial, workforce and operational performance assurance
Peter O'Donnell, Non-Executive Director and committee Chair
Assurance
59-24 FPC assurance report to Board Sept 2024 FINAL

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

61.24 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 12 September 2024

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

MEMBERSHIP
BOARD OF DIRECTORS
September 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
Interim Chief Nursing Officer	-	Jane Dickson
Chief Finance Officer	-	Maria Wheeler
Chief Operating Officer	-	Kirsten Timmins

In full attendance (non-voting):

Chief Strategy Officer	-	Abigail Jago
Chief People Officer	-	Helen Edmunds
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
Jane Dickson Interim Chief Nursing Officer	Non-Executive Director for Ashford and St	Nil	Nil	Nil	Nil	Nil	Nil	Nil

	Peters Hospitals NHS FT							
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
Jane Dickson Interim 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 12 September 2024
10.00-12.00

Agenda: session held in public		
WELCOME		
43-24	**Welcome, apologies and declarations of interest** *Jackie Smith, Trust Chair*	
STANDING ITEMS		**Purpose**
44-24	**Draft minutes of the public meeting held on 4 July 2024** *Jackie Smith, Trust Chair*	*Approval*
45-24	**Matters arising and actions pending from previous meetings** *Jackie Smith, Trust Chair*	*Review*
46-24	**Patient story** *Liz Blackburn, deputy Chief Nursing Officer*	*Discussion*
47-24	**Chair's report** *Jackie Smith, Trust Chair*	*Assurance*
48-24	**Chief Executive's report** *James Lowell, Chief Executive Officer*	*Assurance/ approval*
ANNUAL REPORTS		
49-24	**Learning from deaths annual report 2023/24** *Tania Cubison, Chief Medical Officer*	*Assurance*
50-24	**Workforce annual reports** • **Equality, diversity and inclusion annual report 2022/23** • **WRES and WDES annual reports 2023/24** • **Gender pay gap report as at 31 March 2024** • **Ethnicity pay gap report as at 31 March 2024** *Helen Edmunds, Chief People Officer*	*Approval*
GOVERNANCE, STRATEGY AND RISK		
51-24	**Risk management framework and risk appetite** *Leonora May, Company Secretary* *James Lowell, Chief Executive Officer*	*Approval*
52-24	**Board assurance framework** *Leonora May, Company Secretary* *All executive directors*	*Assurance*

53-24	**Assessment of Estate risks and issues** *Maria Wheeler, Chief Finance Officer*	*Assurance*
54-24	**Trust Constitution updates** *Leonora May, Company Secretary*	*Approval*
55-24	**Vision and values and key strategic objectives** *Abigail Jago, Chief Strategy Officer*	*Approval*
PERFORMANCE		
56-24	**Integrated quality and performance report** *Kirsten Timmins, Chief Operating Officer*	*Assurance*
COMMITTEE ASSURANCE REPORTS		
57-24	**Audit and risk committee assurance** *Paul Dillon-Robinson, Non-Executive Director and committee Chair*	*Assurance*
58-24	**Quality and safety committee assurance** *Shaun O'Leary, Non-executive director and committee Chair*	*Assurance*
59-24	**Financial, workforce and operational performance assurance** *Peter O'Donnell, Non-Executive Director and committee Chair*	*Assurance*
MEETING CLOSURE		
60-24	**Any other business (by application to the Chair)** *Jackie Smith, Trust Chair*	*Discussion*
MEMBERS OF PUBLIC		
61-24	**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 (DRAFT)	
Meeting:	**Board of Directors (session in public)** **10.00-12 noon 4 July 2024** **Microsoft Teams meeting (pre-election period)**	
Present:	Jackie Smith	Trust Chair (voting) (Chair)
	Paul Dillon-Robinson (PDR)	Non-executive 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)
	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)
	Jane Dickson (JD)	Interim Chief Nursing Officer
	Jackie Doherty (JDo)	Freedom to Speak up Guardian, The Guardian Service
Apologies:	Tania Cubison (TC)	Chief medical officer (voting)
Members of the public:	Three governors, four members of public and four members of staff	

29-24 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board including JD who will take up the role of interim Chief nursing officer from mid-July, and those observing the meeting including three governors, four members of public 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. She also reminded all in attendance that the meeting was being held during the pre-election period which means that discussion is limited to matters which require operational or financial sight. There would be no discussion about strategy or policy.

The Chair invited declarations of interest from Board members. KN declared that she has been appointed as a Non-executive director for the South East Coast Ambulance Service from 8 July 2024. JL declared that he has been appointed as the Senior Responsible Officer for the South East Imaging Network. There were no further declarations of interest other than those recorded on the register of interests.

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

30-24 **Draft minutes of the public meeting held on 2 May 2024**

The Board **agreed** that the minutes of the public Board meeting held on 2 May 2024 are a true and accurate record of that meeting and **approved** them on that basis.

31-24 **Matters arising and actions pending from previous meetings**

The Board **noted** that there are two pending actions which are not yet due, and that the gender pay gap update has been delayed due to the pre-election period. The Board **noted** the updates within the report.

32-24 **Chair's report**

JS presented the Chair's report to the Board, highlighting the following:

- Strategic development committee assurance will be included in the next Chair's report to the Board due to the pre-election period

	- Chris Barham has been appointed as the Lead Governor for a further term and Janet Hall has been appointed as the Deputy Lead Governor for a further term. JS extended thanks to both for standing for a further term and for their support - JS continues to visit services with the Lead and Deputy Lead governors. She encouraged all governors to take up the opportunity to join the Non-executive directors on their service visits - Since the last Board meeting, the Board completed the final part of its self-assessment of its own effectiveness through a survey which included questions about the quality of papers, Chairing and Board support, the Board's approach to partnerships, Board development and the annual cycle of business. JS confirmed that feedback indicated that there is still work to do regarding the quality and the length of Board papers which will be an increased area of focus for the Board to ensure that reports are accessible to the public - During May, a development day had been held for all governors supported by NHS Providers. JS described the event as extremely beneficial and confirmed that a second event will be held later in the year for new governors Discussion was had regarding Board member visits to services and Non-executive Board collectively encouraged governors to join them on service visits. In response to a question regarding feedback from visits, LM confirmed that this feedback is collated and reported to the executive team regularly to ensure that issues are picked up. Going forward, themes will be included within the Chief Executive and Chair reports to Board. The Board **noted** the contents of the report.
33-24	**Chief Executive's report** JL presented the report to the Board, highlighting that: - The Trust reported 90% against the cancer diagnostic standard for March 2024 which was the highest ever record for the Trust. He confirmed that the Trust remains focussed on making significant changes to the way that access of care is delivered - The Trust had ended the 2023/24 year in a strong financial position and will continue to make the best use of resources whilst maintaining the delivery of high quality care to patients - Nicky Reeves, the Trust's Chief nursing officer will shortly retire after 40 years' service to the NHS. JL thanked NR for her service and welcomed JD who would take up the role of interim Chief nursing officer from 15 July 2024 - Sir Julian Hartley, the Chief executive of NHS Providers, visited the Trust in May and had written a very positive blog post about what he had observed during the visit - JL extended thanks to all who had helped to support the Trust through recent periods of industrial action in a calm and supportive manner The Board considered and discussed the updates as follows: - A Board member asked about communication and expectation management for long waiting patients. JL confirmed that patients are being communicated with via the usual routes but that work continues to ensure that these channels are modernised to ensure ease of access for patients, including the Patient Knows Best portal - The Board noted the significant financial and operational challenges faced by the system and QVH's supporting role. JL confirmed that QVH is striving to be part of the system's solution to challenges and to play an integral role in addressing health inequalities - In response to a question from a Board member regarding the recent visit from Sir Julian Hartley, JL confirmed that his main takeaway was the breadth and depth of services provided by QVH and how little people outside of the Trust know about them, as well as multidisciplinary ways of working The Board **noted** the contents of the report.

34-24	**Freedom to Speak up Guardian report** The Board welcomed JDo, the Trust's new Freedom to Speak up Guardian, to the meeting to present the repot. JDo presented the report to the Board and reported that The Guardian Service have provided the independent external Freedom to Speak up service to the Trust since 29 April 2024. She reported that the service is being promoted to all staff and drop in sessions have been well received. As the service is relatively new, there is currently limited data to analyse and report on themes, although conversations with staff have indicated some unsettlement regarding changes within the Trust's leadership team. The Board noted that there have been three speak ups to date, one of which is a legacy issue. The Board thanked JDo for the report and agreed that there is in an increased level of confidence in the service with it being independent. The Board considered and discussed the update as follows: - The Board noted an increase in activity since the new guardian has been in post - The Board agreed it would be helpful to have some benchmarking data from other organisations with the next update. **ACTION JDo** - A Board member emphasised the importance of those who raise concerns being content with the outcome. In response, JDo confirmed that cases are not closed until the person is happy with the outcome and that they are kept informed as the case progresses. Feedback is sought following the closure of the case The Board **noted** the contents of the report, acknowledging that analysis on themes and benchmarking data will be included with the next update to Board. [JDo left the meeting]
35-24	**Board assurance framework** LM presented the report to the Board as read, highlighting that: - The key strategic risks have been reviewed in detail by each of the sub-committees ahead of being presented to the Board - The revised risk management framework has been reviewed by the Audit and risk committee and will be presented to the Board with the risk management approach at its September meeting - Feedback on the document from the last Board meeting has led to some changes in the presentation of this report which is simplified with key issues and updates. The summary table demonstrates that overall, the risk profile of the Trust has improved during the period The Board agreed that the report is much improved and more accessible, highlighting the key risk areas and issues. A Board member noted the target date for BAF3 (physical infrastructure) as being 2031 and asked whether the Trust is able to effectively manage this risk in the period between now and then. In response, MW confirmed that 2031 is the target date which she feels as the risk lead that the risk score will be low enough. This has been discussed in detail but the Finance and performance committee and an interim date when all maintenance works will be completed will be included on the BAF. A Board member suggested that clinical harm reviews should be an area for the Board to look at more closely related to the waiting lists. In response, KT suggested that there is a need for the Trust to modernise its approach to clinical harm reviews, considering the

	impact on a patient's mental health and daily life. It was agreed that the modernised approach should be presented to the Quality and safety committee. **ACTION TC** In response to a question regarding violence prevention and reduction, HE confirmed that the Trust is part of a system initiative and that there is now funding available to have additional resource in this area. The Trust does not have many reported incidents and work will be completed to understand if this is a true reflection of reality or if speaking up is limited. The Board thanked those who had worked on this report and **noted** its contents.
36-24	**Business plan 2024/25** MW presented the report to the Board, confirming that it had been approved by the Board at its extraordinary meeting on 6 June 2024 and that the plan has been submitted to NHS England. In response to a question, MW confirmed that due to financial challenges across the system, the Trust may be asked to make further efficiencies but that this is not yet confirmed. The Board **ratified** the business plan for 2024/25 as presented.
37-24	**Integrated quality and performance report** KT presented the report to the Board, highlighting its new integrated format. There is still work to be done to improve the analysis of data but it was recognised as a good starting point in order to triangulate performance information. The executive team presented the report highlighting the following: - KSO3 (operational performance): KT reported that the Trust had achieved its highest rate for faster diagnostics for cancer and achieved the 95% diagnostic standard at year end. The Trust continually exceeds the four hour standard wait time for the minor injuries unit. The Trust's focus is on addressing long waits for patients and ensuring that they wait well and do not come to clinical harm. There are challenges related to industrial action and anaesthetist availability - KSO1 and KSO2 (patient experience and clinical services): NR reported that there are no serious incidents reported for April and May 2024 and that investigations using the patient safety incident response (PSIRF) framework are helping the Trust to embed learning. Additional key performance indicators will be included for KSO1 and KSO2 going forwards which will include safeguarding and information governance as well as more detailed information about PROMs for services. Phase one had been delivered for the local anaesthetic unit and phase two is underway- this project aims to take minor procedures out of main theatres and support productivity - KSO4 (financial performance): MW reported that the Trust had broken even as planned in month 1 and month 2 and delivered efficiencies as expected. Income levels are as expected and MW has confidence that he capital resource limit will be met - KSO5 (organisational excellence): HE reported that the team are prioritising improving time to hire. A people promise manager is now in post. The exit interview process has improved and the team are receiving better information which allows for triangulation. The team are closely monitoring temporary staffing and agency use and focus continues on monitoring the quality of appraisals The Board thanked the executive team for the much improved integrated performance reporting whilst acknowledging that there is still work to do with analysis of the data.

	POD highlighted that whilst the Finance and performance committee were pleased with operational performance overall, there remains significant concern about the growth in waiting lists and lack of analysis and detailed information around this issue. He suggested that patient experience should be used as a measure as opposed to national targets. KT committed to providing detailed analysis regarding what is driving the increase of the waiting lists. A Board member requested that future reports triangulate staffing and activity data, highlighting that this may be a missing piece of analysis. Discussion was had regarding the local anaesthetic unit and KT confirmed that phase one was a pilot and that currently there is not so many minor cases. The project was paused in order to understand demand and where it is best placed. The Board **noted** the contents of the report.
38-24	**Audit and risk committee assurance** PDR presented the report to Board and reported that the committee had agreed to recommend the Annual report and accounts 2023/4 to the Board for approval following a smooth process with the Trust's new external auditors. He confirmed that key areas of focus for the committee moving forwards will be procurement processes, ensuring value for money is obtained and grip and control. The Board **noted** the contents of the report,
39-24	**Quality and safety committee assurance incl. quality and safety annual reports 2023/24** SOL presented the committee assurance report to the Board and reported that each of the Annual reports had been reviewed in detail at the recent committee meeting. He highlighted that antimicrobial prescribing remains a key area of focus for the committee as it has been an issue for a long time; there have been some improvements with appointments to posts but this will continue to be monitored until there is evidence of long term improvements. He highlighted the great work during 2023/24 which is set out in detail within the Quality account 2023/24. A Board member requested that clear objectives are developed for the next year for research and innovation, and the Board noted that these will be included within the Research and innovation enabling strategy document. The Board: - **Noted** the contents of the Quality and safety committee assurance report - **Noted** the contents of the Annual reports presented for assurance - **Ratified** the Professional standards: Framework for quality assurance and improvement (FAQI) Annual report 2023/24, confirming that the Trust is compliant with the regulations
40-24	**Financial, workforce and operational performance assurance** POD presented the report to the Board and expressed thanks to HE, MW and KT for much improved reporting to the committee which was increasing the committee's effectiveness. POD reported that the committee is monitoring progress against the key strategic projects for 2024/25, some of which are slow starting. The committee are keen to see progress accelerate during the coming months. He confirmed that other key areas of focus for the committee will include ensuring that long waiting patients are being treated well and embedding learning from the fire safety issues.

	The Board **noted** the contents of the report,
41-24	**Any other business (by application to the Chair)** The Board acknowledged that this was NR's last meeting, as she was leaving the Trust after 18 years of working at QVH. JS praised NR for her fantastic leadership which had been instrumental in the Trust's excellent inpatient survey results and quality of nursing for patients. She acknowledged that NR had stepped into the role during the pandemic, leading staff through what was a very challenging time. The Board will miss her for her common sense, sense of humour and honest approach. NR was thanked for all she had done for QVH. NR stated that she had loved working at QVH for the last 18 years and is proud of the standard of patient care delivered. There was no further business and the meeting closed.
42-24	**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 lead governor made the following comments: - He emphasised the need to closely monitor the output from staff speak ups as staff governors are reporting that staff may feel unsettled about changes - He commented on the BAF being in a much better place in order for governors to understand key risks and issues

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	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.	**CLOSED**
2	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**~~ **JD**	**1 October 2024**	September 2024: Scheduled for the Quality and safety committee in October 2024	**NOT YET DUE**
3	July 2024	34-24	FTSU	FTSU benchmarking information from other Trusts to be provided with next FTSU update for the Board	**JD, Jdo**	**16 January 2025**	September 2024: Scheduled for January 2025 Board meeting	**NOT YET DUE**
4	July 2024	35-24	Clinical harm	Clinical harm update to be presented to the Quality and safety committee	**TC**	**1 August 2024**	September 2024: Update presented to the Quality and safety committee in August 2024	**CLOSED**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024	**Agenda reference:**	**47-24**		
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	• Welcome to new public governors- further elections to be held during September 2024 • AGM is being held on 16 September 2024 • Increased number of service visits undertaken by Non-executive directors and governors are now joining them on visits • Board maturity and skills assessment undertaken during August 2024 • An NHS Sussex committee in common meeting was held in July 2024 where system leaders are working collaboratively to improve population health outcomes, reduce health inequalities and enhance the productivity of the NHS services in Sussex • Three strategic development committee meetings held since the Board's last assurance report from the committee				
Recommendation:	The Board is asked to note the contents of the report				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	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:	47-24
Date of meeting:	12 September 2024
Report from:	Jackie Smith, Trust Chair
Report author:	Jackie Smith, Trust Chair
Date of report:	5 September 2024
Appendices:	None

Chair's report

Council of Governors

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

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

I am really pleased that we have welcomed Antony, John, David and Richard to the Council of Governors as public governors from 5 August 2024. We are holding another election for our remaining 9 public governor vacancies from 17 September 2024.

The Board signed off the Annual report and accounts 2023/24 in June which is testament to the hard work of everyone who works at QVH. I was pleased to thank the governors for the oversight and challenge during the year, and Board members, old and new, for their dedication to ensure we do the very best for our patients and staff.

This year's Annual General Meeting (AGM) is being held on 16 September 2024. Our AGM will include a review of 2023/24 including our Annual report and accounts and a presentation from the Trust's external auditor regarding their findings for 2023/24. There will also be an opportunity to hear about the development of the Trust's forward strategy ahead of publication in November 2024.

Board of Directors

We will shortly be going out to recruitment for a clinical Non-executive director and two associate Non-executive directors.

During August 2024, the Board completed a maturity and skills assessment in order to gain a shared understanding of gaps, strengths and opportunities for development to support succession planning and recruitment. High level findings indicated a need for associate Non-executive directors to support succession planning and specific skills gaps related to information management technology and cyber and property and estates. These are important gaps to be addressed with upcoming recruitment.

Service visits

Since the last Board meeting the non-executive directors have visited a number of teams including estates, pharmacy, research, burns, charity and corneo. I have continued visiting services with the lead and deputy lead governor. The main challenge raised by staff continues to be the estate and environment.

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 joined 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
I continue to meet regularly with the Chair of NHS Sussex. An NHS Sussex committee in common meeting was held in July 2024 where system leaders are working collaboratively to improve population health outcomes, reduce health inequalities and enhance the productivity of the NHS services in Sussex. A system leader's development session is planned for 11 September 2024.

Strategic development committee
Strategic development committee – 28 May 2024

Key agenda items
- Trust Vision and Values
- Clinical Strategy
- Engagement update

Alert
- Extensive discussion was had on the draft revised Trust vision and values. Recognising the significant progress which had been made, the committee requested that further consideration is given to how the 'delivering excellence' element of the vision statement will be measured and how the Trust's commitment to candour is expressed in its values. The committee stressed importance of embedding the values across the organisation.

Assure
- Eight of the 10 engagement commitments for Trust's strategy development programme are on track. The committee commended the quality of the work which has been undertaken to date and welcomed the extensive engagement with patients, stakeholders and staff.

Advise
- The committee commended the excellent progress which has been made on the on the development of the clinical strategy; the approach has been well considered, based on patient outcomes and financial assessments.

Risks discussed and new risks identified
- Consideration was given to the risks arising from the commencement of the pre-election period for the general election and the impact on the Trust's ability to continue with external engagement and approval timescales.

Strategic development committee – 24 July 2024

Key agenda items
- Committee in Common update
- Committee effectiveness review
- Clinical strategy

- Trust Vision & values and refreshed KSOs
- Behaviour framework
- Continuous improvement

Assure

- The committee undertook its annual effectiveness review. The results were positive and a robust discussion was had on the continuation and role of the committee beyond the agreement of the strategy. The committee will revisit these matters in December 2024.

Advise

- The committee agreed to recommend the proposed vision, values and key strategic objectives to Board for approval.
- The committee supported the Trust's behavioural framework. The importance of creating a mature organisation which is equipped to deal with challenges and a culture in which staff are able to speak up is recognised.
- The committee supports the approach being taken to the development of the clinical strategy. There will be further discussion of the clinical strategy options at the Board seminar in September 2024

Risks discussed and new risks identified

- There is recognition of the external landscape and the risks and opportunities for the Trust which may emerge

Strategic development committee – 21 August 2024

Key agenda items

- Strategy design
- Behavioural framework implementation plan
- Board Assurance Framework
- Health Inequalities Strategy
- Anchor Strategy

Alert

- Although the overall timeline for the delivery of the strategy is on track, there are some specific challenges relating to the development of the Estates and Research and Innovation enabling strategies. The Trust is now at a critical phase of its strategy development and the committee will be kept informed if any risks emerge.

Advise

- The committee agreed to recommend the Health Inequalities Strategy and the Anchor Strategy to the Board for approval
- The committee agreed to recommend the year 2 Sussex Delivery Plan to the Board for approval
- The overall look and feel of strategy document was reviewed. A summary version of the strategy accessible to patients will be developed
- The implementation plan for the Trust's behavioral framework was reviewed and approved by the committee. The ownership and embedding of the framework across the Trust will be key to its success.

Risks discussed and new risks identified

The BAFs for key strategic risks 04 and 08 were reviewed and the committee were assured that that good progress is being made

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024		**Agenda reference:**	**48-24**	
Report title:	Chief Executive's report				
Sponsor:	James Lowell, Chief Executive Officer				
Author:	Michelle Baillie, Associate Director of Communications, Engagement and Charity				
Appendices:	Appendix one: NHS Sussex Shared Delivery Plan year 2 refresh				
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 was rated best in the country by patients in the CQC Adult Inpatient Survey in the same month that help from ward staff was rated highly in the NHS National Cancer Patient Experience Survey • QVH continues to excel in a number of our operational performance domains. We have established a work programme to address theatre utilisation and patient flow to help us improve productivity. • I am pleased to confirm that financially we broke even at the end of month 3. • We have invested £750,000 in a new CT Scanner to help us reduce our waiting times for patients from across Sussex, Surrey and Kent.. • In July we hosted our Star Awards, celebrating the achievements and dedication of our colleagues, kindly supported by the QVH Charity • We celebrated the 80th anniversary of our Canadian Wing including planting a Canadian Maple Tree to signify the enduring bond between the Canadian Armed Forces, its people and QVH. • Our response to a social media trend video resulted in a leading digital platform removing its content.				
Recommendation:	It is recommended that the Board: - **Notes** the contents of the report - **Approves** the Shared Delivery Plan year 2 refresh				
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:	SDP Year 2 refresh approved by NHS Sussex				

Report to:	Board Directors
Agenda item:	48-24
Date of meeting:	12 September 2024
Report from:	James Lowell, Chief Executive Officer
Report author:	Michelle Baillie, Associate Director of Communications, Engagement and Charity
Date of report:	4 September 2024

Chief Executive's report

Operational performance

We are continuing to do well in a number of our operational performance domains, for example achieving for the last three months 95% against the DM01 diagnostic waiting time target. But we know there is more that we can do. We have established a work programme to address theatre utilisation and patient flow to help us improve productivity, and are continuing to focus on the Faster Diagnostic Standards. As part of supporting the system to provide equality of access to services and reduce long waiting patients we have received over 150 patients who have chosen to be transferred to QVH from the NHS Sussex system.

Financial performance

As a trust we are in a positive financial positon as we head into Q2 of the new financial year. We broke even at month 3 and are continuing to look at how we can make the best use of our resources whilst maintaining the delivery of high quality care to our patients.

QVH tops national surveys

At the end of last month we received the fantastic news that our patients have rated their overall experience of care at our hospital as the best in the country. The results of the latest Care Quality Commission Adult Inpatient Survey showed that across the 49 questions we received the highest scores and an overall positive rating of 84%.

These results came in the same month that the latest NHS National Cancer Patient Experience Survey showed our patients receiving Cancer treatment rated help from our ward staff as the best in the country. In response to the statement the "Patient was always able to discuss worries and fears with hospital staff" 86% of our patients said they could, the highest score received by any Trust.

To achieve results like these takes a whole team effort and an immense amount of dedication. Everyone at QVH, whether in a clinical or non-clinical role, should be rightly proud of the recognition that we have received from the people that matter most to us, our patients.

NHS Sussex Year 2 Strategic Delivery Plan

The NHS Sussex Year 2 Strategic Delivery plan is included with this report as appendix one for approval by the Board. The plan is a refresh of the delivery plan which underpins the agreed system strategy, Improving Lives Together. It reminds the reader of our agreed strategy and the rationale for the 11 areas of focus (now extended to 12 due to the addition of children and young people as a standalone area of focus). The

plan briefly outlines the achievements in 2023/24 and signposts the reader to a more detailed summary of year one which will be published in parallel with the year 2 plan and includes case studies highlighting the impact of the work undertaken in year one of the strategy, a draft of which was reviewed by the Sussex assembly on 10 April 2024.

The plan then outlines the milestones which have been agreed for Year 2 and which form the detailed delivery plan, outlining what we expect the impact of achieving these to be. These milestones have been signed off by each of the Delivery Boards and reviewed by both the Executive Committee of NHS Sussex and the System Oversight Board and are designed to ensure that in 2024/25 we continue both to progress the delivery of our overarching strategy but also to make demonstrable progress in tackling the key challenges experienced by both those delivering and receiving Healthcare in Sussex.

The plan was shared with NHS England and published on 5 July 2024. Each of the provider Boards are asked to confirm approval.

Committee in Common

We are working with other system leaders across Sussex to help improve the health outcomes of our local populations, reduce health inequalities and enhance the productivity of the NHS services. As has been mentioned in previous Board meetings, a committee in common has been established to lead the work and met in July, which myself and Jackie, our Chair, attended. A system leader's development session is planned for next month and we will share through future reports more on the role QVH is playing in supporting the NHS Sussex Improving Lives Together strategy.

Investing in diagnostics

With 90% of patients needing imaging at some point in their diagnosis or treatment, state-of-the-art diagnostic equipment is essential. Our new CT Scanner, an investment of around £750,000 will help us increase our capacity by around 20% and form an important part of our Community Diagnostic Centre service, providing greater access for patients who need a scan to support a decision to determine the care they need.

There has been a consistent increase in the number of patients nationally needing diagnostic services and diagnostics is a priority for Sussex as part of the shared delivery plan, looking to increase capacity and reduce waiting times. The scanner, which replaces our first CT which was opened in 2018, will help us to not only reduce our waiting lists but support other providers across Sussex, Surrey and Kent to reduce theirs.

Celebrating our Stars

In July I had the pleasure of hosting our QVH Star Awards alongside Jackie, our Chair. It was an opportunity to celebrate the amazing work that takes place at our hospital and the wonderful people who we work with.

We talk about the exceptional commitment and dedication of our colleagues and on the night we recognised colleagues who had achieved 25 years NHS long-service and above which totalled an incredible 850 years! We also celebrated colleagues who have gained educational and vocational achievements, as well as the winners of the peer and patient nominated awards. A huge thank you to our QVH Charity for supporting the event which is definitely a highlight in our year.

Service visits

One of the commitments I made when I first joined QVH a year ago this month was to spend time with colleagues in teams across our organisation, listening, learning and observing. I appreciate how open colleagues have been to me joining them, allowing me to ask questions and also to respond to any comments or concerns they have on anything relating to QVH.What has come across through each visit I have done, and I am sure it is the same with other executive colleagues, is how proud teams are of what they do and the difference they make. We have many challenges ahead of us as an organisation, including a number of issues with our estate and development of our Electronic Patient Record (EPR) system, but we also have one of the most supportive and committed workforces in the country.

As an executive team we will be continuing to increase our visits to teams as well as supporting the ongoing rollout of continuous improvement methodology throughout our organisation.

Celebrating 80 years of our Canadian Wing

On 28 August 1944 our Canadian Wing was handed to the Royal Canadian Air Force by the Corps of Royal Canadian Engineers who had built it. And at the end of World War Two it was gifted to us. To mark its 80th anniversary we held a special celebration to recognise the achievements of Canadian Wing and the outstanding care our staff have provided since its creation.

I was honoured to be part of the event where we were joined by Captain Chris Peschke, Naval Adviser for Canadian Defence, Mims Davies, our

local MP, Steve Ody, East Grinstead Mayor as well as staff, patients, and military personnel. To mark the occasion we planted a Canadian Maple Tree at the front of our hospital to signify the enduring bond between the Canadian Armed Forces, its people and QVH. A huge thank you to everyone involved in the event, especially our patients who spoke.

Our estate
Whilst celebrating the heritage of our site, we are also aware that our estate continues to present us with a number of challenges. The Board are receiving regular updates regarding any issues arising, which will be covered as a separate item in this meeting, and as always our focus remains on providing the best environment we can for patients and staff.

Social media trends
Whilst social media can be a quick and effective way of communicating and keeping on top of the latest news, it can also be a dark place for misinformation. In July, with the support of our Melanoma experts, we were quick to provide advice against a social media trend which suggested not using sunscreen and instead expose your skin to the sun as a health boost or even intentionally burning their skin to ‘heal’ acne. Advice like this is dangerous and has the potential to increase your risk of developing skin Cancer in later life I’m pleased to say that following our media statement TikTok confirmed they had removed all content relating to the craze.

Recommendation
The Board is asked to:
- **Note** the contents of the report
- **Approve** the NHS Sussex Shared Delivery Plan year 2.

Sussex Health&Care

Improving Lives Together

Shared Delivery Plan

Year Two

Contents

1. Introduction

Introduction

In 2023, the Sussex Health and Care system published a strategy for the next five years called Improving Lives Together that sets out our ambition and the long-term improvement priorities we will be focusing on across health and care to bring the greatest benefits to local people and our workforce.

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

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

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

Achieving our ambition will take time as we cannot do everything we need to do all at once.

In July 2023, health and care partners in Sussex agreed Our Plan for our Population – a shared delivery plan that outlines the agreed actions that will be taken across health and care over the next five years that will help to address many of the issues and challenges we face and improve local people's health, and health and care services now and in the future.

Our Plan for our Population aims to bring together into one place the key strategic, operational and partnership work taking place across our system to improve health and care for our population.Significant action has taken place in 2023-24 in the first year of the Shared Delivery Plan, and now health and care partners are focused on the 12 months ahead for 2024-25.

In line with operational guidance, Sussex Health and Care partners have reviewed and refreshed the delivery aims for year two of Our Plan for our Population. This is to ensure that the plan not only reflects any changes in national guidance, but also addresses opportunities and risks, and ensures that we continue to direct our resources in a way which will maximise benefit for the population which we serve.

This document provides a summary of what has been achieved in year one and the focus for health and care partners for 2024-25 to progress our work in achieving the ambition set out in Improving Lives Together for our population across Sussex.

Read more on our ambitions and how these will be delivered in our full ***Shared Delivery Plan.***

Read more about what we've achieved in year one in our ***Summary of year one.***

2.

Making our ambition a reality

Our ambition

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

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

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

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

We also have long-standing health inequalities, with communities and groups of people having worse health than other people because of who they are or where they live, particularly those who are most disadvantaged. In addition, individuals, communities and our workforce have told us that people are not always getting what they need, when they need it due to difficulties accessing services, support and information, and the disjointed and confusing way the 'system' works.

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

Improving Lives Together represents that ambition and has four aims:

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

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

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

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

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

Our full Shared Delivery Plan sets out how we will do this over the next five years and this document covers 2024-25 (year 2).

Our Shared Delivery Plan

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

Delivery Area 1:

Long-term improvement priorities (Section 1)

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

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

Delivery Area 2:

Immediate improvement priorities (Section 3)

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

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

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

Delivery Area 3:

Continuous Improvement Areas (Section 4)

To bring about the improvements we want to make to achieve our ambition, there are five key areas that need continuous focus and improvement. Four of these were original improvement areas identified, and this year Children and Young People has been agreed as a specific area of focus.

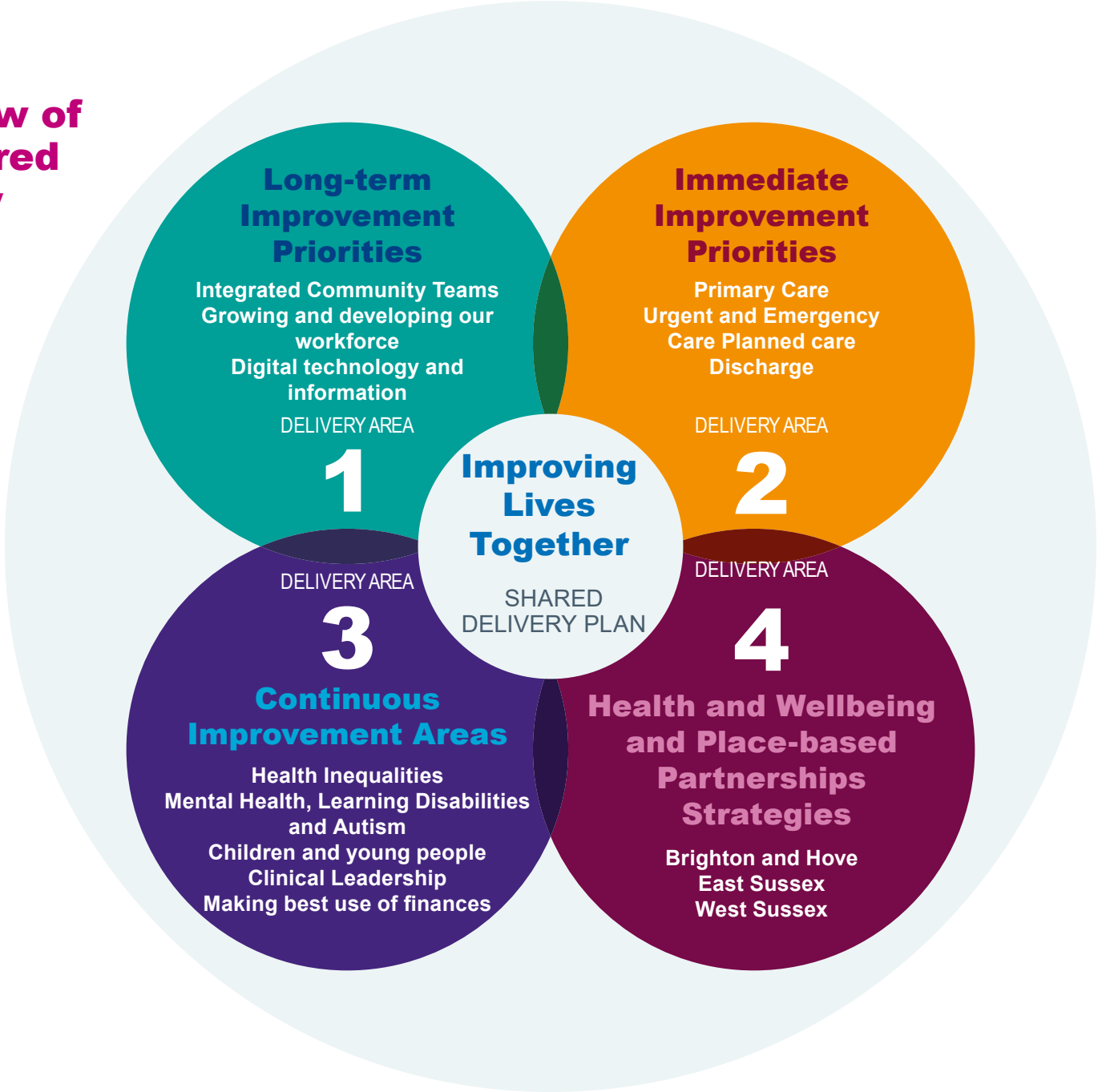
- **Addressing health inequalities that exist across our population to achieve greater equity in the experience, access, and outcomes of our population.** This is a 'golden thread' running through the delivery of all the actions we are taking, and we also have a specific system-wide focus to help bring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

Delivery Area 4:

Health and Wellbeing Strategies and Place-based Partnerships (Section 5)

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

Overview of our Shared Delivery Plan



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

YEAR 2
Immediate Improvement Priorities

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

Improving lives of local people

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

PROGRESS AND IMPROVEMENT
YEARS 2-5

3.

Long-term Improvement Priorities

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

Integrated Community Teams

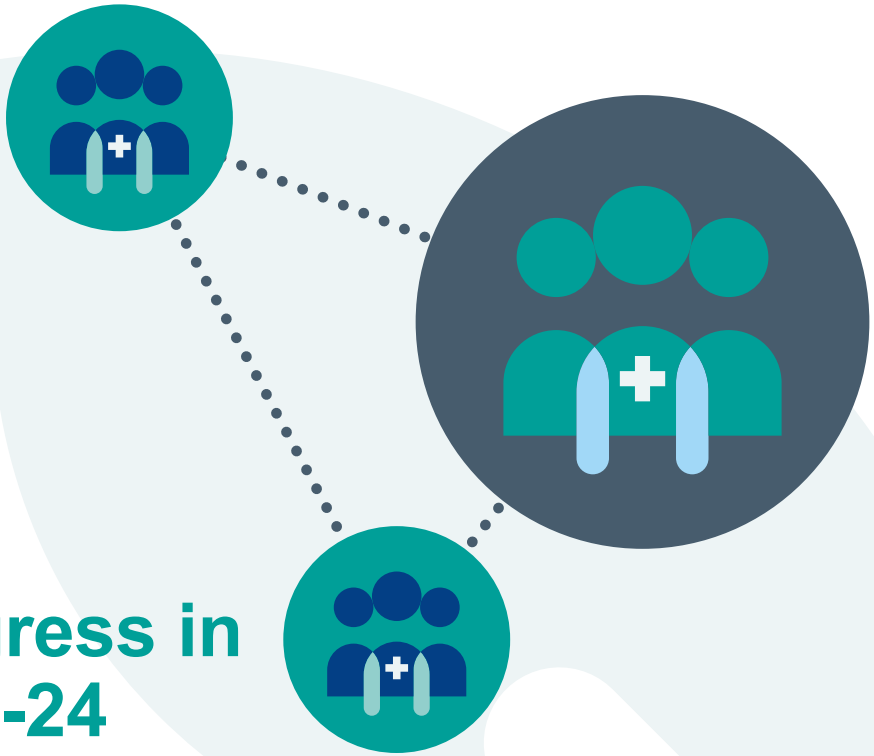
Over the next five years we will be integrating health, social care, and health-related services across local communities in a way that best meets the needs of the local population, improves quality, and reduces inequalities. This will involve us working with local people to build on what works best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

A **'core offer'** will be delivered by each Integrated Community Team to everyone, in addition to the individual support and services available to meet the specific needs of different communities.

This new service model will be enabled by the delivery of our digital and workforce priorities, meaning our workforce has more time for direct care and to focus on population health management, prevention, and community engagement.

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

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



Progress in 2023-24

In the first year of the development of Integrated Community Teams (ICTs) across Sussex, we have made significant progress in line with our ambition.

- **We have defined 16 ICT footprints across Sussex.** These are broadly coterminous with District and Borough boundaries in East Sussex and West Sussex, whilst Brighton & Hove have been divided into four locality areas.
- **For each of these footprints we have created community data and insight packs**, which will be used to inform priority areas for each footprint, ensuring a data driven approach to the development of each ICT in Sussex and providing a baseline data set to evaluate the programme against.
- **In addition, we have incorporated learning** from our three frontrunner programmes, Hastings, Crawley and East Brighton, to test and refine our new ways of innovative working.
- **The learning to date has also informed the development of our ICT core offer** which is the health and care model that will be consistently delivered across all 16 ICT footprints. This will be complemented by our local offer which will be uniquely developed and informed by local priorities and inequalities of our ICT communities.

The actions we are taking this year (2024-25) to progress Integrated Community Teams are:

What we will do	What we will achieve	When
We will refocus the development of ICTs to be place-led in Brighton & Hove, East Sussex and West Sussex.	Oversight and delivery from the full range of health and care partners within the three place Health and Care Partnerships.	June 2024
We will complete a mapping of community assets, services and leadership in each ICT area.	Greater understanding of what is currently available and the baseline for development of the ICT.	Sept 2024
We will codesign a service specification for the 'core offer'.	Working through our system collaboratives there will be wide system involvement in the development of the 'core offer'.	Nov 2024
We will implement the 'core offer' with an initial focus on delivering proactive care to the most complex and vulnerable patients.	The aim will be to reduce avoidable exacerbations of ill-health and improving the quality of care for older and frail people. We will start with the coordination of care for people who have regular and ongoing complex care needs by providing support with managing multiple long-term physical and mental health conditions, and frailty.	Dec 2024
We will develop plans for piloting our approaches to the preventative aspect of the 'core offer'.	To provide a clear way forward to address prevention through the ICTs.	March 2025
We will develop the scope for our critical enabling infrastructure which will support delivery of our ICTs, in collaboration with our estate, workforce and digital programmes.	To ensure that ICTs are fully supported by the necessary infrastructure to be successful.	March 2025

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

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

Growing and developing our workforce

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

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

Progress in 2023-24

The publication of the People Plan in 2023 was a significant milestone in our system commitments to collaboratively deliver on a sustainable workforce plan.

- **The plan has a five-year ambition,** which is underpinned by the NHS Long Term Workforce Plan, the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan, the plans for a Social Care Workforce Strategy. Our People Plan will enable staff to work differently, supported by system working to enable access to equal health and wellbeing resources, working closer with our training providers and universities and providing quality of shared services.
- **This year we will go further by developing a digitally enabled workforce, removing slow processes and enabling more innovation to find solutions to workforce gaps.** It also creates a standard baseline of knowledge for all staff across the system, which assists in embedding new ways of working regarding digital. The package of training will be jointly developed and delivered through digital and teams.
- **Developing a pipeline of future clinicians is vital** to keeping our services running effectively. Sussex Partnership Foundation Trust, worked with the University of Brighton to develop a Guaranteed Employment model. The model gave student nurses an offer of employment when they graduated, providing them with certainty of employment and keeping them within Sussex, where data tells us that some of our students do leave Sussex after they have completed their degree. This innovative solution will be spread to other partners across health and social care.
- **Our EDI teams across the system play a pivotal role** in meeting our duties as inclusive employers and ensuring our diverse workforce is representative of the population we serve.
- **The People Delivery Board will oversee the development of the ICT workforce models** and infrastructure, including team development training, health and wellbeing support and ways of working. The People Board's Clinical Reference Group will take a lead role in development of the workforce model.

The actions we are taking this year (2024-25) to better grow and develop our workforce are:

What we will do	What we will achieve	When
We will develop a digital training programme for Sussex.	Our staff will be better digitally trained.	March 2025
Based on the success of the SPFT Guaranteed Employment model, we will adapt and adopt this process for an extended number of professions.	Guaranteed employment model will be adapted and adopted to create a pipeline of future workforce.	March 2025
We will review our Equality, Diversity, and Inclusion (EDI) offer across our system to strengthen our consistent approach in tackling inequalities, building on the success of our system Workforce Race Equality Strategy and Statement.	One approach to EDI support in place, taking account of individual organisations or professional context and needs.	March 2025
Build on the work to be undertaken in year one with our pilot Health Care Assistant collaborative bank and our South East regional collaborative with other systems.	Collaborative Bank process established.	March 2025
We will support the development of a workforce model for ICTs through clinical leaders in the system	Integrated Community Teams workforce model agreed.	March 2025

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

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

Improving the use of digital technology and information

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

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

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

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

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

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

We will continue to support those less digitally able, and will continue to offer a non-digital alternative to those members of our communities who do not have access to the internet or digital devices.

Progress in 2023-24

A significant amount has been achieved over the past 12 months to progress the digital elements of the system's strategy.

- **In September 2023, we agreed a system-wide digital and data charter.** The purpose of the charter is to help partners steer their work towards the common ambitions of the ICS Strategy and Shared Delivery Plan and to develop a shared digital and data culture.
- **Three Digital Centres of Excellence were established by the December 2023 target for innovation, infrastructure and data / intelligence.** The development of distributed Centres of Excellence will enable Provider partners to take a leadership role in developing practice, capability, and resourcing for a specific area in line with the development of the Provider Collaboratives.
- **In October 2023, we agreed a system-wide Digital and Data Charter, with sign up from all NHS partners.** This will enable alignment on principles around procurement, managed convergence, user centred design and Digital Transformation, ensuring that NHS Sussex can continue to develop as a leader in digital and data practice.
- **The Sussex Digital Inclusion Framework has been developed** in collaboration with NHS Sussex, the University of Sussex and Health Innovation Kent Surrey Sussex, working with health and care partners and the public, examining digital inclusion based on known barriers and enablers. The Framework will allow us to ensure that future Digital Transformation projects and programmes map and mitigate against digital exclusion in Sussex, and that we can target our efforts in the most impactful areas.
- To reduce inequalities of digital access within our population, **a Digital and Data People's Panel has been established with 17 members from a range of backgrounds and experiences.** They have met 7 times to date. The People's Panel brings value to the digital and data delivery board through ensuring that a population and insight led approach is used to deliver the right digital and data services for our population.
- **Close to one million people in Sussex are now signed up to the NHS App,** and more than 400,000 people are using it each month to request medication or check records. All GP Practices in Sussex now have Cloud Based Telephony, to improve access and experience for people calling into practices. Many of our GP Practices have also implemented advanced Cloud Based Telephony with functions that include call back, call queuing and enhanced telephony data.
- **The number of people using remote monitoring to report their blood pressure results** more than doubled in the year 2023/24, from 13,500 to 32,300.

The actions we are taking this year (2024-25) to improve the use of digital technology and information are:

What we will do	What we will achieve	When
We will develop a strategic case for Digital Innovation Labs approach across Sussex. A Frontrunner Digital Innovation Lab will be established with its learning inputted into the Strategic Case.	A coordinated approach to innovation across the system.	March 2025
We will agree a system-wide Digital Inclusion Strategy including a roadmap of proposed interventions and target metrics for the reduction in the impact of digital exclusion and digital poverty.	We will ensure we have a clear approach to reduce inequalities, especially in relation to digital exclusion and digital poverty.	March 2025
We will increase NHS App utilisation rates to ~1m logins per month, 8k appointments booked or cancelled each month and 65% of the population registered. For My Health and Care Record we will increase monthly logins to 200k and population registrations to 600k.	We will increase access to a range of digital services across our population.	March 2025
We will support the development of ICTs, taking a user centred design approach to understand the digital and data requirements for both our patients and health and care professionals.	ICTs will have clear digital and data infrastructure to support their development.	March 2025
We will develop and agree an ICS cybersecurity strategy by December 2024.	A coordinated strategy across the system.	March 2025

What we will do	What we will achieve	When
Plexus Care Record will be made available in 30% of Care Homes and frontrunner VCSE provision.	Improved information sharing across health and care partners.	March 2025
Kent Medway & Sussex Secure Data Environment for Research and Development will deliver its Minimum Viable Product	There will be an agreed approach across the system.	March 2025
The Digital People's Panel will establish its draft Social License for review and develop the metrics and method for assessing public confidence and trust in digital and data services.	A clear involvement approach will be in place, with work informed by public and patient insight.	March 2025
Following the baseline assessment through the Digital, Data and Technology (DDaT) workforce census a DDaT Workforce Plan will be developed including the business case for delivery of the Digital and Data Science Academy with University and Further Education partners.	Greater integration with university and further education partners.	March 2025
Data, Insight and Intelligence Strategy will be delivered during 2024/25 including a partner-wide Charter agreed by the Assembly.	A strategy will be in place that will allow us to use data, information, and insight better.	March 2025

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

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

4. Immediate Improvement Priorities

Alongside the Long-term Improvement Priorities, there are immediate improvements that need to be made across our health and care services. We have developed an operational plan for 2024-25 which sets out the key actions that will be taken and how we will ensure best use of finances across our services.

Increasing access to, and reducing variability, in Primary Care

GP practices across Sussex work extremely hard to ensure their patients and carers get the timely support, treatment and care they need in the best possible way. During the year, GP services delivered 10.8 million appointments, which is around 900,000 appointments per month, and approximately 30,000 per day across Sussex.

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

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

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

Progress in 2023-24

In 2023/24 we focused on increasing capacity across GP services, improving the quality of services and patient outcomes and supporting general practice services to be more sustainable. This was in recognition of the fact that demand on these services was growing and that people were having mixed, and often frustrating experiences, when trying to book an appointment with their GP.

During this year, GP services delivered 10.8 million appointments, which is 5.6% more appointments than in 2022-23, with 63.7% being on the same day and 78.7% within two weeks. Now, when calling a practice in Sussex, most people will experience new triaging and telephony systems which facilitate quicker advice from the practice on what to do about their symptoms and call-backs if there are multiple people calling the practice simultaneously. This is also giving us a better understanding of demand which will inform future plans.

Other key achievements have been:

- We have made progress in enabling messaging services, appointment booking and repeat prescription ordering **through the NHS App** across 95%, 92% and 97% of practices respectively.
- **1,104 additional staff have been recruited** through the Additional Roles Reimbursement Scheme against a 2023/24 target of 754
- **We launched a new Pharmacy First service,** with over 95% participation rate from Community Pharmacies, which offers support for a range of minor illnesses without requiring referral from a general practitioner.
- **We commissioned an additional 130,589 Units of Dental Activity (UDA's)** in 2023/24 and plan to increase this further by extending the rapid commissioning process, expanding the Urgent Dental Care and Stabilisation pilot and testing new schemes aimed at enhancing services for targeted groups, including children.

Despite these improvements, we recognise that unwarranted variation in how people can access general practice, and the availability of NHS dental appointments, persists.

For this coming year (2024/25), addressing these challenges will be our focus.

More specifically, we will:

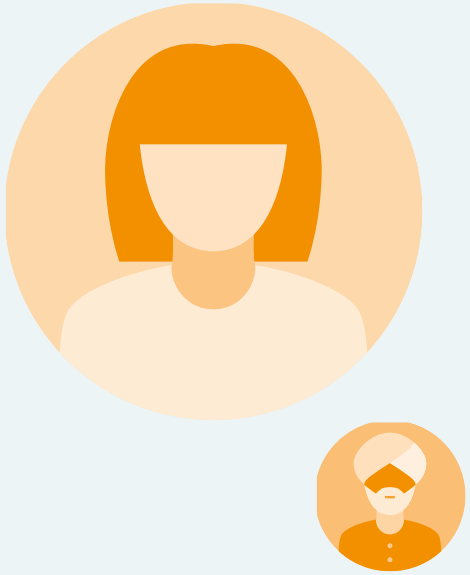
- deliver a 2% increase in the number of general practice appointments
- reverse the current trend and deliver – on average – 85% of all appointments within two weeks.
- improve patient experience by improving on the average score for overall satisfaction of general practice service as being good from that achieved in the 2024 General Practice Patient Survey
- sustain current workforce levels at around 6,200 professionals.
- embed pharmacy first, offering a total of 32,000 consultations.

The actions we are taking this year (2024-25) to increasing access to, and reducing variability, in Primary Care, are:

What we will do	What we will achieve	When
We will support Primary Care Networks (PCNs) to develop clear Capacity and Access Plans that reflect seasonal demands on appointment capacity.	Further increased access to GP practices across our communities.	March 2025
We will review appointment data and develop an improvement plan, with clear actions for some PCNs, to improve the number of people seen on the day and within two weeks (to at least the England average).	More people will be seen on the day and within two weeks at GP practices in Sussex.	October 2025
We will ensure consistent delivery of Units of Dental Activity (UDAs) vs contracted levels.	There will be a target for 95% of all contracted UDAs to be delivered.	March 2025
We will enhance utilisation of Pharmacy First consultations within Sussex.	There will be a target that there are 32,700 completed consultations over the course of the year.	March 2025
We will maintain baseline staffing levels with General Practice. (Target = 5% recruitment levels across various roles, allowing 3.5% for usual attrition rates and sickness leave, to ensure workforce sustainability)	GP practices will have consistent staffing numbers to ensure access for patients.	March 2025

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

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



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

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

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

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

Progress in 2023-24

Significant progress was made in 2023/24 in improving various aspects of urgent and emergency care services across Sussex, aimed at enhancing patient care and streamlining service delivery.

Work focused on improving response times to 999 calls and reducing A&E waiting times, with initiatives to increase ambulance service capacity, support out-of-hospital care, and implement standardized care for individuals at risk of rapid deterioration. Measures have also been taken to accelerate patient flow and discharge, including the development of improvement plans, proactive discharge planning, economic modelling for discharge, and workforce capacity building, all targeted for completion by March 2024.

During 2023/24:

- **We focused on high users of Emergency Departments** to make sure that there is appropriate support in place more widely.
- **The Sussex Admissions Avoidance Single Point of Access was expanded** through a pilot to provide access to care homes across Sussex. The ambition is to expand this for all health and care professionals in 2024/25.
- **Urgent Community Response services have provided support** to improve ambulance response times within Sussex, by identifying and providing care to those patients who phone 999 but who can be cared for safely and effectively in their own homes by community services. This releases ambulance service capacity and ensures that patients are treated in the most appropriate setting for their needs, avoiding unnecessary conveyance to hospital.
- **Virtual ward capacity increased** over the course of the year and its utilisation increased above 80%. Further work has been undertaken to develop admissions avoidance pathways which utilise virtual wards, in order to maximise the number of individuals who can safely and effectively be cared for in their own homes.
- Advancements in supporting emergency response were delivered through the **implementation of the 111 Starline** providing direct clinical support to healthcare professionals and improving communication channels.

During 2024-25, health and care partners will continue to expand on the work achieved to date. There will also be the development and design of an Urgent and Emergency Care strategy.

The actions we are taking this year (2024-25) to improve response times to 999 calls and reduce A&E waiting times are:

What we will do	What we will achieve	When
We will design and develop an Urgent and Emergency Care strategy.	To ensure services and pathways going forwards are being developed in a way which meets future demand.	January 2024 – pre-mobilisation
We will develop a programme of work to manage high intensity and high-risk patients ahead of winter, inclusive of both physical and mental health conditions.	To ensure that people receive timely and appropriate care in the right place, first time. This will also reduce A&E attendances and improved demand management.	Sept 2024
We will optimise our use of out of hospital alternatives, including further developments of our Virtual Wards, Urgent Community Response, and Admissions Avoidance Single Point of Access.	To increase capacity and improved patient flow, ensuring that people receive timely and appropriate care in the right place, first time.	March 2025
We will optimise pathways to manage lower acuity activity, working with system partners across primary and community services to ensure patients are seen by the most appropriate services for their needs and in a way which enables us to balance demand more effectively.	Reduced A&E attendances and improved demand management Improved access to patient care as well as increased patient satisfaction.	March 2025

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

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

Reducing diagnostic and planned care waiting lists

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

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

Progress in 2023-24

Health and care partners have had a clear focus to reduce the time people are waiting for treatment this year.

- The system delivered improvements in our cancer waiting time standards achieving a compliant position in terms of the Faster Diagnosis Standard (time from referral to diagnosis) and **we have reduced the number of patients waiting over 62 days for definitive treatment.**
- We have also maintained our focus on improving early diagnosis of cancer. One example of this is through the **expansion of the Targeted Lung Health Check screening programme** which identified 61 patients in the early stages of lung cancer.
- **Seven Community Diagnostic Centres are now in place** across the system and in 2023-24 they delivered more than 20% of all diagnostic tests performed in Sussex.
- **We have also rolled out new digital functionality via the My Health and Care + programm**e to support patients along their elective care pathway which means patients are notified when their referral has been accepted, are sent reminders for appointments, and are signposted to self-care and waiting well information.
- Whilst we have made progress in reducing the number of long waiting patients – **we ended the year with 337 patients waiting over 78 weeks and face a significant challenge to deliver a position of zero patients waiting over 65 weeks** and in moving to sustainable delivery of the Referral to Treatment (RTT) standard. The plan in year 2 therefore shifts to how we make best use of our system capacity enabled by mobilisation of the Elective Coordination Centre and a shared waiting list (PTL) and a continued focus on increasing productivity and efficiency and redesigning pathways in challenged specialties e.g. ENT (Ear, Nose and Throat).
- **We also must make improvements in our diagnostic waiting times** – a key enabler for both cancer and elective pathways – and will continue the roll out of Community Diagnostic Centres and transformation of diagnostic pathways.
- **For cancer, our priority will be to continue improvements in early diagnosis** and in achieving a significant increase in the percentage of patients who have a confirmed diagnosis and start their treatment within 62 days.

The actions we are taking this year (2024-25) to reduce diagnostic and planned care waiting lists are:

What we will do	What we will achieve	When
We will continue to realise productivity opportunities though improved theatre utilisation and day case rates and use Further Faster methodology to transform outpatient pathways across the 19 specialties.	We will increase our theatre utilisation rate to a minimum of 85% and continue to deliver at least 85% of surgery as a day case procedure. We will reduce the length of stay for key pathways such as hip and knee replacement surgery in-line with best practice rates. We will use Further Faster methodology to transform outpatient pathways across the 19 specialties.	March 2025
We will take a system wide approach to how patients are managed along the elective pathway to harmonise waiting times and making better use of our available capacity.	We will mobilise an elective co-ordination centre during quarter one and make better use of our available capacity via a shared PTL across all provider types (NHS and IS). We will provide enhanced support to GP practices to increase uptake in Advice and Guidance and ensure patients are offered choice at the point of referral.	July 2024
We will ensure a more personalised experience for patients and will digitally transform how patients interact with the NHS whilst on an elective pathway via full roll out E meet and Greet via the NHS App.	Patients will be notified of their appointment, validated every 12 weeks whilst on the waiting list and have access to a personalised library to help waiting well, supported self care and inform choices around treatment and care. We will introduce a system wide early health screening tool for patients who need surgery reducing the need for pre-assessment appointments by 20%.	July 2024

What we will do	What we will achieve	When
We will engage effectively with the ICT workstream to develop a planned care ICT core offer to patients.	Inclusion of planned care within the ICT core offer.	December 2024
We will identify the top five clinical pathways that require a strategic approach to be ensure they are clinically and financially sustainable, and develop clear plans including consideration of service reconfiguration and workforce development where necessary	We will implement our new MSK pathway model in December 2024. We will prioritise the redesign of services in ophthalmology, ENT and dermatology this year.	December 2024
We will make further use of our Community Diagnostics Centres (CDCs) across Sussex, providing greater access to patients who need a test to support a decision for the care that they need.	We will intelligently book CDC capacity, prioritise direct access for primary care and implement new pathways including Non-Specific Symptoms, teledermatology and bleeding on HRT (Hormone Replacement Therapy)	March 2025
To support patients referred on a cancer pathway, we will ensure referrals are made in-line with standardised referral protocols and local pathways are optimised.	We will work with the Surrey and Sussex Cancer Alliance to implement best practice timed pathways to support delivery of Faster Diagnosis and deliver a minimum 2% stage shift in earlier cancer diagnosis (against the 75% target by 2028). We will fully implement new pathways such as FIT (Fecal Immunochemical Test) pathway and Non-Specific Symptoms. We will work with partners to increase uptake and coverage of the NHS screening programmes, including continuing to roll out Targeted Lung Health Checks and uptake of HPV (human papillomavirus) vaccination.	March 2025

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

Difference for local people	How will this be measured
We will continue to reduce our waiting times with a commitment to deliver a maximum wait for treatment for patients referred for elective care.	No patient will wait more than 65 weeks for their elective care treatment from September 2024.
We will continue to reduce the number of patients who are waiting too long to start their cancer treatment.	We will ensure that by March 2025 at least 70% of patients receive a diagnosis and start treatment within 62 days of their urgent cancer referral.
We will enhance access to diagnostics for patients across Sussex with our CDC capacity, improved diagnostics pathway, and capital investment in services.	We will ensure at least 77% of patients by March 2025 referred on a cancer pathway will be diagnosed within 28 days. We will continue to reduce our waiting times across 15 diagnostic modalities with no more than 8% of patients waiting more than six weeks.

Accelerating patient flow through, and discharge from, hospitals

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

We have a good track record of system partnership working to improving discharges and we will be building on this and accelerating existing and new initiatives. Sussex is one of six national systems selected as Discharge Frontrunners, which involves health and social care partners locally working together, and with carers and wider partners, to rapidly find innovative solutions and new approaches which have the potential to make a substantial difference. Discharge Frontrunners use tried and tested improvement tools to find what works, how and why and will make recommendations for how their approaches can be adopted across the country.

The objective of our programme is to develop, design and test new approaches and service models for discharges across all settings by focusing on integrated workforce models, deploying new technologies, developing shared business intelligence, and developing an economic and financial model to underpin this sustainably.

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

Progress in 2023-24

2023/24 has been a challenging year for the discharge programme. Some significant steps forward have been achieved including:

- **Improved sharing of information across system partners** to support earlier discharge of patients, through the development of an Acute and Community Integrated Transfer of Care case management dashboard
- **The development of transfer of care hubs in all three places**
- **Sharing of learning** between our acute providers through peer reviews,
- **The development of an economic model** to support the shift of resources and increase capacity in the right parts of the system to reduce delays which was used to inform the deployment of National Better Care Fund Discharge funding.
- **The development of an acute therapy model and participation in the NHSE Skills for Health Intermediate Care Workforce demand and capacity modelling pilot,** and
- **The securing of Hospital Technology Accelerator funding** to scale up of a small number of digital care solutions including point of care testing in virtual wards

However, we have not seen a translation of these changes into a sustained reduction in the delays experienced by patients at the point of discharge. Consequently, there is a need to deliver a sustainable step change improvement in our discharge pathways and operating model in 2024-25.

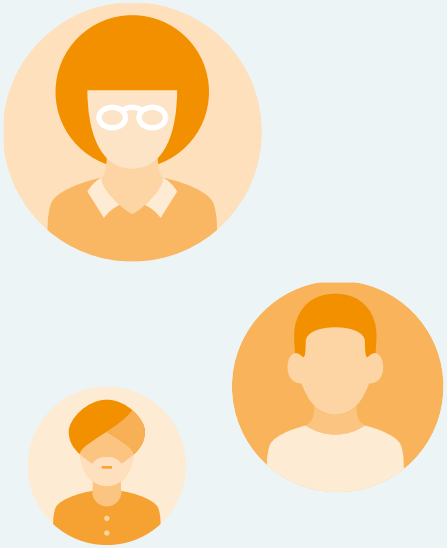
Discharge improvement remains a significant priority for our system and our plans for further improvement to be delivered during 2024-25 have been shaped and informed by our participation in the national discharge front runner programme over the last year and the recommendations following an external review of our discharge arrangements, undertaken by Professor John Bolton as part of an agreed Better Care Fund Support programme support offer to the system.

The actions we are taking this year (2024-25) to accelerate patient flow through, and discharge from, hospitals are:

What we will do	What we will achieve	When
We will complete a review of our pathway 2 intermediate care bedded model to ensure that we optimise the use of our community beds to enable both a step up and step-down responsive model that can meet the needs of a patients with broader range of dependencies.	We will have completed an analysis of our intermediate care services that will help us deliver an improvement plan to provide better outcomes for local people needing community based support and helping people stay as independent as possible.	Sept 2024
We will fully roll out and embed our integrated digital transfer of care discharge planner to ensure that there is single shared understanding of patients discharge needs across health and social care teams.	We will achieve a system oversight of the patient journey so that health and care has a good understanding of people' s needs upon discharge and the transfer of care hub teams across Sussex will be using the digital planner to make better informed decisions about discharge.	Sept 2024
We will further develop and embed our new care transfer data system to enable our care transfer hubs to have visibility of a single integrated dataset at patient level.	We will enable a closer overview of discharges across multiple providers to support joined up planning for a better patient experience.	March 2025

What we will do	What we will achieve	When
We will take action to enable earlier and more consistent mobilisation of patients whilst in hospital, to reduce the risk of deconditioning and to support an increase in the number of patients that can be discharged to their normal place of residence, with little or no support.	We will have fewer people needing enhanced support to help them safely go home from hospital and more people will have targetted input in hospital to help them recover quicker before discharge.	March 2025
We will establish a Homefirst discharge to recover and then assess model and refocus existing hospital assessment resources to support our community pathways. This will require the scaling up of our community homefirst pathway services enabled by a shift in investment from acute escalation capacity into community Urgent Community Response capacity.	We will increase the number of people discharged from hospital to their own place of residence with the right support for their needs. We will reduce the time people wait in hospital before this support is in place.	March 2025

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



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

5. Continuous Improvement Areas

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

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

When the Shared Delivery Plan was agreed last year, four key areas were agreed, and in the refresh process for the year two document, it was agreed to add Children and young people to this delivery area to recognise the specific needs of this population group and the work underway across the system.

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

Addressing health inequalities

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

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

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

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

Progress in 2023-24

As a health and care system, we are committed to embedding population health management, prevention, and personalised care approaches to help realise our ambition for all people in Sussex live to a good age in the best possible health and to experience the high-quality care necessary to help them achieve this.

- **We have fully adopted the NHS England Core20PLUS5 approach** to inform the action we are taking to reducing healthcare inequalities and these have been the focus of our year one priorities.
- We have aimed to improve our position against our 2022-23 baseline on 'Hypertension identification and treatment' and 'Lipid lowering therapy (LLT) prescription'. **As of April 2024, there is an improvement in hypertension performance to 65.9%** (England average - 66.8%), and work is underway to reach the SDP target of 77%.
- **We have continued the roll-out of the NHS funded offer of universal smoking tobacco treatment services** and ensure investment at scale and sustainability beyond 2023/24 across adult inpatient services and maternity services. We have successfully increased the proportion of maternity settings offering tobacco dependence services across Sussex – meeting our 5-year target in our first year. We are in the process of increasing the proportion of adult inpatient settings offering tobacco dependence services to 20%.
- **We have developed a defined work programme around the Children and Young people Core20PLUS5 five clinical areas**. Sussex is one of the first ICBs to prioritise baselining the CYP Clinical areas, we continue to work closely with NHSE to help shape this further nationally.
- **We have been measuring our waiting times / people who do not attend / cancellation rates for those with protected characteristics and/ or reside in our deprived geographical areas.** We continue to work closely to ensure mitigating actions are in place to redress any imbalance identified and are developing an evidenced based action plan for 2024/25, building upon our Equality and Health Inequality Impact Assessment.
- **We have invested into projects and programmes through our health inequalities allocation** which are showing impacts in relation to improved outcomes, more accessible information and services and ensuring the voice of those with lived experience are being fed into our governance, strategies and decision making processes.
- **Sussex has achieved its target to improve ethnicity recording,** completeness is now at 94.9%. Further analysis is underway to support data recording quality to reduce the number of 'not stated' or 'not known' coded ethnicity.

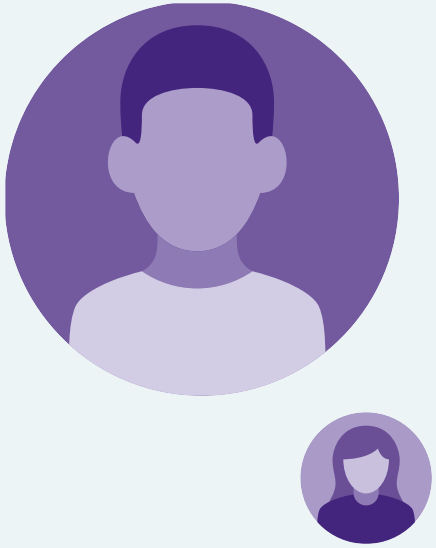
The actions we are taking this year (2024-25) to make progress to address health inequalities are:

What we will do	What we will achieve	When
Working with children and young people (CYP), partners, and young carers to develop a defined work programme around the CYP Core20PLUS5 similar to the adults' Core20PLUS5. This will include: **Address over-reliance on asthma reliever medication and decrease in number of asthma attacks.** **Increase access to real time continuous glucose monitoring, and insulin pumps, in the most deprived areas, and from ethnic minority backgrounds.** **Increase access to epilepsy specialist nurses within the first year for those with learning disabilities or autism.** **Address backlog for tooth extractions for under-10's.** Improve Mental Health access rates for 0–17-year-olds from ethnic minorities and children in greatest areas of deprivation.	Develop CYP Core20PLUS5 baseline and improvement trajectory across each of the five clinical areas.	March 2025

What we will do	What we will achieve	When
We will deliver a dedicated Adult Programme for Core20PLUS5.	**Hypertension:** We will continue to improve performance and aim to meet the 24/25 national ambition of 80%. **Lipid Lowering** We will continue to improve performance and aim to meet the 24/25 ambition of 65%. **Chronic Respiratory Disease:** We will maintain the exemplary performance of NHS funded offer of universal smoking tobacco treatment services in maternity services and fully embed within 20% of adult inpatient services. **Cancer:** We will begin to measure delivery of the national expectation of 75% cases of cancer being diagnosed at stage one or two by 2028 by deprivation and ethnicity.	March 2025

What we will do	What we will achieve	When
We will improve the quality of recording ethnicity across all providers.	There will be a clear data position to inform work across the system.	March 2025
We will implement the actions agreed in the recently published Sussex Social Prescribing Works Plan and it will inform future commissioning of social prescribing.	Support across our communities and a clear plan for future commissioning.	March 2025

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



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

Mental Health, Learning Disabilities and Autism

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

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

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

Progress in 2023-24

For Mental Health, Learning Disability and Autism, during 2023/24 we had a key focus on delivering a number of key targets including reducing the number of our of area placements to ensure care is offered closer to home, increasing our perinatal mental health services, increasing dementia diagnosis rates, and increasing the number of people on the Learning Disability Register who have received an annual health check and action plan.

Together this has supported more people accessing services and enabling greater levels of support closer to where people live.

We have also worked to develop plans to transform approaches to how we support children and young people's mental health and well-being and how we plan to better support our neurodiverse communities. This work continues into the year ahead as part of our strategic approach to needs-based integrated community provision. We have more to do in ensuring good community-based access and this is a key focus for our plans for year two, reflected in a key target for us to fully implement community transformation with a clear neighbourhood-based model.

Our year two plans build on the year one deliverables during 2023-24, and there have been some small amendments to the years 2-5 deliverables that were included in the published Improving Lives Together strategy.

It should be noted that the key deliverables as previously set out for 2024-25 have not altered in purpose as these continue to reflect our shared system priorities. However, amendments have been made to recognise the development of the neighbourhood community transformation model and its alignment to the development of Integrated Care Teams. It also recognises the new national requirements for all systems to develop an inpatient improvement strategy and the importance of aligning this to continued work to ensure out of area placements remain at an absolute minimum.

Our adults and children and young people's urgent and emergency care improvement plans remain critical in underpinning our aims for inpatient care and community transformation as part of a whole system pathway. Similarly, there is an ambition regarding Children and Adolescent Mental Health Services that is stated for delivery in 2026. This work is not slowing and for 2024/25 we will finalise this year's plans for transforming CAMHS as well as working towards our longer-term goals into 2025-26.

The actions we are taking this year (2024-25) to make progress for those with mental health issues, learning disabilities, and autism are:

What we will do	What we will achieve	When
We will develop a strategy that strengthens commissioning aligned to a collaborative delivery of outcomes; enabling increased lead provider arrangements that deliver whole pathway approaches.	Reduced pathway fragmentation, increased provider sustainability and productivity and improved patient and carer outcomes and experience.	March 2025
We will fully implement the community transformation plan within Sussex with an agreed and defined model in each neighbourhood, including a functional single point of access and developed specialist pathways.	A consistent approach to supporting all people that present with mental health problems at primary care level and more cohesive service offer within Primary Care and secondary care mental health services.	March 2025
We will develop closer linking of mental and physical health planning and delivery through aligning the community transformation with the Integrated Community Teams approach.	Increased integrated community-based access to support, reducing reliance on more specialist care and delivering improved health outcomes for local people.	March 2025
We will develop and begin implementation of a 3-year plan to improve the quality of inpatient provision, including maintaining the ambition to reduce out of area placements	Assurance on quality of inpatient care, and patient experience. Continuation of the reduction of out of area placements offering better experiences for those that require admission and maintain a 0% tolerance.	March 2025

What we will do	What we will achieve	When
We will develop a Sussex-wide dementia strategy and plan that meets best practice and local needs, alongside continuing to support diagnostic rates	There will be a coordinated and clear ambition across all partners.	March 2025
We will develop and fully embed physical health checks for people with severe mental illness outreach and health improvement support in Primary Care as part of neighbourhood mental health teams.	There will be a coordinated and clear ambition across all partners.	March 2025

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

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

Children and young people

We are committed to working together to achieve the best health and wellbeing outcomes for children and young people. All children deserve the best possible coordinated support through their childhood.

Promoting good health and wellbeing for children and young people is important to minimise poor health in adults. We are also keen to equip and empower children and their families to take maximum responsibility for their health and wellbeing and to manage any long-term conditions they may have in a way which puts them in control while providing them with the best possible support.

Although not one of the original 11 SDP areas, Sussex health and care partners have agreed that children and young people is an ongoing improvement area and consequently we have developed a set of deliverables for 2024/25 which will be taken forward by the Pan-Sussex Children's Board.

Key areas of challenge, that have been highlighted through the Pan-Sussex Children's Board and the Sussex Joint Area Special Educational Needs and Disabilities (SEND) CQC (Care Quality Commission) and Ofsted Inspections include:

- Increasing levels of need and recruitment challenges mean that some children and young people wait too long for some specialist health assessments and treatment.
- Waiting times for speech and language therapy (SaLT), Child and Adolescent Mental Health Services (CAMHS) and the neurodevelopmental (ND) pathway are too long. Arrangements to ensure that families can 'wait well' are inconsistent. This impacts negatively on some children and young people, including school or family breakdown.
- In neurodevelopmental services, demand growth is outstripping available capacity in line with national trends. Referral for Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Condition (ASC) assessment have risen since 2019/20 by between 40% - 700% dependent on provider. As at September 2023, there were over 13,000 children and young people on a waiting list for assessment with average waiting/waited times ranging from 38 to 75 weeks depending on the service across our Child Development Centres and our CAMHS Neurodevelopmental service
- Impacts of delayed access to children's health services can include increased demand on specialist hospital services (such as inpatient beds), increased numbers of children coming into care, reduced school attendance and attainment impacting on children and young people reaching their potential, exacerbating health inequalities.

Building on partnership arrangements and in response to these challenges, the system is committed to delivering against our five key pillars for children and young people:

1. **To help them have the best possible start to life** through integrated health and care support during pregnancy and postnatally for babies, young children, and their families, tailored to meet their specific individual needs.

2. **To promote good understanding of children's emotional needs across communities and services** so that children and young people experiencing distress have the right support at the right time, and to ensure that high quality specialist mental health support is provided to those who need it.

3. **To promote the best possible physical health for children and young people** through effective public health programmes and swift response to physical health needs by primary, secondary and as appropriate tertiary care providers.

4. To ensure that there is clear shared understanding across the county of the current and future needs of children and young people who have **special educational needs and long-term conditions and/or disabilities** and well-planned delivery of effective, jointly commissioned services. We will ensure that all statutory responsibilities for these children are effectively discharged.

5. To develop the best possible shared understanding of the health and care needs of **particularly vulnerable children and young people including children who are looked after, care leavers, young people who are supported by the Youth Offending Teams, asylum seekers and refugees and young carers.** We will ensure there is effective joint working to address the needs of these groups, both at local level and across the county.

The actions we are taking this year (2024-25) to make progress for children and young people are:

What we will do	What we will achieve	When
We will develop a shared S117 process across Sussex	Development of a shared S117 process across Sussex	December 2024
Following CAMHS stocktake completed in 23/24, we will develop priortised plans for implementation	Have clarity on mental health service offer for CYP (including those that are neuro-divergent), funding & pathways across Sussex	December 2024
We will develop an integrated and seamless pathway of care for young people aged 16-25 to improve transfers of care, outcomes and patient experience, avoiding unnecessary admission	Agree priorities, including potential invest to save proposals	March 2025
We will develop robust and consistent governance around individual funding and complex cases.	Revised governance arrangements for individual funding of complex cases	December 2024
We will develop an integrated model for paediatrics with partners across acute, community and primary care, aligned to virtual ward and paediatric hub models	Agree outline integrated model for paediatrics and establish pilot project	March 2025

What we will do	What we will achieve	When
We will implement the CYP Core20Plus5 framework to address health inequalities in relation to asthma, epilepsy and diabetes	Confirm baseline dataset against the CYP Core20Plus5 framework	March 2025
We will implement national standards for Paediatric End of Life Care to ensure equitable access across Sussex.	Development of a paediatric specialist palliative care team which is in line with adults.	March 2025
Speech & Language Therapy (SaLT) and Special School Nursing (SSN) services will be reviewed across three places, to develop a consistent offer that is proportionate to need	Mapping of Speech & Language Therapy / Special School Nursing offer to inform future commissioning arrangements	March 2025
We will support full engagement of key stakeholders in Sussex Neuro-Development Programme to develop clear CYP pathways of care (with or without a diagnosis) and co-ordinated support for those waiting for an assessment	Standardisation of current NDP assessment and diagnostic (pre and post) pathways	March 2025

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

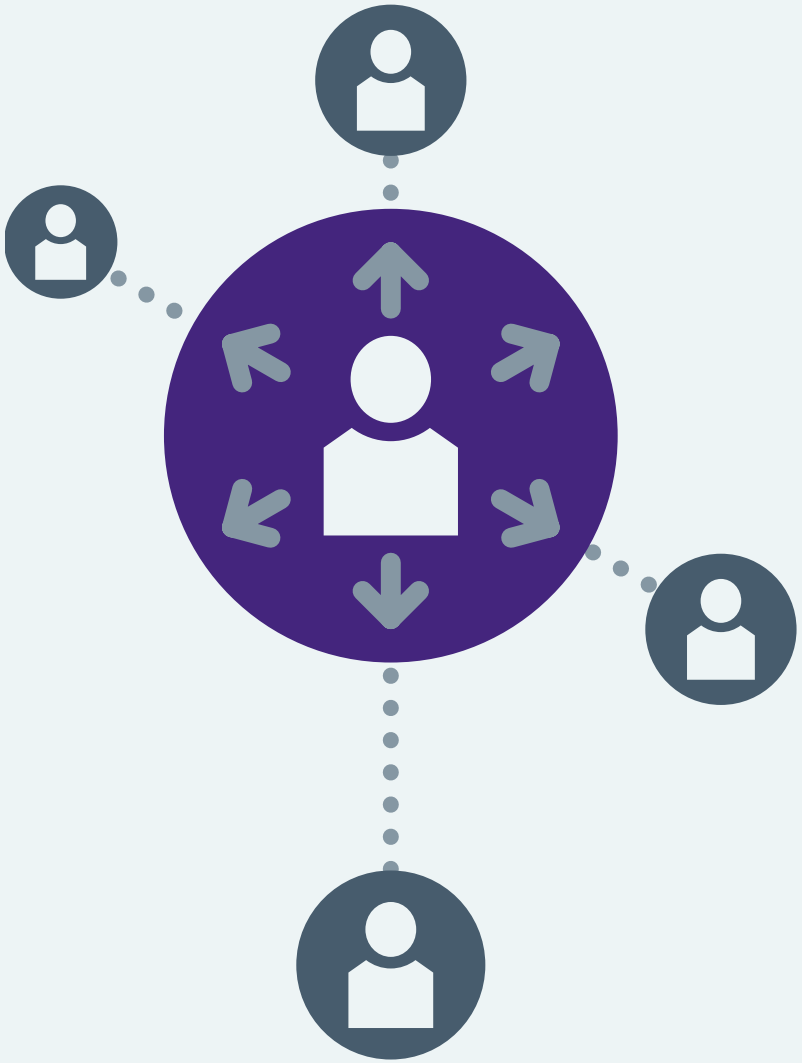
Difference for local people	How will this be measured
More integrated offers of support for children and young people aged 0-25 and their families across education, health and care	Children, young people and parent/carer satisfactions surveys and CQC/Ofsted SEND inspections

Clinical Leadership

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

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

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



Progress in 2023-24

Clinical Leadership is identified in the ***Sussex Shared Delivery Plan (SDP)*** as an area in which Sussex needs to develop and strengthen. The SDP recognises that strong clinical and care professional leadership leads to higher productivity, better organisational performance, and improved outcomes for local people.

- **A clinical leadership delivery board** has been established to oversee the delivery of the year one objectives with clinical leads from all other delivery board being part of the membership.
- Each of the delivery boards has also implemented a **clinical and care professional reference group (CRG)** to provide a strong multi-professional, cross organisational clinical voice. Working with provider training and development leads system wide leadership training offers have been developed to support staff working outside of traditional organisational boundaries; Leading Sussex Together has been launched to provide these opportunities.
- Each delivery board has agreed a **suite of metrics to support the delivery of their objectives,** as part of these, each board has agreed key clinical outcomes.
- Clinical outcomes are measurable changes in health, function or quality of life that result from the care that the person receives. Developing a culture of constant review of clinical outcomes establishes standards against which to continuously improve all aspects of practice and help focus on changes across patient pathways.

The actions we are taking this year (2024-25) to make progress in clinical leadership are:

What we will do	What we will achieve	When
We will ensure clinical leadership support for SDP delivery workstreams, review current function of Clinical Reference Groupsand develop a model to support changes in SDP governance framework.	Ensure clear clinical leadership across the system for the SDP workstreams.	September 2024
We will ensure that the emergent ICTs have strong clinical and care professional leadership in place to enable the delivery of new clinical models or pathways of care, which build on the use of data, digital & technology opportunities. A clinical leadership structure will be identified with appointments in place. Clinical and care professional leads for ICTs will be supported to utilise opportunities identified by data and digital technology.	Ensure that clinical leaders selected for each of the Integrated Community Teams areas are well trained and supported for leadership.	December 2024
We will develop a virtual offer as part of the Sussex Population Health Academy to enable quality improvement and innovation across Sussex which will support opportunities for wider collaboration. Training, webinars and an outline innovation platform will be set up for collaboration. 150 leaders are engaged.	Agree Quality Improvement training and data baseline. Progress training plan in identifed Clinical Leadership Group.	December 2024

What we will do	What we will achieve	When
We will increase the number of clinical and care professionals being offered system-wide leadership development opportunities. With 100 leaders having utilised leadership training and development system-wide offers, we will ensure an ongoing evaluation of these programmes for effectiveness.	100 leaders will have undertaken the programme.	March 2025
We will embed delivery of clinical outcomes as related to each of the SDP Boards, improve the clinical outcomes of greatest importance for the population of Sussex to deliver measurable impacts, and align clinical and care professional focus around the delivery of shared clinical outcomes, including improvements in our wiser population outcomes.	Improve the clinical outcomes of greatest importance for	March 2025

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

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

Getting the best from the finances available

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

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

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

The Sussex system receives a capital allocation, used to upgrade estates and equipment, and must prioritise all the capital requirements to make sure the funding available is spent in the most effective way. In addition, we receive national capital funding for specific programmes and projects.

Over the next five years we will invest in some significant developments which will radically improve patient experience and our productivity. Examples include a new Emergency Department in Brighton, a programme which will eradicate mental health dormitory accommodation, the development of community diagnostic centres and new facilities to deliver elective activity.

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

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

Progress in 2023-24

The Sussex system is financially challenged but needs to be sustainable to deliver our ambitious ***Shared Delivery Plan (SDP).*** Therefore, the focus is on financial recovery and productivity and putting in place the building blocks of the financial framework to support the Improving Lives Together strategy.

In 2023/24 we have:

- **Developed four productivity workstreams** to support the system's drive for financial sustainability.
- **Identified significant cost pressures** in year and so had a far greater drive to improve productivity, reduce costs and target services appropriately. Additional cost control measures have been implemented.
- **Developed a joint system-wide Medium Term Financial Plan** that demonstrates a route to a recurrent breakeven position by 2025/26. It illustrates the scale of the system financial challenges is significant over the next 5 years.
- For 2024/25 the financial challenge is significant, and we will have to make very difficult decisions.

We are working to ensure we have a clear and robust process to considering these decisions and where efficiencies can be made and are committed to working with providers and partners throughout this process.

The actions we are taking this year (2024-25) to get the best from the finances available are:

What we will do	What we will achieve	When
We will optimise our capital allocation through prioritising strategic capital requirements for 2025/26 and 2026/27	We will have a clear approach for capital allocation.	October 2024
A financial recovery plan will be prepared detailing the investment and efficiency plan required to achieve a sustainable financial balance position	We will have a plan across the system.	October 2024
We will agree a programme of productivity and efficiency improvements	A programme will be taken forward led by clinicians.	December 2024
We will model and plan the financial impact of the five-year plan.	We will meet our financial budget at the end of the year.	March 2025
We will ensure Sussex can live within it's financial allocation each year giving us the freedom to implement the SDP	We will meet our financial budget at the end of the year.	March 2025

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

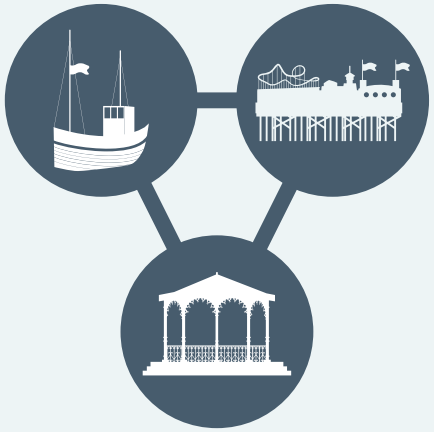
Difference for local people and workforce	How will this be measured
Living within our financial allocation will allow for greater investment in new services and innovation to support and accelerate improvements for local people.	Financial positions across system partners at the end of each financial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

6.

Health and Wellbeing Strategies and developing Place-based Partnerships

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

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



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

Alongside the delivery of the Health and Wellbeing Strategies, one of the key priorities of Improving Lives Together is 'maximising the power of partnerships' and during year one we will be strengthening how partners can work together across our populations in Brighton and Hove, East Sussex, and West Sussex, focussing on the distinct needs and challenges in our local areas.

We call this working at 'place', and it is where the local NHS, local government and a wide range of local partners come together to shape and transform health and care and make the most of the collective resources available. We will do this by working in our three Health and Care Partnerships, whose work is overseen by the Health and Wellbeing Boards. Further details of how these partnerships fit into the way of working across our system is in Section 7.

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

Brighton and Hove

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

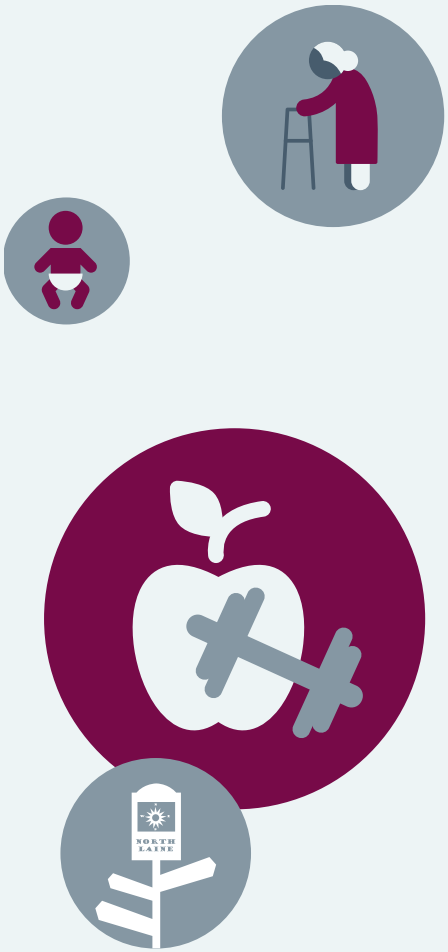
Our ambition for Brighton and Hove in 2030 is that:

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

Read more on our ambitions and how these will be delivered in our full ***Shared Delivery Plan.***

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

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



Progress in 2023-24

The Brighton & Hove Health and Care Partnership brings together key local health and care partner organisations to work collaboratively to deliver the objectives of the Brighton & Hove Health and Wellbeing Strategy and the Sussex wide strategy, Improving Lives Together. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board. Together we have developed key transformational priorities to:

- **Address health inequalities** that focus on areas and communities of most need
- **Integrate models of care** to further develop how our services work together to streamline pathways for patients, improve experience and create more integrated approaches.
- **Transform the way we do things** to improve our services where it will have the greatest impact

During Year one we were able to make significant improvements. We have piloted and started an evaluation of a multidisciplinary team model to better integrate services for people with multiple compound needs in the city (one of our five local population health priorities). We have implemented our local community mental health transformation programme aligning with the recommendations from our recent mental health Joint Strategic Needs Assessment. We have completed and evaluated a successful community health inequalities programme aligned with our Core20Plus5. As part of our work on early cancer diagnosis we completed our targeted lung health checks programme.

And as part of our hospital discharge programme, we established our new transfer of care hub in RSCH (Royal Sussex County Hospital).

Our plans for Year 2, build on many of these achievements and reflect the next phase for them. In addition, we have responded to the next phase in the implementation of ICTs through the further development of our multiple compound needs frontrunner programme and the development of an ICT implementation plan to support alignment with our new ICT neighbourhood areas in the city.

The actions we are taking this year (2024-25) to deliver our Brighton and Hove Placed-based priorities are:

What we will do	What we will achieve	When
We will further support people with multiple compound needs.	We will develop a Multiple compound needs (MCN) community frontrunner. As part of our Central ICT we will use the learning from the MCN transformation programme to establish an MCN Integrated Community Team. We will complete the external evaluation of the multidisciplinary team pilot. We will develop the detailed business case for the MCN Integrated Community and Integrated commissioning approach. We will signoff the MCN partners compact agreement.	March 2025
We will progress the development of Integrated Community Teams.	To support the development of our new ICT footprints we will establish a local ICT implementation plan that builds on our community development approach and establishes strong local partnerships. We will map our local ICT community assets across the four ICT footprints. We will align ICT development with our Healthy Communities, Family Hubs and Community Mental Health programmes. We will establish four Health Forums and test two ICT partnership pilots across our four ICT areas.	March 2025

What we will do	What we will achieve	When
We will maintain a focus on reducing health inequalities across the city	We will continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people. We will develop the learning from last year's health inequality programmes as part of our local ICT development. We will implement locally the priorities set out in the new Sussex Health Inclusion Framework.	March 2025
We will ensure support for children and young people	Develop a joint triage for Wellbeing Service, CAMHS and Schools mental health service Develop a joined up approach between Family Hubs and the development of ICTs Deliver the SEND health & care partnership priorities as set out in the city's SEND Strategy 2021-26	March 2025
We will maintain a focus on mental health	We will continue to implement the recommendations of the 2022 B&H Mental Health & Wellbeing JSNA, aligning our local community mental health transformation programme with ICT development. We will test Neighbourhood Mental Health Teams with at least two PCN (primary care networks) populations/ICT partnerships. We will reduce demand on urgent and crisis care, improve system flow and reduce the numbers of inappropriate out of area placements. We will increase the number of people both on SMI (Serious Mental Illness) registers and having a physical health check.	March 2025

What we will do	What we will achieve	When
We will continue our work across the city to support early cancer diagnosis and appropriate support	Cancer - We will continue our work to improve early diagnosis of cancer with a particular focus on Core20 and Health Inclusion groups. We will increase screening rates across our Core 20 communities and health inclusion groups. We will improve performance against the headline 62-day standard. We will improve performance against the 28-day Faster Diagnosis.	March 2025
We will help people with multiple long term conditions	We will develop our cardiovascular disease reduction priorities, including hypertension, and restore the NHS health checks programme through a health inequalities lens. We will develop a cardiovascular disease reduction action plan. We will increase the percentage of patients with hypertension treated according to NICE guidance. We will increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies.	March 2025
We will work with our partners to support appropriate and timely hospital discharge	We will implement the 2024-25 Discharge Transformation Plan. We will improve patient waiting times to meet NHSE targets for patients seen within 4 hours (through generating flow, thereby increasing front door capacity). We will roll out a new Care Transfer Hub model. We will improve outcomes for patients through the same day discharge team at front access, preventing admission.	March 2025

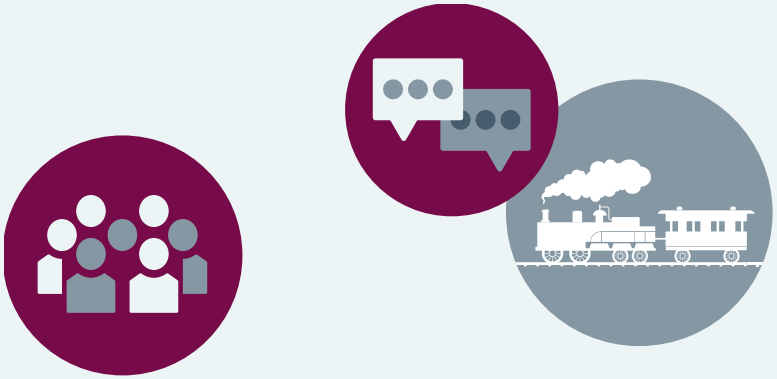
Difference this will make to local people and workforce in Brighton and Hove and how it will be measured

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

Difference for local people and workforce	How will this be measured
Mental Health: Life expectancy will improve for people with serious mental illness. Improved experience of people using services by reducing barriers between services and the need to re-tell their story, reducing the potential for re-traumatisation. Increase in availability of preventative support including suicide prevention. Improve access by making it easier and quicker to get support.	Through a clear outcomes framework, that is consistent across all partner organisations. Through a successful redesign and commissioning of services for people with multiple compound needs.
Cancer: Improved take-up rates of FIT testing, including groups with low participation, particularly men, people from minority ethnic backgrounds and people from deprived areas. Targeted lung health checks will lead to an increase in lung cancers being diagnosed at an earlier stage.	Public Health Screening Data. Cancer Action Group Dashboard. Increase take-up rates of FIT testing by 7%. Increase lung cancer stage 1 diagnosis by 47%.

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

East Sussex



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

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

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

Read more on our ambitions and how these will be delivered in our full ***Shared Delivery Plan.***

Progress in 2023-24

The East Sussex Health and Care Partnership brings together NHS, Local Government and Voluntary, Community and Social Enterprise (VCSE) partner organisations to work collaboratively to deliver shared priorities in the Joint East Sussex Health and Wellbeing Strategy and the Sussex Assembly Improving Lives Together Strategy. On behalf of the Health and Wellbeing Board, the Partnership leads on delivering shared programmes aimed at improving population health outcomes and reducing health inequalities and ensuring a clear focus on increasing levels of prevention and integrated care. Priorities cover children and young people, mental health, community services and health outcomes improvement for people of all ages and align with pan-Sussex SDP plans to ensure a strong focus on the population.

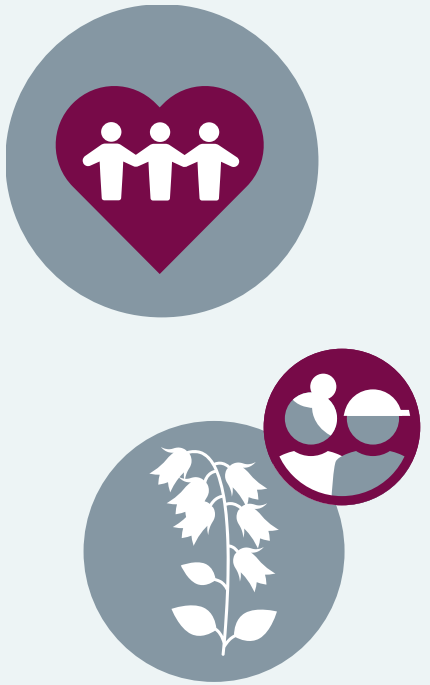
As snapshot, in summary in Year 1 of the SDP we have:

- Delivered and evaluated the proposition phase of our **Hastings Universal Healthcare community frontrunner,** and initiated a further phase of prototypes which will report in October 2024.
- **Held initial sessions with senior executives and key front-line teams and services in Hastings,** to start our Integrated Community Teams (ICT) development and help shape our model and focus for ICTs more widely in East Sussex.
- **Developed and agreed a whole system action plan** focussed on the conditions that significantly contribute to gaps in life expectancy and healthy life expectancy in our population to drive improved health outcomes.
- **Reduced delays** experienced by patients who have been waiting in our hospitals over 21 days by 17%.
- **Opened 11 Family Hubs in East Sussex** which will provide additional support for families with young children and developed a joint Mental Health and Emotional Wellbeing Strategic Plan (2023 – 25) to improve wellbeing and to promote whole school approaches in educational settings.

- **Worked closely with our Primary Care Networks (PCNs)** to establish the foundations of the new integrated community mental health support offer through the delivery of new Emotional Wellbeing Services and increased the supply of supported accommodation for people with mental health needs to 54 units whilst improving integrated working between social care and mental health rehabilitation teams, to improve the success of all supported housing placements.
- **Mapped over 60 infrastructure and community networks** across the county and co-produced a 'Connecting People and Places' programme to combat social isolation and loneliness.

More information about this can be found **here**. Our plans for Year 2 build on many of these achievements and reflect the next phases of implementation.

We will continue with our plans to implement more integrated delivery in neighbourhoods to offer proactive and well-coordinated care to the most vulnerable people in our population, including older people and those who need support with their mental health, as well as enabling opportunities for early intervention and prevention across the whole life course. In addition, we will ensure a strong focus on our partnership actions to help us meet the health, care and housing needs for our population, as a new area in 2024/25.



The actions we are taking this year (2024-25) to deliver our East Sussex Placed-based priorities are:

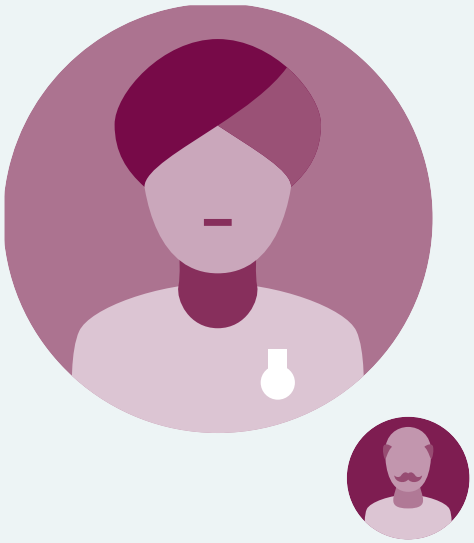
What we will do	What we will achieve	When
We will commence implementation of the approved whole system action plans on cardiovascular disease (CVD), Chronic Respiratory Disease (CRD), healthy ageing and frailty and mental health prevention, and monitor progress on a quarterly basis through the Health Outcomes Improvement Oversight Board, with a deep dive into one priority area each quarter.	Improved outcomes for the population.	March 2025
We will implement the improvements to cardiology and ophthalmology through reconfigured acute hospital services.	Agreed transformation plans fully implemented improving efficiency and outcomes for local people.	March 2025
We will strengthen the focus and role of the Health and Wellbeing Board and the East Sussex Health and Care Partnership by strategically aligning partnerships and working to support our shared priorities for delivering a joined-up offer for health, care and wellbeing, including prevention, across NHS, local government and VCSE sector services for our population. We will develop proposals for the Health and Wellbeing Board (HWB) to phase in during 2024/25, focussed on the Joint Strategic Needs Assessments (JSNAs) and needs and assets in East Sussex	A clear focus and approach across all partners.	March 2025

What we will do	What we will achieve	When
We will enhance support to families to enable the best start in life including delivery of an integrated pre and post-natal offer, and implementation of the Early Intervention Partnership Strategy.	Improved experience and increased opportunities to support our most vulnerable families.	March 2025
We will implement integrated delivery of community mental health services and a wider range of earlier mental health support for adults of all ages and people with dementia, through the evolution of neighbourhood mental health teams in line with the Sussex-wide approach, and increased access to supported accommodation.	Reduced reliance on specialist services and improved population health and wellbeing.	March 2025
We will continue to develop our neighbourhood delivery model through the evolution and implementation of our five Integrated Community Teams (ICTs) across East Sussex. In line with the ICTs across Sussex, this will focus on providing proactive, joined up care for the most complex and vulnerable people alongside approaches to improving the health and wellbeing of our communities through an asset-based approach.	In year plan delivered.	March 2025

What we will do	What we will achieve	When
We will further develop and implement efficient hospital discharge processes, supported by digital automation, with a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into ‘business as usual’.	More people will be able to be discharged safely to a community setting.	March 2025
We will develop and agree a partnership Housing Strategy to set out a shared vision for housing sector in East Sussex, including a strong focus on health, housing and care, and provide the strategic partnership framework to complement the borough and district housing authority strategies.	A clear ambition for all partners.	March 2025

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

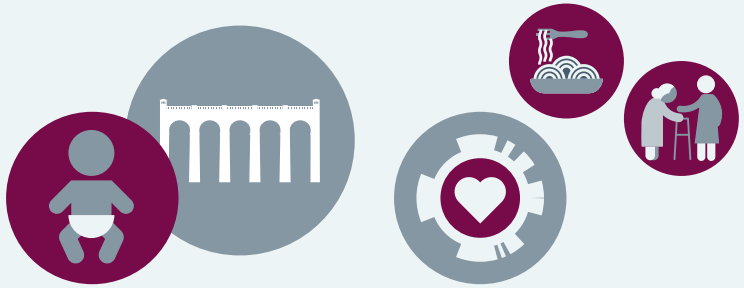
Difference for local people and workforce	How will this be measured
People will be supported to stay healthy for longer and more proactive preventative care will be available for those who need it, across the full range of organisations that can support this.	Reduction in the numbers of people accessing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



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

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

West Sussex



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

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

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

Read more on our ambitions and how these will be delivered in our full ***Shared Delivery Plan.***

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

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

Progress in 2023-24

The West Sussex Health and Care Partnership brings together key local health and care partner organisations to work collaboratively to deliver the objectives of the Joint West Sussex Health and Wellbeing Strategy and the Sussex wide strategy, Improving Lives Together. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board.

Together we have developed key transformational priorities to:

- **Address health inequalities** that focus on areas and communities of most need
- **Integrate models of care** to further develop how our services work together to streamline pathways for patients, improve experience and create more integrated approaches.
- **Transform the way we do things** to improve our services where it will have the greatest impact

During Year 1 of the SDP we made significant improvements. We have developed three year service redesign plans to tailor services to the needs of Crawley communities, implemented phase 1 of the Bognor Community Diagnostic Centre, begun to mobilise a new model of stroke services for Coastal West Sussex following the approval of the post consultation business case, agreed a new model for intermediate care services (rehab, reablement and recovery), developed a hospital discharge improvement plan between health and adult social care and begun a review of Section 75 joint arrangements for learning disabilities and mental health.

Our plans for Year 2, build on many of these achievements and reflect the next phase for them. In addition, we have recognised the need to implement local Integrated Community Teams across West Sussex as well as included a focus for children and young people and to implement the West Sussex SEND inspection recommendations.

The actions we are taking this year (2024-25) to deliver our West Sussex Placed-based priorities are:

What we will do	What we will achieve	When
We will develop our Integrated Community Team approach West Sussex, implementing the core offer and developing the wider offers across our ICTs.	We will develop integrated community teams across West Sussex to provide coordinated health and care to our communities.	March 2025
We will finalise Phase 2 Business Case for a new Bognor Diagnostics Academic Centre	We will contribute to the West Sussex diagnostic programme to enhance access to diagnostics for patients across Sussex with our CDC capacity, improved diagnostics pathway, and capital investment in services. We will increase in numbers of physiological and imaging workforce being trained or being employed.	September 2025
We will implement the first changes agreed to NHS and Adult Social Care community intermediate care services and reprocure new Adult Social Care community-based hospital discharge reablement and recovery service for West Sussex. We will establish system programme governance for partnership delivery of new model.	We will be able to ensure people receive rehabilitation and reablement care in a timely manner, through teams working together in reducing unnecessary duplication and handovers.	March 2025

What we will do	What we will achieve	When
We will deliver Adult Social Care improvement actions around assessment and placement and begin first stages of implementing the newly agreed discharge to recover and assess model across all partners.	We will be able to ensure people who no longer need acute inpatient care can go home or to a community setting to continue recovery. We will also ensure Place-based discharge pathways are aligned to national best practice and achieving maximum efficiency.	March 2025
We will respond to the recommendation within the West Sussex SEND inspection report to address 'waiting well' arrangements, and gaps in service provision to meet the full range of needs of children and young people with SEND. This includes speech and language provision, neurodevelopmental pathways and CAMHS.	Children and young people will receive further improved care and services.	March 2025
We will undertake a strategic approach to understand and address the housing challenge across West Sussex and develop solutions together	There will be a collective understanding across health and care partners.	March 2025
We will delivery joint S75 review and withdraw from old joint commissioning arrangements and establish new joint commissioning arrangements	We will reform our joint commissioning governance to support the continued development of integrated health and care partnership working at system, place and local community level.	March 2025

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

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

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

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

7.
Other areas of focus

Helping the NHS support broader social and economic development

The Sussex Health and Care system has set a strategic direction towards the creation of a health and care system moving beyond service delivery to improving the lives of Sussex residents using its statutory levers, including commissioning and procurement, use of assets and employment opportunities, as well as wider policy levers and spheres of influence through local strategic partnerships and planning. The priority is to establish the anchor role of the NHS in Sussex over the next five years, and this has begun with benchmarking anchor related activity happening across the health and care system to ensure we begin by building on the good work already happening.

In Year Two, NHS Sussex has begun development of its plan to outline the anchor role of the integrated care board and the way the NHS can work with partners to deliver improved social and economic wellbeing outcomes. The plan identifies first year priorities for the ICB, including the way it uses the Apprenticeship Levy to benefit local communities, how it includes social value considerations in its procurement contracts and how the NHS participates in local economic planning to support improved health outcomes for communities.

What will we do to help the NHS support broader social and economic development

What we will do	What we will achieve	When
We will develop a Social and Economic Wellbeing Plan, articulating our first-year priorities which align with the anchor role of the NHS, focused on social value in procurement, spending the Apprenticeship Levy and participating in place based economic partnerships.	A clear plan with system agreement and coordination.	November 2024
We will develop a Sussex Anchor Network to share good practice, learning and develop shared priorities in line with the social and economic wellbeing plan.	A positive way to work together across the system to further our aspirations and ambitions in this area.	November 2025
We will develop a communications plan to drive the implementation of our social and economic wellbeing priorities.	Clear, coordinated proactive communications across the system.	January 2025

Find out more

Read more on our ambitions and how these will be delivered in our full ***Shared Delivery Plan.***

Read more about what we've achieved in year one in our ***Summary of year one.***

Sussex
Health&Care

To read our full Shared Delivery Plan go to

www.sussex.ics.nhs.uk

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024	**Agenda reference:**	**49-24**		
Report title:	Responding to and Learning from Deaths 2023/24				
Sponsor:	Tania Cubison, Chief Medical Officer				
Author:	Matthew Lees Deputy Medical Director Bethany Bishop Interim Head of Quality and Compliance				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance as to QVH's processes for and responses to & learning from deaths within the stated time period				
Summary of key issues	1. There was one in-patient death at QVH in this timeframe – review found no concerns regarding care. 2. There were no variances in terms of numbers or place of deaths within 30 days of procedures at QVH when complared to previous years. 3. No concerns were found about deaths of QVH patients within 30 days of procedures conducted at the hospital 4. No inquests occurred in this timeframe, but three are pending – one from 22/23 and two from 23/24. Extensive review and discussion for internal learning has occurred for all three, as well as external peer review in each case. 5. Trust ME services are now provided by SASH ME service as per new national requirements 6. The trust has moved to the PSIRF framework for investigations.				
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:	Executive Leadership team Quality and Safety committee				
	Date:	August 24	Decision:	Reviewed and noted	

Report to:	Board of Directors
Agenda item:	Responding to and Learning from Deaths
Date of meeting:	49-24
Report from:	Tania Cubison, Chief Medical Officer
Report author:	Matthew Lees Deputy Medical Director Bethany Bishop Interim Head of Quality and Compliance
Date of report:	20/8/24

Responding to and Learning from Deaths April 23 – March 24

BACKGROUD

The Queen Victoria NHS Foundation Trust (QVH) is committed to following the principles of the NQB framework and to learning from deaths that occur in our care. The deaths which are reviewed may have occured whilst the patient is in QVH or within 30 days of an admission or out-patient interventions and treatments. Our commitment extends to ensuring learnings are identified and acted upon and we do this by engaging with carers and families as well as our clinicians.
Following changes in National Regulations Medical Examiner Services are provided by the independent Surrey and Sussex ME Service.

QVH monitors mortality data by area, speciality and diagnosis on a monthly basis, in particular for burns and head and neck oncology, both of which are monitored at regional and national level. QVH's outcomes for our MF patients remain excellent. Our MF patients' survival within 30 days of surgery is 99.1%, which is equivalent to the highest performing units in the country.
The care provided for all inpatient burns patients who die is reviewed by peers at the London South East Burns Network (LSEBN). No 'outlier' burns deaths were identified during this time period.

PROCESS

- All deaths are reviewed for internal learning and to ensure that relatives are informed of what happened to their loved ones
- A Trust Mortality Surveillance Panel has been implemented to ensure that all inpatient deaths which occur at QVH or post transfer out are reviewed quickly so as to identify any which require formal investigation.
- Structured Judgement Review (SJR) or formal investigation is undertaken as part of the Trust's clinical Governance framework as required.
- Data is collated on all deaths occurring within 30 days of treatment or inpatient admission at QVH to confirm care at QVH was appropriate
- Deaths are reported monthly to the appropriate specialty clinical leads for discussion and so that any learnings are identified and shared
- All deaths are noted and, where necessary, presented and discussed at the bi-monthly joint hospital governance meetings and external peer review meetings where appropriate.
- **Classification of deaths is undertaken as follows:**
    - Expected inpatient deaths at QVH.
    - Unexpected inpatient deaths at QVH.

- Death within 30 days of inpatient/ outpatient episode from condition unrelated to QVH diagnosis/ care.
- Expected deaths related to conditions treated by QVH within 30 days of QVH inpatient/ outpatient episode.
- Unexpected death from condition treated by QVH within 30 days of QVH inpatient/ outpatient episode**.**

FINDINGS

In the period between the 1st April 2023 – 31th March 2024 there were 35 adult deaths which occurred during inpatient episodes at QVH or within 30 days of an outpatient procedure or inpatient episode at QVH. These are shown on Chart 1. The majority of deaths occurred elsewhere (EW) either as inpatients (In) or outpatients (Out), with 1 patient dying as inpatient at QVH during this time period.

Chart 1.

	2023/24			
	Qtr1	Qtr2	Qtr3	Qtr4
Expected inpatient deaths at QVH	1			
Unexpected inpatient deaths at QVH				
Death within 30 days of inpatient/ outpatient episode from condition unrelated to QVH diagnosis/ care	5	3	11	2
Expected deaths related to condition treated by QVH within 30 days of QVH inpatient/ outpatient episode				1
Unexpected death from condition treated by QVH within 30 days of QVH inpatient/ outpatient episode			2	
NA / unknown cause of death		2	1	1
(blank)			2	4
Grand Total	6	5	16	8

Learning Disabilities Mortality Review (LeDeR) Programme
One of QVH's off-site mortalities required reporting to the LeDeR programme. This patient died in a Nursing home and was reported by them. There was no shared learning highlighted.

Deaths from the last reporting year.
One further death (Unexpected inpatient death at QVH) that occurred in March 23 is still undergoing a coronial process. There has been a full investigation from this case and learning incorporated in to practice.

DISCUSSION

QVH on site deaths (n=1)
The one on site inpatient death at QVH occurred whilst the patient was on the palliative care pathway. The SJR identified excellent end of life care, with full involvement of the patient, relatives and the Multi-disciplinary team (MDT).

This patient was effectively managed on the NACEL – end of life pathway with full family involvement.

This case will be the subject of a coronial process due to the mechanism of injury rather than the care of the patient or the mode of her death.

Learning from QVH off-site deaths within 30 days of transfer out from QVH. (n=2)
SJRs were completed for 2 patients who died within 30 days of emergency transfer out to another NHS hospital.

One of these patients died from the condition for which they were being treated at QVH. This has been extensively review internally and externally (peer review) utilising the PSIRF framework and is the subject of awaited coronial inquest.

The other patient died of complications which were unrelated to their burn injury. The patient had sustained a severe injury and would have been an unexpected outlier survivor had they not died. Their care was reviewed at the LSEBN mortality meeting which concluded that they had received excellent care.

Neither of the SJRs reviewed identified any potential QVH lapses in care which contributed to their deaths.

- The Trust Mortality Surveillance Panel was effectively used so that the immediately learning was implemented and then a full PSIRF process was followed.
- The inquest process is still underway.

Off-site deaths within 30 days of an outpatient procedure (n=18)
Whilst the data for these deaths is captured, none of the 18 reported cases necessitate an SJR. Preliminary reviews were completed for all these patients, no issues related to the care delivered was identified which required further review.

One patient died following discharge back to the Care Home in which he normally resided and as the patient had a learning difficulty, this case was reported to LeDer as mentioned in the relevant section above.

QVH Responding to and Learning from Deaths Main themes 2023/2024

- There was no unwarranted variation in the number or specialty of deaths during this period.
- None of the SJRs during this time period following inpatient deaths raised concerns/ identified any deficiencies in care which required further formal Trust investigations.
- QVH provides good quality, Multi-Disciplinary Team (MDT) led palliative care for patients.
- SJRs completed for inpatient deaths which occurred during the time period of this report consistently identified that family involvement in shared decision making and communication between the MDT and family/loved ones was excellent.
- The Learning from deaths policy has been reviewed and amended;
- A Trust Mortality Surveillance Panel has been utilised to ensure that all inpatient deaths that occur at QVH, or post transfer to another facility, are reviewed promptly to identify any that require formal investigation or immediate learning plans.
- The trust has complied with new national recommendations regarding the mandatory utilisation of independent ME services
- The trust has moved to the PSIRF frmawork for investigating patient safety incidents.

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

Queen Victoria Hospital
NHS Foundation Trust

QVH Responding to and Learning from Deaths – Annual Report

Covering dates

1st April 2023 – 31st March 2024

Background

The National Quality Board 2017[1] (NQB) published *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.* This document sets out how NHS Trusts identify, report, investigate and learn from deaths. The principles of the framework include all deaths where families/carers or staff have raised significant concerns about a death, all deaths of those with a learning disability or severe mental health illness and all deaths in areas where people are not expected to die (e.g., elective procedure).

The Queen Victoria NHS Foundation Trust (QVH) is committed to following the principles of the NQB framework and to learning from deaths that occur in our care. These may be whilst the death occurs whilst the patient is in QVH or within 30 days or following interventions and treatments. Our commitment extends to ensuring learnings are identified and acted upon and we do this by engaging with carers and families as well as our clinicians.

Whilst most people receive excellent care from NHS Providers, death is sometimes an inevitable outcome of that excellent care from the NHS in the months and years leading up to their death. QVH is primarily a surgical hospital which manages complex surgical cases but has very low numbers of deaths each year. QVH has a process in place to review all deaths on that occur on site, including those patients who are receiving planned care at the end of their life. Care provided to patients at the end of their life is assessed to ensure it is consistent with national guidance[2].

In accordance with this guidance Queen Victoria Hospital has in place a *Responding to and Learning from Deaths* policy which details the clinical governance process by which it responds to and learns from deaths of patients in its care. The policy at QVH supports a culture of openness, honesty and transparency. It incorporates Duty of Candour which was made a contractual obligation[3] in April 2013 and reinforces the fundamental obligation to be open and honest in the event of an incident where patient harm has occurred.

This is the sixth annual report on learning from deaths at the QVH and covers the period 1st April 2023 – 31st March 2024.

Learning Principles

- All deaths are reviewed for internal learning and to ensure that relatives are informed of what happened to their loved ones
- Data is collated on all deaths occurring within 30 days of treatment or inpatient admission at QVH to confirm care at QVH was appropriate
- Deaths are reported monthly to the appropriate specialty clinical leads for discussion and so that any learnings are identified and shared
- All deaths are noted and, where necessary, presented and discussed at the bi-monthly Joint Hospital Clinical Governance Committee (JHCGC) meetings and external peer review meetings where appropriate. There was one expected death that will be included for discussion in the JHCGC in November which was that of a frail, elderly patient who sustained extensive burns injuries and another who was under the care of the MF team. Both are Coroner's cases which have been extensively reported from which learnings have been taken, and action plans developed. A decision was made

[1] nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

[2] Palliative-and-End-of-Life-Care-Statutory-Guidance-for-Integrated-Care-Boards-ICBs-September-2022.pdf (england.nhs.uk)

[3] https://www.legislation.gov.uk/uksi/2014/2936/contents/

to delay discussion at JHCGC until November and/or until the outcome of the inquests are into both deaths.

QVH Learning from Deaths Process

The Trust's policy for '*Responding to and Learning from Deaths'* stipulates that all patient deaths that occur within thirty days of discharge from QVH inpatient care, or following an outpatient procedure should have an initial preliminary review to estalish whether the death was related to QVH treatment/ care. Cases are escalated to a Structured Judgement Review (SJR) or formal investigation as part of the Trust's clinical Governance framework as required.

Investigation through SJR, is recommended in following circumstances:

- Unexpected death, for example following elective surgery
- Any paediatric death
- Any death of a patient with learning difficulties or serious mental health disease
- Patients who are not under the care of QVH at the time of death but where another organisation suggests that the Trust should review the care provided to the patient previously.
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
- All deaths where concerns have been raised internally or externally about the quality of care, or where service improvements are in progress

To provide assurance that QVH's *Responding and Learning from Deaths* process is robust, over 2023/4 a Trust Mortality Surveillance Panel (TMSP) was introduced the previous financial year to:

- Decide whether very urgent learning might be necessary, requiring an accelerated process that might need to be quicker than, but not replacing, a PSIRF investigation.
- Oversee, monitor and support the Specialties with the implementation of the *Responding and Learning from Deaths* policy.
- Monitor compliance/ progress with detailed formal investigations, and escalate to the Clinical Governance Group and Quality & Governance Committee as necessary.
- Ensure that external reporting to other agencies, is completed in a timely way.
- Ensure that the process for following up the outcome of patients who die within 30 days of emergency transfer out from QVH is robust

In order that QVH is compliant with the national, mandatory changes that took effect in April 2024, all Medical Examiner (ME) Services are provided by Surrey & Sussex Healthcare Medical Examiners service, which is independent from the NHS trust of that name. The changes mean that all deaths are to be discussed with the ME regardless of whether the cause of death appears to be clear. The ME Service then advises in all patient deaths whether there is a need for Coronial referral. MEs are senior medical doctors who are contracted to provide independent scrutiny of all inpatient deaths occurring in acute hospital settings. They put the bereaved relatives at the centre of the process. The introduction by the Department of Health on 15th April 2024 of *Death Certification Reforms* which will come into force on 9th September 2024 when a new *Medical Certification of Cause of Death (MCCD)* will be implemented. This represents a simplification of the current regulations that,

prior to 9th September, required a coroner to review the death of patient who had not been seen by a doctor within the 28 days prior to death.

The ME service supporting QVH will support colleagues to ensure that the *Responding and Learning from Deaths* Policy is consistently embedded into practice by:

- Providing greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- Ensuring the appropriate direction of deaths to the Coroner
- Providing an improved service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improving the quality of death certification
- Improving the quality of mortality data.

QVH has introduced and utilises the *Patient Safety Incident Reporting Framework*[4] (PSIRF) to investigate all patient safety-related incidents, including those related to the unexpected death of a patient in our care. It is the NHS's approach to the development and maintenance of processes to effectively respond to patient safety incidents for the purposes of learning. This process came about as the result of a number of different national reports[5],[6],[7],[8] which highlighted shortcomings in the way in which patient safety incidents were investigated and reported and learned from.

The *Patient Safety Incident Response Policy* for QVH was published in December 2023 and supports the requirements of PSIRF and integrates the four main aims:

1. Compassion, engagement and involvement of those affected by safety incidents.
2. Application of a range of system-based approraches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents and safety issues.
4. Supportive oversight, focused on strengthening response systems and improvements.

For those affected by patient safety incidents that occur at QVH this policy is intended to:

- Provide an improved experience for those affected by patient safety incidents
- A more proportionate and effective response to patient safety incidents.
- An improved range of learning methods
- Strengthened Governance and oversight

The *NHS Standardised Hospital Mortality Index* (SHMI) is the ratio between the actual number of patients who die following hospitalisation at an NHS trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. QVH is on the NHSE exemption list for participating in SHMI as it is not possible to benchmark our unique patient mix against any other providers.

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[4] NHS England » Patient Safety Incident Response Framework

[5] House of Commons (2015) Public Administration Select Committee. *Investigating Clinical Incidents in the NHS.* Sixth Report of Session 2014-2015.

[6] A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged | Parliamentary and Health Service Ombudsman (PHSO)

[7] Briefing: Learning from serious incidents in NHS acute hospitals (cqc.org.uk)

[8] 20161213-learning-candour-accountability-full-report.pdf (cqc.org.uk)

QVH monitors mortality data by area, speciality and diagnosis on a monthly basis, in particular for burns and head and neck oncology, both of which are monitored at regional and national level. QVH undertakes detailed reviews of all on-site deaths to identify any potential areas of learning which can be used to improve patient safety and care quality.

All of the inpatient deaths during this time period were Burns or Maxillofacial (MF) patients.

QVH's outcomes for our MF patients remain excellent. Our MF patients' survival within 30 days of surgery is 99.1%, which is equivalent to the highest performing units in the country.

The care provided for all inpatient burns patients who die is reviewed by peers at the London South East Burns Network. No 'outlier' burns deaths were identified during this time period.

Classification of Deaths to aid learning

To assist in the identification of patients requiring more detailed investigation, all deaths are now being classified, to reflect the cause of death and whether the death was expected. This will focus on QVH core conditions and identify specific issues, while also noting any intervention that might be indicated for other conditions and continue to improve end of life pathways. The groups of patients are:

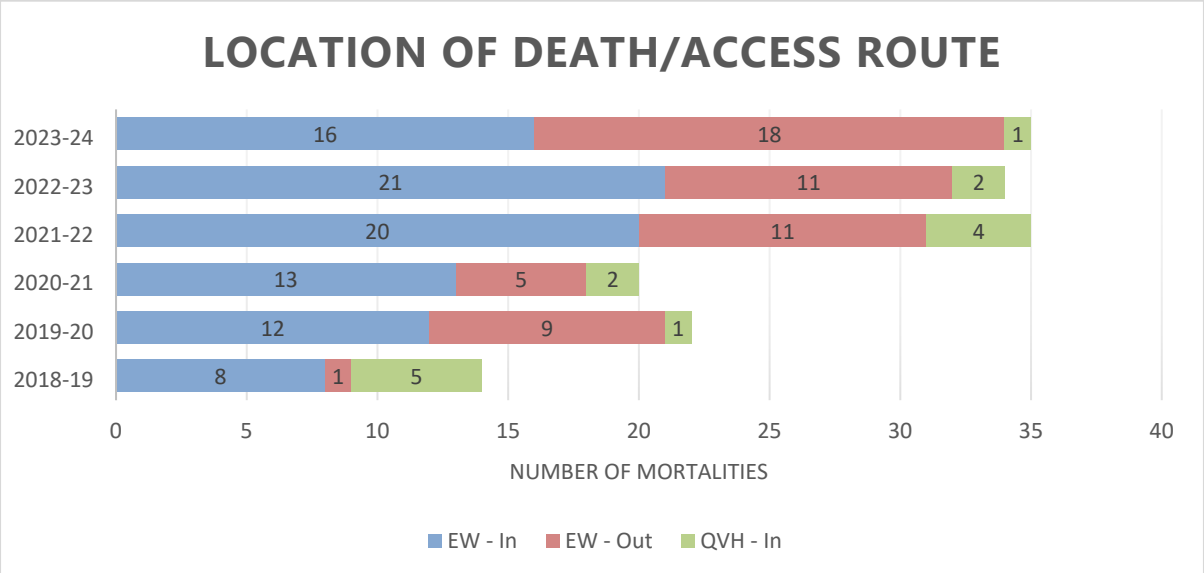
1. **Expected inpatient deaths at QVH.** Some patients have very advanced cancer or severe burns, and although they are not expected to survive for long the QVH multidisciplinary teams make a significant contribution to their care including end of life care. Many can have good quality of life in the short term although their longer term outcome is less favourable. If they die at QVH there are often learning points that can enhance care for other patients. Families also benefit from the reassurance that everything that should have been done for their loved one, was done. If areas or gaps in care are identified, lessons are taken from these for improvements to be made that will positively impact future patients and their relatives.
2. **Unexpected inpatient deaths at QVH.** Occasionally a patient dies at QVH with a condition that was not life limiting, their treatment might have been an issue and mistakes can be made. These deaths must be identified and investigated in a timely and effective manner with an inclusive open process, so that leaning can be identified and changes made.
3. **Death within 30 days of inpatient/ outpatient episode from condition unrelated to QVH diagnosis/ care.** This includes unrelated medical conditions and accidents. There is less likely to be learning for QVH from these deaths, but a brief notes review is undertaken to confirm this.
4. **Expected deaths related to conditions treated by QVH within 30 days of QVH inpatient/ outpatient episode.** Patients with significant medical conditions and complications are sometimes transferred to other providers due to lack of specialist staff and facilities at QVH. Although they die at another Trust from an expected cause there will sometimes be learning and actions to undertake
5. **Unexpected death from condition treated by QVH within 30 days of QVH inpatient/ outpatient episode.** This group is very likely to have learning that could be missed. It is now a requirement of the transfer out datix that the outcome of the patient is recorded so that learning /action can be undertaken.

Classification of Death	2022/23				2023/24			
	Qtr1	Qtr2	Qtr3	Qtr4	Qtr 1	Qtr 2	Qtr 3	Qtr 4
1 Expected inpatient deaths at QVH		1			1			
2 Unexpected inpatient deaths at QVH				1				
3 Death within 30 days of inpatient/ outpatient episode from condition unrelated to QVH diagnosis/ care	5	3	3	7	5	3	11	2
4 Expected deaths related to condition treated by QVH within 30 days of QVH inpatient/ outpatient episode	6	2		1				1
5 Unexpected death from condition treated by QVH within 30 days of QVH inpatient/ outpatient episode		1					2	
NA						2	1	1
(blank)	1		4				2	4
Grand Total	12	7	7	8	6	5	16	8

Overview of All Mortalities during period 01/04/2023- 31/3/2024

In the period between the 1st April 2023 – 31th March 2024 there were 35 adult deaths which occurred during inpatient episodes at QVH or within 30 days of an outpatient procedure or inpatient episode at QVH. These are shown on Chart 1. The majority of deaths occurred elsewhere (EW) either as inpatients (In) or outpatients (Out), with 1 patient dying as an inpatient at QVH during this time period.

Chart 1. Mortalities trend 01/04/2023 – 31/03/24

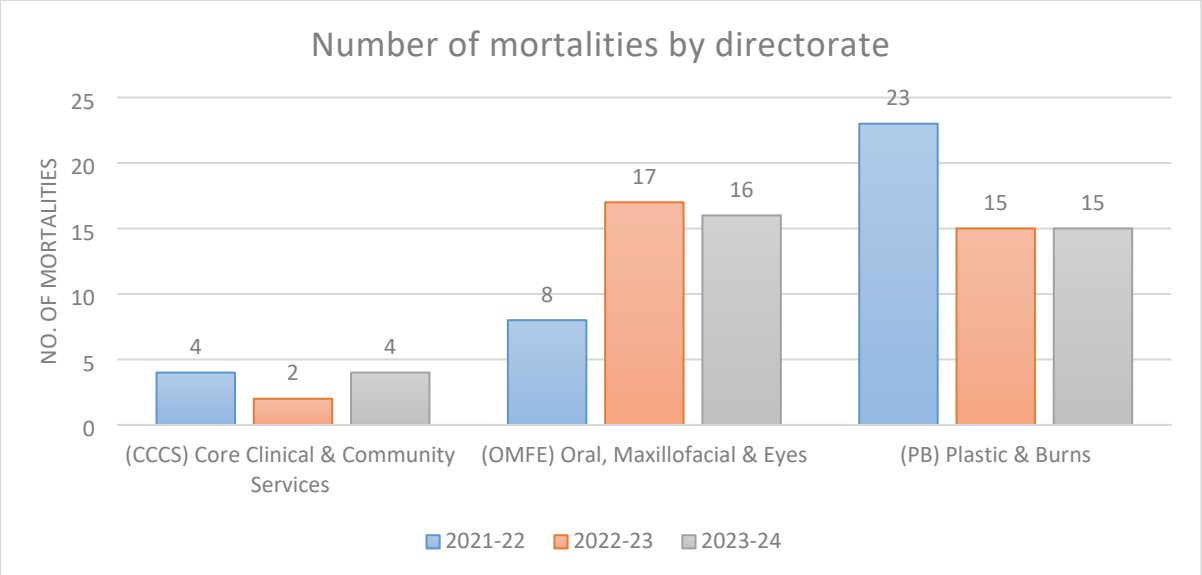


Benchmarking QVH's inpatient death rate

2021/22	2022/23				2023/24			
Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
1 (Bur)		1(Bur)		1(MF)	1(Bur)			

QVH Inpatient Mortality	2016/7	2017/8	2018/9	2019/20	2020/21	2021/22	2022/23	2023/24
In-hospital mortality per 100 bed days	0.00	0.02	0.03	0.00	0.02	0.02	0.02	0.01
In-hospital deaths	1	4	5	1	2	4	2	1

Chart 2. Mortality by Directorate



Patients whose cause of death is unknown

At the time of writing this report QVH is awaiting the cause of death for 6 patients who died within 30 days of inpatient/ outpatient treatment at QVH during this time period. In each case the cause of death has been requested by QVH from the patient's GP and/or the hospital in which they died.

Where the cause of deaths is established they will be reviewed as per the QVH responding to and learning from deaths governance process. Therefore, in the first instance, an initial preliminary review will be undertaken for each one so as to determine whether further review of the care delivered at QVH is required. It can often be quite obvious that patients who may have had a minor intervention at the hospital (e.g., corneal tomography who die 2 or 3 weeks later), but who have multiple co-morbidities there is unlikely to be a link between the procedure and their death. However, where there is any doubt at all, a preliminary review

will be undertaken with good collaboration between clinical staff in order to determine whether or not a serious review is necessitated.

Mortalities by protected characteristics

No statistically significant unwarranted variation was identified in relation to protected characteristics.

Deaths within 30 days of a QVH inpatient episode of care.

There was no unwarranted variation in the specialities that patients were treated under prior to dying within 30 days of inpatient treatment at QVH.

Learning from QVH off-site deaths within 30 days of transfer out from QVH. (n=2)

SJRs were completed for 2 patients who died within 30 days of emergency transfer out to another NHS hospital. One of these patients died from the condition for which they were being treated at QVH. This case has been extensively reviewed internally and externally (peer review) and is the subject of an awaited coronial review. The other patient died of complications which were unrelated to their burn injury. The patient had sustained a severe injury and would have been an unexpected outlier survivor had they not died. Their care was reviewed at the LSEBN mortality meeting which concluded that they had received excellent care. Neither of the SJRs reviewed identified any potential QVH lapses in care which contributed to their deaths.

Off-site deaths within 30 days of an outpatient procedure (n=18)

Whilst the data for these deaths is captured, none of the 18 reported cases necessitate an SJR. Preliminary reviews were completed for all these patients, no issues related to the care delivered was identified which required further review..

One patient died following discharge back to the Care Home in which he normally resided and as the patient had a learning difficulty, this case was reported to LeDer as mentioned in the relevant section of this report.

There was no unwarranted variation in the specialities that patients were treated under prior to dying within 30 days of inpatient treatment at QVH.

QVH on site deaths (n=1)

The one on site inpatient death at QVH occurred whilst the patient was on the palliative care pathway. The SJR identified excellent end of life care, with full involvement of the patient, relatives and the Multi-disciplinary team (MDT).

Learning from Inquests (n=0)

Within the reporting period there were no inquests held during this time period. Of note there are three pending inquests; 1) An unexpeted death of a major maxillofacial patient, who died in Q4 of 22/23, 2) The burn patient mentioned above, for whom there were no concerns about the care delivered at QVH and who was on palliative care pathway, for whom the circumstances of the original injury are at the centre of the inquest and, 3) A major maxillofacial patient died after transfer to University Hospital Sussex. As previsouly stated, all three have had extensive internal learning and discussion at QVH.

Learning Disabilities Mortality Review (LeDeR) Programme

LeDeR is a service improvement programme for people with either a learning disability and/or autism.

Barriers to health and care to keep themselves healthy are often more difficult for people with a learning disability, who also often have poorer physical and mental health than other people. *"Too many people with a learning disability are dying earlier than they should, many from things which could have been treated or prevented."*[9]

A LeDeR review looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. They look for areas of care that require improvement and also those areas where good practice has been identified. They use examples of good practice to share across the country in an effort to improve care more widely. This helps reduce inequalities in care for people with a learning disability and/or autism. It aims to reduce the number of people dying sooner than they should.

None of the mortalities that occurred on site at QVH were required to be reported to the LeDeR programme. However, one off site case was reported where a patient died in their Care Home facility within 30 days following discharge from QVH. A review of the case revealed that this patient had multiple co-morbidities and the burn injury they had sustained was relatively minor. Therefore, it was concluded that the burn injury and the care the patient received at QVH was not likely to have had an impact on their death. However, the case was reported to the Coroner due there being reported Safeguarding concerns in relation to the incident from which the patient sustained their injury.

LeDeR – Learning from Lives & Deaths

For the first time QVH reported the death of a patient to LeDeR. The case was reviewed as above and no further action has been required.

Anyone is able to advise LeDeR when someone with a learning disability and/or autism dies. Once LeDeR is notified of someone's death, the patient's case is referred to a reviewer in the person's local area. The reviewer will contact the following people to talk about the person's life and death:

- family member or carer,
- the person's GP
- at least one other person who knew them well, for example, another healthcare professional, a care provider, another family member or a friend.

They will not necessarily contact the care provider organisation. There is a national publication LeDeR 2023 (2022 report), with key highlights, but no relevant recommendations/improvement plans for QVH were identified in the report. The report for 2024 will be published later this year.

QVH continues to focus on the following actions/recommendations from the LeDeR national report:

[9] NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)

- *Providers should clearly identify people requiring the provision of reasonable adjustments, record the adjustments that are required, and regularly audit their provision.*
- *Local services must strengthen their governance in relation to adherence to the Mental Capacity Act, and provide training and audit of compliance 'on the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.*
- *Mandatory learning disability awareness training should be provided to all staff, and be delivered in conjunction with people with learning disabilities and their families.*

End of Life Care

National Audit of Care at the End of Life (NACEL)

The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient facilities[10].

The overall aim of NACEL is to improve the quality of care for adults (18 years +) who are at or close to the end of their life in England, Wales and Jersey.

The overarching aims of this organisation are to:

- *Improve the quality of care by identifying areas for action in relation to delivery and outcomes, and adapting Quality Improvement (QI) priorities in line with evidence and guidance*
- *Reducing unwarranted variation through benchmarking of outcome measures as well as identifying and managing outliers using the appropriate guidance*
- *Understanding and reducing health inequalities in relation to impact on the specified measures*
- *Sharing and adopting best practice including QI examples, and signposting to resources available in the wider End of Life landscape[11]*

Update on organisational actions identified from round 3 of the NACEL in Learning from Deaths Report

- The End of Life (EoL) Policy has been updated it to meet the current national guidelines and standards of EoL care
- An end of life individualised care plan for use in clinical areas which follows NICE guidance is embedded in practice
- There is a developed Palliative Care Study day
- The Lead Macmillan Head and Neck Clinical Nurse Specialist also supports staff with EoL care as required

[10] National Audit of Care at the End of Life (nacel.nhs.uk)
[11] National Audit of Care at the End of Life (nacel.nhs.uk)

QVH Responding to and Learning from Deaths Main themes 2023/2024

- There was no unwarranted variation in the number or specialty of deaths during this period.
- None of the SJRs during this time period following inpatient deaths raised concerns/ identified any deficiencies in care which required further formal Trust investigations.
- QVH provides good quality, Multi-Disciplinary Team (MDT) led palliative care for patients.
- SJRs completed for inpatient deaths which occurred during the time period of this report consistently identified that family involvement in shared decision making and communication between the MDT and family/ loved ones was excellent.
- The Learning from deaths policy has been reviewed and amended;
- A Trust Mortality Surveillance Panel has been utilised to ensure that all inpatient deaths that occur at QVH, or post transfer to another facility are reviewed promptly to identify any that require formal investigation or immediate learning plans.
- The trust has complied with new national recommendations regarding the mandatory utilisation of independent ME services
- The trust has moved to the PSIRF frmawork for investigating patient safety incidents.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024		**Agenda reference:**	**50-24**	
Report title:	Equality, Diversity & Inclusion (EDI) Summary Annual Report 2022/23				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide a summary annual update on the Trust's EDI metrics, challenges and proposed actions for improvement. This report summarises our Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap and our progress against our objectives and actions. The report also provides an update on our performance against Equality Delivery System 2 (EDS2) Workforce Goals. This is a report looking back rather than forward so although referenced, does not focus on our current ongoing work.				
Summary of key issues	The report highlights the progress made in 2023 in increasing declaration rates for staff with protected characteristics. As defined in our WRES, WDES and Gender Pay reports for 2022/23 we have EDI challenges as an organisation which we are seeking to address through our Trust EDI action plan.				
Recommendation:	The Board is asked to **approve** the report for publication on the Trust's website.				
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:	Finance and performance committee				
	Date:	June 2024	Decision:		
Next steps:	To be published on the Trust website				

Report to:	Board of Directors
Agenda item:	50-24
Date of meeting:	24 June 2024
Report from:	Helen Edmunds, Chief People Officer
Report author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	23 May 2024
Appendices:	None

EDI Summary Annual Report

Introduction

This summarised annual EDI workforce report for QVH covers the period 1 April 2022 to 31 March 2023.

Queen Victoria Hospital NHS Foundation Trust (QVH) recognises its workforce and patients are core to achieving its business and social responsibilities. This report aims to demonstrate progress in delivering the best possible inclusive healthcare services for our patients and staff. Our people are our most important asset, and through workforce diversity monitoring we continue to demonstrate commitment to understanding, valuing and incorporating differences, in order to ensure a workplace that is fair, equitable and inclusive for all being the best place to work.

QVH is a small organisation with 1,131 whole time equivalent (WTE) staff (as at 31 March 2023), based in East Grinstead, with some staff based at spoke sites in Kent, Surrey and other locations in Sussex.

The Trust is duty bound by legislation to ensure everyone receives a fair and equitable service, promoting a culture of active inclusion.

The Equality Act 2010 specifically states that people should not be treated unfavourably because of nine protected characteristics:

- their age
- any disabilities they may have
- their ethnic background or race
- their gender (sex is the characteristic listed in the act)
- their gender identity (gender reassignment is the characteristic listed in the act)
- their marital status
- if they are pregnant or recently had a baby
- any religion or beliefs they may have
- their sexual orientation

We believe that an inclusive workplace, where staff, patients and community stakeholders are treated with dignity and respect, is everyone's responsibility: these and the Trust values of *Humanity, Pride, Quality and Continuous Improvement* guide the way in which we work.

This report provides an overview of our equality and diversity employment monitoring data as of 31 March 2023, setting out the challenges the Trust faces, the progress that has been made and the future work we want to do over the next year. QVH recognises the need to accelerate cultural change to become a more inclusive organisation and an employer of choice for a diverse workforce.

The data relates only to staff directly and substantively employed or appointed by QVH, including those on secondment hosted by QVH; it excludes those on honorary contracts who are directly employed by other healthcare providers.

Every year the Trust provides statistical data, and a written report for the NHS Workforce Race Equality Standard WRES and NHS Workforce Disability Equality Standard. Both reports use data for the period 1st April 2022 to 31st March 2023. The Trust also provides statistical data and a written report for Gender Pay Gap, taken as a snapshot on the 31st March 2023.

Executive Summary

Workforce Headlines

The total number of staff in the Trust in 2023 was 1131 compared to 2022 where there were 1,100 staff. Overall in 2023, 98% of the workforce had declared their ethnicity, which is comparable to 2022. **19.5% of our staff are from a Black and Minority Ethnic background**, an increase of 0.13% on the previous year.

In the same period, 95.7% of the workforce had declared their Disability status, which is the same as in 2022. From this **5.8% of the Trust's workforce declared that they have a disability**, a 0.4% increase on the previous year

Full-pay relevant employees comprised 77% women and 23% men.

The majority of employees are concentrated in the lower pay bands (2-7). There continue to be more men (58%) than women in medical and dental roles as at 31 March 2023, although the proportion of women in VSM and NED roles (56%) has increased, compared to 2022 (50%).

Workforce Race Equality Standard

Compared to the overall workforce, there is a higher representation of BME staff in Band 5-7 and medical grades. The least number of BME staff are represented in Bands 8a to 9.

Bands 5-6 and medical grades in clinical roles have a higher level of representation of BME staff compared to the overall number of BME staff in the workplace which has remained consistent since 2016. The overall number of BME staff in the workplace is 19.5%.

There is a better representation of BME staff in clinical roles (25.0%) compared to non-clinical roles (9.4%). The representation of BME staff in non-clinical roles has increased by 105.6%. The increase in the number of BME clinical staff is 61.9%.

Band 8c-9 and VSM have no representation of BME staff in clinical roles. However, it is important to note the number of staff in these roles are small (each below 5, with only 1 member of staff in Band 8d and 2 staff in Band 9), resulting in variations appearing more signification than in larger groups.

There is a low level of representation of BME staff in the Board overall at 8.3% compared to the overall number of BME staff in the workplace. However, it is important to note the Board is comprised of only 8 members, with 4 voting members.

21.8% of BME staff had personally experienced discrimination at work from a manager, team leader or other colleagues in 2022.

White applicants were 2.31 times more likely to be appointed from shortlisting compared to BME applicants.

More BME survey respondents have reported experiencing bullying, harassment or abuse from patients, relatives or the public in the last 12 months (28%) compared to white respondents (19.2%).

The number of BME survey respondents reporting experience of bullying, harassment or abuse from staff in the last 12 months (30%) was 12% higher than white respondents (18%).

Workforce Disability Equality Standard

Compared to the overall workforce, in the non-clinical workforce there is a higher representation of Disabled staff in 2023 in Cluster 1 (lowest bands). The least number of Disabled staff are represented in Cluster 4 (highest bands). There is a better representation of Disabled staff in the non-clinical roles compared to clinical role

There is a better representation of Disabled staff among the total executive Board (12.5%) in 2023 when compared to the overall workforce (5.8%). There is a significantly better percentage representation of Disabled staff among the voting members of the Board (25%) when compared to the overall workforce (the Board consists of 8 executive members, with 4 voting members as at 31 March 2023).

The 2023 data suggests non-disabled applicants are 0.71 times more likely to be appointed from shortlisting than Disabled applicants.

The percentage of disabled staff that experienced harassment, bullying or abuse from managers in 2022 was 14.6% which is higher (7.5%) than non-disabled staff where 7.1% responded that they had this experience.

The percentage of disabled staff that experienced harassment, bullying or abuse from other colleagues in 2022 was 24.3% which is 10.2% more than non-disabled staff where 14.1% responded that they had this experience.

The percentage of disabled staff believing that the organisation provides equal opportunities for career progression or promotion in 2022 was 55.4% which is a nominal 2.0% less than non-disabled staff (57.4%).

The percentage of disabled staff that said they had felt pressure from their manager to come to work, despite not feeling well enough to perform their duties, in 2022 was 22% which has significantly improved since 2020 (38%) but slightly higher (2%) than non-disabled staff where 20% responded they had felt pressure.

The percentage of disabled staff that said their employer has made adequate adjustment(s) to enable them to carry out their work in 2022 was 84.8% an increase from 80.7% in 2021.

Gender Pay Gap

The gender pay gap at QVH is driven in part by a disproportionate number of men in more senior admin and clinical scientist roles among our Agenda for Change (AfC) workforce and an older workforce profile of senior male clinicians earning top of grade and bonus payments relative to our total workforce.

The Trust gender pay gap for 2023 is 33.8% (Mean) and 30.6% (Median). The Trust median pay gap has reduced 10% since 2017 and mean gap has reduced 3.3% in the same period.

The gender distribution of staff by Agenda for Change (AfC) Band shows women are predominant at all bands and pay quartiles (1 being the lowest and 4 the highest paid) up to and including Band 8b. From Band 8c to 8d the proportion of men and women are equal and at Band 9 men are predominant, though the numbers are small.

The pay gap for junior doctors is 3.55% (£1.14ph) Mean and 6% (£1.77ph) Median.

Amongst our consultant workforce, we have 62 Male and 27 female consultants at 31st March 2023. This reflects the surgical specialism's of the Trust and the historic over-representation of men in the surgical consultant workforce. 21 men (34%) work part time and 16 female (59%) consultants work part time.

41 out of our 61 male consultants are paid within the top 3 points of the consultant pay scale and over half of these are full time.

9 out of 27 of our female consultants are paid within the top 3 points of the consultant pay scale. Only 22% are full time.

Additional Programmed Activates *(*APA's) are only payable on PA's in excess of 10, which equates to full time. We have 42 males who receive APA compared to 10 females. This

means 60% of our male consultant undertake APA's compared to 25% of our female consultants.

In respect of Agenda for Change (AfC) staff the mean pay gap was 10.1%, a gap of £1.94 an hour in favour of men, because there are more men in higher paid roles (esp. in estates among the more junior staff and then admin and healthcare sciences at more senior grades). The median pay gap was 8.4%, a gap of £1.41 an hour in favour of men.

National Position

Workforce Race Equality Standard

As at 31 March 2023, the NHS had a workforce of approximately 1.4 million people with over 100 nationalities represented, of which 24.2% were from a black or minority ethnic (BME) background. This is an increase from 19.1% in 2018. The total number of BME staff at very senior manager level increased by 69.7% since 2018, and there was a 38.1% improvement of board members from a BME background between 2020 and 2022.

The Workforce Race Equality Standard (WRES) programme has now been collecting data on race inequality for seven years, holding up a mirror to the service and revealing the disparities that exist for black and minority ethnic staff compared to white colleagues. The Covid-19 pandemic has put in the spotlight the disadvantage experienced by staff with protected characteristics. As the NHS recovers its services following the pandemic, addressing the issues of equality and inclusion are core to the success for the workforce.

The WRES uses statistical data to demonstrate the experience and outcomes for BME staff compared to white staff through many stages of the employment journey. The standard requires NHS Trusts to develop action plans to address any areas of inequity that the data highlights. It is an annual process to review and improve working conditions for BME staff in the NHS.

The report uses the acronym BME, recognising that within this there are a multitude of ethnic backgrounds and diversity included within the WRES analysis. It does not suggest that the identified issues affect all BME staff equally or that each group's treatment or needs are the same.

Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is mandated for all Trusts in England with the aim of furthering equality and inclusion for Disabled staff in the NHS. Introduced in 2019, it has now been collecting data on disability inequality for four years, highlighting the collective experiences of Disabled NHS staff and shines a light on disparities between Disabled and non-disabled staff.

The WDES is a collection of 10 metrics that aim to compare the workplace and career experiences of Disabled and non-disabled staff through stages of the employment journey. The standard requires NHS Trusts to develop action plans to address any areas of inequity that the data highlights. It is an annual process to review and improve working conditions for Disabled staff in the NHS.

The report uses a capital 'D' when referring to Disabled staff. This is a conscious decision, made to emphasise that barriers continue to exist for people with long-term conditions. The capital 'D' also signifies that Disabled people have a shared identity and are part of a community that continues to fight for equality.

The WDES is referenced in the NHS People Plan. Published in 2021, the Plan sets out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people, and work together differently to deliver patient care. The Plan makes clear that the NHS must welcome all, building understanding, encouraging and celebrating diversity in all its forms.

The WDES helps to demonstrate compliance with:

- The UK Government's pledge to increase the number of Disabled people in employment – made in November 2017
- The NHS Constitution – relating to the rights of staff
- The 'social model of disability' – recognising that it is the societal barriers that people with disabilities face which is the disabling factor, not an individual's medical condition or impairment
- The Equality Act 2010 – specific requirements not to discriminate against workers with a disability, advancing equality and fostering good relations
- 'Nothing about us without us' - a phrase used by the disability movement to denote a central principle of inclusion: that actions and decisions that affect or are about people with disabilities should be taken with disabled people.
- 'Disability as an Asset' – refers to the benefits of employing Disabled staff and the positive impact that disability inclusion can have in the workplace, developing a culture in which people can speak openly and positively about disability and bring their lived experience into work.

Gender Pay Gap

Organisations with 250 or more employees are mandated under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 to publish information annually on their gender pay gap using specific measures.

The gender pay gap is the difference between average hourly earnings (excluding overtime) of men and women as a proportion of men's average hourly earnings (excluding overtime). The gender pay gap is a measure across all jobs in the hospital, not of the difference in pay between men and women for doing the same job.

The gender pay gap report is a snapshot as at 31 March 2023.

Gender pay gap reporting is based on the government's methodology for calculating the difference in pay between full-pay relevant female and male employees.

'Relevant employees' are all employees employed on the snapshot date, including employees who are part-time, job-sharing, on leave, and those who are self-employed, where they must perform the work themselves and not subcontract any part of the work or employ their own staff to do it.

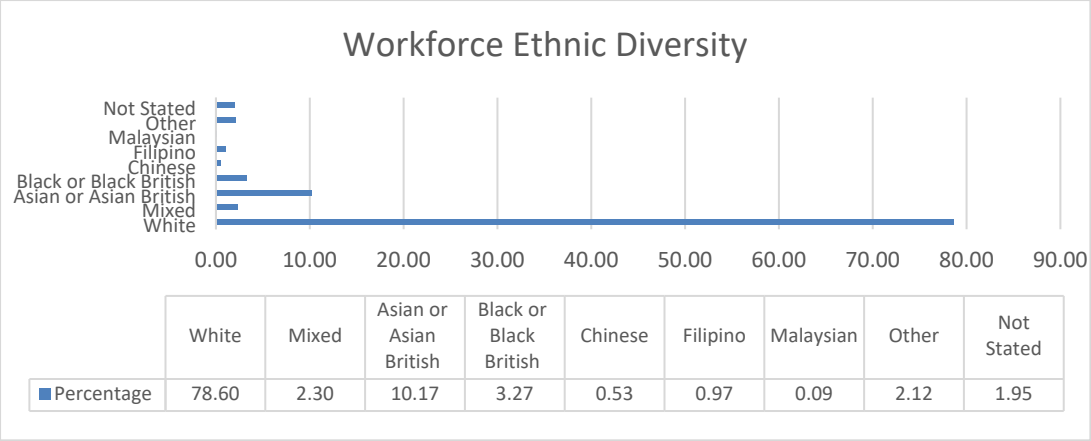
'Full-pay relevant employees' refers to all employees employed on the snapshot date who are either paid their usual full basic pay or paid less than their usual basic pay but not because of leave (for example, because they have irregular working hours). It does not include anyone who was not paid their usual full basic pay because they were on leave (including maternity, paternity, adoption, parental leave, sick leave, special leave, study leave).

Data on 'relevant employees' is used to calculate any gender pay gap in bonus pay. Data on 'full-pay relevant employees' is used for all other gender pay gap calculations.

'Equal pay' means being paid equally for the same/similar work. The 'pay gap' is the difference in the average pay between the two groups.

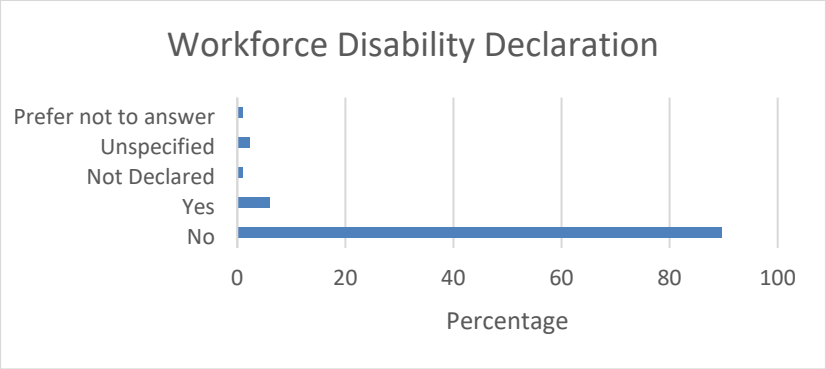
Our Workforce

The total number of staff in the Trust in 2023 was 1131 compared to 2022 where there were 1,100 staff. Overall in 2023, 98% of the workforce had declared their ethnicity, which is comparable to 2022. **19.5% of our staff are from a Black and Minority Ethnic background**, an increase of 0.13% on the previous year.



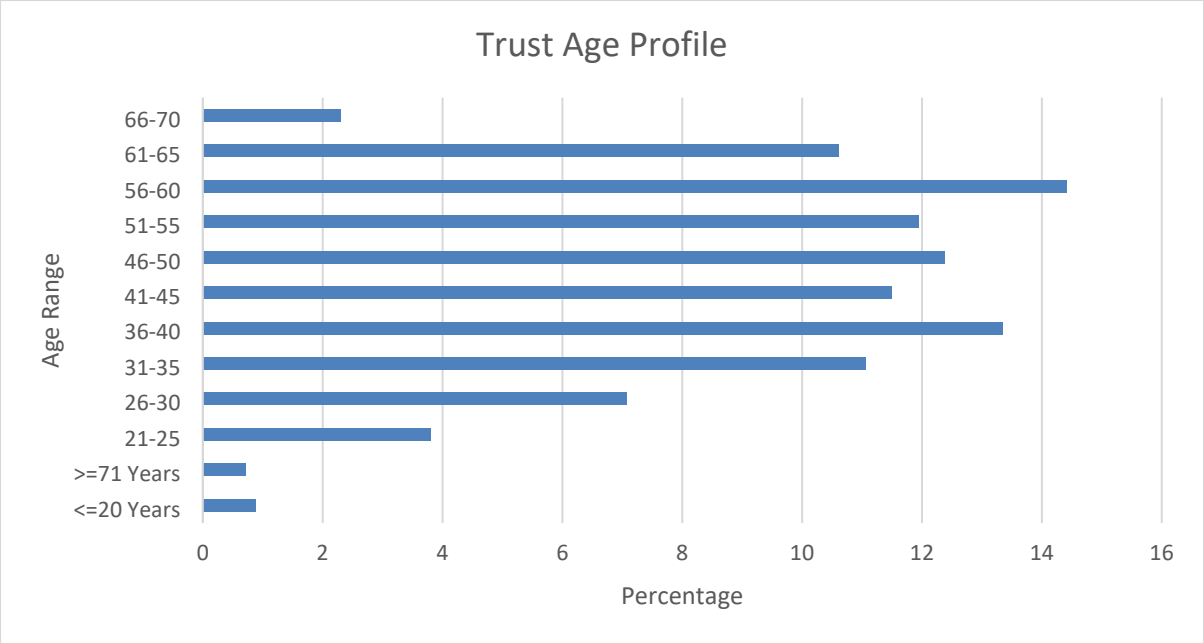
	White	Mixed	Asian or Asian British	Black or Black British	Chinese	Filipino	Malaysian	Other	Not Stated
Percentage	78.60	2.30	10.17	3.27	0.53	0.97	0.09	2.12	1.95

In the same period, 95.7% of the workforce had declared their Disability status, which is the same as in 2022. From this **5.8% of the Trust's workforce declared that they have a disability**, a 0.4% increase on the previous year

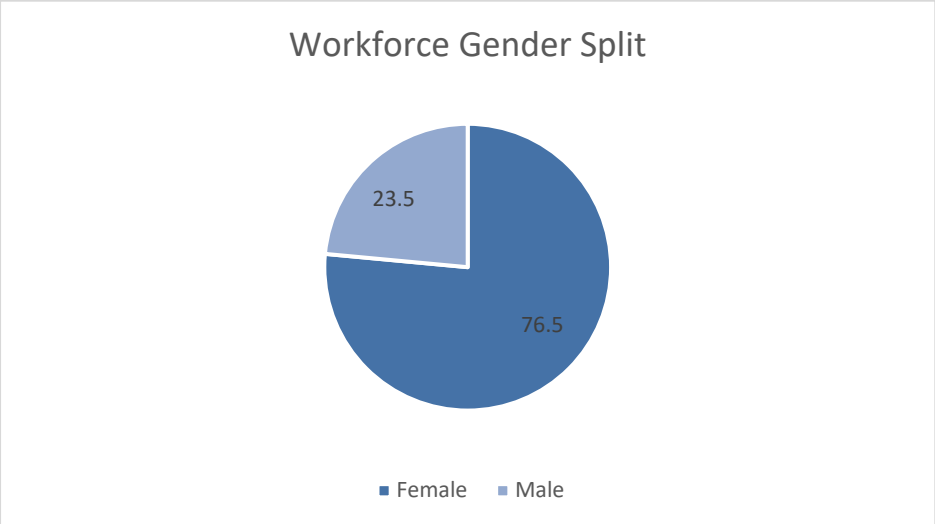


84% of the Trust's workforce declared that they were Heterosexual. 2.9% of our workforce declared that they were either Bisexual, Gay or Lesbian which is a 0.9% increase from last year. 4.7% of our workforce however have not specified their sexual orientation.

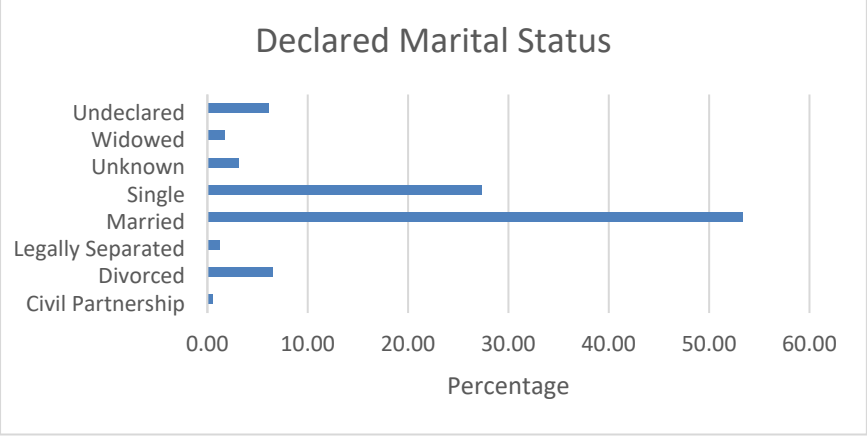
22.81% of our workforce are aged under 35, a decrease compared to 2022 where 24.18% was reported. **28.20% of our workforce are aged over 55**, an increase from 26.00% the previous year; 3% of our workforce are over 65.



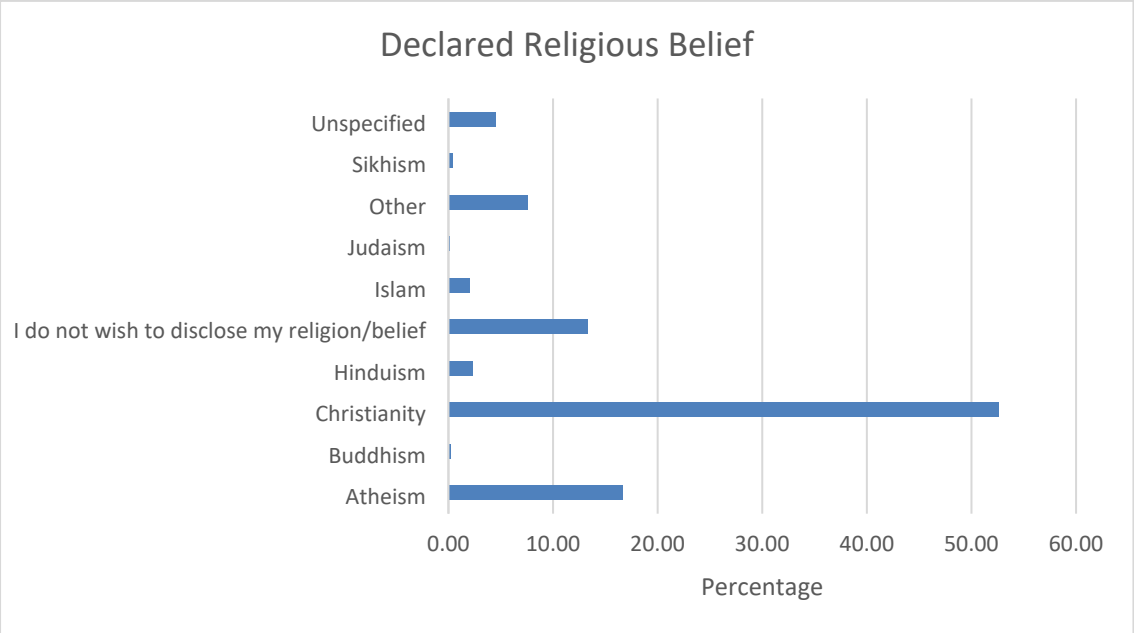
76.48% of our workforce are female which is slightly higher to the previous year of 75.82% – this is significantly higher than the 51.4% female population of East Grinstead



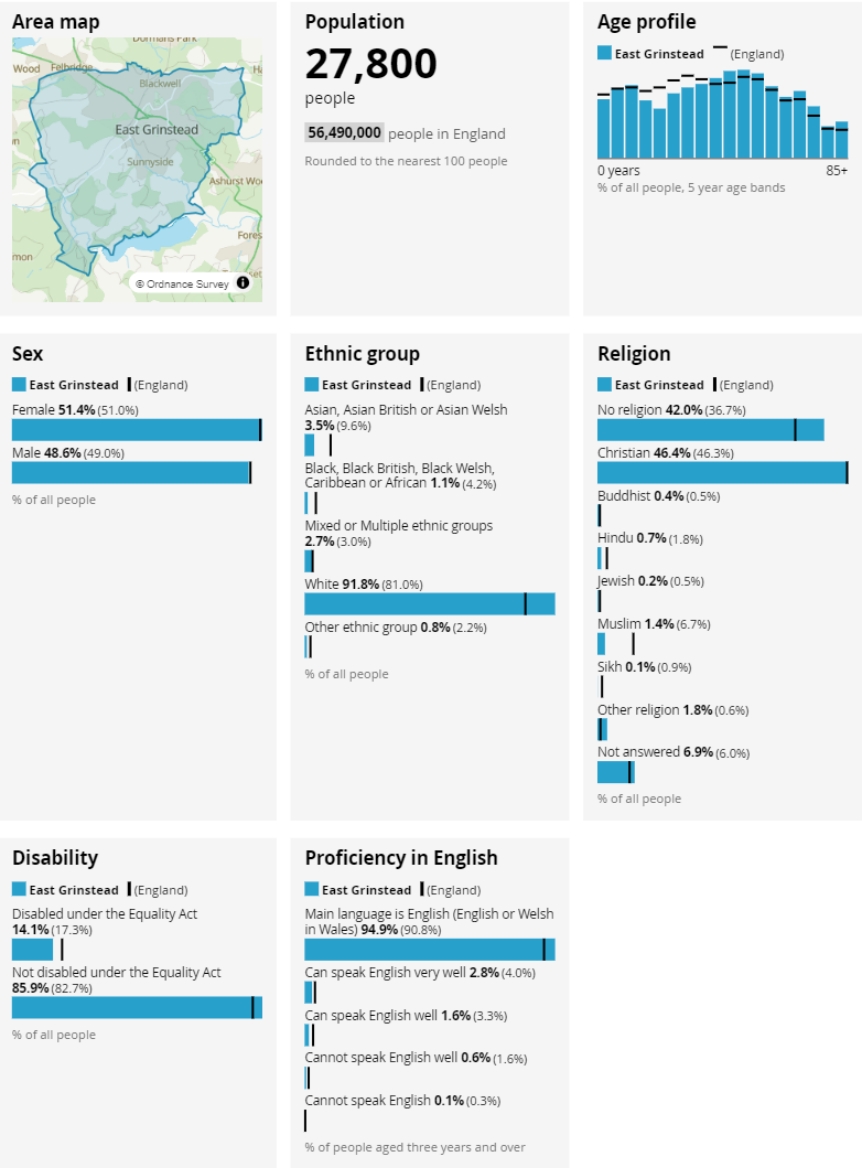
53.93% of our workforce are married or in a civil partnership, which is a marginal decrease from last year's figure of 55.00%



82.14% of our workforce declared a religion or belief, slightly up from the previous year's disclosure of 81.09%.



Our Local Population Headlines



Source: Office for National Statistics - Census 2021

The Equality Delivery System (EDS2)

QVH supports the national Equality Delivery System which sets goals to ensure:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. We have inclusive leadership.

EDS2 is measured using outcomes against these 4 areas. The main purpose of the EDS was, and remains, to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED)

This report focusses on our workforce and our progress against goals 3 and 4.

Goals and Outcomes of EDS2		
Goal	**Number**	**Our Progress**
A representative and supported workforce	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	➢ *Maintained the Trust status as a disability confident employer and continue to work towards Disability leader status* ➢ *Continue to ensure all applicants disclose Equal Opportunity Data as part of the recruitment process and any that do not return data are asked to update personally via ESR self-service.* ➢ *Monitored compliance against NHS Employer checks standards in respect of equality, diversity and inclusion monitoring.* ➢ *Introduced a bank of equality questions to be used at all interviews for all staff groups and levels* ➢ *Introduced diverse interview panels for senior Trust positions*
	3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	➢ *Completed the sixth annual Gender Pay gap assessment, with an action plan in place to improve the gender pay gap.* ➢ *Ensured every new and revised job description has been through an appropriate job evaluation process (non-medical).* ➢ *Approval process in place for any increases in payment outside of basic pay to ensure consistency for all staff groups and bands with any decisions over pay increases.*
	3.3 Training and development opportunities are taken up and positively evaluated by all staff	➢ *Promoted Non mandatory and statutory (Mast) training and development opportunities to staff at all levels across the Trust using both electronic and face to face methods of delivery* ➢ *Promoted the Trusts Funding Panel application windows to all permanent clinical and non-clinical staff to enable attendance at externally costed development and encouraging applications from diverse staff groups* ➢ *Continued to offer career appropriate apprenticeship programmes for all staff and encourage applications from diverse staff groups* ➢ *Developed and offered 'Apprenticeship Ready' programmes to support all staff who do not presently meet apprenticeship entry criteria.* ➢ *Offered a 'Leadership and Management' development programme accessible to all staff who supervise/manage others.* ➢ *Promoted the Stepping-Up programme led by the South East Leadership Academy in conjunction with the Sussex Health and Care Partnership (SHCP) for BME staff.* ➢ *Ensured that processes are in place to enable all staff to have the opportunity of evaluating all training and development*

		programmes offered by QVH. Any concerns raised are addressed with specific trainers to improve the quality of training delivery. 95% of evaluations received show that the programmes offered are very good/excellent.
	3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	➢ *Acted upon concerns raised in respect of perceived unprofessional conduct or behaviours* ➢ *Actively promoted channels for staff to raise concerns (anonymously if they prefer) to the Trust's Freedom to speak up guardian or to the Trust's Executive team* ➢ *Engaged with the Sussex Violence Reduction and Prevention initiative to develop a strategy to support staff with violence and abuse at work.*
	3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	➢ *Reviewing the Flexible Retirement Policy to ensure that requests are considered fairly and in a transparent manner.* ➢ *Introduced a new Agile Working Policy across the Trust which enhances the flexible working options for staff* ➢ *Introduced specific Hot Desking areas for staff to book to allow staff to work remotely and on site with greater flexibility*
	3.6 Staff report positive experiences of their membership of the workforce	➢ *Undertaken a full census survey for the National NHS Staff Survey, and integrated actions into a QVH attraction and retention plan*
Inclusive leadership	4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	➢ *Engaged with organisations across the Sussex Integrated Care System (ICS) on regional workforce initiatives including the Turning the Tide programme staff.* ➢ *Trust Board have committed to supporting the NHS Sussex Anti-Racism statement* ➢ *The Trust's Senior Leadership Team have actively promoted the Trust's Ethnically Diverse Staff Network, and supported the expansion of further staff networks across the organisation, with Executive Team each sponsoring a staff network,*
	4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	➢ *Reviewed the Equality Impact Assessment process and replaced with Equality Due Regard Assessments which are integral to all major decisions, requiring consideration, consultation and approval before items are considered at Board Committees*
	4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	➢ *Continued to offer a progressive 'Leadership and Management' development programme which is, accessible to all staff who supervise/manager others, including the 'Managing Our People' and 'Developing Our People' modules focusing on best practice approaches to managing people at work fairly and transparently* ➢ *Utilisation of the QVH trained facilitators (mediators) across the Trust to create more opportunities for informal resolution of sensitive issues in a timely way*

Steps taken and progress in the last reporting period against Actions

Programme	Action	Progress made
Workforce Race Equality Standard	Trust to launch the Integrated Care Board (ICB) anti-racism statement and promote throughout QVH	A soft launch of the ICB anti-racism statement was issued in October 2022 during Black History Month through promotions, published on the Trust Intranet and staff newsletter. In March the statement was further shared on posters in all staff areas across QVH.
	Monitor shortlisting process to ensure equal opportunities given and challenge managers where candidates not shortlisted	Ongoing spot checks of shortlisting to interview stage to ensure no bias taking place over any protected characteristics with meetings taking place with managers to ensure fair and consistent shortlisting takes place.
	Develop equality and unconscious bias training as a mandated requirement for all managers	To form part of trust wide equality and diversity training alongside current one to one training for recruitment managers on specific unconscious bias training.
	Introduction of developmental roles including direct appointment	A soft launch with some roles where a full recruitment episode does not have to take place where an existing employee is deemed suitable for a developmental role. Direct external appointments made for specialist and more senior roles where candidates are sourced outside of a standard recruitment episode to ensure the right person is recruited in a faster way. Ongoing work to look at "grow our own" roles within the trust; for example assistant radiographers appointed, training and qualification worked through and provided by the trust to enable move to more senior qualified role without separate application and recruitment process.
	Implement NHS People Promise – compassionate and inclusive	All staff diversity and inclusion training to close the reality gap – all staff have a mandatory requirement to complete Equality & Diversity training at QVH; as at 31 March 2023 the overall Trust compliance was 93.86%. The Trust engaged and procured ENACT to train and communicate key messages in respect of diversity and inclusion through an interactive drama based training using actors which was well received by staff and managers from a cross-section of the organisation. All staff bullying, harassment and incivility in the workplace training – the Trust also engaged and procured ENACT to train and communicate key messages in respect of bullying and harassment which was also valued by our people.
	Build closer working relationships with Freedom to Speak Up Guardian and Guardian of Safe Working	The Health, Wellbeing and Inclusion Coordinator has reached out to both the Freedom to Speak Up Guardian (FSUG) and the Guardian of Safe Working (GoSW). The GoSW has engaged and regular meetings are scheduled to discuss feedback from Junior Doctors and their forum conversations and actions to improve working experiences.

	To increase workplace satisfaction of BME staff through initiatives such as:	The Ethnically Diverse Staff (EDS) network continued to encourage membership through promotion by various mediums. In March the Health, Wellbeing and Inclusion Coordinator offered all staff the opportunity to utilise confidential drop-ins over a week-long period.
Workforce Disability Equality Standard	Monitor shortlisting process ensuring candidates who declare a disability under the Two Ticks scheme are invited to interview if they meet all essential requirements	Introduction of disability awareness in recruitment including “what is a reasonable adjustment”
	To increase workplace satisfaction of Disabled staff	Reasonable adjustments and improve opportunity for flexible working across the Trust – the HR Advisors have been working with managers to support their staff to improve flexible working options within teams/departments in particular those who have been absent from work due to sickness related to a disability. Commencement of a Disabled Staff Network planned for 2023/24 Educate and support our staff to be proactive in their health and wellbeing – annual calendar of initiatives and information with monthly themes such as ‘Keeping Ourselves Healthy’.
	Implement NHS People Promise – We are safe and healthy	The Health, Wellbeing and Inclusion Coordinator engaged with staff and managers to develop an ‘Embracing Neurodiversity at QVH’ guidance document which was launched during Equality, Diversity and Human Rights Week in May, celebrating our diverse staff and encouraging inclusive behaviours/culture across the Trust. Training available to all staff was delivered on disability awareness training. This included learning disability and autism awareness, visual impairment awareness, ADHD workshops, dignity and respect workshops, diversity and inclusion workshops and mandatory equality and diversity training.

Action Plans for ongoing commitment to accelerate cultural change

Workforce Race Equality Standard

WRES Indicator	2021-2022 Data	2022-2023 Data	2022-2023 Action	Timescale
2.Relative likelihood of white staff being appointed from shortlisting	1.27	2.31	Recommit to trust anti-racism statement though Board, exec and senior leadership development and awareness raising for all staff Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes Undertake an enquiry into workplace belonging – including a specific focus on eliminating discrimination and barriers to career progression Expand career development opportunities within roles and support internal and external career progression for more staff	October 2023 December 2023
7. % of staff believing that the Trust provides equal opportunities for career progression or promotion	BME 48.9% White 60.8%	BME 47% White 59%		January 2024 January 2023
5. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from…Patients / service users, their relatives or other members of the public	BME 15.4% White 20%	BME 28% White 19.2%	Multi-disciplinary violence prevention and reduction group established and focused reducing incidents involving staff and patient. Undertake an enquiry into workplace belonging – including a specific focus on bullying and harassment at work To review existing and commission new provision for training for managers and all staff to increase cultural competence, civility and a just restorative culture.	November 2023 January 2024 November 2023
8. In the last year have you personally experienced discrimination at work from your manager, team leader or other colleagues	BME 18.3% White 5.2%	BME 21.8% White 5.5%	Establish individual and collective EDI objectives for all executive and non-executive board members Establish a Trust EDI group as a focus for all our EDI work and to ensure a safe space for conversations on workplace belonging To invite expression of interest and training to become an inclusion agent within the workplace Support networks development and growth Support the trusts action plan to improve Speak Up and psychological safety for all staff	From October 2023 November 2023 November 2023 December 2023 From January 2024

Workforce Disability Equality Standard

WDES Metrics	2022 Data	2023 National Average	2022-2023 Action	Timescale
Metric 1 - Percentage of staff in AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce	5.80%	4.90%	Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes Undertake an enquiry into workplace belonging – inc. a specific focus on eliminating discrimination and barriers to career progression	December 2023 January 2024
Metric 2 - Relative likelihood of non-disabled applicants compared to Disabled being appointed from shortlisting across all posts	2.04	0.99	Establish a Trust EDI group as a focus for all our EDI work and to ensure a safe space for conversations on workplace belonging Become a Disability Confident Leader organisation	December 2023 March 2024
Metric 4 – d) Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	59.50%	51.30%	Oliver McGowan Training embedded to improve manager insight and competence To review existing and commission new provision for training for managers and all staff to increase cultural competence, civility and a just restorative culture.	October 2024 November 2023
	46.30%	49.50%	Support the trusts action plan to improve Speak Up and psychological safety for all staff Undertake an enquiry into workplace belonging – inc. a specific focus on bullying and harassment at work	November 2023 January 2024

Gender Pay Gap

Action	Timescale
Establish individual and collective EDI objectives for all executive and non-executive board members, focussing on key areas of addressing disparities and inequalities across the organisation.	Ongoing
Support the trusts action plan to improve Speak Up and psychological safety for all staff – implementation of FTSU contract, signing of the Sexual Safety Charter.	Q1 2024
To review existing and commission new provision for training for managers and staff to increase cultural competence, civility and a just restorative culture.	Ongoing
To invite expression of interest and training to become an inclusion agent within the workplace.	Ongoing
Establish a Trust EDI group as a focus for all our EDI work and to ensure a safe space for conversations on workplace belonging and to review pay gap data and develop further improvements, including: • widening participation though school and community engagement, to support more diverse recruitment and training roles • analysis of historic trends and potential gender bias at appointment	November 2023

• barriers to career development and promotion • promote flexible working for all	
Support staff networks development and growth, including our women's network. This includes establishing and supporting chair/co-chairs of the network, providing development into these vital roles, with a named member of the Executive Leadership Team as a sponsor of each network. Work with comms to promote networks to encourage greater membership.	Q1 2024
To continually review the use of CEA's to promote positive action and eliminate pay gaps.	Ongoing
Undertake an enquiry into workplace belonging – including a specific focus on promoting flexible working, eliminating sexual harassment and discrimination and barriers to career progression.	January 2024
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process. This will include reviewing our job advert wording to be more inclusive of flexible working options, removing any gender bias and reviewing where and how we advertise eg, use of social media platforms, and using data to inform which platforms provide the most diversity of applicants.	Q1 2024
Advertising all jobs as available less than full time to attract more diverse applicants to joining QVH.	Ongoing
Expand career development opportunities within roles and support internal and external career progression for more staff, through provision of career mapping, new roles/extended roles, and meaningful talent conversations within appraisals, supporting succession planning.	Ongoing
Work as an influencer with NHSE WT&E, HEIs, FEs and apprenticeship providers to influence and attract a more diverse population into careers in health. Eg – what would be needed for HEIs / medical schools etc. to attract more women into surgical specialities?	Ongoing
Commit to flexible working principles and champion promoting work-life balance to reduce barriers for women to advance their careers. Commit to better use of digital solutions across the organisation to further enable and embed smart flexible working options.	Q1 2024
Establishment of a Hybrid Working group to develop a Hybrid Working Toolkit to support QVH staff in different ways of working.	Q1 2024
Recruitment of a 'People Promise Manager' (NHSE funded) to be an advocate for improving the experience of working for the NHS at QVH for all staff.	June 2024
Commit to providing additional menopause awareness sessions to colleagues, promoting allyship, as well as having information readily available on Qnet for staff and managers to support colleagues in the workplace, with a commitment to working across our system to achieve menopause accreditation.	Ongoing

Conclusion

There continues to be more to do for our staff with protected characteristics to improve their experience at work, build psychological safety and workplace belonging. Alongside this, there is more to do to attract diverse applicants into roles at QVH and for us to be an employer of choice for our local community as part of our anchor institution commitment. Over the next financial year we are committed to accelerating our cultural transformation programme as we develop our Trust Strategy, vision, values with a behaviours framework to support civility and respect at work.

Recommendation

The Board is asked to **approve** the report for publication on the Trust's website.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024		**Agenda reference:**	**50-24**	
Report title:	NHS Workforce Race Equality Standards (WRES) Annual Report 2023/24 & NHS Workforce Disability Equality Standards (WRES) Annual Report 2023/24				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer				
Appendices:	Appendix 1 - Workforce Race Equality Standards (WRES) Annual Report 2023/24 Appendix 2 - Workforce Disability Equality Standards (WDES) Annual Report 2023/24 Appendix 3 – NHS Staff Survey Additional Information Q13 and Q14 Issue				
Executive summary					
Purpose of report:	This paper sets out the annual WRES and WDES reports and associated actions that will be taken, based on data collected on 31 March 2024.				
Summary of key issues	• There is an increase of 1.63**%** BME staff, from 19.57% 22/23 to **21.20%** in 23/24. • Harassment, bullying or abuse from staff towards BME colleagues has improved significantly with a decline of **8.26%**, from **30%** in 22/23 to **21.7%** in 23/24. • There is a decrease of **4.24%** of BME staff that have personally experienced discrimination at work from manager/team leader or other colleagues. From **21.8%** in 22/23 to **17.5%** 23/24, however, BME staff are over 4 times as likely to experience discrimination compared to white staff, **17.5%** compared to **4.0%.** • There is an increase of **0.41** in the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants, from **2.31** in 22/23 to **2.72** in 23/24. • There has been an increase in the proportion of disabled staff, from 5.77% in 22/23 to **6.67** in 23/24. • There is an increase of 5.67% in the number of disabled staff believing the trust provides equal opportunities for career progression or promotion, from 55.4% in 22/23 to **61.1%** in 23/24 • Bullying and harassment towards disabled staff from managers has increased by 1.4%, from 14.6% in 22/23 to **16.0%** in 23/24				
Recommendation:	The Board is asked to approve the report for publication on the Trust's website.				
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:	BAF2				
Corporate risk register:	None				
Regulation:	Individual and collective EDI objectives become a mandatory requirement for board members from October 2023				
Legal:	None				
Resources:	Emergent requirements e.g. in relation to strengthening our networks, funding for shadow boards and reverse mentoring will be raised separately.				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date: June 2024		Decision:	Approved	
Next steps:	Published on our website.				

Queen Victoria Hospital
NHS Foundation Trust

Report to:	Board of Directors
Agenda item:	50-24
Date of meeting:	12 September 2024
Report from:	Helen Edmunds, Chief People Officer
Report author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	24 May 2024
Appendices:	Appendix 1 - Workforce Race Equality Standards (WRES) Annual Report 2023/24 Appendix 2 - Workforce Disability Equality Standards (WDES) Annual Report 2023/24 Appendix 3 – NHS Staff Survey Additional Information Q13 and Q14 Issue

NHS Workforce Race Equality Standards (WRES) and NHS Workforce Disability Equality Standards (WDES) Annual Reports 2023/24

National context - WRES

The Workforce Race Equality Standard (WRES) programme has now been collecting data on race inequality for seven years, holding up a mirror to the service and revealing the disparities that exist for black and minority ethnic staff compared to white colleagues. The Covid-19 pandemic has put in the spotlight the disadvantage experienced by staff with protected characteristics. As the NHS recovers its services following the pandemic, addressing the issues of equality and inclusion are core to the success for the workforce.

The WRES uses statistical data to demonstrate the experience and outcomes for BME staff compared to white staff through many stages of the employment journey. The standard requires NHS Trusts to develop action plans to address any areas of inequity that the data highlights. It is an annual process to review and improve working conditions for BME staff in the NHS.

The report uses the acronym BME, recognising that within this there are a multitude of ethnic backgrounds and diversity included within the WRES analysis. It does not suggest that the identified issues affect all BME staff equally or that each group's treatment or needs are the same.

This report contains a data snapshot comparison between 1st April 2023 and 31st March 2024, and highlights the improvements that have been seen and the areas that require further action.

In line with the categories taken from the 2001 Census:

The BME category includes:	The White category includes:	The unknown category includes:
• D – Mixed white and black Caribbean • E – Mixed white and black African • F – Mixed white and Asian • G – Any other mixed background • H – Asian or Asian British – Indian • J – Asian or Asian British – Pakistani • K – Asian or Asian British – Bangladeshi • L – Any other Asian background • M – Black or black British – Caribbean • N – Black or black British – African • P – Any other black background • R – Chinese • S – Any other ethnic group	• A – White – British • B – White – Irish • C – Any other white background	• Z – not stated • Null (NHS Electronic Staff Records code) • Unknown (NHS Electronic Staff Records code)

National context – WDES
The Workforce Disability Equality Standard (WDES) is mandated for all Trusts in England with the aim of furthering equality and inclusion for Disabled staff in the NHS. Introduced in 2019, it has now been collecting data on disability inequality for four years, highlighting the collective experiences of Disabled NHS staff and shines a light on disparities between Disabled and non-disabled staff.

The WDES is a collection of 10 metrics that aim to compare the workplace and career experiences of Disabled and non-disabled staff through stages of the employment journey. The standard requires NHS Trusts to develop action plans to address any areas of inequity that the data highlights. It is an annual process to review and improve working conditions for Disabled staff in the NHS.

The report uses a capital 'D' when referring to Disabled staff. This is a conscious decision, made to emphasise that barriers continue to exist for people with long-term conditions. The capital 'D' also signifies that Disabled people have a shared identity and are part of a community that continues to fight for equality.

The evidence set out in the first three data analysis reports for the WDES in the NHS overall highlights that Disabled NHS staff continued to experience inequalities across all of the metrics. The data provides a robust evidence-base and reinforces the need for the WDES to act as a catalyst for change in creating a fairer and more equal NHS.

The WDES is referenced in the NHS People Plan, which was published in 2021. The plan sets out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people, and work together differently to deliver patient care. The Plan makes clear that the NHS must welcome all, building understanding, encouraging and celebrating diversity in all its forms.

Executive Summary
The full details for the Workforce Race Equality Standard and Workforce Disability Quality Standard reports are detailed in appendices 1 and 2, with summary highlights as follows:

Workforce Race Equality Standard

Workforce & Board Representation
There is an increase of 1.63% BME staff, from 19.57% 22/23 to **21.20%** in 23/24. However most BME staff are still clustered at Band 5 (25.31%), closely followed by Band 6 (22.50%) and Band 8b (21.43%). There is still very low representation at Band 4 (7.19%) and none from Band 8c to VSM (0%).

Discrimination
There is a decrease of 4.24% of BME staff that have personally experienced discrimination at work from manager/team leader or other colleagues. From 21.8% in 22/23 to **17.5%** 23/24. BME staff are over 4 times as likely to experience discrimination compared to white staff, 17.5% compared to 4.0%.
As per the NHS England WRES report, the Trust performed worse than the national average of 16.4%.

Career Progression
There is an increase of 11.77% of BME staff that believe there is equal opportunity in career progression or promotion, in comparison to white staff, from 47.7% in 22/23 to **58.8%** in 23/24.
As per the NHS England WRES report, the Trust performed better than the national average of 46.7%.

Accessing CPD and Non-Mandatory Training
The Trust has achieved equal access to non-mandatory training and CPD for 23/24.

Bullying and Harassment
There is a decrease of 1% of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public, from 28% in 22/23 to **27%** in 23/24. Harassment, bullying or abuse from staff towards BME colleagues has improved significantly with a decline of 8.26%, from 30% in 22/23 to 21.7% in 23/24.
This is below the national average of 27.5%

Disciplinary Processes
There is a decline in the relative likelihood of BME staff entering the formal disciplinary process from 0.00 in 22/23 to **1.82** in 23/24.
It is important to note the context to this for QVH. In 22/23 there were no formal conduct cases for reference. In 23/24 there is a total of 9 cases. The difference in disparity is 0.006 vs 0.01 however this is auto calculated to 1.82

Recruitment
There is an increase of 0.41 in the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants, from 2.31 in 22/23 to **2.72** in 23/24.

Board Representation
The difference between the board's membership and the Trust Workforce has fallen by 9.20% in 23/24 to -**21.0%.** None of the Trust's board are from a BME background.
As per the NHS England WRES report, The Trust performed worse than the national average of 15.6%.

Workforce Disability Equality Standard

Workforce & Board Representation
There has been an increase in the proportion of disabled staff, from 5.77% in 22/23 to **6.67** in 23/24. The highest reported under representation is in Medical and Dental roles. Board representation has decreased for the first time since 2018 to **6.3%** but is broadly reflective of the Trust which has 6.7% declaration. There is no representation of disabled staff in bands 8c – 9.

Feeling Valued
There is an increase of **0.68%** in disabled staff who felt pressure to come to work, from 22.0% in 22/23 to **22.7%** in 23/24.
However, there is a 3.33% increase in feeling that their work is valued, from 42% in 22/23 to **45.3%** in 22/23.

Staff Engagement
There is an increase of 0.2 points in the staff engagement score for disabled staff.
As per the 2023 NHS England WDES report, the overall rank compared to 212 trusts nationally,

Career Progression
There is an increase of 5.67% in the number of disabled staff believing the trust provides equal opportunities for career progression or promotion, from 55.4% in 22/23 to **61.1%** in 23/24

Recruitment
There has been a real improvement in the likelihood of disabled candidates being appointed into roles from 2.05 in 22/23 to **1.11** in 23/24. As per the 2023 NHS England WDES report, the overall rank compared to 212 trusts nationally, QVH ranked 205th for the likelihood of appointing from shortlisting.

Reasonable Adjustments

This is a slight decrease of 0.18% in the number of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work, from 84.8% in 22/23 to **84.6%** in 23/24.

As per the 2023 NHS England WDES report, the overall rank compared to 212 trusts nationally, QVH ranked 12th for this indicator.

Bullying and Harassment

There is an increase of 0.2 % in bullying and harassment towards disabled staff from patients, service users, relatives and members of public, from 28.5% in 22/23 to **28.7%** in 23/24

Bullying and harassment towards disabled staff from managers has also increased by 1.4%, from 14.6% in 22/23 to **16.0%** in 23/24. As per the NHS England WDES report, the overall rank compared to 212 trusts nationally, QVH were ranked 80th in 2023 for Bullying and harassment towards disabled staff from managers.

There is an increase of 1.03% in bullying and harassment towards disabled staff from colleagues, from 24.3% in 22/23 to **25.3%** in 23/24.

There has however been an increase of 7.43% in the number of disabled staff reporting incidents, from 46.3% in 22/23 to **53.7%** in 23/24.

Conclusions

It is encouraging there has been a further increase of 1.63**%** BME staff, from 19.57% 22/23 to **21.20%** in 23/24.

The lack of representation of BME staff in clinical and non-clinical roles at Band 8c-9 and VSM remains a concern, however it is important to consider the statistical relevance as there are fewer roles at these levels. Work will continue to support attraction and recruitment of diverse staff across all roles throughout 2024/25.

The number of incidences of bullying, harassment or abuse experienced towards BME colleagues has improved significantly with a decline of 8.26%, from 30% in 22/23 to 21.7% in 23/24.

Whilst there is a decrease of 4.24% of BME staff that have personally experienced discrimination at work from manager/team leader or other colleagues, from 21.8% in 22/23 to **17.5%** 23/24, BME staff are over 4 times as likely to experience discrimination compared to white staff, 17.5% compared to 4.0%. Work will continue to improve the experiences of BME staff through our staff networks, manager and staff workshops and promotion of the freedom to speak up guardian creating a safe space to report incidents.

There has been an increase in the proportion of disabled staff, from 5.77% in 22/23 to **6.67** in 23/24.

It's encouraging that there has been an increase of 5.67% in the number of disabled staff believing the trust provides equal opportunities for career progression or promotion, from 55.4% in 22/23 to **61.1%** in 23/24. Ongoing work relating to succession planning, talent management and a coaching culture will continue to ensure all colleagues have quality appraisal conversations to support their learning and development.

Bullying and harassment towards disabled staff from managers has increased by 1.4%, from 14.6% in 22/23 to **16.0%** in 23/24. There is an increase of 1.03% in bullying and harassment towards disabled staff from colleagues, from 24.3% in 22/23 to **25.3%** in 23/24. Work will continue to support disabled staff feel psychologically safe to speak up and report their concerns, with ongoing manager training being provided to support a just and learning coaching culture, with coaching for managers being delivered throughout 2024/25.

Action plan
Within Appendix 1 and 2, details are provided for key areas of progress from 2023/24 and ongoing actions relating to these areas for 2024/25.

Also detailed are additional actions for 2024/25 to address the main areas of concern, including reducing discrimination at work for BME staff, and reducing incidents of bullying and harassment by colleagues and managers towards disabled staff, therefore improving the experience of colleagues with protected characteristics at work.

Recommendation
The Board is asked to approve the report for publication on the Trust's website.

Queen Victoria Hospital
NHS Foundation Trust

WRES-Workforce Race Equality Standard

Report 2023-24

Introduction

Nationally, it is known, based on various sources of data and lived experiences, colleagues from a Black, Asian and Minority Ethnic background have a poorer experience of working within the NHS. QVH are committed to improving those lived experiences and strive towards creating a culture where race and ethnicity are not barriers to progression, individuals feel safe in the workplace and difference is embraced.

The importance of race equality is embedded into the NHS People Plan where it states *'The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms'. T*he People Promise declares *'a commitment to creating and maintaining a compassionate and inclusive culture where diversity is valued and celebrated as a critical component, and not just a desirable one.'* The Trust must also meet its legal obligations under the Equality Act 2010 and The Human Rights Act 1998.

QVH's People and Culture strategy is currently being developed and due for publication in September 2024, where the voices of our workforce will be key to our aims and objectives. This approach is also strengthened by the NHS EDI Improvement Plan, which sets out targeted actions to address the prejudice and discrimination –direct and indirect –that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

As a Trust we want to focus on working in partnership with our patients, service users and workforce, to change our workforce systems, rather than trying to change individuals. This enables our staff to thrive and deliver the best possible services and care to our patients and working environment to our colleagues.

Each year the Trust is required to publish Workforce Race Equality Standard (WRES) data.

The WRES provides a framework for NHS organisations to report, demonstrate and monitor progress against nine indicators of workforce equality. The indicators are a combination of workforce data and results from the NHS national staff survey and help to ensure employees receive fair treatment in the workplace and have equal access to career opportunities.

The WRES is included in the NHS Standard Contract and has been a requirement of NHS commissioners and NHS healthcare providers since July 2015.

The information in this report details key findings from the data collated for 2023/2024, comparisons of data from previous years, the progress made and actions we will be put in place to address the findings.

We encourage anyone reading this report, to give us feedback about the contents and suggest improvements, so we can enable appropriate and effective lived experiences for our diverse colleagues.

WRES Metrics

There are nine WRES indicators. Four of the indicators focus on **workforce data**, four are based on data from the **national NHS Staff Survey** questions, and one indicator focuses upon **BME representation on boards**. Based on the requirement from the National team, the Trust submitted the WRES data for Indicators 1 -4 and indicator 9 on the National Data Collection Framework (DCF) on **31st May 2024**.The staff survey results for Indicators 5 to 8, are taken directly from the WRES publications available on the NHS Staff Survey website.

Workforce Indicators:

1. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:

a) Non-Clinical Staff
b) Clinical Staff-of which
- Non-Medical Staff
- Medical and Dental Staff

Data Sourced from ESR

2. Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts). **Data Sourced from ESR**

3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. **Data sourced from Human resources team records**

4. Relative likelihood of staff accessing non-mandatory training and CPD. **Data sourced from ESR and Organisational Development records**

National NHS Staff Survey indicators (or equivalent):

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

7. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

8. In the last 12 months have you personally experienced discrimination at work from any of the following?

b) Manager/team leader or other colleagues

Data Sourced from NHSS

Board representation indicator: For this indicator, compare the difference for white and BME staff

9. Percentage difference between the organisations' Board membership and its overall workforce disaggregated:
- By voting membership of the Board
- By executive membership of the Board

Data Sourced from ESR

Data Limitations

Four of the WRES indicators (5 to 8) are drawn from questions in the National NHS staff survey.

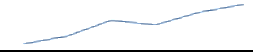
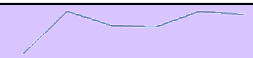
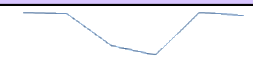
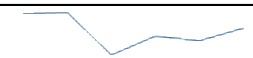
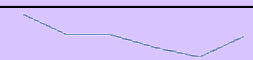
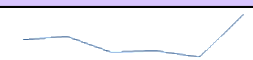
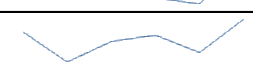
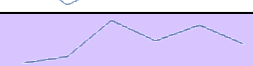
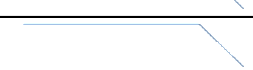
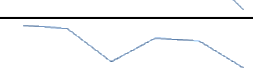
The reliability of the data drawn from those indicators is dependent upon the overall size of samples surveyed, the response rates to the survey questions, and whether the numbers of BME staff are large enough to not undermine confidence in the data.

Potential issues have been identified with the National Staff Survey Results affecting all NHS Trusts. Close to publication date, a problem was identified with the quality of the data. Further investigation determined that, for respondents at some organisations working with one of the main providers of survey services who had completed the survey using an iPhone, questions 13 a to d and question 14 a to d. This affects approximately 20,000 of the 707,460 respondents. Accompanying this report is the NHS Briefing (Appendix 3).

Definitions

Definitions as per Technical Guidance by NHS WES Team	
Term	Definitions
White Staff	Includes White British, Irish and Eastern European and any “white other”.
BME Staff	Staff that are from a Black or Minority Ethnic background that is not white.
Unknown	Refers to anyone who has not declared ethnicity. (i.e., staff who have either indicated that they ‘Prefer not to say’ or have not responded to the ethnic background monitoring question in ESR)
Non-mandatory training	Any learning, education, training, or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g. fire safety training) or mandated by the organisation. Accessing non-mandatory training and CPD, in this context refers to courses and developmental opportunities for which places were offered and accepted.

Yearly comparison 2019-2024

	WDES Metrics		Year								
			2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Trend	Difference between 2023 & 2024	
1	Percentage of black and minority ethnic (BME) staff	Overall	14.68%	15.91%	18.81%	19.33%	19.57%	21.20%		1.63%	↑
		Non-Clinical (inc M&D)	7.06%	7.61%	8.83%	8.50%	9.36%	10.00%		0.64%	↑
		Clinical	18.93%	20.39%	24.19%	25.17%	25.03%	27.06%		2.03%	↑
2	Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts).		1.32	1.47	1.79	1.27	2.31	2.72		0.41	↑
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation		0.00	1.27	0.00	0.00	0.00	1.82		1.82	↑
4	Relative likelihood of staff accessing non-mandatory training and CPD		0.65	1.04	0.90	0.89	1.04	1.00		-0.04	↑
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	27.6%	27.4%	18.3%	15.4%	28.0%	27.0%		-1.04%	↑
		Non-BME	24.6%	25.3%	16.0%	20.0%	19.2%	21.8%		2.63%	↑
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	22.8%	34.3%	34.9%	36.0%	30.0%	21.7%		-8.26%	↑
		Non-BME	24.5%	21.2%	21.4%	19.5%	18.0%	21.1%		3.12%	↑
7	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	BME	51.8%	52.8%	48.2%	48.9%	47.0%	58.8%		11.77%	↑
		Non-BME	61.2%	58.1%	60.2%	60.8%	59.1%	62.5%		3.45%	↑
8	In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleague?	BME	13.0%	14.5%	23.2%	18.3%	21.8%	17.5%		-4.24%	↑
		Non-BME	4.1%	5.8%	5.6%	5.3%	5.5%	4.0%		-1.48%	↑
9	Percentage difference between the organisations' Board membership and its overall workforce disaggregated	Voting Membership	N/A	N/A	N/A	N/A	N/A	-21.0%			
		Executive Membership	N/A	N/A	N/A	N/A	N/A	-21.0%			
		Overall Board	-6.5%	-7.6%	-18.8%	-10.9%	-11.8%	-21.0%		-9.20%	↑

Executive Summary

Queen Victoria Hospital NHS Foundation Trust

Workforce & Board Representation

There is an increase of 1.63% BME staff, from 19.57% 22/23 to **21.20%** in 23/24.
However most BME staff are still clustered at **Band 5** (25.31%), closely followed by **Band 6** (22.50%) and **Band 8b** (21.43%). There is still very low representation at **Band 4** (7.19%) and none from **Band 8c to VSM** (0%).

Discrimination

There is a decrease of **4.24%** of BME staff that have personally experienced discrimination at work from manager/team leader or other colleagues. From **21.8%** in 22/23 to **17.5%** 23/24.

BME staff are over 4 times as likely to experience discrimination compared to white staff, **17.5%** compared to **4.0% .**

As per the NHS England WRES report, the Trust performed worse than the national average of 16.4%.

Career Progression

There is an increase of **11.77%** of BME staff that believe there is equal opportunity in career progression or promotion, in comparison to white staff, from **47.7%** in 22/23 to **58.8%** in 23/24.
As per the NHS England WRES report, the Trust performed better than the national average of 46.7%.

Accessing CPD and Non-Mandatory Training

The Trust has achieved equal access to non mandatory training and CPD for 23/24.

Bullying and Harassment

There is an decrease of **1%** of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public, from **28%** in 22/23 to **27%** in 23/24.

Harassment, bullying or abuse from staff towards BME colleagues has improved significantly with a decline of **8.26%**, from **30%** in 22/23 to **21.7%** in 23/24.

This is below the national average of 27.5%

Disciplinary Processes

There is a decline in the relative likelihood of BME staff entering the formal disciplinary process from **0.00** in 22/23 to **1.82** in 23/24.

It is important to note the context to this for QVH. In 22/23 there were no formal conduct cases for reference. In 23/24 there is a total of 9 cases. The difference in disparity is 0.006 vs 0.01 however this is auto calculated to 1.82

Recruitment

There is an increase of **0.41** in the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants, from **2.31** in 22/23 to **2.72** in 23/24.

Board Representation

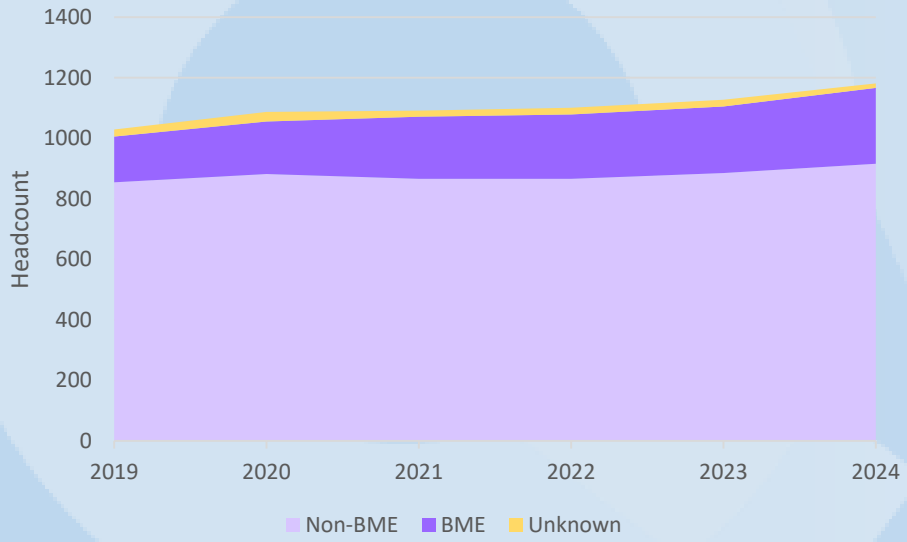
The difference between the board's membership and the Trust Workforce has fallen by 9.20% in 23/24 to **-21.0%**. None of the Trust's board are from a BME background.

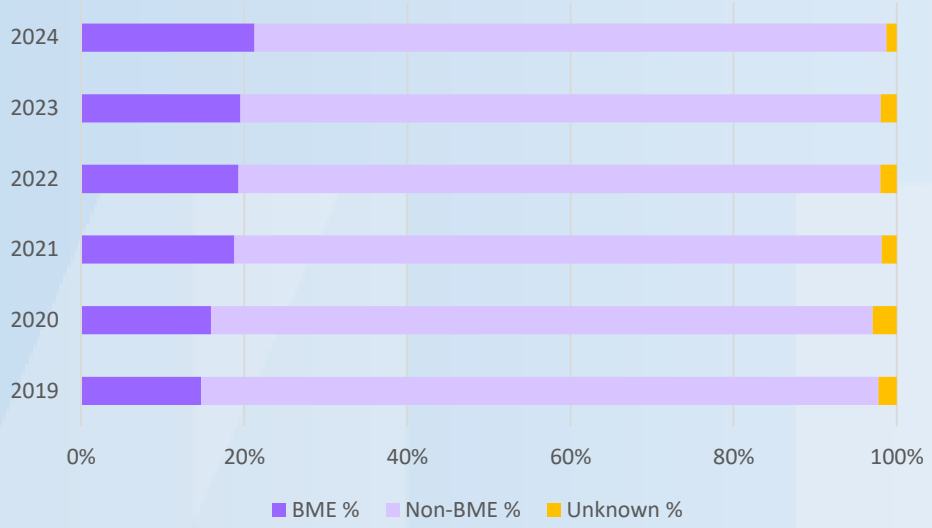
As per the NHS England WRES report, The Trust performed worse than the national average of 15.6%.

WRES Indicator 1

Workforce Representation

	Headcount				Percentage		
	Non-BME	BME	Unknown	Total	Non-BME %	BME %	Unknown %
2019	854	151	23	1028	83.1%	14.7%	2.24%
2020	882	173	32	1087	81.1%	15.9%	2.94%
2021	866	205	20	1091	79.4%	18.8%	1.83%
2022	866	212	22	1100	78.7%	19.3%	2.00%
2023	885	220	22	1127	78.5%	19.5%	1.95%
2024	915	251	15	1181	77.48%	21.25%	1.27%





The overall headcount for the Trust is **1181**. This has increased between 2023 and 2024 with the number of staff declaring as BME increasing to **251 (21.25%),** an additional **31** people. The Data shows the percentage of BME staff at the Trust continues to increase, growing by 1.75% in the last year.

There has also been a decrease in the proportion of staff who have not declared their ethnicity (unknown), which is now at **15 (1.27%)**.

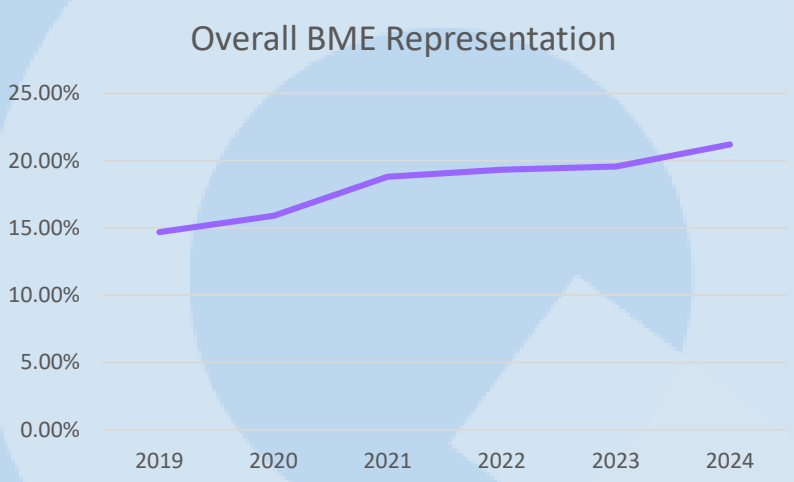
NHS Workforce Race Equality Standard 2023

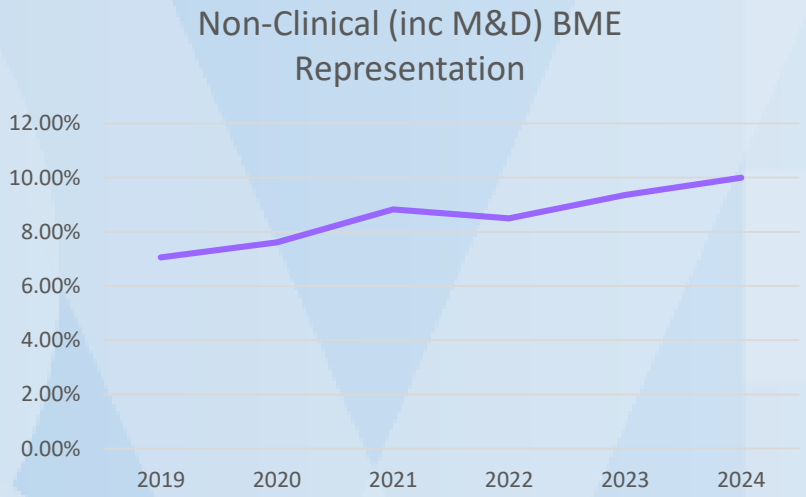
National Average
BME: 26.4%
Non-BME: 73.6%

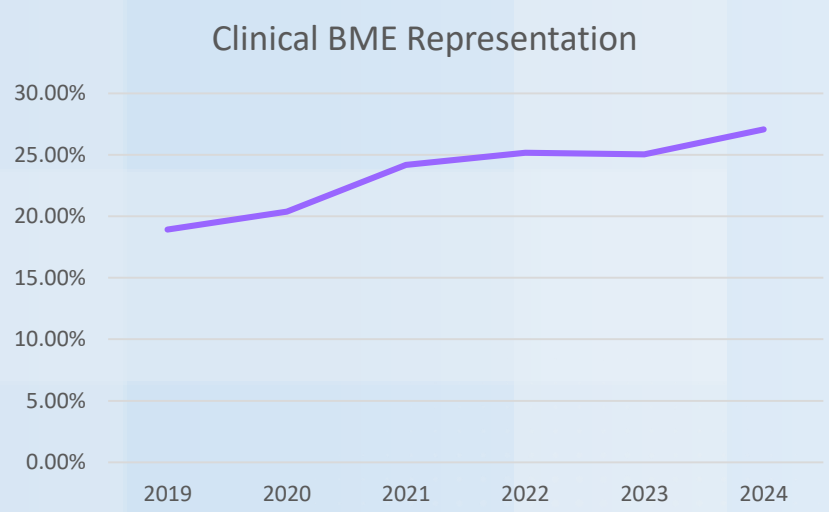
WRES Indicator 1

Workforce Representation

	Year					
	2019	2020	2021	2022	2023	2024
Overall	14.68%	15.91%	18.81%	19.33%	19.57%	21.20%
Non-Clinical (inc M&D)	7.06%	7.61%	8.83%	8.50%	9.36%	10.00%
Clinical	18.93%	20.39%	24.19%	25.17%	25.03%	27.06%



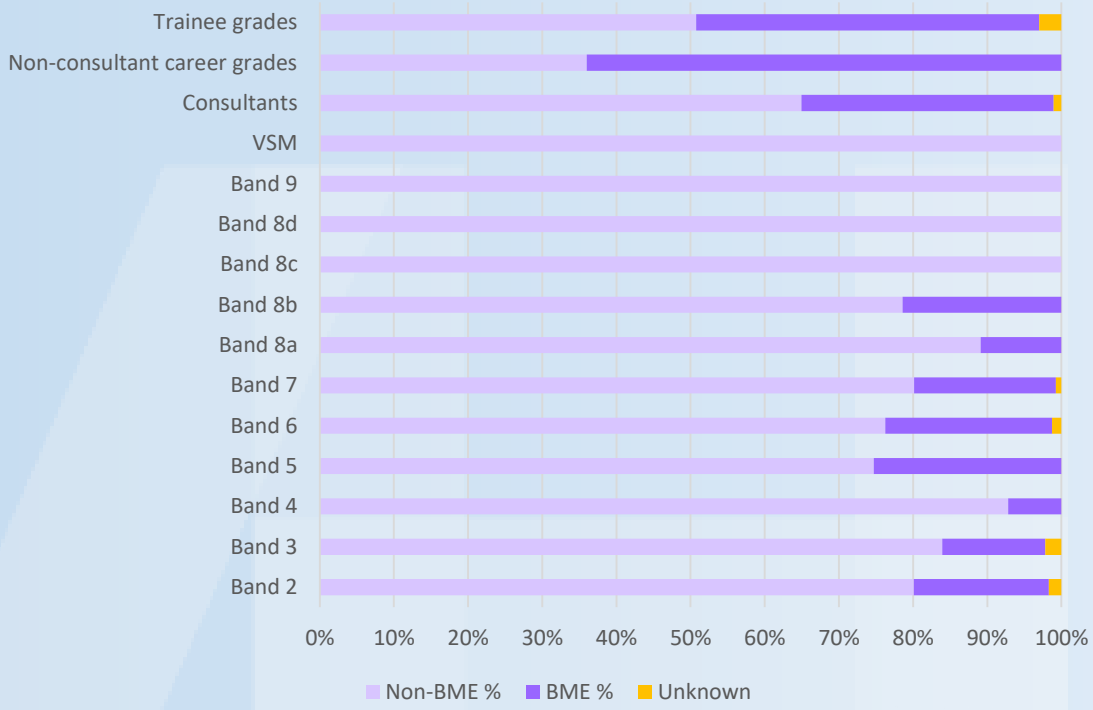




WRES Indicator 1

Workforce Representation

Pay banding	White	BME	Unknown	Total	White %	BME %	Unknown
Band 2	141	32	3	176	80.11%	18.18%	1.70%
Band 3	115	19	3	137	83.94%	13.87%	2.19%
Band 4	129	10	0	139	92.81%	7.19%	0.00%
Band 5	121	41	0	162	74.69%	25.31%	0.00%
Band 6	122	36	2	160	76.25%	22.50%	1.25%
Band 7	105	25	1	131	80.15%	19.08%	0.76%
Band 8a	41	5	0	46	89.13%	10.87%	0.00%
Band 8b	11	3	0	14	78.57%	21.43%	0.00%
Band 8c	9	0	0	9	100.00%	0.00%	0.00%
Band 8d	5	0	0	5	100.00%	0.00%	0.00%
Band 9	1	0	0	1	100.00%	0.00%	0.00%
VSM	9	0	0	9	100.00%	0.00%	0.00%
Consultants	63	33	1	97	64.95%	34.02%	1.03%
Non-consultant career grades	9	16	0	25	36.00%	64.00%	0.00%
Trainee grades	34	31	2	67	50.75%	46.27%	2.99%



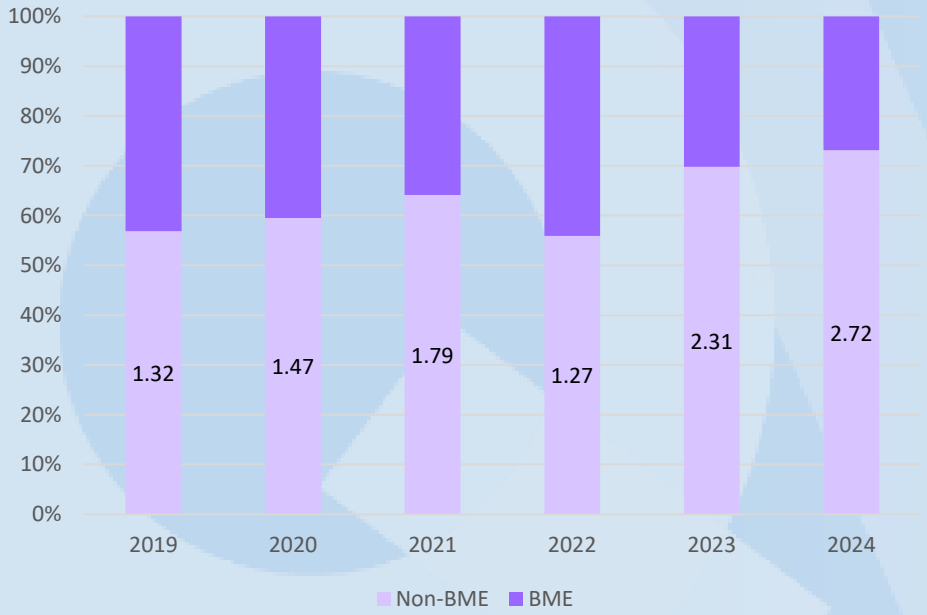
The majority of BME representation in the workforce are still clustered at **Band 5** (25.31%), closely followed by **Band 6** (22.50%). There is also higher representation at **Band 8b** (21.43%) although there are only 14 staff at this level across the organisation.

There is still very low representation at **Band 4** (7.19%) and significantly **0%** representation from **Band 8c to VSM.**

WRES Indicator 2

Recruitment

	Year					
	2019	2020	2021	2022	2023	2024
Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts).	1.32	1.47	1.79	1.27	2.31	2.72



The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants has increased since last year by **0.41**.

For the last two years we have appointed proportionately less BME applicants from shortlisting than white applicants.

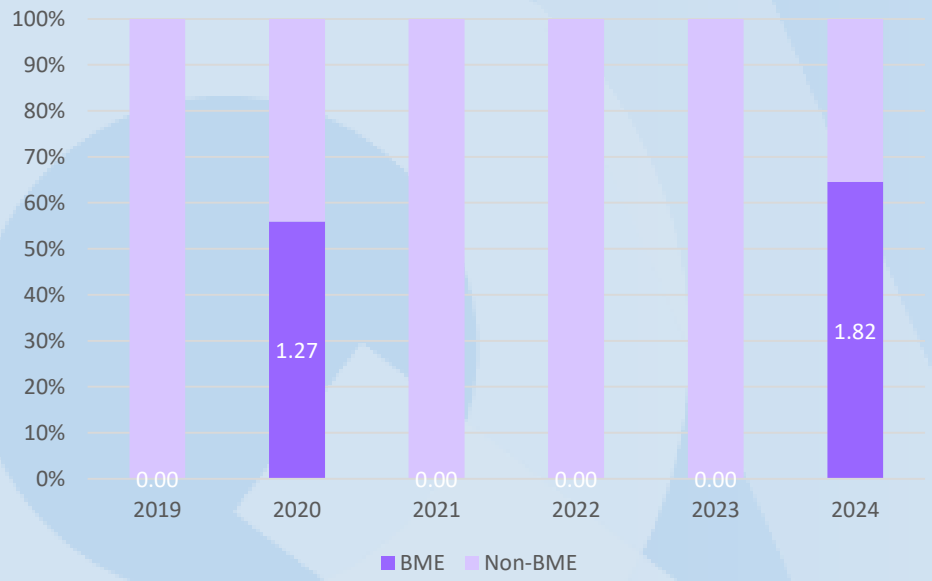
NHS Workforce Race Equality Standard 2023

National Average
1.59

WRES Indicator 3

Disciplinary

	Year					
	2019	2020	2021	2022	2023	2024
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	0.00	1.27	0.00	0.00	0.00	1.82



There is a significant decline in the relative likelihood of BME staff entering the formal disciplinary process from **0.00** in 22/23 to **1.82** in 23/24.

It is important to note the context to this for QVH. In 22/23 there were no formal conduct cases for reference. In 23/24 there is a total of 9 cases. The difference in disparity is 0.006 vs 0.01 however this is auto calculated to 1.82.

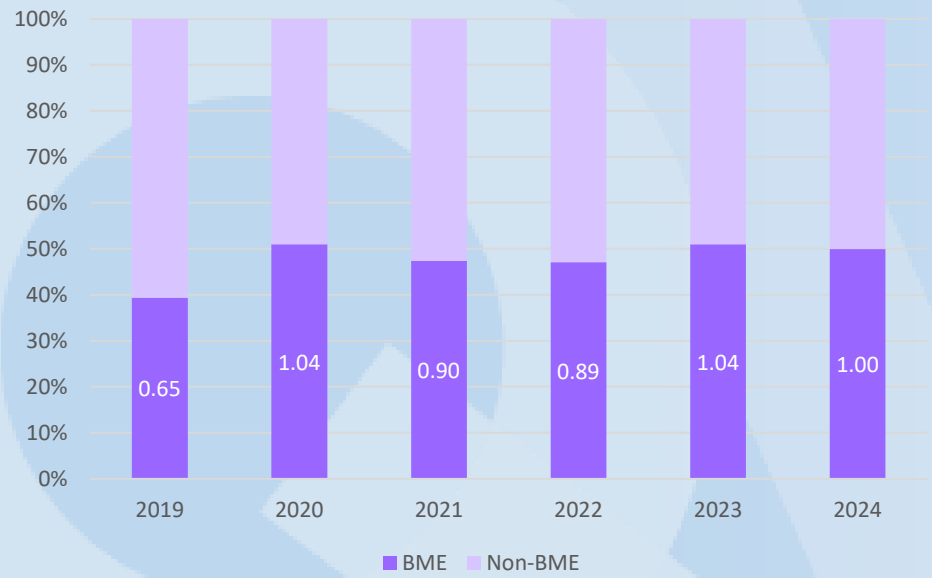
NHS Workforce Race Equality Standard 2023

National Average
1.03

WRES Indicator 4

Training and Continual Professional Development

	Year					
	2019	2020	2021	2022	2023	2024
Relative likelihood of staff accessing non-mandatory training and CPD	0.65	1.04	0.90	0.89	1.04	1.0



The Trust has achieved equal access to non mandatory training and CPD for 23/24.

NHS Workforce Race Equality Standard 2023

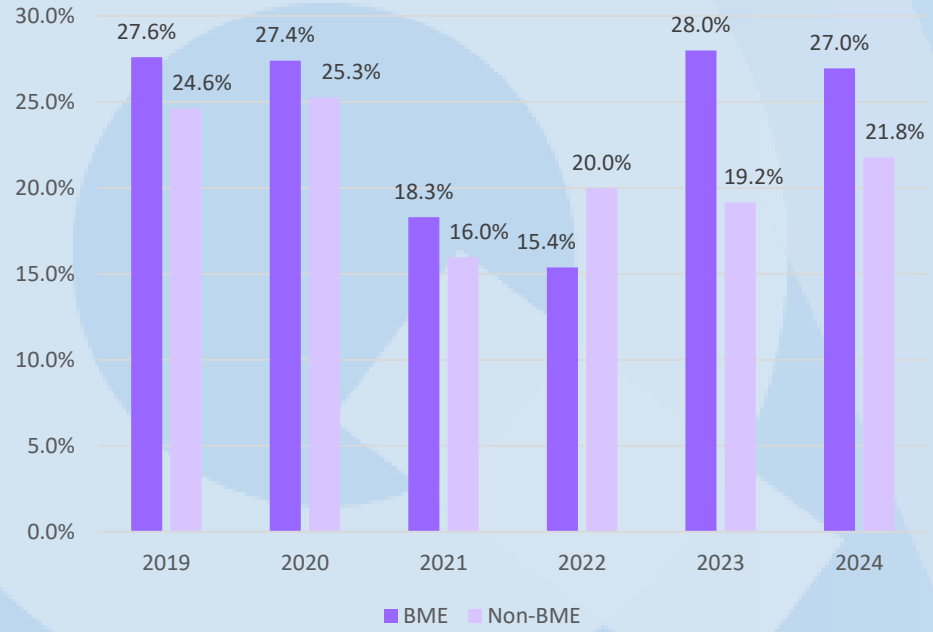
National Average
1.12

WRES Indicator 5

Bullying, harassment or abuse from patients, relatives or the public

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

	Year					
	2019	2020	2021	2022	2023	2024
BME	27.6%	27.4%	18.3%	15.4%	28.0%	27.0%
Non-BME	24.6%	25.3%	16.0%	20.0%	19.2%	21.8%



This data is from the National Staff Survey results.

Over 20% of all staff experience harassment, bullying or abuse from patients, relatives or the public.

There is a **decrease of 1%** of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public, from 28.0% to 27% in 23/24.

NHS Workforce Race Equality Standard 2023

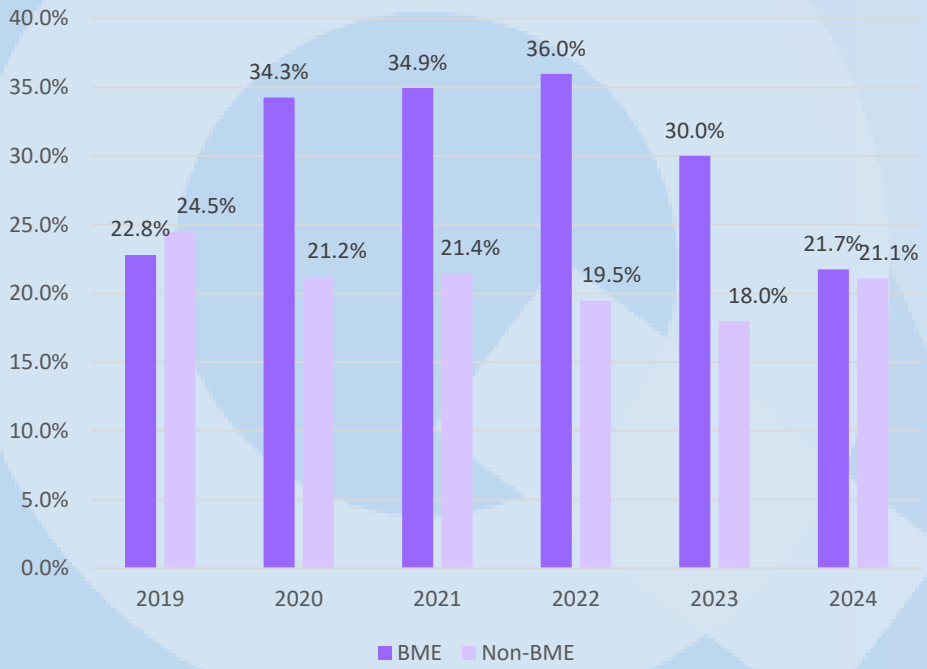
National Average
BME: 30.5%
Non-BME: 26.9%

WRES Indicator 6

Bullying, harassment or abuse from colleagues

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

	Year					
	2019	2020	2021	2022	2023	2024
BME	22.8%	34.3%	34.9%	36.0%	30.0%	21.7%
Non-BME	24.5%	21.2%	21.4%	19.5%	18.0%	21.1%



This data is from the National Staff Survey results.

Over 20% of all staff experience harassment, bullying or abuse from patients, relatives or the public.

There is a **significant decrease of 8.3%** of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public, from 30.0% to 27.1% in 23/24.

NHS Workforce Race Equality Standard 2023

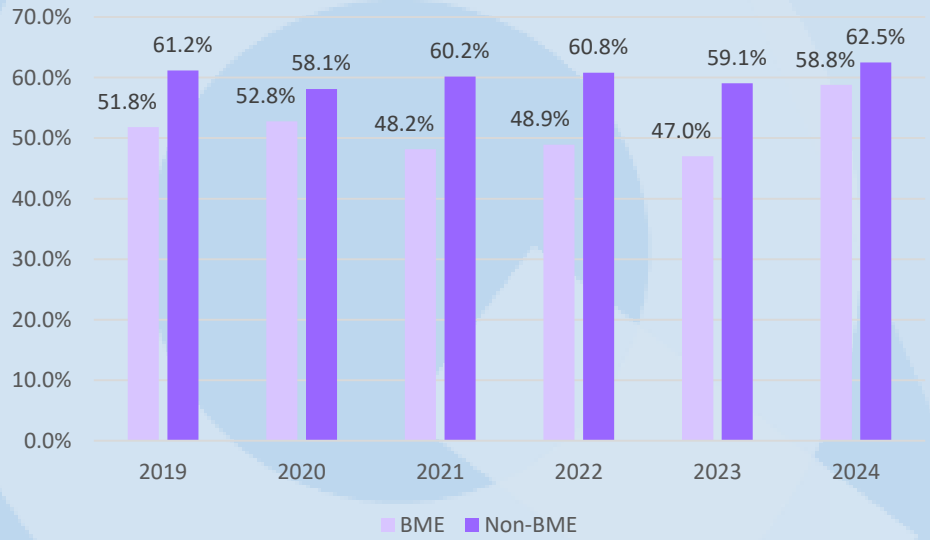
National Average
BME: 27.5%
Non-BME: 21.7%

WRES Indicator 7

Career Progression

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

	Year					
	2019	2020	2021	2022	2023	2024
BME	51.8%	52.8%	48.2%	48.9%	47.0%	58.8%
Non-BME	61.2%	58.1%	60.2%	60.8%	59.1%	62.5%



This data is from the National Staff Survey results.

There has been a **significant increase by 11.8%** for the number BME staff that believe the Trust provides equal opportunities for career progression or promotion.

However, the percentage of staff who believe that the trust provided equal opportunities for career progression or promotion is lower for BME staff than for non-BME staff.

The Trust is significantly better than the national average for both BMW and Non-BME staff

NHS Workforce Race Equality Standard 2023

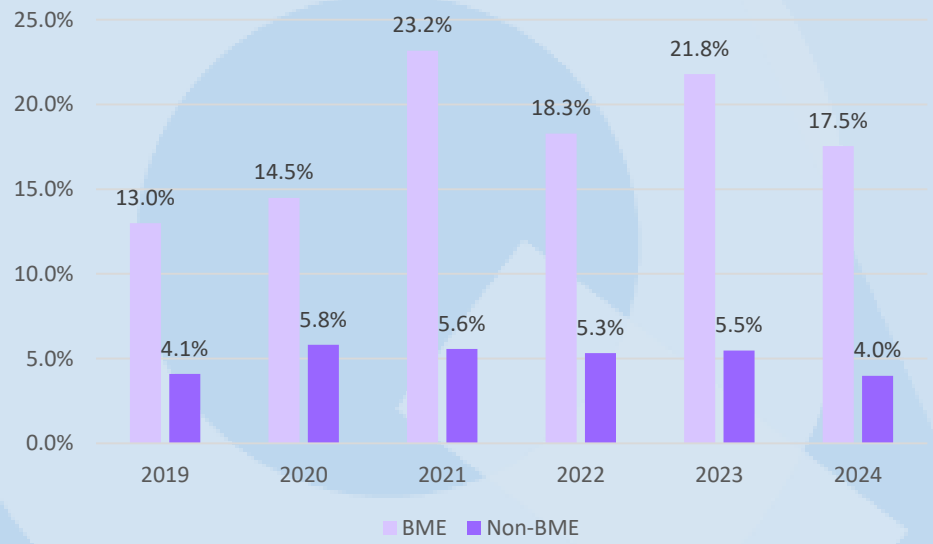
National Average
BME: 46.7%
Non-BME: 59.4%

WRES Indicator 8

Discrimination at work

In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleague?

	Year					
	2019	2020	2021	2022	2023	2024
BME	13.0%	14.5%	23.2%	18.3%	21.8%	17.5%
Non-BME	4.1%	5.8%	5.6%	5.3%	5.5%	4.0%



This data is from the National Staff Survey results.

There is a decrease of **4.24%** of BME staff that have personally experienced discrimination at work from manager/team leader or other colleagues. From **21.8%** in 22/23 to **17.5%** 23/24.

The overall percentage of staff who personally experienced discrimination from manager/team leader or other colleague is significantly higher for BME staff than for white staff BME staff, being over 4 times as likely to experience discrimination compared to white staff, **17.5%** compared to **4.0% .**

As per the NHS England WRES report, the Trust performed worse than the national average of 16.4%.

NHS Workforce Race Equality Standard 2023

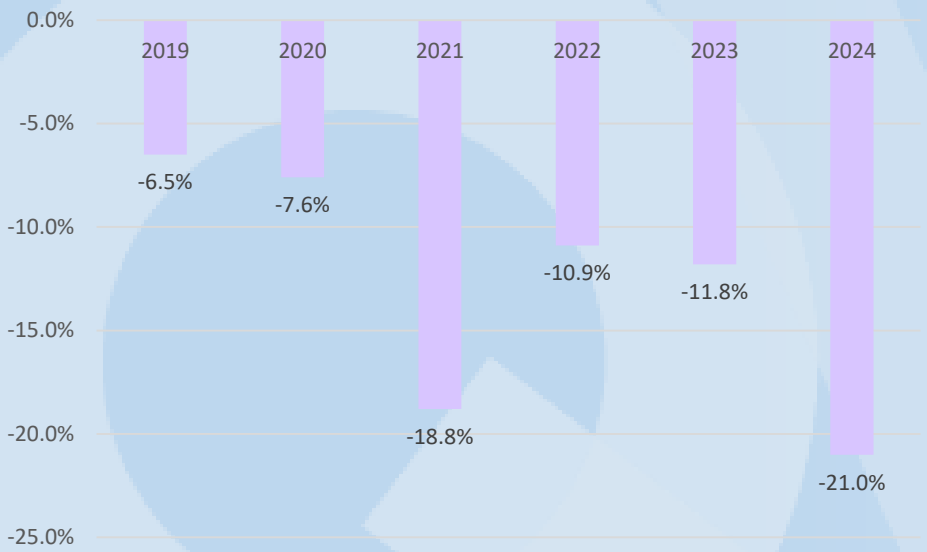
National Average
BME: 16.4%
Non-BME: 6.6%

WRES Indicator 9

Board Representation

Percentage difference between the organisations' Board membership and its overall workforce disaggregated

	2019	2020	2021	2022	2023	2024
Overall Board	-6.5%	-7.6%	-18.8%	-10.9%	-11.8%	-21.0%



The number of BME board members has reduced in 23/24 to 0 members.

Since 2019 the Trust board representation has been below the workforce representation, and has fluctuated each year as there has been BME representation previously.

100% of the board have declared their ethnicity.

As per the NHS England WRES report, The Trust is significantly below the national average of 15.6%

NHS Workforce Race Equality Standard 2023

National Average
15.6%

Key Areas of Progress and Ongoing Actions for Next 12 Months

Culture Change	1. **People and Culture Strategy-** The Trust is currently working on the enabling People and Culture Strategy for 2025-2030, alongside other enabling strategies and the Trust overall strategy, to be launched in the Autumn of 2024. This strategy will include a specific pillar for compassion and inclusivity to drive forward the work and identify priorities to harness culture change across the Trust. 2. **Workforce Belonging**- The Trust has in place a comprehensive action plan, aligned with NHS England's EDI Improvement Plan, to address High Impact Action 6, which is to 'Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. As part of this action the Trust has undertaken a series of Workplace belonging workshops with staff to understand what will improve working lives for staff with protected characteristics. The Trust's Violence Prevention and Reduction group has increased compliance against the national standards by over 30%. The Trust's Domestic Abuse for staff policy has been re-written with safeguarding oversight. The Trust have signed up to the Sexual Safety Charter and continue to work towards meeting all the requirements by March 2025. 3. **Freedom to Speak Up-** The Trust's speak up provision has been enhanced and supported by an external provider to provide 24/7 support to staff. This service is available to all staff, and compliments the Trusts embedded mechanisms for raising concerns relating to patient care and safety, whistleblowing & bullying and harassment. Being operated by a 3rd party it is anticipated this will improve psychological safety of staff to raise concerns confidentially. The workforce team will be meeting with the Trusts FTSU Guardian on a monthly basis to discuss themes and look at areas for learning and development. 4. **Refreshed Vision and Values & Behavioral Framework-** Continual development through wide staff engagement and consultation, with a behavior framework to support an inclusive learning culture, increasing psychological safety of staff to support the embedding of a enhanced speak up process for staff. The Trust vision and values are being revised and co-produced with staff to be embedded throughout the organisation. The behaviour framework will be used as part of the recruitment process, objective setting and promoting civility and respect for our staff.
Recruitment	5. **Inclusive Recruitment Process and Practice-** A comprehensive review has been undertaken into the Trust's recruitment and attraction process in partnership with the Trust's EDI Group. This review and the changes to be taken throughout 24/25 revise the Trust's recruitment process and practice to ensure it is an inclusive as possible. Further work needs to be done on how we reach candidates with protected characteristics, and support them through the application process. 6. **Increase in Apprentice and Internship Opportunities-** QVH supports the use of apprenticeships across all staffing areas. In 2023/24 the Trust supported its highest number of apprentices to date, however further work is needed over 24/25 to ensure the diversity of staff accessing apprentice opportunities increase, and our use of the levy is increased. Further work is planned to enhance work experience opportunities and further embed internships to support a diversity of applications, working with DWP to attract those who aren't in education , employment or training.
Career Development	7. **Appraisal Process Revised with a focus on Wellbeing and career development-** A revised appraisal process was launched in 2023 to provide focus on health, wellbeing and career development. As part of the introduction of this process , a mechanism for feedback has been introduced for 24/25 to monitor effectiveness of appraisal alongside our National Staff Survey results. 8. **Triumvirate Structure-** The clinically led triumvirate structure launched on the 13 May 2024, providing a structure to support career progression. Development of the senior triumvirate leadership team commences on 3 June 2024 to build skills, expertise and capability to develop a high performing team. 9. **Developing a management and leadership strategic framework-** In conjunction with system colleagues QVH has commenced development of a management and leadership framework with the vision being to highlight opportunities for BME staff, expand career development opportunities within roles and support internal and external career progression for more staff, through provision of career mapping, new roles/extended roles, and meaningful talent conversations within appraisals, supporting succession planning. 10. **Leadership through Education for Excellent Patient Care Programme (LEEP)-** Continue to deliver our LEEP programme with a focus on multidisciplinary team work increasing opportunities for staff

Key Areas of Progress and Actions for next 12 Months

Bullying and Harassment	11. **EDI Group-** The Trust has introduced an EDI Group to support all staff. This group is lead by senior Trust leadership to raise awareness of EDI issues, and consider appropriate responses. The group also shares good practice, provides scrutiny, check and challenge on Trust activities and provides a voice for staff to raise awareness of EDI Issues. The group was established in January 2024 on an informal basis whilst the Trust undertakes a review of its internal governance structure, and it is expected that this group will evolve to become part of an overall People Group. 12. **NHS England High Impact Actions-** The Trust has in place an action plan aligned with NHS England's EDI Improvement Plan, to address High Impact Action 6, which is to 'Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. As part of this action the Trust has undertaken a series of Workplace belonging workshops with staff. 13. **Restorative and Just Learning Culture**- A key pillar within the People and Culture strategy will be to start the work on introducing a Restorative and Just Learning Culture in the Trust. The key focus will be the psychological safety of staff and civility and respect. This not only extends to Employee Relations but also through Patient Safety Incident Response Framework (PSIRF) and learning from incidents, understanding what has happened and what the learning is rather than seek a punitive approach. 14. **Reverse Mentoring –** The trust are committed to launching a reverse mentoring programme in 2024/25, to support cross-generational collaboration and knowledge sharing and reduce power imbalances that can occur between senior leaders and other roles in the organization. This will support the embedding of our continuous learning culture. 14. **Enact Sessions-** The Trust delivered a series of sessions for Dignity and Respect for staff in 23/24 from a 3rd Party provider, Enact Solutions utilising funds provided from the QVH Charity.
Staff Engagement	15. **Re-Introduction of Team Brief-** In 23/24 the Trust re-introduced its team brief to enhance engagement and communication. This is Executive led and delivered through a hybrid model both face to face and virtually for those unable to attend and to improve accessibility and inclusivity. Team Brief is also recorded for those unable to attend on the day. Those attending team brief ensure information is disseminated throughout the organisation and compliments other methods of communication in the Trust 16. **Strategy and Engagement Work -**Through 23/24 and into 24/25 the Trust is embarking on co-designing its future strategy. This has led to a large engagement exercises with staff and stakeholders from across the organisation. There has also been further engagement relating to the enabling strategies and the development of the revised vision and values and behaviour framework.
Board Sponsorship	17. **Board Accountability-** The Trust has agreed each Board member will act as a sponsor for one of staff networks. This will result in dedicated and targeted leadership support , provide accountability and governance from senior leaders. reinforce the commitment to improving lived experiences and develop an inclusive leadership culture. The board have re-committed to the Anti-Racisim statement and supported the introduction of the Trust EDI Group. Further work is underway to sign up to an anti-racism charter.

Actions for next 12 months

Action	By When	Lead
A review of the structures and roles across departments specifically looking at succession planning and talent management from Band 8a to VSM	Q3 2024-2025	CPO, supported by Head of OD & L
Development and implementation of a reverse mentoring programme, using our networks to determine areas of initial focus to support career progression	Q3 2024-2025	CPO
Develop a QVH anti-racism charter for all staff utilising established external frameworks (e.g Unison) to ensure there is a safe space and psychological safety for staff.	Q2-2024-2025	DCPO
Continued rollout of Active Bystander training and education to support speaking up and providing a tool kit for managers and staff to address inappropriate behaviours for those with a disability or long term health condition.	Q2 2024-2025	Education and Development
Creation and implementation of the Trust behavioural framework as part of the launch of the Vision and Values supporting psychological safety, accountability and speaking out for those from a BME background	Q3 2024-2025	CSO/CPO
Creation of a dedicated Executive led People Group to provide the governance for the EDI Group to report and to highlight areas of challenge to the Trust Board relating to those from a BME background.	Q2 2024-2025	CPO
Through an enhanced Freedom to Speak Up service, capture and act on themes highlighted by staff in relation to poor behaviours that are disadvantaging staff from a BME background, triangulated with patient complaints and organisational risks and mitigations	Q2 2024-2025	CNO
Thorough review of employment policies to reduce the amount and length of documentation whilst making the content more accessible for managers and staff.	Q4 2024-2025	Head of Employee Relations & Wellbeing
Recruitment of a Trust Wellbeing and Inclusion Manager to lead the implementation and delivery of the EDI sub-strategy as the EDI operational lead for the Trust	Q2 2024-2025	Head of Employee Relations & Wellbeing
Through widening participation (apprenticeship, internship, veteran awareness, school ambassadors etc) attract more diverse candidates to trust roles	Q3 2024-2025	DCPO
Development and implementation of a shadow board programme to develop future leaders, build board level experience and confidence to support succession planning and talent management	Q4 2024-2025	CPO

Queen Victoria Hospital
NHS Foundation Trust

WDES-Workforce Disability Equality Standard

Report 2023-24

Introduction

Nationally, it is known, based on various sources of data and lived experiences, that disabled colleagues have a poorer experience of working within the NHS. Our workforce consists of people with varied disabilities and long-term health conditions. They include a whole range of hidden and often changing conditions that will affect different individuals in different ways, in terms of their ability to work, so we need to cater for all their bespoke needs.

The importance of disability equality is embedded into the NHS People Plan where it states *'The NHS must welcome all, with a culture of belonging and trust.We must understand, encourage and celebratediversity in all its forms'. T*he People Promise declares *'a commitment to creating and maintaining a compassionate and inclusive culture where diversity is valued and celebrated as a critical component, and not just a desirable one.'* The Trust must also meet its legal obligations under the Equality Act 2010 and The Human Rights Act 1998.

QVH's People and Culture strategy is currently being developed and due for publication in September 2024, where the voices of our workforce will be key to our aims and objectives.. This approach is also strengthened by the NHS EDI Improvement Plan, which sets out targeted actions to address the prejudice and discrimination –direct and indirect –that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

As a Trust we want to focus on working in partnership with our patients, service users and workforce, to change our workforce systems, rather than trying to change individuals. This enables our staff to thrive and deliver the best possible services and care to our patients and working environment to our colleagues.

Each year the Trust is required to publish Workforce Disability Equality Standard (WDES) data.

The WDES is a set of ten specific measures (metrics) that enable NHS organisations to compare the experiences of Disabled and Non-disabled staff. This information informs the development of an action plan to demonstrate progress against the metrics to improve equality and inclusion for Disabled staff. The WDES was mandated for all Trust's from April 2017. It is included in the NHS Standard Contract .

The WDES is important because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety. It supports positive change for existing employees and enables a more inclusive environment for disabled people working in the NHS.

The following information in the report details key findings from the data collated for 2023/2024, comparisons of data from previous years, the progress made and actions that will be implemented to address the findings.

We encourage anyone reading this report, to give us feedback about the contents and suggest improvements, so that we can enable appropriate and effective lived experiences for our diverse colleagues.

WDES Metrics

There are ten (10) WDES metrics. Three (3) metrics focus on **workforce data**; Five (5) are based on questions from the **NHS Staff Survey**; One (1) metric focuses on disability representation on boards; One (1) metric (metric 9b) focuses on the voices of Disabled staff. Based on the requirement from the National team, the Trust submitted the WDES data for Metrics 1 –3, and Metric 9b and Metric 10 on the National Data Collection Framework (DCF) on 31st May 2024. The staff survey results for the Metrics 4 –9a, are taken directly from the WDES publications available on the NHS Staff Survey website.

Workforce Metrics:

1. Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. This calculation should be undertaken separately for non-clinical and for clinical staff for clusters 1 to 4. **Data Sourced from ESR**

2. Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts. **Data Sourced from ESR**

3. Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process as measured by entry into the formal capability procedure**. Data sourced from HR records**

National NHS Staff Survey metrics (or equivalent): For each of the following four metrics, compare the responses for both Disabled and non-disabled staff. Data Sourced from NHSS

4. Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

a) Patients/service users, their relatives or other members of the public
b) Managers
c) Other colleagues,
d) Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

5. Percentage of disabled staff compared to non-disabled staff believing that the organisation provides equal opportunities for career progression or promotion.

6. Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

7. Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

The following NHS Staff Survey metric only includes the responses of Disabled staff

8. Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.

9. NHS Staff Survey and the engagement of disabled staff For part a)compare the staff engagement scores for Disabled, non-disabled staff.
a)The staff engagement score for Disabled staff, compared to nondisabled staff. b) Have you taken action to facilitate the voices of disabled staff in your organisation to be heard (Yes or No)?

Board representation metric: For this metric, compare the difference for Disabled and non-disabled staff.

10. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

By voting and non-voting membership of the board. **Data Sourced from ESR**
By Executive and non-exec membership of the board.**Data Sourced from ESR**

Data Limitations

Five of the WDES metrics (4 to 9a) are drawn from questions in the National NHS staff survey.
The reliability of the data drawn from those metrics is dependent upon the overall size of samples surveyed, the response rates to the survey questions, and whether the numbers of disabled staff are large enough to not undermine confidence in the data.

Some of QVH's staff groups within services are below the 11 required to generate meaningful staff survey data, therefore a larger sample is sometimes used which can lead to limitations for specific areas or departments.

For WDES, the National NHS staff survey (NHSS) Benchmark report has been used

5 Benchmarking groups
NHS organisations vary in the services they provide and relatedly, the challenges they face. Organisations are assigned to a benchmarking group based on the services they offer. This means that comparisons are only made between organisations of a similar type and ensures comparisons are fair. In the benchmark reports organisations' results are presented in the context of their benchmarking group's best, average and worst results.

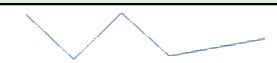
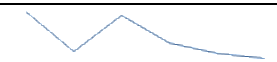
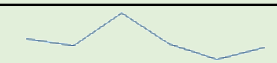
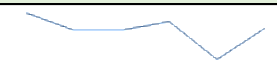
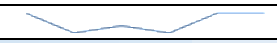
Data from ESR is provided based on those staff who had declared their disability to the Trust. Staff survey data is not on this basis and is provided anonymously by the individual carrying out the survey a disability recorded if they self identify. In 23/24 figures 6.67% of staff declared a disability, however in the staff survey 23.29% of respondents identified as disabled.

Potential issues have been identified with the National Staff Survey Results affecting all NHS Trusts. Close to publication date, a problem was identified with the quality of the data. Further investigation determined that, for respondents at some organisations working with one of the main providers of survey services who had completed the survey using an iPhone, questions 13 a to d and question 14 a to d. This affects approximately 20,000 of the 707,460 respondents. Accompanying this report is the NHS Briefing.

Definitions

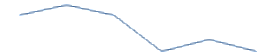
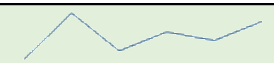
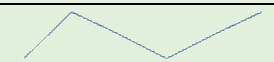
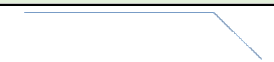
Definitions as per Technical Guidance by NHS WDES Team	
Term	Definitions
Disabled staff	Disabled staff refers to those staff who have recorded a disability in Electronic Staff Record (ESR).
Non-disabled staff	Non-Disabled staff may include staff who are disabled but have not recorded it.
Unknown	"Unknown" disability status (i.e., staff who have either indicated that they 'Prefer not to say' or have not responded to the disability monitoring question in ESR)
Clusters	The WDES standard requires organisations to 'group' staff into 'clusters.' Cluster 1: AfC Band 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, non-consultant career grade Cluster 7: Medical and Dental staff, Medical and Dental trainee grades

Yearly comparison 2019-2024

	WDES Metrics		Year						Trend	Difference between 2023 & 2024	
			2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024			
1	Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce	Overall	5.23%	5.02%	4.70%	5.36%	5.77%	6.67%		0.90%	↑
		Non-Clinical	6.20%	6.30%	6.00%	5.90%	7.30%	8.30%		1.00%	↑
		Clinical	5.50%	5.30%	4.90%	5.60%	5.90%	6.80%		0.90%	↑
2	Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts		2.18	1.71	2.41	0.68	2.05	1.11		-94.00%	↑
3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process as measured by entry into the formal capability procedure		0.00	5.78	0.00	0.00	0.00	4.49		449.00%	↑ *
4a	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patient/Service users, their relativves or other members of the public	Disabled	24.7%	31.0%	18.6%	30.1%	28.5%	28.7%		0.17%	↑
		Non-disabled	24.9%	23.8%	16.2%	16.6%	18.3%	21.1%		2.80%	↑
4b	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers	Disabled	19.5%	12.8%	20.0%	13.5%	14.6%	16.0%		1.40%	↑
		Non-disabled	10.2%	7.3%	9.9%	7.9%	7.1%	6.7%		-0.37%	↑
4c	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues	Disabled	24.1%	27.2%	21.4%	22.6%	24.3%	25.3%		1.03%	↑
		Non-disabled	16.0%	15.4%	18.5%	15.6%	14.1%	15.3%		1.21%	↑
4d	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse at work and they or a colleague reported it	Disabled	57.9%	53.4%	53.7%	55.8%	46.3%	53.7%		7.43%	↑
		Non-disabled	59.6%	47.5%	52.1%	47.3%	59.5%	59.4%		-0.12%	↑

***In 2 years we have had an average of 0.5 disabled, 1.5 Non-disabled and 0.5 unknown enter into a formal capability process. The difference in disparity is 0.006 vs 0.001 however this is auto calculated to 4.49.**

Yearly comparison 2019-2024

	WDES Metrics		Year							
			2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Trend	Difference between 2023 & 2024
5	Percentage of disabled staff compared to non-disabled staff believing that the organisation provides equal opportunities for career progression or promotion	Disabled	53.4%	61.3%	54.8%	57.8%	55.4%	61.1%		5.67% ↑
		Non-disabled	61.6%	56.1%	58.1%	58.9%	57.4%	60.7%		3.26% ↑
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled	29.3%	33.3%	38.0%	31.8%	22.0%	22.7%		0.68% ↑
		Non-disabled	25.3%	27.8%	25.5%	17.7%	20.0%	17.5%		-2.50% ↑
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Disabled	39.3%	43.2%	41.9%	40.7%	42.0%	45.3%		3.33% ↑
		Non-disabled	52.0%	57.1%	55.9%	51.8%	54.1%	57.1%		2.98% ↑
8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	Disabled	77.4%	73.7%	82.4%	80.7%	84.8%	84.6%		-0.18% ↑
9	NHS Staff Survey and the engagement of disabled staff For part a)compare the staff engagement scores for Disabled, non-disabled staff	Disabled	6.8	7.3	6.9	7.1	7.0	7.2		0.20 ↑
		Non-disabled	7.4	7.6	7.5	7.4	7.5	7.6		0.10 ↑
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated		5%	5%	5.00%	5%	5%	3%		-2.00% ↑

Executive Summary

Queen Victoria Hospital NHS Foundation Trust

Workforce & Board Representation

There has been an increase in the proportion of disabled staff, from **5.77%** in 22/23 to **6.67** in 23/24. The highest reported under representation is in Medical and Dental roles.

Board representation has decreased for the first time since 2018 to **6.3**% but is broadly reflective of the Trust which has 6.7% declaration

Feeling Valued

There is an increase of **0.68%** in disabled staff who felt pressure to come to work, from **22.0%** in 22/23 to **22.7%** in 23/24.

However, there is a **3.33%** increase in feeling that their work is valued, from **42%** in 22/23 to **45.3%** in 22/23.

Staff Engagement

There is an increase of 0.2 points in the staff engagement score for disabled staff.

As per the 2023 NHS England WDES report, the overall rank compared to 212 trusts nationally,

Career Progression

There is an increase of **5.67%** in the number of disabled staff believing that the trust provides equal opportunities for career progression or promotion, from **55.4%** in 22/23 to **61.1%** in 23/24

Recruitment

There has been a real improvement in the likelihood of disabled candidates being appointed into roles from **2.05** in 22/23 to **1.11** in 23/24

As per the 2023 NHS England WDES report, the overall rank compared to 212 trusts nationally, QVH ranked **205th** for the likelihood of appointing from shortlisting

Reasonable Adjustments

This is a slight decrease of **0.18%** in the number of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work, from **84.8%** in 22/23 to **84.6%** in 23/24.

As per the 2023 NHS England WDES report, the overall rank compared to 212 trusts nationally, QVH ranked **12th** for this indicator.

Bullying and Harassment

There is an increase of **0.2 %** in bullying and harassment towards disabled staff from patients, service users, relatives and members of public, from **28.5%** in 22/23 to **28.7%** in 23/24

Bullying and harassment towards disabled staff from managers has also increased by **1.4%,** from **14.6%** in 22/23 to **16.0%** in 23/24. As per the NHS England WDES report, the overall rank compared to 212 trusts nationally, QVH were ranked 80th in 2023 for Bullying and harassment towards disabled staff from managers.

There is an increase of **1.03%** in bullying and harassment towards disabled staff from colleagues, from **24.3%** in 22/23 to **25.3%** in 23/24.

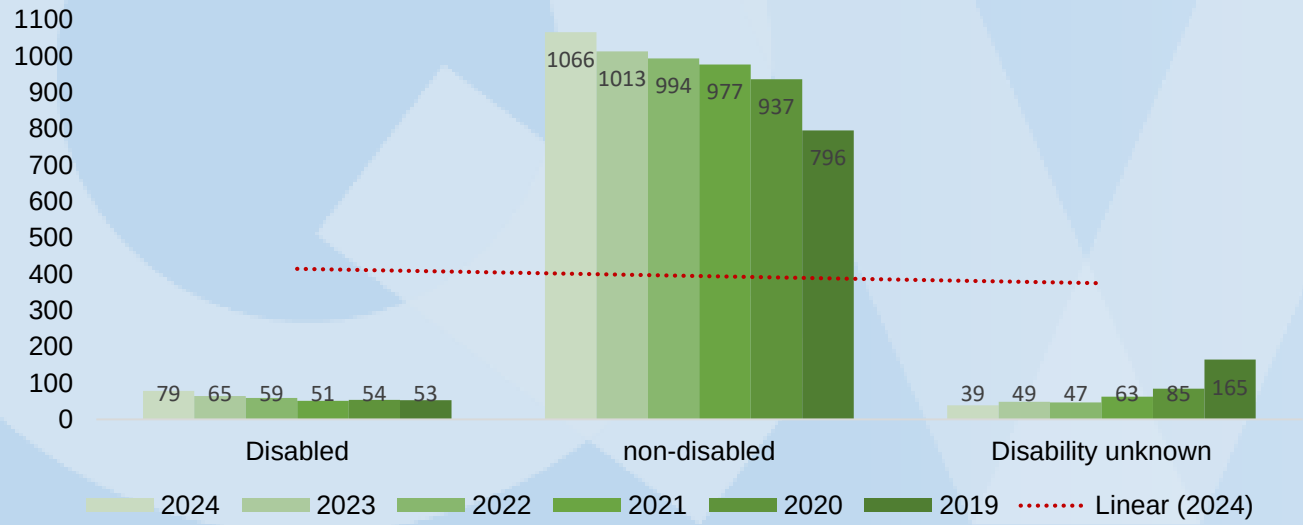
There has however been an increase of **7.43%** in the number of disabled staff reporting incidents, from **46.3%** in 22/23 to **53.7%** in 23/24.

WDES Metric 1

Workforce Representation

Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce

Staff Group	2024	2023	2022	2021	2020	2019
Disabled	79	65	59	51	54	53
non-disabled	1066	1013	994	977	937	796
Disability unknown	39	49	47	63	85	165
Total headcount	1184	1127	1100	1091	1076	1014
Percentages						
Disabled	6.67%	5.8%	5.4%	4.7%	5.0%	5.2%
non-disabled	90.03%	89.9%	90.4%	89.6%	87.1%	78.5%
Disability unknown	3.29%	4.3%	4.3%	5.8%	7.9%	16.3%



QVH has 79 individuals with a recorded disability amongst its workforce (6.67%) which is an increased from 65 (5.8%) in 2023. The national average for reporting is 4.9%*

Since 2019 the Trust has undertaken a number data cleanse activities, alongside communication to staff to ensure disclosure is encouraged. Staff can undertake this via ESR self service or with support from their line manager or Trust Workforce team

* national average for 2023

WDES Metric 1

Workforce Representation

	Pay banding	Disabled	non-disabled	Unknown	Total	Disabled %	non-disabled %
Non-Clinical	Cluster 1 (Bands 1-4)	22	256	7	285	7.7%	89.8%
	Cluster 2 (Bands 5-7)	8	70	2	80	10.0%	87.5%
	Cluster 3 (Bands 8a-8b)	4	23	0	27	14.8%	85.2%
	Cluster 4 (Bands 8c-9 & VSM)	0	15	1	16	0.0%	93.8%
	All non-clinical roles	**34**	**364**	**10**	**408**	**8.3%**	**89.2%**
Clinical	Cluster 1 (Bands 1-4)	12	157	1	170	7.1%	92.4%
	Cluster 2 (Bands 5-7)	27	337	12	376	7.2%	89.6%
	Cluster 3 (Bands 8a-8b)	0	31	2	33	0.0%	93.9%
	Cluster 4 (Bands 8c-9 & VSM)	1	6	1	8	12.5%	75.0%
	Total clinical	**40**	**531**	**16**	**587**	**6.8%**	**90.5%**
Medical and Dental	Cluster 5 (M&D: Consultants)	2	87	8	97	2.1%	89.7%
	Cluster 6 (M&D: Non-Consultant career grades)	0	23	2	25	0.0%	92.0%
	Cluster 7 (M&D: trainee grades)	3	61	3	67	4.5%	91.0%
	Total Medical and Dental	**5**	**171**	**13**	**189**	**2.6%**	**90.5%**

Total Workforce	Disabled	non-disabled	Unknown	Total	Disabled %	non-disabled %
	79	1066	39	1184	6.67%	90.03%

The overall headcount for QVH is 1184 which includes:

- 79 disabled staff
- 1066 non-disabled staff
- 39 who have not provided monitoring information to the Trust

Non-Clinical staff in Cluster 1 (Bands 1-4) have the highest headcount of workforce with a recorded disability (22)

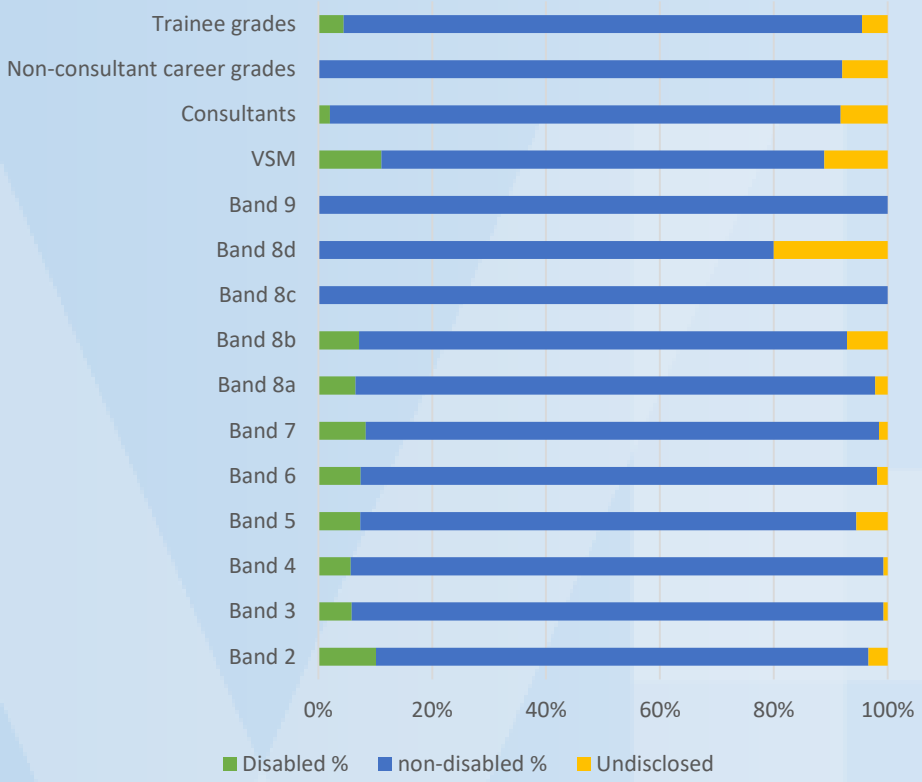
Clinical staff in Cluster 2 (Band 5-7) have the highest headcount of workforce who have recorded a disability (27)

Clinical Cluster 3 (Band 8a-8b) and Cluster 6 (M&D Non-Consultant career grades) have no staff with a recorded disability

WDES Metric 1

Workforce Representation

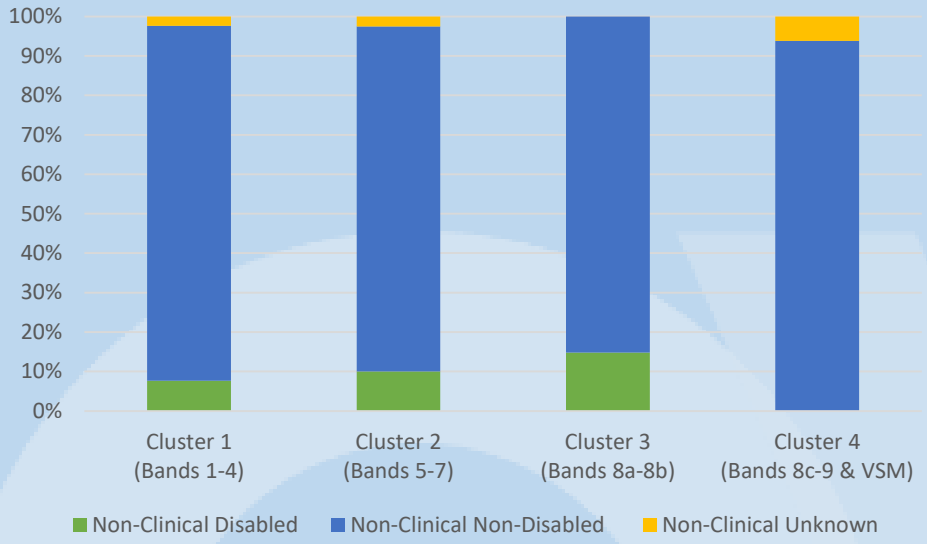
Pay banding	Disabled	non-disabled	Unknown	Total	Disabled %	non-disabled %
Band 2	18	154	6	178	10.11%	86.52%
Band 3	8	128	1	137	5.84%	93.43%
Band 4	8	131	1	140	5.71%	93.57%
Band 5	12	142	9	163	7.36%	87.12%
Band 6	12	146	3	161	7.45%	90.68%
Band 7	11	119	2	132	8.33%	90.15%
Band 8a	3	42	1	46	6.52%	91.30%
Band 8b	1	12	1	14	7.14%	85.71%
Band 8c	0	9	0	9	0.00%	100.00%
Band 8d	0	4	1	5	0.00%	80.00%
Band 9	0	1	0	1	0.00%	100.00%
VSM	1	7	1	9	11.11%	77.78%
Consultant	2	87	8	97	2.06%	89.69%
Non-consultant career grades	0	23	2	25	0.00%	92.00%
Trainee grades	3	61	3	67	4.48%	91.04%



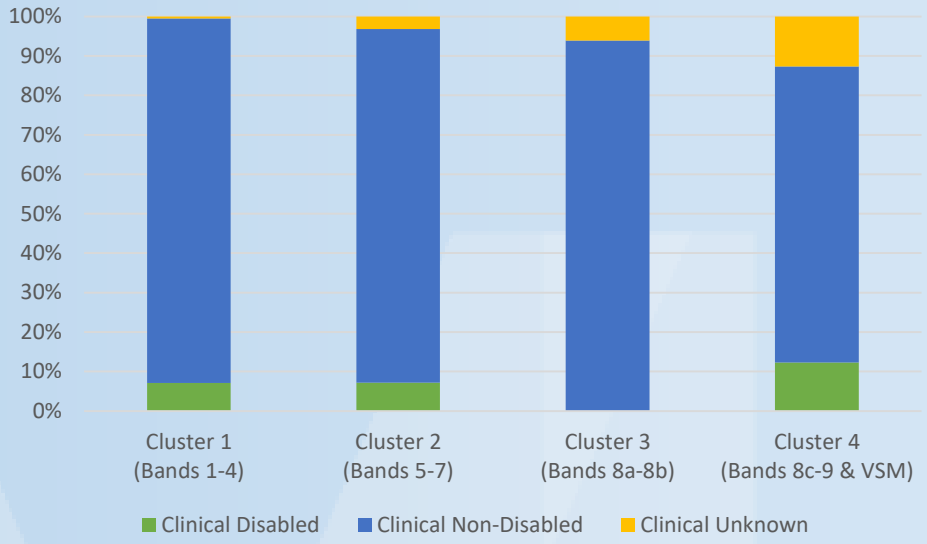
Data shows that we have no disabled staff in senior banded positions 8c, 8d and band 9. The highest declaration of disability is amongst Band 2 and VSM staff

Workforce Representation

Non-Clinical



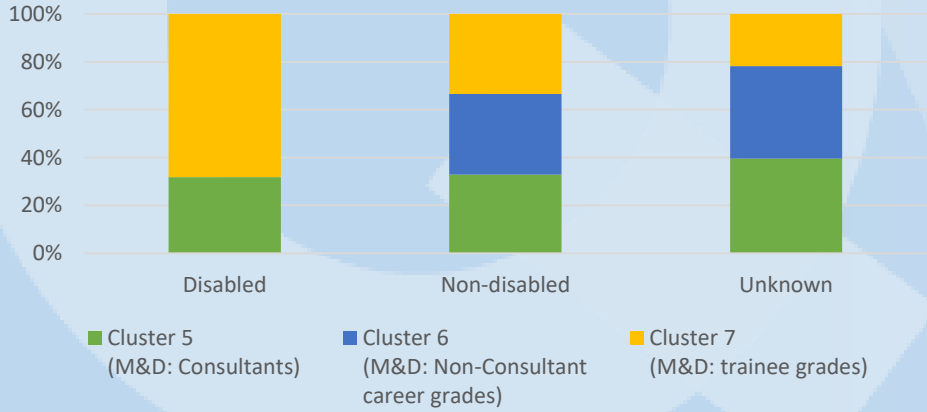
Clinical



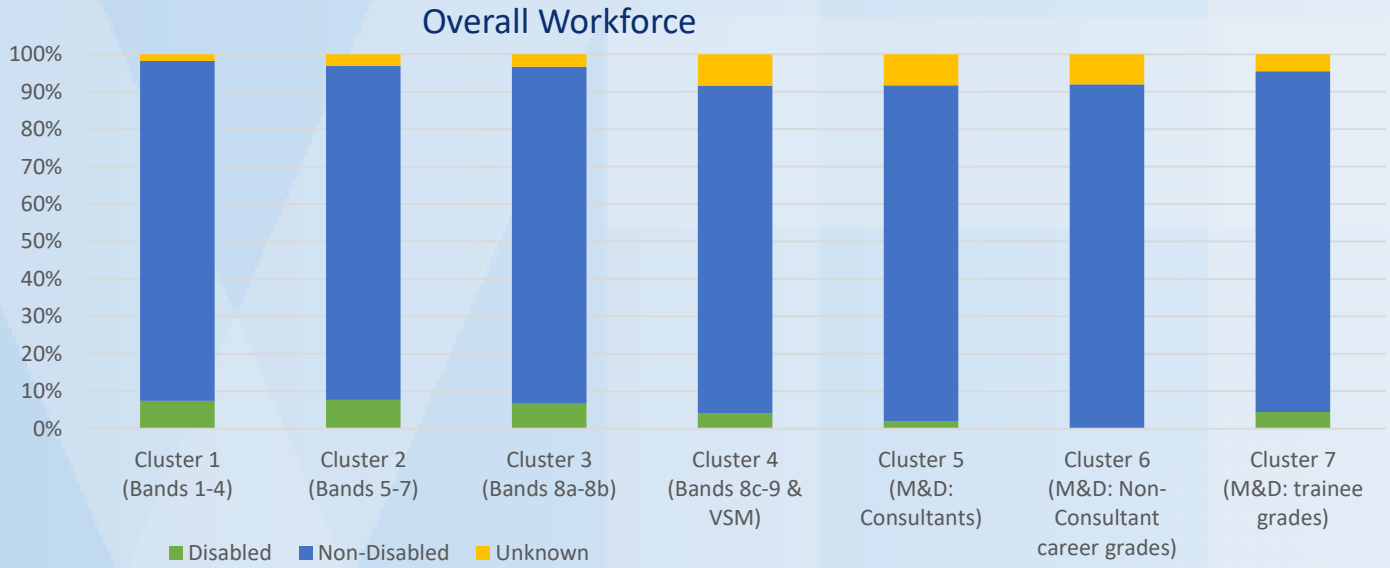
This metric demonstrates the proportion of declaration reduces as pay banding increases.

The data also demonstrates that declaration rates amongst our Medical and Dental workforce are low, particularly clusters 5 & 6

Medical and Dental



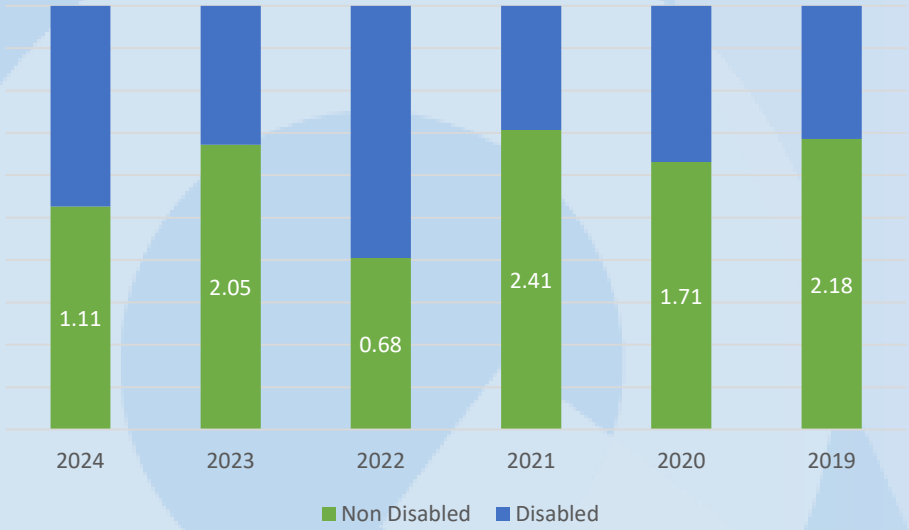
Overall Workforce



WDES Metric 2

Recruitment

	2019	2020	2021	2022	2023	2024
Relative likelihood	2.18	1.71	2.41	0.68	2.05	1.11



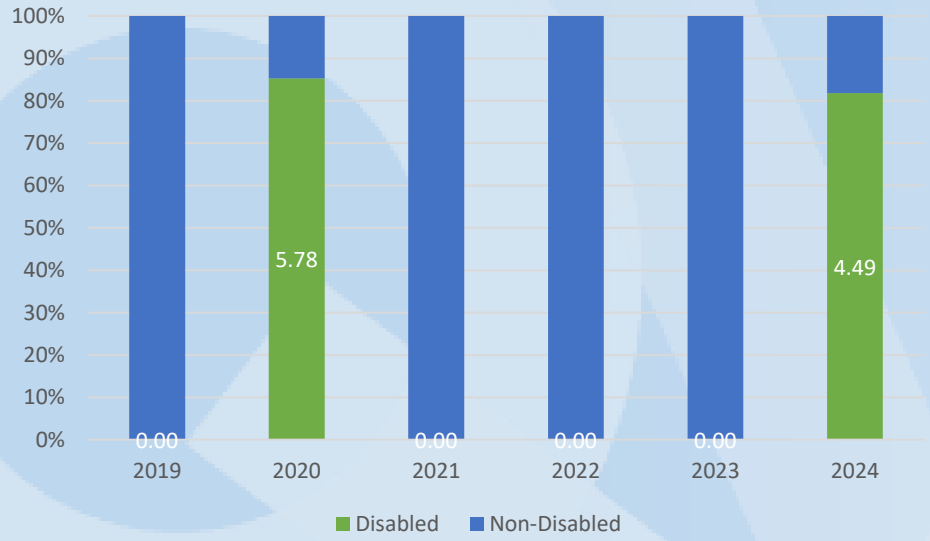
This metric shows non-disabled candidates are 0.11 times more likely to be appointed from shortlisting to Disabled candidates

This demonstrates a significant progress from 2023 where candidates were more than 2 times likely to be appointed.

WDES Metric 3

Capability

	Year to March					
	2019	2020	2021	2022	2023	2024
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process as measured by entry into the formal capability procedure	0.00	5.78	0.00	0.00	0.00	4.49



Data shows that disabled staff are 4.49 times more likely to enter into a formal capability process. It is important to stress that QVH has incredibly low numbers which provides a distorted picture.

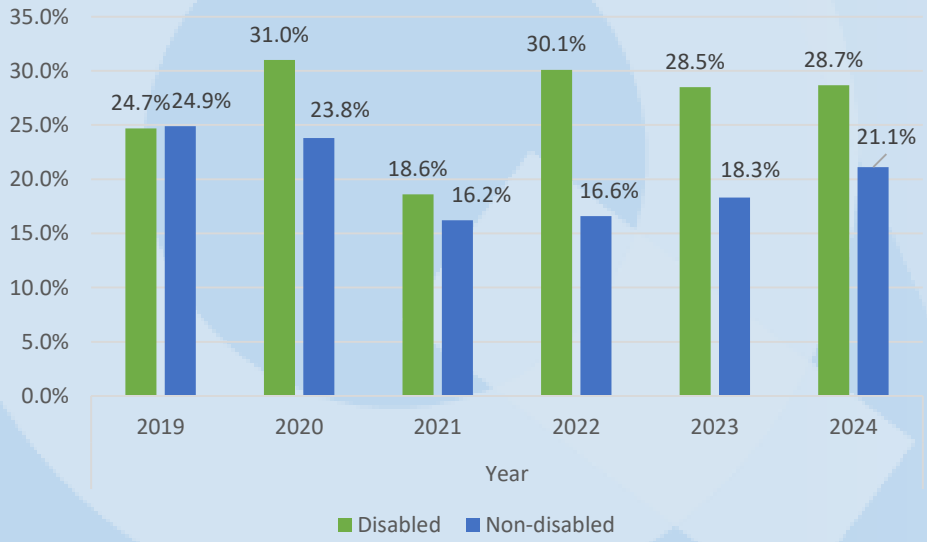
In the last 2 years we have had an average of 0.5 disabled, 1.5 Non-disabled and 0.5 unknown (2.5 cases in total) enter into a formal capability process. The difference in disparity is 0.006 vs 0.001 however this is auto calculated to 4.49.

WDES Metric 4a

Harassment, bullying or abuse

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patient/Service users, their relatives or other members of the public

	Year					
	2019	2020	2021	2022	2023	2024
Disabled	24.7%	31.0%	18.6%	30.1%	28.5%	28.7%
Non-disabled	24.9%	23.8%	16.2%	16.6%	18.3%	21.1%



There has been a slight increase in bullying from patients/service users, their relative or other members of the public by 0.2%

A higher proportion of disabled staff experience bullying, harassment and abuse from the public than non-disabled staff

These results are below the national average.

NHS Staff Survey Benchmark report 2022

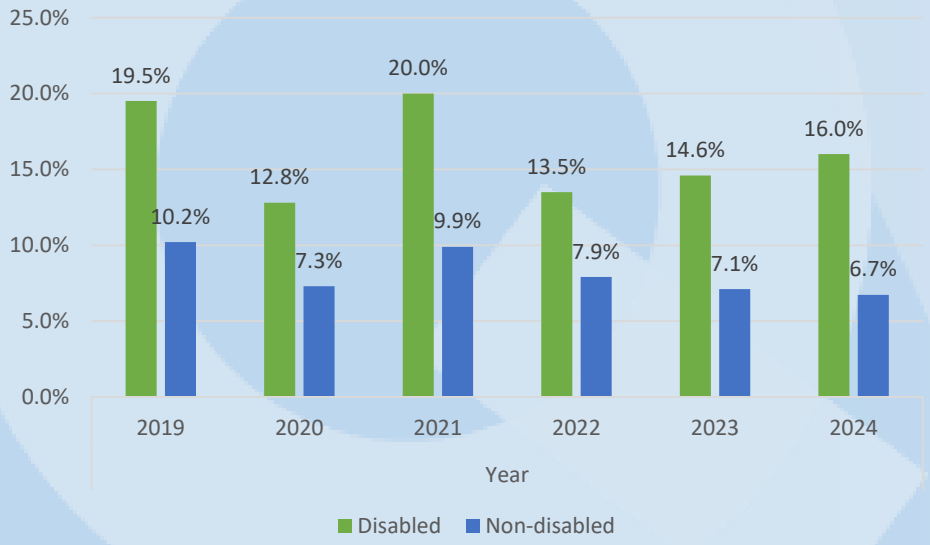
National Average
Disabled: 33.0%
Non-Disabled: 26.6%

WDES Metric 4b

Harassment, bullying or abuse

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers

	Year					
	2019	2020	2021	2022	2023	2024
Disabled	19.5%	12.8%	20.0%	13.5%	14.6%	16.0%
Non-disabled	10.2%	7.3%	9.9%	7.9%	7.1%	6.7%



There has been an increase of 1.4% in the number of disabled staff experiencing bullying, harassment or abuse from managers

A higher proportion of disabled staff experience bullying, harassment or abuse than non-disabled staff-a 9.3% difference

QVH are below the national benchmark

NHS Staff Survey Benchmark report 2022

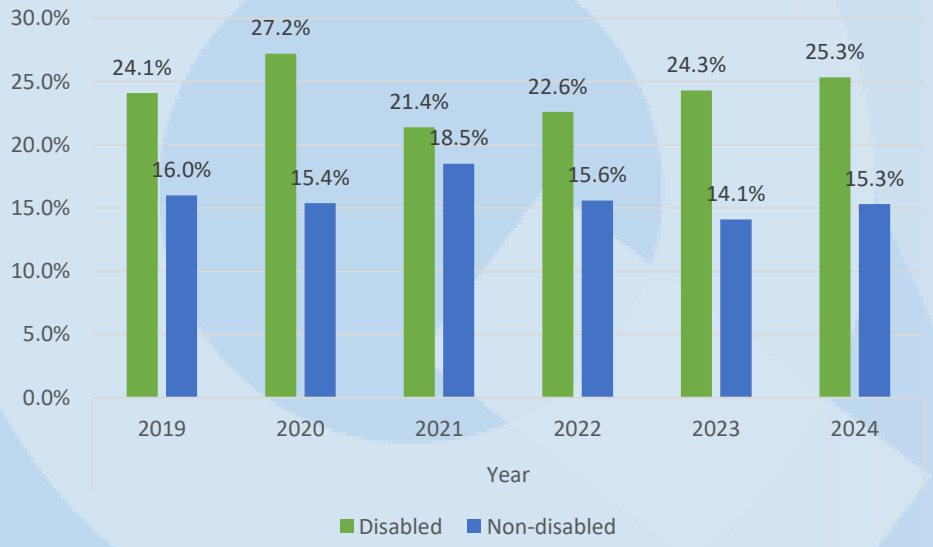
National Average
Disabled: 17.1%
Non-Disabled: 9.9%

WDES Metric 4c

Harassment, bullying or abuse

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues

	Year					
	2019	2020	2021	2022	2023	2024
Disabled	24.1%	27.2%	21.4%	22.6%	24.3%	25.3%
Non-disabled	16.0%	15.4%	18.5%	15.6%	14.1%	15.3%



There has been an increase of 1% in the number of disabled staff that have experienced harassment, bullying or abuse from colleagues

A higher proportion of disabled staff experience bullying, harassment or abuse than non-disabled staff-a 10% difference

QVH are below the national benchmark

NHS Staff Survey Benchmark report 2022

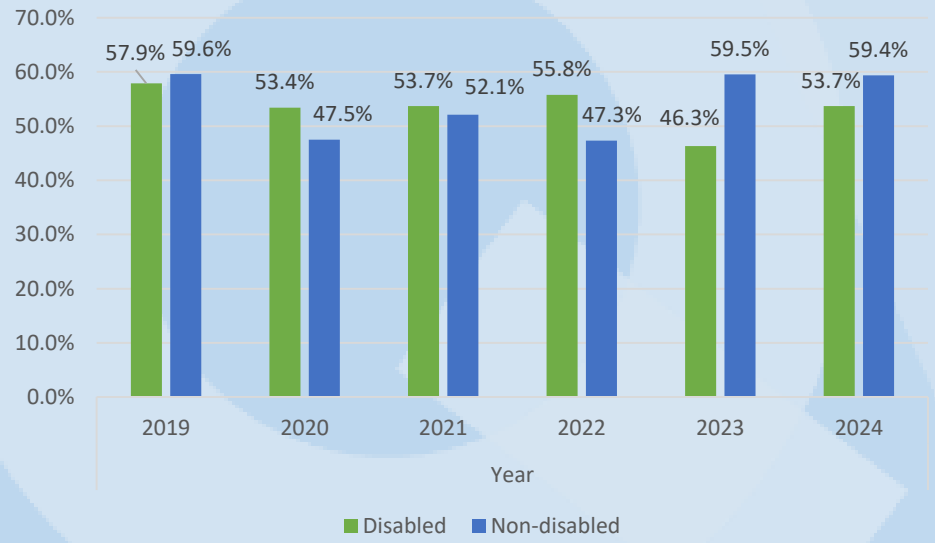
National Average
Disabled: 26.9%
Non-Disabled: 17.7%

WDES Metric 4d

Harassment, bullying or abuse

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse at work and they or a colleague reported it

	Year					
	2019	2020	2021	2022	2023	2024
Disabled	57.9%	53.4%	53.7%	55.8%	46.3%	53.7%
Non-disabled	59.6%	47.5%	52.1%	47.3%	59.5%	59.4%



There has been an increase of 7.4% in the number of disabled staff that have experienced harassment, bullying or abuse from colleagues and have reported it.

A lower proportion of disabled staff have reported these behaviours compared to non-disabled staff which has remained static

QVH are above the national benchmark

NHS Staff Survey Benchmark report 2022

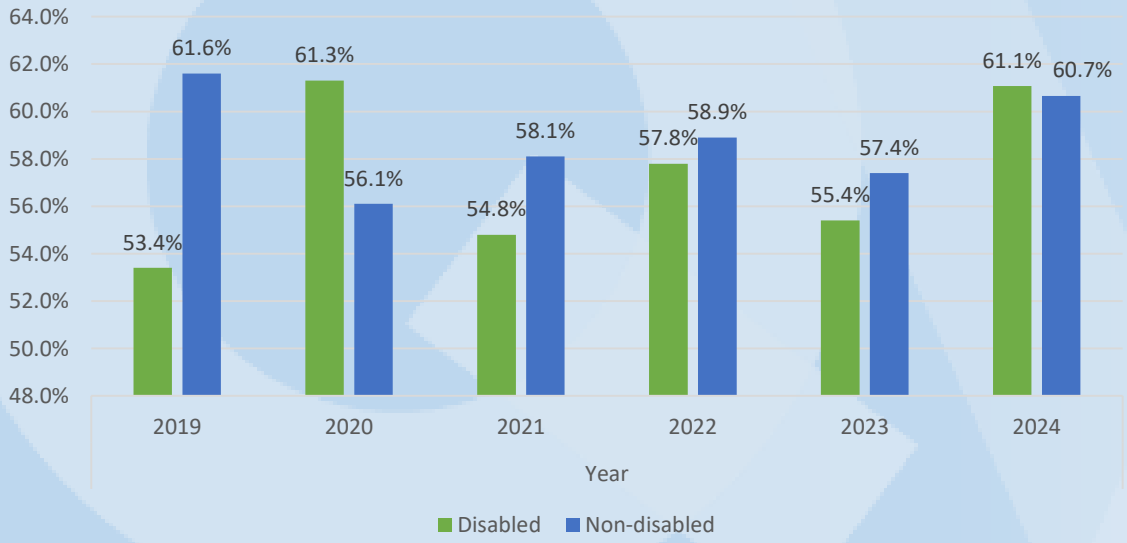
National Average
Disabled: 48.4%
Non-Disabled: 47.3%

WDES Metric 5

Career Progression

Percentage of disabled staff compared to non-disabled staff believing that the organisation provides equal opportunities for career progression or promotion

	Year					
	2019	2020	2021	2022	2023	2024
Disabled	53.4%	61.3%	54.8%	57.8%	55.4%	61.1%
Non-disabled	61.6%	56.1%	58.1%	58.9%	57.4%	60.7%



61.1% of disabled staff believe the Trust provides equal opportunities compared to 60.7% of non-disabled staff.

This represents an increase for both disabled (5.7%) and non disabled (3.3%) staff from 2023

QVH are 10% above the national average for disabled staff

NHS Staff Survey Benchmark report 2022

National Average
Disabled: 51.4%
Non-Disabled: 57.3%

WDES Metric 6

Presenteeism

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

	Year					
	2019	2020	2021	2022	2023	2024
Disabled	29.3%	33.3%	38.0%	31.8%	22.0%	22.7%
Non-disabled	25.3%	27.8%	25.5%	17.7%	20.0%	17.5%

22.7% (1 in 4.5) of QVH disabled staff have felt pressure from their manager to come to work when not feeling well enough to perform their duties.

This has marginally increased since 2023, however has significantly reduced since 2022

QVH remains below the national average

NHS Staff Survey Benchmark report 2022

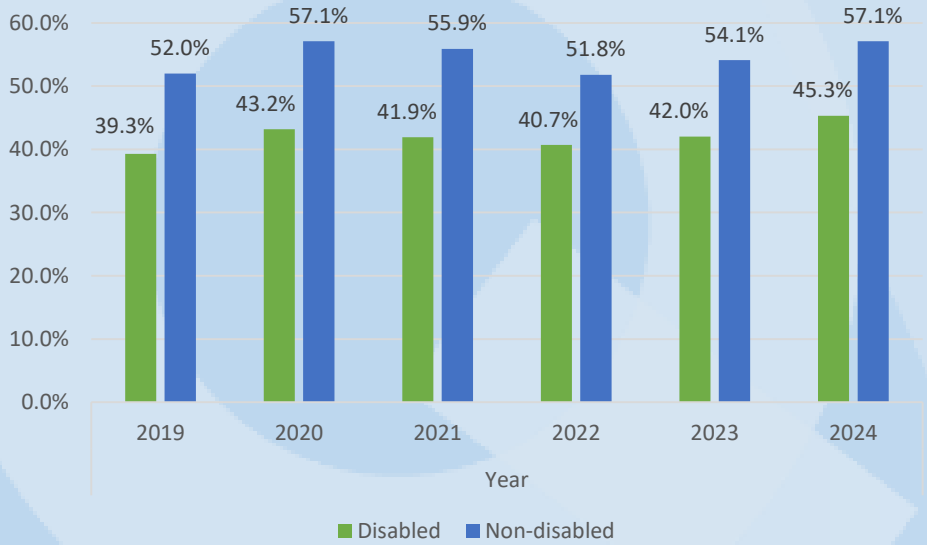
National Average
Disabled: 30.0%
Non-Disabled: 20.8%

WDES Metric 7

Feeling Valued

Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

	Year					
	2019	2020	2021	2022	2023	2024
Disabled	39.3%	43.2%	41.9%	40.7%	42.0%	45.3%
Non-disabled	52.0%	57.1%	55.9%	51.8%	54.1%	57.1%



45.3% of disabled staff feel the Trust values their work compared to 57.1% of non-disabled staff.

This percentage has gradually increased over the years since 2019 for disabled staff, and constant for non-disabled staff

QVH remain above the national average

NHS Staff Survey Benchmark report 2022

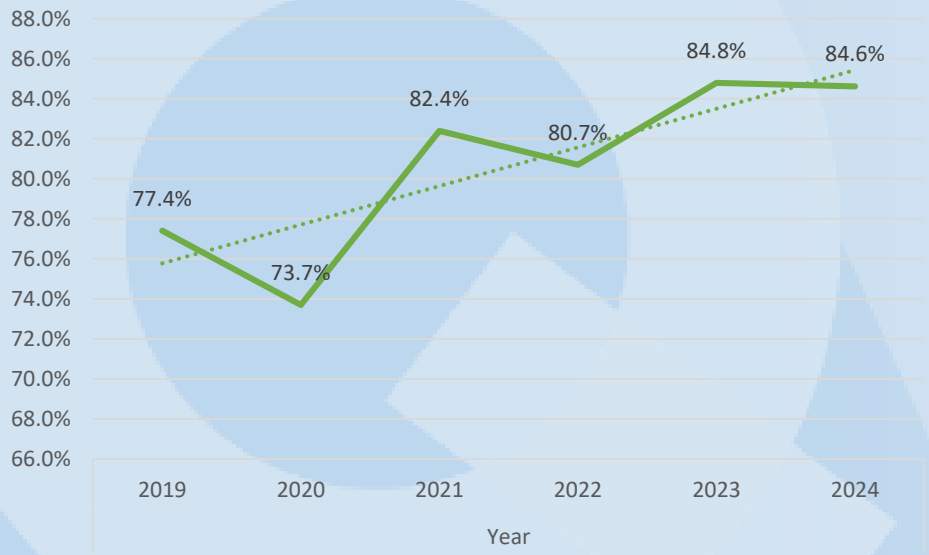
National Average
Disabled: 32.5%
Non-Disabled: 43.6%

WDES Metric 8

Workplace Adjustments

Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work

Year					
2019	2020	2021	2022	2023	2024
77.4%	73.7%	82.4%	80.7%	84.8%	84.6%



84.6 % of disabled staff say that the Trust has made reasonable adjustments, which is above the national average.

This has reduced very slightly since 2023, however has remained consistently over the current national average since 2019

NHS Staff Survey Benchmark report 2022

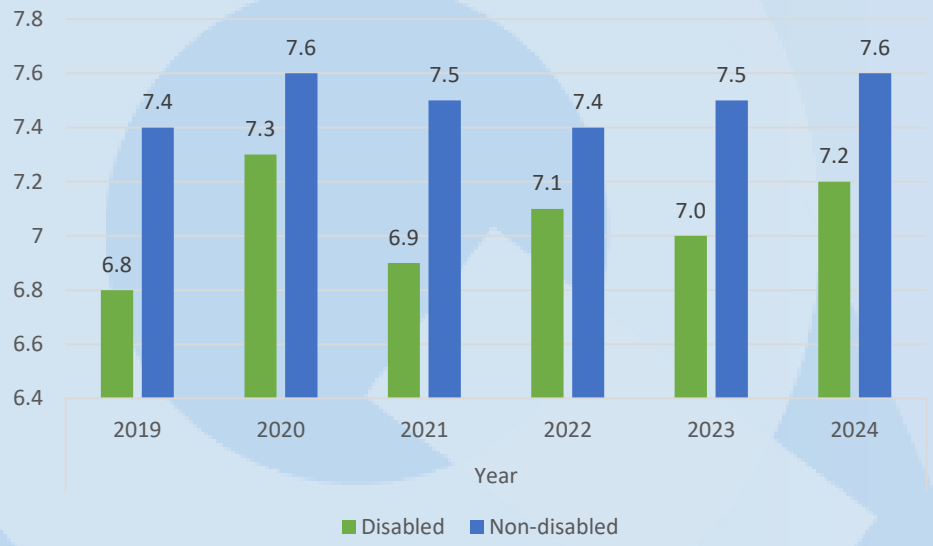
National Average
71.8%

WDES Metric 9

Staff Engagement

NHS Staff Survey and the engagement of disabled staff For part a) compare the staff engagement scores for Disabled, non-disabled staff

	Year					
	2019	2020	2021	2022	2023	2024
Disabled	6.8	7.3	6.9	7.1	7.0	7.2
Non-disabled	7.4	7.6	7.5	7.4	7.5	7.6



The staff engagement score for disabled staff (7.2) is lower than non-disabled staff (7.6) however has improved since 2023.

The gap between disabled and non-disabled has narrowed slightly, however engagement for both disabled and non disabled is higher than the national average

NHS Staff Survey Benchmark report 2022

National Average
Disabled: 6.4
Non-Disabled: 6.9

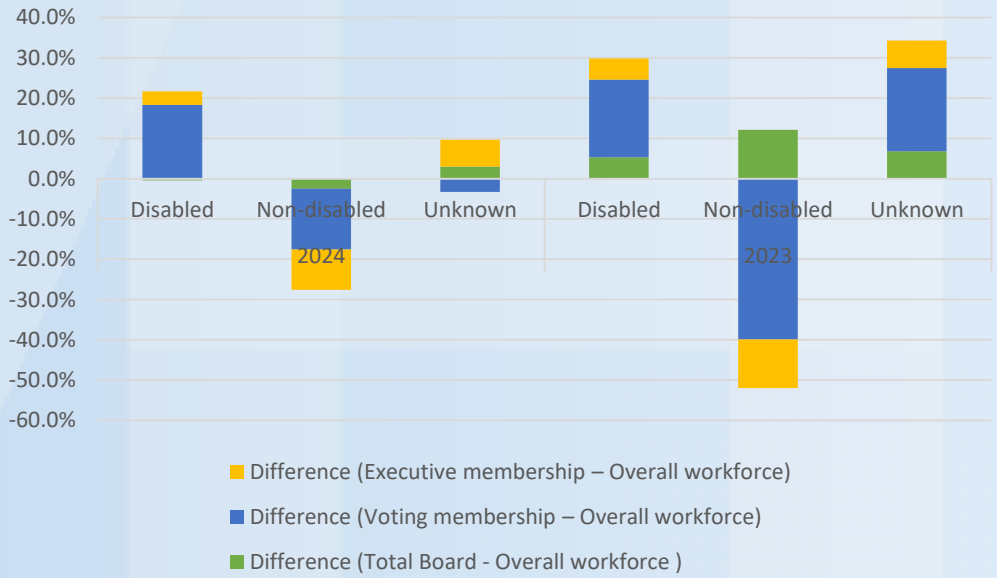
WDES Metric 10

Board Representation

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated

	2024				2023				2022			
	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total
Total Board members	1	14	1	16	2	10	1	13	1	11	0	12
of which voting	1	3	0	4	1	2	1	4	1	3	0	4
of which non-voting	0	11	1	12	1	8	0	9	0	8	0	8
Total Board members	1	14	1	16	1	9	2	13	1	11	0	12
of which Executive	1	8	1	10	1	6	1	8	0	7	0	7
of which Non-Executive	0	6	0	6	1	4	0	5	1	4	0	5

	2024				2023			
	Disabled	Non-disabled	Unknown	Total	Disabled	Non-disabled	Unknown	Total
Number of staff in overall workforce	79	1066	39	1184	65	1013	49	1127
Total Board members - % by Disability	6.3%	87.5%	6.3%		11.1%	77.8%	11.1%	
Voting Board Member - % by Disability	25.0%	75.0%	0.0%		25.0%	50.0%	25.0%	
Non-Voting Board Member - % by Disability	0.0%	91.7%	8.3%		0.0%	88.9%	0.0%	
Executive Board Member - % by Disability	10.0%	80.0%	10.0%		11.1%	77.8%	11.1%	
Non-Executive Board Member - % by Disability	0.0%	100.0%	0.0%		20.0%	80.0%	0.0%	
Overall workforce - % by Disability	6.7%	90.0%	3.3%		5.8%	89.9%	4.3%	
Difference (Total Board - Overall workforce)	-0.4%	-2.5%	3.0%		5.3%	-12.1%	6.8%	
Difference (Voting membership – Overall workforce)	18.3%	-15.0%	-3.3%		19.2%	-39.9%	20.7%	
Difference (Executive membership – Overall workforce)	3.3%	-10.0%	6.7%		5.3%	-12.1%	6.8%	



6.3% of Trust board membership has a declaration of a disability, which is broadly reflective of the overall workforce of 6.7%. This is a reduction from last year as the Trust board has grown as of 31st March 2023 and there has been a reduction in members who have declared a disability.

The national average is 5.7%

Key Areas of Progress and Actions for next 12 Months

Culture Change	1. **People and Culture Strategy-** The Trust is currently working on the enabling People and Culture Strategy for 2025-2030, alongside other enabling strategies and the Trust overall strategy, to be launched in the Autumn of 2024. This strategy will include a specific pillar for compassion and inclusivity to drive forward the work and identify priorities to harness culture change across the Trust. 2. **Workforce Belonging**- The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan, to address High Impact Action 6, which is to 'Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. As part of this action the Trust has undertaken a series of Workplace belonging workshops with staff to understand what will improve working lives for staff with protected characteristics. The Trust's Violence Prevention and Reduction group has increase compliance against the national standards by over 30%. The Trust's Domestic Abuse for staff policy has been re-written with safeguarding oversight. 3. **Freedom to Speak Up-** The Trust's speak up provision has been enhanced and supported by an external provider to provide 24/7 support to staff. This service is available to all staff, and compliments the Trusts embedded mechanisms for raising concerns relating to patient care and safety, whistleblowing & bullying and harassment. By being operated by a 3rd party it is anticipated this will improve psychological safety of staff to raise concerns confidentially. 4. **Refreshed Vision and Values & Behavioral Framework-** Continual development through wide staff engagement and consultation, with a behavior framework to support an inclusive learning culture increasing psychological safety of staff to support the embedding of a enhanced speak up process for staff. The Trust vision and values are being revised and co-produced with staff to be embedded throughout the organisation
Recruitment Career Development	5. **Inclusive Recruitment Process and Practice-** There has been an improvement in the likelihood of disabled candidates being appointment to positions in the Trust. This will be built on following a thorough review of the Trust's recruitment process and practice to ensure it is an inclusive as possible. Work needs to be done on how we reach candidates with protected characteristics, amend our practice to support candidates and work to be a disability confident employer. 6. **Appraisal Process Revised with a focus on Wellbeing and career development-** A revised appraisal process was launched in 2023 to provide focus on health, wellbeing and career development. As part of the introduction of this process , a mechanism for feedback is being introduced for 24/25 to monitor effectiveness of appraisal alongside our National Staff Survey results. 7. **Increase in Apprentice & Internship Opportunities-** QVH supports the use of apprenticeships across all staffing areas. In 2023/24 the Trust supported its highest number of apprentices to date, however further work is needed over 24/25 to ensure the diversity of staff accessing apprentice opportunities increase, and our use of the levy is increased. Work is underway to embed internships at QVH identifying where the trust can offer more inclusive opportunities to those in under-represented groups.
Staff Engagement	8. **Oliver McGowan** Training-23/24 saw the introduction of the Oliver McGowan training mandated for all staff it increase learning and understanding of neurodiversity. Since its introduction QVH have been working towards completion compliance, and in 24/25 will look to expand the programme with enhanced training for clinical colleagues. 15. **Re-Introduction of Team Brief-** In 23/24 the Trust re-introduced its team brief to enhance engagement and communication. This is Executive led and delivered through a hybrid model both face to face and virtually for those unable to attend and to improve accessibility and inclusivity. Team Brief is also recorded for those unable to attend on the day. Those attending team brief ensure information is disseminated throughout the organisation and compliments other methods of communication in the Trust. 16. **Strategy and Engagement Work -** Through 23/24 and into 24/25 the Trust is embarking on co-designing its future strategy. This has led to a large engagement exercises with staff and stakeholders from across the organisation. There has also been further engagement relating to the enabling strategies and the development of the revised vision and values and behaviour framework.

Key Areas of Progress and Actions for next 12 Months

Bullying and Harassment	11. **EDI Group-** The Trust has introduced an EDI Group to support all staff. This group is lead by senior Trust leadership to raise awareness of EDI issues, and consider appropriate responses. The group also shares good practice, provides scrutiny, check and challenge on Trust activities and provides a voice for staff to raise awareness of EDI Issues. The group was established in January 2024 on an informal basis whilst the Trust undertakes a review of its internal governance structure, and it is expected that this group will evolve to become part of an overall People Group. 12. **NHS England High Impact Actions-** The Trust has in place a comprehensive action plan aligned with NHS England's EDI Improvement Plan, to address High Impact Action 6, which is to 'Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. As part of this action the Trust has undertaken a series of Workplace belonging workshops with staff, undertaken a review of
Board Sponsorship	13. **Board Accountability-** The Trust has agreed each Board member will act as a sponsor for one of staff networks. This will result in dedicated and targeted leadership support , provide accountability and governance from senior leaders. reinforce the commitment to improving lived experiences and develop an inclusive leadership culture. Most importantly it will enable Board members to hear the voices of disabled staff.

Actions for next 12 months

Action	By When	Lead
Creation and implementation of the Trust behavioural frame work as part of the launch of the Vision and Values supporting psychological safety, accountability and speaking out for those with a disability or long term health condition.	Q3 2024-2025	CSO/CPO
Continued rollout of Active Bystander training and education to support speaking up and providing a tool kit for managers and staff to address inappropriate behaviours for those with a disability or long term health condition.	Q2 2024-2025	Education and Development
Creation of a dedicated Executive led People Group to provide the governance for the EDI Group to report and to highlight areas of challenge to the Trust Board relating to those with a disability or long term health condition.	Q2 2024-2025	CPO
Through an enhanced Freedom to Speak Up service, capture and act on themes highlighted by staff in relation to poor behaviours that are disadvantaging staff from those with a disability or long term health condition.	Q2 2024-2025	CNO
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process.	Q3 2024-2025	DCPO
Thorough review of employment policies to reduce the amount and length of documentation whilst making the content more accessible for managers and staff.	Q4 2024-2025	DCPO
Recruitment of a Trust Wellbeing and Inclusion Manager to lead the implementation and delivery of the EDI sub-strategy as the EDI operational lead for the Trust	Q2 2024-2025	Head of Employee Relations & Wellbeing

NHS Staff Survey 2023
Additional information regarding data collection issue with question 13 and question 14

This file was updated on 25th March 2024.

Close to the publication date of the survey, a problem was identified with the quality of the data. Further investigation determined that, for respondents at some organisations working with one of the main providers of survey services who completed the questionnaire using an iPhone, questions 13 a to d were not always presented as expected.

This is the first time an issue of this nature has arisen and affects only a minority of respondents (roughly 20,000 of the 707,460 respondents).

Actions at publication on 7 March 2024

Due to the short timescale involved and the full nature of the issue being unknown, it was decided **some results in the 2023 NHS Staff Survey were unable to be published.**

2023 results for the following four questions have not been reported:

- **Q13a** – In the last 12 months how many times have you personally experienced physical violence at work from patients/service users, their relatives, or other members of the public.
- **Q13b** – In the last 12 months how many times have you personally experienced physical violence at work from managers.
- **Q13c** – In the last 12 months how many times have you personally experienced physical violence at work from other colleagues.
- **Q13d** – The last time you experienced physical violence at work, did you or a colleague report it?

2023 results for the following two People Promise element sub-scores have not been reported:

- "**Negative experiences**", which uses questions 13a, 13b and 13c in its calculation.
- "**Health and safety climate**", which uses question 13d in its calculation.

The "**Burnout**" sub-score remains unaffected, and 2023 results for this measure are reported alongside 2019-2022 historical data.

2023 results for the following People Promise element score have not been reported:

- "**We are safe and healthy**", which uses the "Negative experiences" and "Health and safety climate" sub-scores in its calculation.

Update on 25 March 2024

Further investigations have concluded that respondents who were not presented with the option to complete question 13 are likely to have answered question 14 differently. (Question 14 deals with experience of harassment, bullying or abuse.) This has created a statistical bias in the results for question 14 which needs to be compensated for.

The 2023 results for the following questions, which have previously been published, are therefore considered inaccurate and will be updated as soon as possible:

- **Q14a** – In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients/service users, their relatives, or other members of the public.
- **Q14b** – In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers.
- **Q14c** – In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues.
- **Q14d** – The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?

Detailed statistical testing has concluded that **no other questions have been affected** by the problems with the data.

Further actions

The following actions are being undertaken:

1. **Warning messages** have been placed on most* online resources to indicate that the results for question 14 are potentially inaccurate and are subject to change.
   *The benchmarking reports for each organisation will not be updated at this time.

2. A **full explanation** of the cause of the problem, its apparent affects, and the remedial actions being undertaken, is being prepared and will form part of a future update to this document. This will include a detailed description of the statistical methodology used.

3. A **potential solution** which allows question 13 to be reported at all levels (organisation, ICS, regional and national) is being tested. It is hoped these results, along with the People Promise sub-scores and scores they feed, will be published, along with revised results for question 14, by the end of May. Publication will involve updating all results on the website, including benchmarking reports.

Please note:

1. 2023 results for question 13 and associated measures have not been reported at any level at this time (national, benchmarking group, region, ICS, or organisation).

2. Historical results (2019 to 2022) for all the measures mentioned above are unaffected and will continue to be reported at all levels.

3. The problems identified with question 14 will affect some of the results for the Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) and the potential solution outlined above will look to address this as well.
   Reports recently published on the NHS England website relate to 2022 data and are therefore unaffected.

4. Similar issues appear to have affected the NHS Staff Survey for bank only workers. This is also being investigated.

5. **If you have been advised by your survey contractor that your results have not been affected by the question 13 technical issue, then please be aware that this will be the same for question 14. Benchmarking scores you have been given**

for both question 13 and question 14 are likely to have been affected and will be looked at as part of the potential solution outlined above.

NHS
Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024	**Agenda reference:**	**50-24**		
Report title:	Gender Pay Gap Report as at 31 March 2024				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the position of the QVH Gender Pay Gap for as at 31 March 2024, the reasons behind our gender pay gap and actions to give reassurance on how QVH are planning to reduce the Gender Pay Gap.				
Summary of key issues	• Our gender pay gap continues to be driven in part by a disproportionate number of men in more senior admin among our Agenda for Change (AfC) workforce and senior male clinicians earning top of grade and bonus payments relative to our total workforce. • Staff in Admin & Clerical have seen the pay gap reduce from 2023 by 7.87%, however it is still very significant at 27.07% (reduced from 34.94%) • The Trust gender pay gap for 2024 is 33.1% (Mean) and 32.2% (Median) • The AfC gender pay gap for 2024 is 7.83% (Mean) and 5.83% (Median) • The Medical and Dental gender pay gap for 2024 is 16.9% (Mean) and 11.31% (Median). This is a significant median improvement from 2023 (31.3%)				
Recommendation:	The Board is asked to approve the report for publication on the Trust website.				
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:	Individual and collective EDI objectives become a mandatory requirement for board members from October 2023				
Legal:	None				
Resources:	None at this stage				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	June 2024	Decision:	Approved	
Next steps:	Publication of the report on Trust website.				

Report to:	Board of Directors
Agenda item:	50-24
Date of meeting:	12 September 2024
Report from:	Helen Edmunds, Chief People Officer
Report author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	24 May 2024
Appendices:	None

Gender Pay Gap Report as at 31 March 2024

Executive Summary

Our overall workforce is predominantly female (76.25%) and has remained relatively constant over the past several years. The majority of Medical and Dental (M&D) staff fall within the 4th pay quartile (this is the highest of the four quartiles), the majority of which are male.

Our gender pay gap continues to be driven in part by a disproportionate number of men in more senior admin roles among our Agenda for Change (AfC) workforce and senior male clinicians earning top of grade and bonus payments relative to our total workforce.

Staff in Admin & Clerical have seen the pay gap reduce from 2023 by 7.87%, however it is still very significant at 27.07% (reduced from 34.94% in 2023)

The overall Trust gender pay gap for 2024 is 33.1% (Mean) and 32.2% (Median).

The AfC gender pay gap for 2024 is 7.83% (Mean) and 5.83% (Median).

With regard to Medical and Dental (M&D) staff, the mean pay gap is significant at 16.9%, a gap of £7.82 an hour in favour of male staff. The median pay gap has greatly improved since 2023 to 11.31%, a gap of £4.54 an hour in favour of male staff.

1. Introduction

Organisations with 250 or more employees are mandated under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 to publish information annually on their gender pay gap using specific measures, as detailed in this report.

The gender pay gap is the difference between average hourly earnings (excluding overtime) of men and women as a proportion of men's average hourly earnings (excluding overtime). **The gender pay gap is a measure across all jobs in the hospital, not of the difference in pay between men and women for doing the same job.**

The intention of pay gap reporting is to focus attention on the evidence for taking action to reduce pay inequality, improve staff experience, retention and make Queen Victoria NHS Foundation Trust (QVH) a great place to work.

The gender pay gap report is a snapshot as at 31 March 2024.

As at 31 March 2024, QVH employed 1221 people in full time and part time positions compared to 2023, where there were 1,127 staff. For the purposes of this report, electronic staff record (ESR) data has been used to undertake this analysis, and therefore it is dependent on staff reporting their gender via ESR self-service. There were no gaps in the reporting of gender this year.

2. Data Used to Calculate Gender Pay Gap Figures

There are six key indicators against which an employer must publish its calculations

- **Mean gender pay gap** – The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees.
- **Median gender pay gap** – The difference between median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees.
- **Mean bonus gender pay gap** – The difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees.
- **Median bonus gender pay gap** – The difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees.
- **Bonus proportions** – The proportion of males and females receiving a bonus payment.
- **Quartile pay bands** – The proportion of males and females in each of the four pay quartiles

3. Definitions

- Full-pay relevant employee - the employee must be paid their full usual pay during the pay period in which the snapshot date falls. If the employee is paid less than their usual rate because of leave for that period, they should not be counted as a full-pay relevant employee.

- If an employee is on any kind of leave and not being paid their full usual amount in the pay period, they are not full-pay relevant employees. For example, if they are paid Statutory Sick Pay or Statutory Maternity Pay which is less than their usual pay.

- "Pay" includes;
    - basic pay
    - full paid leave including annual, sick, maternity, paternity, adoption or parental leave,
    - bonus pay received in the pay period in which the snapshot date falls (bonus pay should be pro-rated where it relates to a period longer than the pay period)
    - area, on-call and other allowances such as recruitment and retention allowances shift premium pay
    - pay for piecework.

  It does not include;
    - overtime pay
    - expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, for example, mileage for use of vehicle)
    - remuneration in lieu of leave
    - benefits in kind (for example, child care vouchers)
    - redundancy pay and tax credits.

4. Methodology

The data used in this report has been generated using the Electronic Staff Record (ESR) Business Intelligence report designed specifically for gender pay gap reporting

5. Data Analysis- Gender

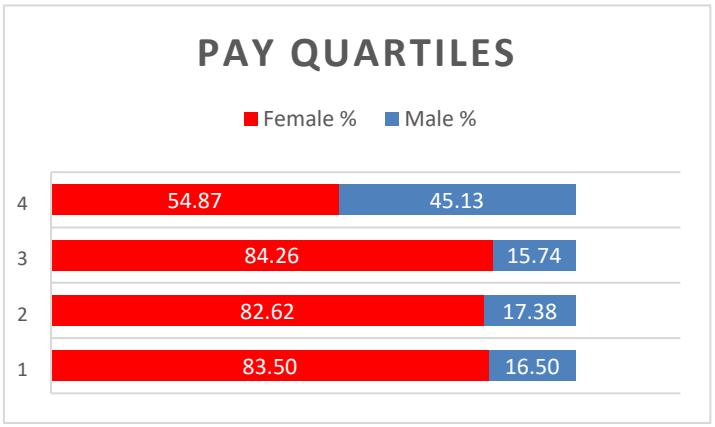
5.1 Gender Profiles

Our workforce is predominantly female (76.25%) and has remained relatively constant over the past several years.

Gender Distribution Pay Quartiles

The data below demonstrate the proportion of female to male staff members separately across all quartiles by Gender, Band and Staff Group

Quartile	Female	Male	Female %	Male %
1	253.00	50.00	83.50	16.50
2	252.00	53.00	82.62	17.38
3	257.00	48.00	84.26	15.74
4	169.00	139.00	54.87	45.13



The majority of female staff at QVH are located in quartiles 1, 2 and 3. Representation in the highest quartile becomes more evenly distributed between male and female staff.

Pay Quartile	1		2		3		4	
AfC Pay Grade	Female	Male	Female	Male	Female	Male	Female	Male
Band 2	125	38	56	15	1	2	2	
Band 3	129	14	22	9				
Band 4	47	10	91	11	2			
Band 5			119	20	48	7	2	
Band 6			18	5	131	21	28	5
Band 7					93	19	36	10
Band 8 - Range A					16	1	21	9
Band 8 - Range B							10	4
Band 8 - Range C							7	3
Band 8 - Range D							4	3
Band 9							1	1
M&D and VSM		1	1		16	8	90	133

*based on ordinary pay which includes bank work

The gender distribution of staff by Agenda for Change (AfC) Band demonstrates women are predominant at all bands and pay quartiles (1 being the lowest and 4 the highest paid) up to and including Band 8a. From Band 8b to 8d the proportion of men and women become more equal and at Band 9 there is an equal distribution, though the numbers are small

The majority of M&D staff fall within the 4th Quartile, the majority of which are male.

Upon a further deep dive of the quartile data it is apparent the banding is not the only thing that influence where an individual sits within the quartiles, additional payments also impact this as they contribute to overall earning. This is particularly seen in roles where a number of band 2, band 5 and band 6 sit within the upper quartiles because of additional earnings. This is because of the frequency of call outs resulting in significant levels of overtime payments on the given date of the report. This would further compound, and extend pay gaps within this staff group.

5.2 Mean and Median Hourly Rate

The mean pay gap is the difference between the average earnings of two groups, in this case male and female colleagues. This is widely considered the most suitable way to calculate the average as it incorporates all of data.

The median pay gap is the difference in hourly pay gap between the mid-point of the two groups when their salaries are listed by size. It therefore is not influenced by extremes in salaries and so the median would be more reflective of what the majority of individuals are paid.

Exploring the data from the 31st March 2024, it demonstrates that there is still a significant gender pay gap in favour of male colleagues. However, when comparing this to data from the 31st March 2023 it is apparent that the mean gap has slightly decreased by 0.7% however the median gap has increased by 1.2%.

Overall Workforce

	2023		2024	
Gender	**Mean average hourly rate**	**Median average hourly rate**	**Mean average hourly rate**	**Median average hourly rate**
Male	£29.25	£24.38	£30.66	£25.60
Female	£19.36	£16.91	£20.51	£17.36
Difference	£9.89	£7.47	£10.15	£8.24
Pay Gap %	**33.8%**	**30.6%**	**33.1%**	**32.2%**

Gender pay gap – Agenda for Change (AfC) workforce

Agenda for Change Staff				
	2023	**2023**	**2024**	**2024**
Gender	**Mean average hourly rate**	**Median average hourly rate**	**Mean average hourly rate**	**Median average hourly rate**
Male	£19.23	£16.84	£19.56	£16.64
Female	£17.29	£15.43	£18.03	£15.67
Difference	£1.94	£1.41	£1.53	£0.97

Pay Gap %	**10.1%**	**8.4%**	**7.83%**	**5.83%**

In respect of Agenda for Change (AfC) staff (excluding Executives, Non-Executives and Medical & Dental), the mean pay gap was 7.83% a gap of £1.53 an hour in favour of male staff. The median pay gap was 5.83% a gap of £0.97 an hour in favour of men.

Gender pay gap – Medical and Dental (M&D) workforce

Medical & Dental Staff				
	2023	**2023**	**2024**	**2024**
Gender	**Mean average hourly rate**	**Median average hourly rate**	**Mean average hourly rate**	**Median average hourly rate**
Male	£44.28	£49.10	£46.28	£40.15
Female	£38.03	£33.75	£38.46	£35.61
Difference	£6.25	£15.35	£7.82	£4.54
Pay Gap %	**14.1%**	**31.3%**	**16.9%**	**11.31%**

With regard to Medical and Dental (M&D) staff, the mean pay gap is significant at 16.9%, a gap of £7.82 an hour in favour of male staff. The median pay gap has greatly improved since 2023 to 11.31%, a gap of £4.54 an hour in favour of male staff. This is expected given there are a higher percentage (67.6%) of men in the M&D consultant workforce and therefore more males are able to undertake bank and WLI work which attract a higher rate premium.

5.3 Staff Groups

The extent of the gender pay gap varies considerably across the 8 different staff groups within the Trust.

	2023				2024			
Staff Group	**Female**	**Male**	**Difference**	**Pay Gap %**	**Female**	**Male**	**Difference**	**Pay Gap %**
Add Prof Scientific and Technic	23.08	19.72	-3.37	-17.07	23.84	21.73	-2.11	-9.71
Additional Clinical Services	12.31	12.11	-0.20	-1.64	13.05	12.86	-0.19	-1.48
Administrative and Clerical	15.55	23.90	8.35	34.94	16.94	23.22	6.29	27.07
Allied Health Professionals	22.20	19.66	-2.53	-12.89	23.22	19.25	-3.97	-20.64
Estates and Ancillary	12.17	14.16	1.99	14.04	12.71	14.33	1.62	11.32
Healthcare Scientists	23.71	29.17	5.46	18.71	26.80	29.95	3.15	10.53
Medical and Dental	39.35	44.25	4.91	11.09	38.46	46.28	7.82	16.90
Nursing and Midwifery Registered	21.27	22.54	1.27	5.64	22.28	23.72	1.43	6.04
Students	12.38	10.37	-2.01	-19.39	12.90	11.45	-1.46	-12.73

Reviewing the areas with the largest pay gaps in 2024, staff in Admin & Clerical have seen the pay gap reduce from 2023 by 7.87%, however is still very significant at 27.07% (reduced from 34.94%).

Medical and Dental staff have seen the gap grow since 2023 by 5.81% to 16.90% in 2024. Staff in Estates and Ancillary have a gap of 11.32% which has reduced from 14.04% the previous year along with Healthcare Scientists which have reduced from 18.71% to 10.53%.

The Allied Health Professional gender pay gap has grown further in favour of female staff. In 2023 the gap was -12.89% and this has grown to -20.64%.

5.4 Bonus Pay

Bonus payments - overall workforce

In 2024, QVH made bonus payments in respect of the national and local Clinical Excellence Awards (CEAs) for medical and dental consultants, and new starter premium for Agenda for Change staff.

Of the 1221 relevant employees, 87 received bonus payments which equates to 2.36% of women and 4.75% of men of the overall workforce.

The bonus payments totalled £520,474.44; of which 66.6% was awarded to men and 33.3% to women. In 2024 the mean bonus gender pay gap for the entire workforce was 49.3% and the median bonus gender pay gap was 0%. The main contributor to this was the historic distribution of CEA awards within the Medical Consultant body; in spite of the equal distribution of payments since 2021; where the majority of the workforce is male (67 male, 32 female).

Pro-rata bonuses received by part-time employees are not adjusted for the purpose of the gender bonus gap calculations, this impacts the gender pay bonus gap.

Gender	Mean Total Bonus	Median Total Bonus
Male	£7,158.95	£3,167.00
Female	£3,629.50	£3,167.00
Difference	£3,529.45	£0.00
Pay Gap %	**49.3%**	**0%**

Bonus payments - Consultant workforce

There are 99 consultants in the workforce at QVH; of which 32 (32.3% of the consultant workforce) are women and 67 (67.6%) are men. Considerably more men (n=56) compared to women (n=20) received bonus payments in the form of Clinical Excellence Awards (CEA's) awarded by the Trust.

CEA payments totalled £508,974.44. The **mean** (20.23%) was in favour of men who on average received £984.74 more in bonuses than women. The **median** was 0% which can be attributed to the Local CEA payments being equally distributed to all eligible consultants in 2024.

Gender	Mean CEA	Median CEA
Male	£5,359.99	£3,167.00
Female	£4,375.25	£3,167.00
Difference	£984.74	£0.00
Pay Gap %	**20.23%**	**0.0%**

Bonus payments - Agenda for Change workforce

In the year 2023-4 the Trust offered a new starter premium payments to AfC staff who referred a candidate subsequently employed. The value of this bonus totalled £11,500.00; of which 81.8% was awarded to females and 18.2% to males. These payments were paid to a total of 11 individuals.

Gender	Mean Total Bonus	Median Total Bonus
Female	£1,000.00	£1,500.00
Male	£1,250.00	£1,250.00
Difference	£250.00	£250.00
Pay Gap %	**22.2%**	**-18.2%**

6. Gender Pay Gap Recruitment for last 4 years

Medical and Dental (M&D) workforce

2021 & 2022

Gender	Mean average hourly rate	Median average hourly rate
Male	£47.52	£46.99
Female	£42.75	£42.91
Difference	£4.76	£4.08
Pay Gap %	**10.03%**	**8.68%**

2023 & 2024

Gender	Mean average hourly rate	Median average hourly rate
Male	£46.26	£46.26
Female	£45.75	£45.25
Difference	£0.51	£1.01
Pay Gap %	**1.11%**	**2.18%**

Consultant recruitment for the last 2 years has made significant steps to improve the pay gap between male and female consultants. The mean pay gap is 1.11% against an overall gap of 16.9%. The median pay gap is 2.18% against an overall gap of 11.31%.

Agenda for Change workforce

The largest pay gap amongst Agenda for Change workforce over the past 4 years of recruitment is within our Admin & Clerical staff group, as shown in the table below:

2021 & 2022

Gender	Mean average hourly rate	Median average hourly rate
Male	£19.99	£14.09
Female	£12.63	£11.49
Difference	£7.35	£2.60
Pay Gap %	**36.78%**	**18.45%**

2023 & 2024

Gender	Mean average hourly rate	Median average hourly rate
Male	£22.83	£16.78
Female	£18.16	£13.05
Difference	£4.67	£3.73
Pay Gap %	**20.45%**	**22.23%**

To provide context, the gap in Admin and Clerical roles is driven by the fact the Trust has recruited more female staff then male staff, however the females occupy lower banded posts. Of the 93 women who have been recruited into Admin and Clerical roles in the last 2 years 52 are either Band 2 or Band 3 which are the lowest paid roles. This is compared to just 5 males out of 22 recruited in the same time period in these bandings.

Of note is the Trust CEO was recruited in this time period, is male and the highest paid individual in the Trust, however the rest of the Executive body are female but this would demonstrate a pay gap at this level.

7. Priorities for 2024/2025

2024/25 Action Plan	Timescale
Establish individual and collective EDI objectives for all executive and non-executive board members, focussing on key areas of addressing disparities and inequalities across the organisation.	Q3 / Q4
Support the trusts action plan to improve Speak Up and psychological safety for all staff – implementation of FTSU contract, signing of the Sexual Safety Charter.	Complete
To review existing and commission new provision for training for managers and staff to increase cultural competence, civility and a just restorative culture.	Q2 / Q3
To invite expression of interest and training to become an inclusion agent within the workplace.	Ongoing

Establish a Trust EDI group as a focus for all our EDI work and to ensure a safe space for conversations on workplace belonging and to review pay gap data and develop further improvements.	Complete
Support staff networks development and growth, including our women's network. This includes establishing and supporting chair/co-chairs of the network, providing development into these vital roles, with a named member of the Executive Leadership Team as a sponsor of each network. Work with comms to promote networks to encourage greater membership.	Q1 – working with Absolute Diversity
To continually review the use of CEA's to promote positive action and eliminate pay gaps.	Complete
Undertake an enquiry into workplace belonging – including a specific focus on promoting flexible working, eliminating sexual harassment and discrimination and barriers to career progression.	Complete
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process. This will include reviewing our job advert wording to be more inclusive of flexible working options, removing any gender bias and reviewing where and how we advertise eg, use of social media platforms, and using data to inform which platforms provide the most diversity of applicants.	Q1 / Q2
Advertising all jobs as available less than full time to attract more diverse applicants to joining QVH.	Ongoing
Work with Clinical Directors / CMO / COO to review job plans / options for alternative job plans / Less than full time Drs	Ongoing
Expand career development opportunities within roles and support internal and external career progression for more staff, through provision of career mapping, new roles/extended roles, and meaningful talent conversations within appraisals, supporting succession planning.	Ongoing
Development and Implementation of succession planning across the Trust, commencing with Board, Deputy Directors, Senior Leaders	Q3
Work as an influencer with NHSE WT&E, HEIs, FEs and apprenticeship providers to influence and attract a more diverse population into careers in health. Eg – what would be needed for HEIs / medical schools etc. to attract more women into surgical specialities?	Ongoing
Commit to flexible working principles and champion promoting work-life balance to reduce barriers for women to advance their careers. Commit to better use of digital solutions across the organisation to further enable and embed smart flexible working options.	Q1 / Q2
Establishment of a Hybrid Working group to develop a Hybrid Working Toolkit to support QVH staff in different ways of working.	Q2

Recruitment of a 'People Promise Manager' (NHSE funded) to be an advocate for improving the experience of working for the NHS at QVH for all staff.	Complete
Commit to providing additional menopause awareness sessions to colleagues, promoting allyship, as well as having information readily available on Qnet for staff and managers to support colleagues in the workplace, with a commitment to working across our system to achieve menopause accreditation.	Q2
A review of job descriptions across the organisation to check for gender bias, updating where required. Peer to peer reviews of job descriptions with system partners to compare roles / bandings.	Q1 / Q2
A review of policies across the organisation to check for gender bias, flexible working / part-time working bias and updating where required. Peer to peer reviews of policies with system partners. Simplifying of policies using a just and learning culture approach,	Ongoing
Delivery of the QVH People and Culture Strategy (2025-2030), with a pillar focusing on inclusion, including a focus on reducing and ultimately eliminating the gender pay gap, with clear delivery plan milestones.	Q2 / Q3
Development and implementation of a reverse mentoring programme, using our networks to determine areas of initial focus to support career progression.	Q1 / Q2
Co-create with our networks to implement initiatives to increase representation of women in AfC leadership positions and medical and dental roles.	Ongoing
Work with system and region partners to ensure we are learning from each other, sharing good practice and taking all opportunities to increase workforce diversity.	Ongoing

Conclusion
There is clear evidence the gender pay gap across the organisation, and specifically within medical and dental roles, has greatly reduced when looking at the past two years recruitment. Work continues to support flexible working, de-biasing of job descriptions and adverts and supporting learning and development to attract a more diverse staff group at all levels.

Recommendation
The Board is asked to approve the report for publication on the Trust's website.

NHS
Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024	**Agenda reference:**	**50-24**		
Report title:	Ethnicity Pay Gap Report as at 31 March 2024				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the position of the QVH Ethnicity Pay Gap as at 31 March 2024, the reasons behind our ethnicity pay gap and actions to give reassurance on how QVH are planning to reduce the ethnicity pay gap across some of our workforce.				
Summary of key issues	• Colleagues from a multicultural background represent 21.25% of the workforce, with year-on-year increases being seen. • For the workforce overall there is a significant ethnicity pay gap in favour of BME colleagues (mean gap -20.79%, median gap -29.67%) • Agenda for Change (AfC) staff (excluding Executives, Non-Executives and Medical & Dental), the mean pay gap is -3.32% a gap of £0.61 an hour in favour of BME staff. The median pay gap is -27.46% a gap of £3.90 an hour in favour of BME staff. • Medical and Dental (M&D) staff, the mean pay gap is 8.89%, a gap of £4.01 an hour in favour of white staff. The median pay gap is 22.14%, a gap of £10.26 an hour in favour of white staff. For context. QVH have 85 M&D staff from a BME background and 104 M&D staff from a white background.				
Recommendation:	The Board is asked to approve the report for publication on the Trust's website.				
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:	Individual and collective EDI objectives become a mandatory requirement for board members from October 2023				
Legal:	None				
Resources:	None at this stage				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	June 2024	Decision:		
Next steps:	Publication of the report on Trust website.				

Report to:	Board of Directors
Agenda item:	50-24
Date of meeting:	12 September 2024
Report from:	Helen Edmunds, Chief People Officer
Report author:	Helen Edmunds, Chief People Officer Lawrence Anderson, Deputy Chief People Officer
Date of report:	5 June 2024
Appendices:	None

Ethnicity Pay Gap Report as at 31 March 2024

Executive Summary

This is the first year we are reporting on our ethnicity pay gap data as at 31 March 2024.

We are seeing a year on year growth in the number of colleagues working at QVH from a multicultural background. As at 31 March 2024 21.25% of the workforce are from a BME background. The largest numbers of BME staff are represented in pay quartiles 3 and 4.

There are 51 staff from 1221 recorded at 31 March 2024 who have not declared their ethnicity. The ethnicity pay gap amongst staff who have not declared is over 20% (mean) in favour of staff from a white background.

For the workforce overall there is a significant ethnicity pay gap in favour of BME colleagues (mean gap -20.79%, median gap -29.67%).

For agenda for Change (AfC) staff (excluding Executives, Non-Executives and Medical & Dental), the mean pay gap is -3.32% a gap of £0.61 an hour in favour of BME staff. The median pay gap is -27.46%, a gap of £3.90 an hour in favour of BME staff.

For Medical and Dental (M&D) staff, the mean pay gap is 8.89%, a gap of £4.01 an hour in favour of white staff. The median pay gap is 22.14%, a gap of £10.26 an hour in favour of white staff. For context QVH have 85 M&D staff from a BME background and 104 M&D staff from a white background.

Reviewing the staff groups with the largest ethnicity pay gaps in 2024, Healthcare Scientists see the highest pay gap at QVH with 33.80% in favour of white staff, the equivalent of £10.37 per hour. This is in relation to a total of 29 staff in this staff group.

Staff in the Additional Professional, Scientific and Technical staff group who have 43 staff demonstrate a -25.84% pay gap in favour of BME staff, the equivalent of £5.78 per hour (Psychotherapies, Optical, Pharmacy, Orthodontic staff).

1. Introduction

In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. High Impact action 3 requires us to develop and implement an improvement plan to eliminate pay gaps.

We are required to analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Plans

should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026. The Trust already report on gender pay gaps.

A pay gap is the difference between the average hourly pay of employees in one group in comparison to another group. This is different to equal pay. Equal pay is a person being paid the same for the same role and it is unlawful to pay someone differently for doing the same job based on a protected characteristic.

QVH is committed to understanding any differences identified in the ethnicity pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate. Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post.

This is our first ethnicity pay gap report. We have analysed information using the categories: White, Not Stated (which includes not known) and BME. BME is all other ethnic minority groups combined

The intention of pay gap reporting is to focus attention on the evidence for taking action to reduce pay inequality, improve staff experience, retention and make Queen Victoria NHS Foundation Trust (QVH) a great place to work.

The ethnicity pay gap report is a snapshot as at 31 March 2024.

2. Data Used to Calculate Ethnicity Pay Gap Figures

There are six key indicators against which an employer must publish its calculations

- **Mean ethnicity pay gap** – The difference between the mean hourly rate of pay of white full-pay relevant employees and that of BME full-pay relevant employees.
- **Median ethnicity pay gap** – The difference between median hourly rate of pay of white full-pay relevant employees and that of BME full-pay relevant employees.
- **Bonus proportions** – The proportion of White and BME staff receiving a bonus payment.
- **Quartile pay bands** – The proportion of White and BME in each of the four pay quartiles

3. Definitions

- Full-pay relevant employee - the employee must be paid their full usual pay during the pay period in which the snapshot date falls. If the employee is paid less than their usual rate because of leave for that period, they should not be counted as a full-pay relevant employee.

- If an employee is on any kind of leave and not being paid their full usual amount in the pay period, they are not full-pay relevant employees. For example, if they are paid Statutory Sick Pay or Statutory Maternity Pay which is less than their usual pay.

- “Pay” includes;
    - basic pay
    - full paid leave including annual, sick, maternity, paternity, adoption or parental leave,

- bonus pay received in the pay period in which the snapshot date falls (bonus pay should be pro-rated where it relates to a period longer than the pay period)
- area, on-call and other allowances such as recruitment and retention allowances shift premium pay
- pay for piecework.

It does not include;

- overtime pay
- expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, for example, mileage for use of vehicle)
- remuneration in lieu of leave
- benefits in kind (for example, child care vouchers)
- redundancy pay and tax credits.

4. Methodology

The data used in this report has been generated using the Electronic Staff Record (ESR) Business Intelligence report designed specifically for ethnicity pay gap reporting

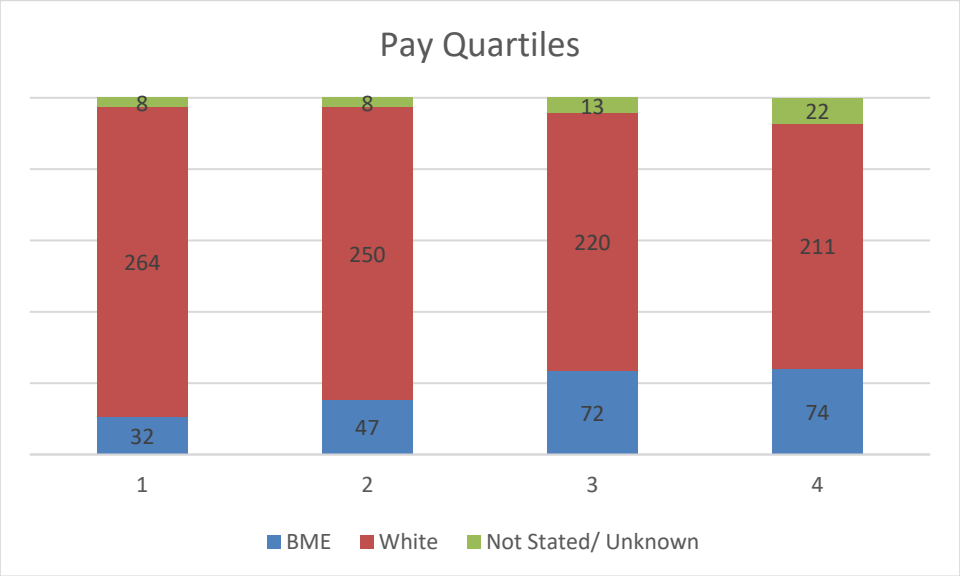
5. Data Analysis-Race

Colleagues from a multicultural background represent 21.25% of the workforce, with year-on-year increases being seen.

	BME %	Non-BME %	Unknown %
2019	14.69%	83.07%	2.24%
2020	15.92%	81.14%	2.94%
2021	18.79%	79.38%	1.83%
2022	19.27%	78.73%	2.00%
2023	19.52%	78.53%	1.95%
2024	21.25%	77.48%	1.27%

5.1 Ethnicity Distribution Pay Quartiles

Quartile	BME	White	Not Stated/ Unknown
1	32	264	8
2	47	250	8
3	72	220	13
4	74	211	22



The majority of BME staff are located in quartiles 3 and 4, with less BME staff occupying the lower paid quartiles. The number of staff who have not stated or have an undeclared ethnicity increases with the pay quartiles.

5.2 Mean and Median Hourly Rate

The mean pay gap is the difference between the average earnings of two groups, in this case BME and White colleagues. This is widely considered the most suitable way to calculate the average as it incorporates all of data.

The median pay gap is the difference in hourly pay gap between the mid-point of the two groups when their salaries are listed by size. It therefore is not influenced by extremes in salaries and so the median would be more reflective of what the majority of individuals are paid.

Exploring the data from the 31st March 2024, it demonstrates there is a significant ethnicity pay gap in favour of BME colleagues. The gap amongst staff who have not declared (51 out of 1221 staff) is over 20% (mean) in favour of staff from a white background.

Overall Workforce

Ethnicity	Mean Hourly Rate	Median Hourly Rate
BME	£27.01	£22.61
Not Known	£17.67	£14.40
White	£22.36	£17.44
Pay Gap - BME	**-20.79%**	**-29.67%**
Pay Gap - Not Known	**20.98%**	**17.41%**

Ethnicity pay gap – Agenda for Change (AfC) workforce

Ethnicity	Mean Hourly Rate	Median Hourly Rate
BME	£18.97	£18.10
Not Known	£16.70	£14.01
White	£18.36	£14.20
Pay Gap - BME	**-3.32%**	**-27.46%**
Pay Gap - Not Known	**9.03%**	**1.34%**

In respect of Agenda for Change (AfC) staff (excluding Executives, Non-Executives and Medical & Dental), the mean pay gap is -3.32% a gap of £0.61 an hour in favour of BME staff. The median pay gap is -27.46% a gap of £3.90 an hour in favour of BME staff.

Ethnicity pay gap – Medical and Dental (M&D) workforce

Ethnicity	Mean Hourly Rate	Median Hourly Rate
BME	£41.13	£36.08
Not Known	£30.07	£30.07
White	£45.14	£46.34
Pay Gap - BME	**8.89%**	**22.14%**
Pay Gap - Not Known	**33.39%**	**33.39%**

With regard to Medical and Dental (M&D) staff, the mean pay gap is 8.89%, a gap of £4.01 an hour in favour of white staff. The median pay gap is 22.14%, a gap of £10.26 an hour in favour of white staff.

For context QVH have 85 staff from a BME background and 104 from a white background

Staff Groups

The extent of the ethnicity pay gap varies considerably across the 8 different staff groups within the Trust.

Staff Group	BME Mean Hourly Rate	White Mean Hourly Rate	Difference per hour	Pay Gap
Add Prof Scientific and Technic	£28.13	£22.35	£5.78	-25.84%
Additional Clinical Services	£13.16	£13.04	£0.12	-0.89%
Administrative and Clerical	£19.10	£17.96	£1.14	-6.33%
Allied Health Professionals	£22.37	£22.76	-£0.39	1.70%
Estates and Ancillary	£13.48	£14.04	-£0.56	3.99%
Healthcare Scientists	£20.32	£30.69	-£10.37	33.80%
Medical and Dental	£41.13	£45.14	-£4.01	8.89%
Nursing and Midwifery Registered	£22.00	£22.82	-£0.82	3.60%

Reviewing the staff groups with the largest pay gaps in 2024, Healthcare Scientists see the highest pay gap at QVH with 33.80% in favour of white staff, the equivalent of £10.37 per hour. This is in relation to a total of 29 staff in this area.

Staff in the Additional Professional, Scientific and Technical staff group who have 43 staff demonstrate a -25.84% pay gap in favour of BME staff, the equivalent of £5.78 per hour (Psychotherapies, Optical, Pharmacy, Orthodontic staff).

Bonus Pay

Bonus payments - overall workforce

In 2024, QVH made bonus payments in respect of the national and local Clinical Excellence Awards (CEAs) for medical and dental consultants, and new starter premium for Agenda for Change staff.

Of the 1221 relevant employees, 110 received bonus payments which equates to 5.5% of white staff and 3.36% of BME staff of the overall workforce.

The bonus payments totalled £520,474.44; of which 61.82% was awarded to white staff and 37.3% to BME staff. In 2024 the mean bonus ethnicity pay gap for the entire workforce was -33.01% and the median bonus ethnicity pay gap was 0%. The main contributor to this was the historic distribution of CEA awards within the Medical Consultant body; in spite of the equal distribution of payments since 2021; where the majority of the workforce is white (61 White, 37 BME and 1 Unknown).

Pro-rata bonuses received by part-time employees are not adjusted for the purpose of the ethnicity bonus gap calculations, this impacts the ethnicity pay bonus gap.

Ethnicity	Mean Total Bonus	Median Total Bonus
BME	£5,615.35	£3,167.00
Not Known	£3,167.00	£3,167.00
White	£4,221.73	£3,167.00
Pay Gap - BME	**-33.01%**	**0.00%**
Pay Gap - Not Known	**24.98%**	**0.00%**

Bonus Payments - Consultant Workforce

There are 99 consultants in the workforce at QVH; of which 37 (37.37% of the consultant workforce) are BME and 61 (61.61%) are white. Considerably more white staff (n=61) compared to BME (n=37) received bonus payments in the form of Clinical Excellence Awards (CEA's) awarded by the Trust.

CEA payments totalled £508,974.44. The **mean** (-33.94%) was in favour of BME staff who on average received £1,552.77 more in bonuses than white staff. The **median** was 0% which can be attributed to the Local CEA payments being equally distributed to all eligible consultants in 2024.

Ethnicity	Mean Total Bonus	Median Total Bonus
BME	£6,127.82	£3,167.00
Not Known	£3,167.00	£3,167.00
White	£4,575.05	£3,167.00
Pay Gap - BME	**-33.94%**	**0.00%**
Pay Gap - Not Known	**30.78%**	**0.00%**

Bonus Payments - Agenda for Change Workforce

In the year 2023-4 the Trust offered a new starter premium payment to AfC staff who referred a candidate subsequently employed. The value of this bonus totalled £11,500.00; of which 63.63% was awarded to white staff and 36.36% to BME staff. These payments were paid to a total of 11 individuals.

Ethnicity	Mean Total Bonus	Median Total Bonus
BME	£875.00	£750.00
Not Known	N/A	N/A
White	£1,142.86	£1,000.00
Pay Gap - BME	**23.43%**	**25.00%**
Pay Gap - Not Known	**N/A**	**N/A**

7. Priorities for 2024/2025

2023-2024 Action	Timescale
Establish individual and collective EDI objectives for all executive and non-executive board members, focussing on key areas of addressing disparities and inequalities across the organisation.	Ongoing
Support the trusts action plan to improve Speak Up and psychological safety for all staff – implementation of FTSU contract, signing of the Sexual Safety Charter.	Complete
To review existing and commission new provision for training for managers and staff to increase cultural competence, civility and a just restorative culture.	Ongoing
To invite expression of interest and training to become an inclusion agent within the workplace.	Ongoing
Establish a Trust EDI group as a focus for all our EDI work and to ensure a safe space for conversations on workplace belonging and to review pay gap data and develop further improvements, including: • widening participation though school and community engagement, to support more diverse recruitment and training roles • analysis of historic trends and potential gender bias at appointment	Complete

• barriers to career development and promotion • promote flexible working for all	
Support staff networks development and growth. This includes establishing and supporting chair/co-chairs of the network, providing development into these vital roles, with a named member of the Executive Leadership Team as a sponsor of each network. Work with comms to promote networks to encourage greater membership.	Ongoing
To continually review the use of CEA's to promote positive action and eliminate pay gaps.	Complete
Undertake an enquiry into workplace belonging – including a specific focus on promoting flexible working, eliminating sexual harassment and discrimination and barriers to career progression.	Complete
Apply an EDI lens through lived experience to an end-to-end review of our current internal and external recruitment processes, with an EDI representative available for interview panels to support the de-biasing of the recruitment process. This will include reviewing our job advert wording to be more inclusive of flexible working options, removing any ethnicity bias and reviewing where and how we advertise eg, use of social media platforms, and using data to inform which platforms provide the most diversity of applicants.	May 2024
Advertising all jobs as available less than full time to attract more diverse applicants to joining QVH.	Ongoing
Expand career development opportunities within roles and support internal and external career progression for more staff, through provision of career mapping, new roles/extended roles, and meaningful talent conversations within appraisals, supporting succession planning.	Ongoing
Work as an influencer with NHSE WT&E, HEIs, FEs and apprenticeship providers to influence and attract a more diverse population into careers in health.	June 2024
Establishment of a Hybrid Working group to develop a Hybrid Working Toolkit to support QVH staff in different ways of working.	July 2024
Recruitment of a 'People Promise Manager' (NHSE funded) to be an advocate for improving the experience of working for the NHS at QVH for all staff.	Complete
A review of job descriptions across the organisation to check for ethnicity bias, updating where required. Peer to peer reviews of job descriptions with system partners to compare roles / bandings.	July 2024
Delivery of the QVH People and Culture Strategy (2024-2028), with a pillar focusing on inclusion, including a focus on our ethnicity pay gap across all staff groups, with clear delivery plan milestones.	Sept 2024
Development and implementation of a reverse mentoring programme, using our networks to determine areas of initial focus to support career progression.	Ongoing

Work with system and region partners to ensure we are learning from each other, sharing good practice and taking all opportunities to increase workforce diversity.	Ongoing

Conclusion
There is evidence the ethnicity pay gap across the organisation as a whole is in favour of BME colleagues, however the reverse is trust for the medical and dental workforce. There are specific areas of a wider ethnicity gap in favour of white colleagues in some of the agenda for change staff groups. We will continue to work with mangers in these areas to attract a wider diversity of applicant into roles and closely monitor where in the pay scale for the banding people are employed.

Work continues to support flexible working, de-biasing of job descriptions and adverts and supporting learning and development to attract a more diverse staff group at all levels.

Recommendation
The Board is asked to approve the report for publication on the Trust's website.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024		**Agenda reference:**	**51-24**	
Report title:	Risk Management Framework and Risk Appetite				
Sponsor:	Leonora May, Company Secretary James Lowell, Chief Executive Officer				
Author:	Glen Curry, Interim Risk Project Lead				
Appendices:	Appendix one: Risk Management Framework and risk appetite				
Executive summary					
Purpose of report:	This report presents the trust's new Risk Management Framework, including a refreshed risk appetite position				
Summary of key issues	• The Risk Management Framework is attached for approval • This includes a refreshed approach to risk appetite • Implementation activities are summarised within the report				
Recommendation:	The Board is asked to **APPROVE** the risk management framework (including risk appetite).				
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 new framework will impact the Board Assurance Framework process				
Corporate risk register:	The new framework will impact the Corporate Risk Register process				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Audit and Risk Committee				
	Date:	4/9/24	Decision:	Approved	
Next steps:	The new policy to take effect immediately				

Report to:	Board Directors
Agenda item:	51-24
Date of meeting:	12/09/2024
Report from:	Leonora May, Company Secretary James Lowell, Chief Executive Officer
Report author:	Glen Curry, Interim Risk Project Lead
Date of report:	05/09/2024
Appendices:	Appendix one: Risk Management Framework and risk appetite

Risk management framework and risk appetite

Introduction

The Board will be familiar with the findings from the Deloitte Well-led review in March 2023 and particularly the recommendations in Theme 5: Embedding risk management.

Significant work has taken place following this review to support the recommendations and to develop the trust's approach to risk management. Further work has been undertaken to fully develop and plan for the implementation of a new risk management framework. This includes a refreshed approach to risk appetite.

The trust's Risk Management Framework is now complete and attached for approval by the Board. The Risk Management Framework and risk appetite has been reviewed by the Audit and Risk committee who recommend it to the Board for approval.

Risk Management Framework overview

There are a number of key changes as part of the new framework which are important in order to ensure consistency in terminology and a clear, easy to understand process for risk management. The key design principle has been to ensure an approach consistent with good practice in risk management, but with the ability to describe principles clearly and to maximise engagement across all levels of the trust.

- Risk management structure and terminology: This includes a change to how we will refer to the different levels of risk management. The approach will be based on **Local Risk Registers,** an **Organisational Risk Register**, **Project/Programme Risk Registers,** and the **Board Assurance Framework (BAF).**

  We will have multiple local risk registers, including a local risk register for each directorate (x4) and a local risk register for each corporate function.

  There will be a single Organisational Risk Register which is the proposed new name for the Corporate Risk Register, with refreshed criteria for inclusion of risks. This is a key document and will clearly articulate the key risks for the organisation.

  It is anticipated this will contain some of the detail currently documented within each BAF to allow the BAF to be simplified and refocussed to provide the board with assurance rather than detailed information which would sit

better in the Organisational Risk Register and provide a clear link between the BAF the risk registers.

- Risk flow and escalation: There will be a clear demonstrable flow of risk management throughout the organisation, at all levels, including clinical and non-clinical functions.

  Previously, a single risk score has been used as a sole trigger for escalation of risk. The new framework expands this criteria out to ensure appropriate organisational oversight of the key risks affecting the trust.

- Governance structure: Each layer of risk management is supported by a clear governance process. This aligns the framework with the trusts integrated assurance framework and the executive sub-committee structure. The Audit and Risk committee have a key role in ensuring the effectiveness of the framework.

- Risk scores: We will capture three risk scores using the existing 5x5 risk matrix (likelihood x consequence). An initial score (when the risk is first identified), a current score (at the time the risk was last reviewed) and a target score (the aim once all actions have been implemented). A clearly defined review schedule ensures risks are reviewed at a frequency aligned to the level of risk.

- Risk Owners and Handlers: The terminology has been clarified to ensure that all risks will have a Risk Owner who has ultimate accountability for the risk. For organisational risks this will be the relevant executive leader. The day-to-day management of the risk and actions will then be undertaken by the identified Risk Handler. There is also the proposal to develop a network of Risk Champions across the trust who can support and promote effective risk management across directorates and corporate functions.

- Support: The framework sets out clear expectations for a central function to support the risk management process and take specific actions for all risks identified across the trust. This includes actions within a set time period to review the risk and ensure correct recording on the appropriate level of register.

- Simplified process: The framework includes a simplified flowchart to demonstrate the process.

- Risk Types and Subtypes: The trust has previously identified nine risk types (or categories). This has been expanded to include subtypes which will allow a better alignment to the risk appetite work, as well as the potential for more detailed reporting on risk.

- Risk matrix: The risk matrix is a guide to support the scoring of risks to aim for consistency in scoring between individuals. This has been remodelled against the nine risk types identified by the framework.

- Digital system: To support this framework, the trust have implemented the risk and BAF apps provided by the Ideagen InPhase system. This functionality will support the recording and management of risks and ensure all levels of the organisation are able to fully understand what risks exist and

how we are managing them. A key objective is to make the risk management process straightforward and the risk app from InPhase provides a simple but powerful platform for us to effectively demonstrate the management of risk.

Risk Appetite

The Board have previously committed to reviewing the trust's risk appetite position as part of the overall development of the risk management framework.

The framework document includes a simple, pragmatic approach to re-defining risk appetite and is recommended for adoption by the Board. This comprises of:

- A refreshed introductory position statement on the risk appetite approach
- A series of statements stating the trust's risk appetite matched against the risk types/subtypes defined within the risk management framework.

Our risk appetite is based on levels outlined within Good Governance Institute guidance and describe our appetite linked to five levels:

Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential
Cautious	Preference for safe delivery options that have a low degree of residual risk and acceptance that these may only have a limited reward potential
Open	Willing to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement/value for money
Seek	Eager to be innovative and to choose options offering higher business rewards, despite greater inherent risk
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

We will use these levels to describe our appetite based on the nature of the risk, recognising that there is no single approach to appetite. This methodology allows us to clearly define risk appetite against how we group risks we identify as part of the risk management framework. This also applies across all elements of our overall risk management approach, allowing a simple way to articulate our risk appetite across the organisation.

Our approach also allows us to describe these levels in relation to the relevant risk scoring model. This supports all those involved in the management of risk to align the current and target risk score to the relevant risk appetite.

We have also set tolerance scores to recognise the difference between where we want to be, compared to what we can tolerate at this time. The proposed risk

appetite for each risk type is set out below.

Risk type: Estates, infrastructure and the environment

Sub-type	*Risk appetite statement*
Property maintenance and management	We will maintain a **cautious** approach to risks associated with property maintenance and management, addressing any risks with the upkeep, maintenance and management of properties and facilities management.
Environmental impact	We will be **cautious** in our approach to risks that cause adverse environment impacts, for example waste management or approach to carbon reduction
Estates development	We will **seek** all opportunities where we can develop or improve our estate for the benefit of staff and patients, for example our approach to risks associated with planning, design, construction or other infrastructure projects
Health and Safety	We have a **minimal** approach to risks associated with estates and infrastructure health and safety issues to ensure the safety of all users of our premises

Risk type: Finance

Sub-type	*Risk appetite statement*
Budgetary control	We will maintain a **minimal** approach to risks that put our financial position at risk or adversely affect the financial stability of the trust, for example variances, overspending or forecasting accuracy
Revenue generation	We will have an **open** approach to risks where the reward is revenue generating, in order to support our growth opportunities
Efficiency	We will **seek** opportunities to improve efficiency in the Trust for the benefit of staff and patients, for example in supplier management, utilisation or resource reviews
Financial compliance and standards	We will have a **minimal** approach for risks associated with financial compliance and standards, such as counter-fraud.

Risk type: Information Governance

Sub-type	*Risk appetite statement*
Data protection	We have a **minimal** approach for any risks associated with data protection including compliance with the Data Protection Act, in order to protect personal data
Information security and cybersecurity	We have a **minimal** approach to all risks affecting the security or resilience of our IT infrastructure, including systems and networks including risks associated with cybersecurity.

Data quality	We have a **cautious** approach to risks that impact on the quality of data we have within the trust, such as the accuracy, completeness and accuracy of data used in the Trust

Risk type: Patient safety, outcomes and experience

Sub-type	***Risk appetite statement***
Clinical safety/quality of care	We will have **minimal** approach for any risks that are likely to impact on patient safety and the high standards of quality care we provide to patients, for example risks associated with medical errors, falls, hospital-acquired infections or medication related incidents.
Patient experience	We will have a **cautious** approach to risks associated with patient experience, such as satisfaction of patients, waiting times or patient communication
Clinical research and development	We will have an **open** approach to risks to ensure we remain committed to research and development in pursuit of new approaches in care to benefit the patient
Clinical effectiveness	We will have a **minimal** approach to risks associated with ensuring the best possible outcomes for patient care.

Risk type: Regulatory and Compliance

Sub-type	***Risk appetite statement***
External regulatory standards	We will have a **minimal** approach to risks associated with external regulatory standards such as non-compliance with CQC regulations or other regulatory bodies
Ethics and professional standards	We will have a **minimal** approach to any risk associated with ethical or professional standards, such as conflict of interest, consent, confidentiality or misconduct
Legal	We will have a **minimal** approach to risks associated with any legal obligations or risks leading to litigation

Risk type: Information Technology and Digital

Sub-type	***Risk appetite statement***
IT infrastructure and availability	We have a **cautious** approach to any risks that threaten our ability to utilise information technology within the trust and ensure its availability, such as system outages, hardware malfunctions or inadequate backup or recovery
Digital transformation and innovation	We will **seek** opportunities to pursue digital transformation and innovation in technology which will benefit staff and patients

Risk type: Staff Safety

Sub-type	*Risk appetite statement*
Occupational Health and Safety	We will have a **minimal** approach to risks associated with occupational health hazards, such as exposure to infectious diseases, radiation safety, muscular-skeletal issues
Violence and aggression	We will have a **minimal** approach to any risks associated with preventing or managing risks of violence and aggression directed towards staff.
Well-being	We will have a **minimal** approach to any risks associated with staff well-being, for example work-related stress, mental health issues resulting from the demands of the job, staffing levels

Risk type: Workforce

Sub-type	*Risk appetite statement*
Recruitment and retention	We will have a **open** approach to risks associated with recruitment and retention, aiming to ensure we recruit and retain high quality talent
Training and development	We will have an **open** approach to risks associated with training and development in support of colleagues progression and development
Diversity and inclusion	We will have a **minimal** approach to risks associated with diversity, equality and inclusion
Employee engagement	We will take an **open** approach to risks associated with how we engage with employees in order to drive opportunities to develop overall employee engagement

Risk type: Governance and Sustainability

Sub-type	*Risk appetite statement*
Governance structure	We have a **minimal** approach to risks associated with failures in good governance, conflict of interests or inadequate mechanisms for accountability
Strategy and planning	We will **seek** opportunities associated with strategy and planning, ensuring that we take these opportunities to develop our strategy and plans and aim for innovation and improvements in our services to patients
Stakeholder engagement and partnerships	We take an **open** approach to risks associated with partnerships and stakeholder engagement, to support our approach to system-wide partnerships in the development of current and future services

Organisational sustainability	We have an **open** approach to risks associated with our sustainability, recognising our aim for innovation and openness to change.

Implementation

Work has already been undertaken to support the implementation of the new risk management framework as well as future planned activities, including:

- The configuration of the Risk and BAF apps within Ideagen InPhase to ensure it is fully customised to QVH requirements
- Workshops with various groups to define the trust's risk appetite
- Workshops with directorates and corporate functions to introduce the principles within the framework and discuss current risks
- The review of all current risks on risk registers to ensure they are current and they are effectively describing the risk and controls, therefore providing a refreshed view of risk across the organisation
- Review of the BAF risks and the BAF approach and transfer of BAF risks into the BAF app in InPhase.
- A range of engagement and training material to support the application of the framework across the trust.

Recommendation

The Board is asked to **APPROVE** the risk management framework (including risk appetite).

Queen Victoria Hospital
NHS Foundation Trust

Risk Management Framework

CLASSIFICATION	*Risk Management*
TRUST POLICY NUMBER	RM.6003.8
APPROVING GROUP OR COMMITTEE	Board
RATIFYING COMMITTEE	Audit and Risk Committee
DATE RATIFIED	*Date of ratifying committee meeting*
DATE FOR REVIEW	*Date by which formal review must be completed*
DISTRIBUTION	All staff (Qnet) and Board members
RELATED DOCUMENTS	None
FORMS AND DOCUMENTS LINKED or ADDED AS APPENDIX IN THIS POLICY	
DIRECTOR LEAD	Jane Dickson, Chief Nursing Officer
AUTHOR	Glen Curry, Risk Project Lead (Interim)
EQUALITY DUE REGARD ASSESSMENT NUMBER	020724-2
CONSULTATION	Members of the ELT and SLT Risk and Governance Teams Corporate Affairs Internal Audit
THIS DOCUMENT REPLACES	Risk Management Policy RM.6003.7
This document is available in alternative formats upon request, such as large print, electronically or community languages.	

Document History and Control:

Version	Date Ratified	Brief summary of significant changes/ amendments	Author/ contributor
1	TBC	Replacement to previous Risk Management Policy	Glen Curry, Interim Risk Project Lead

Contents

1. Glossary of terms

Action	Additional arrangements that need to be put in place to further mitigate/control the risk. For example, recruitment of resources, development of a training programme, launch of a new policy.
Assurance	Assurance is the evidence which allows us to assess and scrutinise how effective risk mitigation/controls are. This typically is described at three levels; local assurance, internal oversight and scrutiny, independent assessment.
Board Assurance Framework	A document that outlines the strategic risks and their controls directly linked to the achievement of the objectives agreed by the Board. The Board should use this document to confirm these risks are adequately controlled in line with the Board risk appetite, and satisfied there is adequate assurance that the control(s) are effective.
Controls	Arrangements in place to assist in the mitigation of the risk
Local Risk Register	These are registers that contain risks specific to individual directorates/business units. They are locally owned and managed. Risks identified locally will escalate to the organisational risk register if they are high level (scoring ≥15) or require organisational wide-action or significant financial spend.
Organisational Risk Register	The Organisational Risk Register contains a summary of risks that exist across the organisation. Risks contained within this register are either high-level (scoring ≥15) or risks that require organisational oversight due to organisation wide-action needed or significant financial spend.
Project/Programme Risk Register	These are registers specific to individual programmes/projects. They are owned and led by the programme/project team and contain risks directly associated with the running of the programme/project. An overarching risk may be added to the organisational risk register if the programme/project risks are deemed to be significant.
Risk	Risk is defined as a situation/event, which should it occur, will have an effect upon (i.e. threaten) the delivery of the Trust's operations or objectives.
Risk Score	A risk is scored depending on the likelihood of the situation occurring and the consequence of that situation happening.
Risk Appetite	The amount of risk that an organisation aims to operate at
Risk Tolerance	The level of risk which the organisation is willing to operate at
Risk Culture	The general awareness, attitude and behaviour towards taking and managing risk within an organisation.
Risk Management	Risk Management is the term used to describe the activities required to identify, assess and score, and mitigate/control risks as far as practicable.
Risk Owner	The person who takes ultimate ownership of the risk, controls and assurance
Risk Handler	The person responsible for leading the activities to control the risk and coordinate any further actions required
Risk Type/Subtype	Categories of risk applied across all levels of risk throughout the Trust and used to operationalise the risk appetite framework.

2. Introduction

2.1 Purpose of this framework:

This framework sets out the Trust-wide approach to risk management and confirms the expectations and requirements of individuals and governance forums at each level within the Trust, clearly outlining the Trust's strategy and policy. It is also designed to be a guide to the practical implementation of the framework to ensure a robust approach to risk management across the Trust.

Risk Management is a key component of good governance as it aims to ensure that:

- Achievement of objectives is more likely
- Risks are managed in line with the organisation's appetite for risk
- Adverse (damaging) events are less likely
- Costly re-work and 'fire-fighting' is reduced
- Capital expenditure and revenue resources are utilised more efficiently and effectively
- Performance is improved (including quality, finance, operational and workforce)
- Decision-making is better informed
- Positive outcomes for patients, service users and stakeholders are increased
- Our reputation is protected and enhanced

Operating a sound Risk Management Framework ultimately enables the Trust to meet its regulatory and legal obligations.

2.2 Scope

This framework applies to:

- **All staff:** this includes permanent employees, locums, contractors, agency staff, students, volunteers, and anyone else performing duties on behalf of the Trust.

- **Management and leadership:** Senior management, Board members, and directorate and business unit heads have specific responsibility for implementing and ensuring adherence to this framework.

- **Governance committees and groups:** including the Board and its sub-committees which contribute to specific aspects of this framework and its implementation.

- **Suppliers and partners:** external entities collaborating with the Trust, like equipment suppliers or outsourced service providers, might need to adhere to certain risk management aspects relevant to their contracted services.

The risk management approach described in this framework applies to all areas and activities of the Trust. The Trust will work in partnership with its staff, service users and stakeholders to ensure it takes a comprehensive approach to risk management and that all opportunities for the

identification and management of risk are fully exploited, including risk management approaches that can only be delivered in partnership with others.

2.3 Format of this framework:

This framework is split into two sections:

1. Trust Risk Management Strategy
2. Trust Risk Management Operational Guidance

3. Risk Management Strategy

3.1 Risk Management Objectives

The Board of the Queen Victoria Hospital NHS Foundation Trust is accountable for setting clear expectations for the Trust through strategic and operational objectives, and ensuring the quality, safety and sustainability of the services it provides to patients.

The Trust, as with any healthcare provider, operates in a high-risk environment and the day to day management of risk is an expected and integral part of the business. Risk is inherent in all the Trust's activities: for example, treating patients, determining service priorities, project management, record-keeping, communication, staffing, service design, and setting strategy. Equally, there is also risk associated with acts of omission.

The Trust have set the following objectives in order to ensure effective management of Risk:

- to take all reasonable and appropriate steps in the management of risk in order to protect patients, staff, the public, its assets and reputation
- to manage risk within the risk appetite that has been agreed by the Trust Board
- to meet statutory, regulatory and legal obligations
- to offer staff appropriate training and support in the principles and practice of risk assessment and management
- to provide assurance to the Board (via the Audit and Risk Committee) regarding the management of key strategic and organisational risks

To deliver these objectives, the Trust has committed to:

- to develop and maintain an effective system to identify, assess, manage and review risks across the Trust

- delivering an integrated Risk Management Framework, which incorporates all aspects of risk including strategic, corporate, clinical, financial, workforce, infrastructure, safety, operational, compliance and reputational risk

- monitoring the effectiveness and robust implementation of the Risk Management Framework and its associated systems and processes

- supporting a dynamic and proactive approach to risk management, with the aim of identifying and managing potential threats and hazards before adverse events occur

- seeing the identification and assessment of risk as an opportunity to improve

- supporting staff in taking an active role in the identification and management of risks associated with the delivery of services in line with the NHS Constitution, and with the delivery of the Trust's objectives. This includes supporting staff to take responsibility for the health, safety, and wellbeing of patients, visitors, staff and others accessing and using the Trust's facilities and services

3.2 Approach to Risk Management

In order to meet the Trust's objectives, the Trust's agreed approach to Risk Management is that:

- The Board determines the organisation's risk management approach, including risk appetite, and has overall accountability for ensuring the effective management of risks across the Trust

- The Board ensures that a robust Risk Management Framework, aligned to the Trust's governance structure, is clearly documented, communicated and complied with consistently throughout the organisation

- The framework ensures that all types of risks applicable to the Trust's objectives are identified, measured, managed, monitored and reported using a consistent methodology

- Roles and responsibilities are clearly defined within the Risk Management Framework, and consistently adhered to

- Reliable risk management information is prepared and reviewed to inform effective decision making throughout the Trust

- Incidents representing the crystallisation of risks are appropriately recorded and addressed

- A risk aware culture is promoted across the Trust whereby all staff are encouraged to engage with the Risk Management Framework, escalate concerns, and improve future outcomes by identifying and implementing lessons learnt

3.3 Board Principles

The Board have agreed a set of key principles that will apply to ensure an effective Risk Management Framework.

Principle 1 - **An engaged Board focuses the business on managing the things that matter**

The Board is committed to setting appropriate messaging which ensures that staff understand the importance of, and engage with risk management to help safeguard the organisation. This includes the Board fostering an open culture of Trust where risks can be highlighted and management can be constructively challenged regarding the effectiveness of mitigation plans (refer to Risk Culture)

Principle 2 - The response to risk is most proportionate when the tolerance of risk is clearly defined and articulated

The Board is committed to ensuring that its appetite for risk in different areas of the organisation is defined and used to inform decision making (refer to Risk Appetite)

Principle 3 - Risk management is most effective when ownership of and accountability for risks is clear

This framework sets out a clear accountability framework which defines roles and responsibilities to strengthen ownership for delivery of the risk management approach at the Trust (refer to responsibilities)

Principle 4 - Effective decision-making is underpinned by good quality information

The Board seeks clearly presented and integrated risk, performance and financial information, linked to the organisation's objectives, to enable active challenge of the quality of the information and consideration of both current and future risks to the organisation

Principle 5 - Decision-making is informed by a considered and rigorous evaluation and costing of risk

The Trust's Executive Leadership Team will support staff to provide quantification of the costs associated with risks to help inform decision making (i.e. enabling a comparison of the financial impact on delivery of objectives should the risk materialise against the investment required to implement mitigating actions)

Principle 6 - Future outcomes are improved by implementing lessons learnt

The Board and its committees encourage reflection time in discussions to learn lessons about how risks have been managed, and challenges management to demonstrate how learning is driving improvements in the organisation (refer to Risk Culture)

3.4 Responsibilities for individuals

All staff have a responsibility for risk management, which may include the identification of risks and delivering actions that they are accountable for in the management of those risks.

The following roles hold specific responsibilities regarding the implementation of the policy:

- **Chief Executive Officer**
  - Ensure a robust and effective Risk Management Framework is in place, encompassing all critical areas of the Trust's operations
  - Establish the Trust's risk appetite in collaboration with the Board
  - Monitor the Trust's effectiveness in managing emerging and ongoing risks
  - Regular reporting to the Board on the Trust's strategic risks, controls and assurance through the Board Assurance Framework
  - Champion a culture of risk awareness through demonstrable leadership and commitment to a risk management where accountabilities are clearly defined and responsible decision-making is embedded in everyday activities.
  - Hold Executive Directors accountable for their risk management responsibilities performance
  - Promote open communication and transparency regarding risks within the Trust to support timely reporting, escalation and collaborative decision-making
  - Provide adequate resources and support, including personnel, training, and technology, to support effective risk management activities throughout the Trust
- **Chief Nursing Officer**
  - As the Executive Lead for Risk, ensure this framework is fully implemented and embedded across the Trust and promote and monitor compliance
  - Provide leadership and support to the Head of Risk, Safety and Patient Experience, including ensuring adequate resources, including personnel, training, and technology are in place to support effective risk management activities throughout the Trust
  - Collaborate with the Executive Team to provide input and subject matter expertise in relation the Risk Management Framework
  - Lead clinical risk management across the Trust to enhance the quality of care delivered. This includes close collaboration with the Trust's Head of Risk, Safety and Patient Experience, Patient Safety and Risk Team, and other relevant departments to ensure risks within clinical settings, covering areas such as patient safety, infection control, and safeguarding, are effectively identified, assessed, addressed, and reported
  - Advocate and allocate resources within clinical departments to support risk management activities, such as staff training, risk assessment tools, and incident reporting systems
  - Cultivate a risk aware culture within clinical teams, encouraging open communication, incident reporting, and learning from mistakes to continuously improve risk management practices.
- **Chief Operating Officer**

- Work closely with the Head of Risk, Safety and Patient Experience and senior leadership to ensure that the Trust's Risk Management Framework is implemented for operational risks within all service areas of the Trust
- Supervise, guide, and monitor the effectiveness of risk management activities in departments under their remit (i.e. ensuring regular risk assessments, incident reporting, and implementation of mitigation plans within operational areas in addition to identifying areas for improvement within the operational risk management strategy)
- Ensure adequate resources, including personnel, training, and technology, are allocated to support effective risk management practices within operational departments
- Promote a culture of risk awareness within the operational staff
- Communicate operational risk information and decisions to relevant stakeholders
- Provide specialist expertise and support to Executive Directors as required in respect of operational matters related to risks arising in other executive portfolios (e.g. clinical, infrastructure)
- Represent the Trust in external forums related to operational risk management

- **All Executive Directors**
  - Identify, manage and report risks specific to their portfolios and objectives within the BAF and Organisational and Local Risk Registers in line with the Risk Management Framework. This includes developing, implementing and monitoring mitigation plans for risks where they are the Risk Owner, ensuring that these they are aligned with the Trust's overall risk management strategy and resource allocation
  - Demonstrate commitment to the Trust's Risk Management Framework through actively participating in risk management activities, championing a culture of risk awareness, and ensuring resources are allocated to support effective risk management practices within their areas of responsibility
  - Ensure the Board Assurance Framework, Organisational and Local Risk Registers for their areas are kept accurate and up to date, reflecting the actions being taken to address gaps in control and assurance
  - Support executive colleagues as required to deliver actions to mitigate strategic and corporate risks in order to enable the delivery of the Trust's objectives
  - Provide expert insights, challenge and contributions to the Board Assurance Framework and Organisational Risk Register through Executive Leadership Team reviews
  - Foster a risk awareness culture by ensuring everyone within their areas of responsibility understands their role in respect of risk management, and is held to account
  - Contribute to the transparent communication of risk information, including mitigation decisions, to staff, the Board, and other stakeholders
  - Represent the Trust at external forums related to risk management, depending on their portfolio.
  - Ensure risk management considerations are embedded in strategic planning and decision-making processes within their area
- **General Managers/Business Unit Managers/Corporate functional leaders**
  - Understand the Trust's Risk Management Framework
  - Lead and oversee implementation of the Risk Management Framework at local level which includes the effective identification, recording, control, monitoring and reporting of the risks which may threaten achievement of departmental objectives
  - Facilitate the reporting and where necessary, escalation of appropriate risks
  - Monitor and report compliance with the Risk Management Framework at local level, as directed by the Head of Risk, Safety and Patient Experience

- **Head of Risk, Safety and Patient Experience**
  - Maintain a fit for purpose Risk Management Framework and associated procedures that are implemented across the Trust to deliver a clear and consistent risk management approach which meets current best practices and regulatory requirements
  - Monitor and report compliance with the Risk Management Framework and effectiveness (e.g. via analysing data, tracking trends etc). Recommend adjustments as needed to ensure continuous improvement
  - Oversee the selection, implementation, and maintenance of risk management software and tools to facilitate efficient data collection, analysis, and reporting
  - Lead and supervise the activities of the risk management team, which includes fostering collaboration between the team and other departments within the Trust to ensure all areas are adequately covered by the Risk Management Framework
  - Support the Board and the Company Secretary team to periodically refresh the Board Assurance Framework by providing expertise and insight from the Organisational and Local Risk Registers
  - Manage the Organisational risk register and ensure systems are in place for review of local risk registers by executives
  - Provide training, support and expertise in relation to risk management, the Trust's systems and procedures, and roles / responsibilities, to staff (including the Patient Safety & Risk Team) and the Board of Directors
  - Support the Trust to effectively identify, assess and mitigate its risks through conducting / facilitating risk assessments, analysing / prioritising risks, helping to develop mitigation plans and monitoring the effectiveness of these
  - Uphold principles of transparency and open communication regarding risk management within the Trust by ensuring proper channels are established for reporting and escalation of risks, and information is disseminated appropriately to relevant stakeholders. This includes the regular reporting of the Trust's Organisational Risk Register, Local Risk Registers, and risk events (i.e. incidents) through the Trust's governance structure
  - Provide credible leadership, challenge and oversight on risk management throughout the Trust, including participating in strategic planning and decision-making processes through a risk lens
  - Provide an annual risk report
  - Represent the Trust on external forums related to risk management and develop effective working relationships with other risk leads across Kent, Surrey and Sussex to ensure that the risk management policy is aligned across the integrated care systems
- **Risk Owners**
  - Identify, measure, manage, monitor and report their risks in line with this framework
  - Communicate effectively with stakeholders regarding the risk, its mitigation plan, and any updates or changes at relevant meetings and discussions. This includes keeping the risk management team, senior management, affected departments, and other relevant individuals informed and providing expert advice and insights based on their knowledge and experience
  - Foster a culture of risk awareness and ownership within their department or area of responsibility. This includes assigning and monitoring the progress of tasks and responsibilities for implementing the mitigation plan to relevant individuals or teams
  - Collaborate with other risk owners and teams to address interdependencies between different risks and share best practices in mitigation strategies

- **Risk Handler**
  - Lead the delivery of actions required for specific risks to ensure their completion in line with agreed timescales
  - Provide regular updates on the progress of the management of the risks and provide assurance around controls and actions
- **Company Secretary**
  - Facilitate the reporting of the Trust's strategic risk profile within the Board Assurance Framework which includes identified risks, control measures and assurance, for presentation to the Board, stakeholders, and regulatory bodies.
  - Manage the procedures and documentation of Board and committee meetings where risk management matters are discussed, ensuring proper record-keeping and adherence to governance principles
  - Provide legal and governance advice on risk management processes and risk events, ensuring compliance with regulations and legal considerations
  - Collaborates with the Head of Risk, Safety and Patient Experience to verify that the Trust's risk management practices comply with relevant NHS regulations, guidelines, and legislative requirements

3.5 Responsibilities for committees/groups

The Trust's governance and management structures support the ward to Board management of risk throughout the Trust. Expectations and duties of specific groups and committees in relation to the delivery of the Trust's risk management systems and processes are detailed below:

Committee / Group	Key responsibilities	Frequency of Review		
		BAF	Organisational	Local
Board	• Overall ownership of Risk Management Framework • Receive assurance of effectiveness of framework through confirm and challenge of executive team • Agree Risk Appetite and Tolerance • Own the Board Assurance Framework • Set messaging around Risk • Oversee delegated responsibilities	Bi-monthly	Bi-monthly	N/A

Committee / Group	Key responsibilities	Frequency of Review		
		BAF	Organisational	Local
Audit and Risk Committee	• Review effectiveness of framework and receive assurance on implementation • Make recommendations to the Board on the framework and approve changes • Routinely review the BAF and organisational risk register and receive assurance from other committees/leadership • Ensure independent scrutiny of the framework and specifically the BAF • Ensure reporting on the Trust's Risk Management Framework internally and externally (e.g. via internal/external audit)	6 monthly	6 monthly	N/A
Other Board Sub-Committees	• Review risk as applicable to the terms of reference of the committee	Bi-monthly	Bi-monthly	N/A
Executive Sub-Committees / Executive Committee for Quality and Risk	• Review organisational risk register to ensure effectiveness • Discuss new risks, risks submitted for closure and ongoing risks • Review local registers to ensure risks have been appropriately graded, ensuring appropriate escalation • Ensure consistency of application of risk management approach through local registers and organisational risk register • Perform deep-dive into risk areas as required	N/A	Monthly	Monthly
Directorate IQPR meetings	• Review local register applicable to the directorate • Discuss new risks, risks submitted for closure and ongoing risks on the local register	N/A	N/A	Monthly

3.6 Risk culture

Risk culture is defined as the awareness, attitude and behaviour towards taking and managing risk. The Trust is committed to promoting a risk aware culture though the Risk Management Policy and associated framework by:

- Setting the messaging with Executive Leadership endorsement of the Risk Management Policy and framework for managing risk, and commitment to embedding these across the Trust
- Clearly defining and communicating accountabilities and responsibilities
- Committing dedicated resources to raise risk awareness and advance risk management capabilities across the organisation through ongoing training and communications
- Encouraging active discussions on the effectiveness of risk management in governance committees with open and transparent reporting of risks, and a no blame culture where the materialisation of a risk is viewed as an opportunity to learn
- Undertaking periodic assessments of the Trust's risk culture to monitor trends and highlight areas requiring further development

While the Trust Board carries overall responsibility for risk management, the key to success is local leadership. The Trust's operational management structure is fundamental to the Risk Management Framework, and operational managers and their teams are required to work with colleagues, and the Trust's executive directors to ensure it is successfully implemented.

It is the responsibility of all staff to identify risk and report concerns that may affect the quality, safety, effectiveness and sustainability of service provision. The Trust aims to work in partnership with staff and support them with their responsibilities by creating a culture of openness and willingness to admit mistakes.

The Trust is committed to continuously developing as a learning organisation and ensuring that it can learn from the outcomes and processes of its Risk Management Framework. Learning will include the identification of actions that will enable incremental improvement in the effectiveness of the risk management system, the implementation of effective controls and risk mitigations, and the development and delivery of assurance. Learning opportunities will be identified throughout the Trust's risk management processes and highlighted to an appropriate level for validation before being rolled out.

The Trust is also committed to learning from mistakes, incidents, near misses, complaints and claims, and using this learning to improve its processes. The Trust is committed to a just culture where the reporting of incidents and concerns is encouraged, and staff are supported in delivering their responsibilities for safe care.

3.7 Risk Appetite and Tolerance

The Board of Queen Victoria NHS Foundation Trust (QVH) is committed to ensuring that risks to the quality, safety, effectiveness and sustainability of it services are identified and managed so that they are reduced to an acceptable level or eliminated as far as reasonably practicable.

Risk appetite determines the levels of risk the Trust aims to operate at for each type of activity undertaken to achieve Trust objectives. Risk appetite therefore is at the heart of how the organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, external agencies and the public.

The amount of risk an organisation aims to operate at can vary from one organisation to another and between one type of risk and another depending upon the specific organisational and risk circumstances. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

In order to transfer, treat, terminate, or tolerate risks those staff undertaking risk assessments and making decisions will need to understand what level of risk the Trust's Board aims for.

The risk appetite of the Trust will be defined by the Board to help guide the allocation of resources and align decision-making across the organisation. The Board will decide on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame.

Risks throughout the Trust should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust's risk appetite will be communicated to relevant staff involved in the management of risk and should be used to determine the target risk rating throughout the risk management process. The Head of Risk, Safety and Patient Experience, working with the Company Secretary, will support the Board to ensure that the risk appetite framework is clearly defined, communicated, and operationalised through this Risk Management Framework.

To support the application of the Trust's Risk Appetite, tolerance levels will be set by the Board for the risk scores for key risk sub types. This will be linked to the risk score to signify where the organisation is prepared to tolerate the risk and therefore should be used when setting target scores.

The Board should review its risk appetite and tolerance scores at least bi-annually, or more frequently as required due to the changes in the Trust's circumstances. The Board and its committees will assess and monitor the effectiveness of risk management against the risk appetite it has set.

The Trust's risk appetite statement is presented at Appendix xxx which sets out the differentiated risk appetite levels by type of risk.

3.8 Training and Awareness

This Risk Management Policy will be made available on the Trust intranet, and staff will be made aware of the policy through:

- Notification as part of mandatory inductions for new starters
- Attendance at training sessions (see below)
- Line manager cascade where individuals hold specific roles in respect of risk management

The Trust will provide a training programme for all staff on the principles contained within this policy, the supporting procedures, and individual roles / responsibilities within the Trust's Risk Management Framework in order to support policy awareness and compliance.

Staff group	Training/awareness topic	Frequency
All staff (clinical and non-clinical)	Risk Management Overview	At induction
Board, Committee members, Executive leadership team	Board Assurance Framework	Annually
	Ad-hoc training	As required
Directorate Leadership Teams, Corporate Leaders, Risk Owners and Handlers	Principles of Risk Management (3 hours)	Once every 3 years
	Ad-hoc training	As required

Awareness training for all staff includes:

- Basic overview of Risk Management (included within staff induction)

Specialist training for key roles includes:

- Board Assurance Framework; annual training on the Board Assurance Framework for Board, committee members and the executive leadership team
- Principles of Risk Management; three hour course on the Risk Management Framework and how to manage risk
- Ad hoc Risk Management Training provided as requested
- Ad hoc system training provided to individuals and specialties as requested

Training may be delivered in house as part of Trust's Learning and Development programme, or may be provided by external specialists. Various training methods will be utilised, such as face-to-face sessions, online modules, and interactive workshops to cater to different learning styles and preferences.

The Head of Risk, Safety and Patient Experience, in liaison with the Learning & Development Team, will continuously assess the effectiveness of training programs and make adjustments as needed.

3.9 Equality

This policy and protocol has been equality due regard assessed in accordance with the Trust's Equality Due Regard Assessment Guidance. Completed assessments are available upon request from qvh.edra@nhs.net

3.10 Freedom of Information

Any information that belongs to the Trust may be subject to disclosure under the Freedom of Information Act 2000. This act allows anyone, anywhere to ask for information held by the Trust to

be disclosed (subject to limited exemptions). Further information is available in the Freedom of Information Act Trust Procedure which can be viewed on the Trust Intranet.

3.11 Records Management

Records are created or received in the conduct of the business activities of the Trust and provide evidence and information about these activities. All records are also corporate assets as they hold the corporate knowledge about the Trust. The Trust has a Corporate Records Management Policy for dealing with records management. Compliance with and the application of this policy will ensure that the Trust's records are complete, accurate and provide evidence of and information about the Trust's activities for as long as is required.

3.12 Review

This framework is subject to review every 3 years. Earlier review may be required in response to exceptional circumstances, organisational change, relevant changes in legislation or guidance, and/or learning and improvement opportunities identified by the Trust including through internal or external reviews the of risk management systems.

Any subsequent versions of the framework will be subject to training and implementation plans to ensure full awareness is maintained across the Trust.

3.13 Monitoring compliance with this policy

The implementation and application of this policy will be monitored as follows to ensure that it remains effective, adaptable, and embedded within the Trust's culture:

Group	Monitoring responsibility
Board	• Receive assurance from the Audit and Risk Committee of overall effectiveness of the Risk Management Framework
Audit and Risk Committee	• The Audit and Risk Committee is responsible for scrutinising and assessing the assurance provided by the Executive Leadership Team and other Board committees that the Trust's risk management processes are operating effectively; this assurance will include the routine reporting of risks and key performance indicators
Executive Leadership Team	• The Executive Leadership Team is responsible for monitoring compliance with this policy across all areas of the Trust, and will perform an annual review in conjunction with the Head of Risk, Safety and Patient Experience to assess any gaps and provide an update to the Audit and Risk Committee
Patient Safety & Risk Team	• The Patient Safety & Risk Team will monitor and escalate any gaps in compliance to the Executive Leadership Team on an ongoing basis, and to help inform their annual review noted above
Internal Audit	• Regular audits of compliance will take place as part of the Internal Audit Programme and will be reported to the Audit and Risk

	Committee; these reviews will assess adherence to the policy's principles and procedures
External Assurance	• Where deemed necessary, external reviews by independent bodies may be carried out to provide a view on the adequacy of this policy and how effectively it is embedded
Learning and Development	• Monitoring of training statistics

4. Operational Guidance

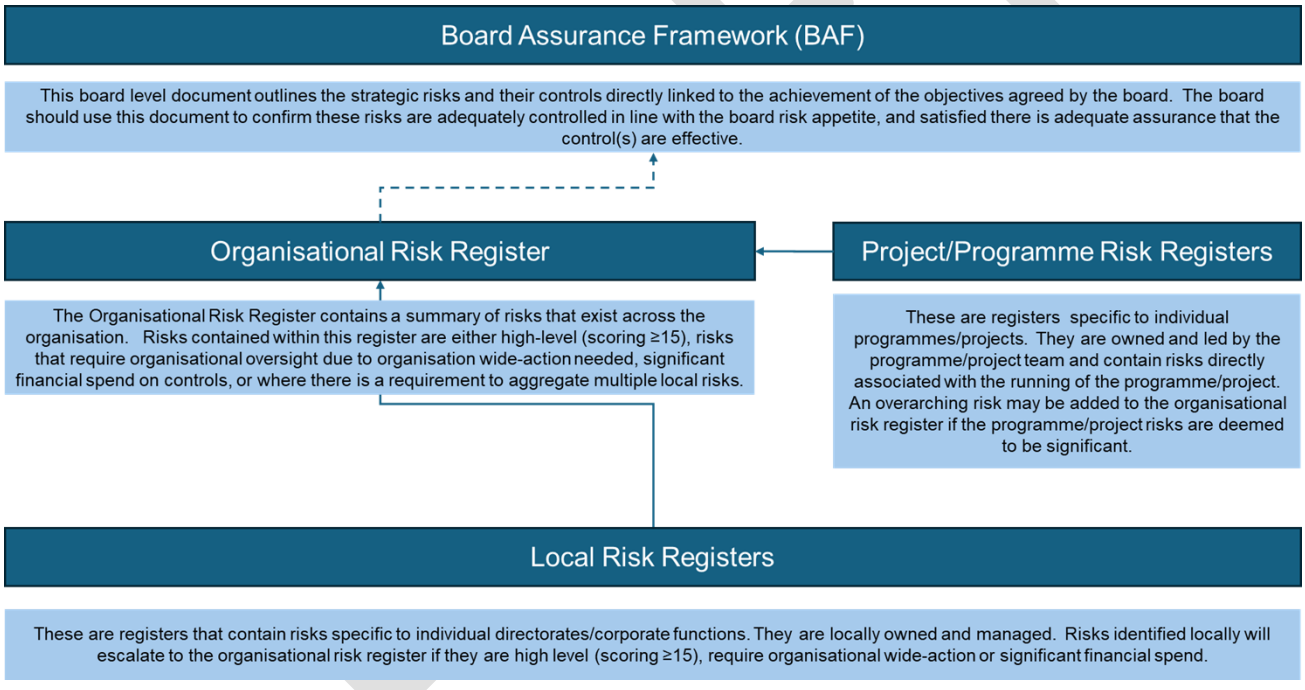
This section contains information to support the implementation of this Risk Management Framework and provides practical guidance to support teams.

4.1 Recording Risks

Risks within the Trust are documented through the following tools:

- Board Assurance Framework (BAF)
- Organisational Risk Register
- Project/Programme Risk Registers
- Local Risk Registers

The Trust have chosen InPhase as a system to manage all Risk Registers, including the BAF.



4.2 Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) sets out the key risks which may threaten the achievement of the Trust's strategic objectives. It enables the Board to monitor progress in achieving the strategic objectives, attend to key accountability issues, ensure the right issues are debated and that remedial actions are taken to reduce risk, strengthen controls and assurances. All NHS bodies are required to sign a full Annual Governance Statement and provide evidence of compliance. The BAF brings together a significant part of this evidence.

The BAF is subject to additional guidance, however the key principles are:

- The BAF is maintained by the Company Secretary and owned by the Executive Leadership Team, with regular review and updating to ensure the information contained within it is reliable. This is to support effective review and challenge throughout the governance structure and enable the Board to remain sighted on how effectively strategic risks are controlled and that the controls are adequate.
- The BAF is designed to assess the strength of the internal control measures that are intended to prevent these risks occurring and to identify and evaluate sources of assurance. It supports the identification of gaps in control and assurance and enables the Board to monitor progress on the actions being taken to address these gaps.
- The BAF describes the controls that Trust executives must ensure are effective in order to manage strategic risks against strategic objectives and to assess that the adequacy and strength of these controls are aligned to the Board's risk appetite for individual strategic risks.
- The BAF also describes the assurances and sources of assurance the Board has agreed are necessary to assess the adequacy of the controls and will thus drive the cycle of Board and Board Committee work and reporting to the Board.
- The BAF is regularly reviewed by the Board and Board Committees as determined by their roles and responsibilities.

As separate detailed guidance exists on the production of the BAF, the operational guidance contained within this document is aimed at the Local and Organisational Risk Register process.

4.3 Organisational Risk Register

The Organisational Risk Register contains a summary of risks that exist across the organisation.

Risks identified for the Organisational Risk Register may be identified for inclusion straight onto the register, or may be a risk escalated from a Local Risk Register.

To feature as part of the Organisational Risk Register, one of the following three criteria must be met:

1. The risk scoring identifies the **current** risk score at 15 or above
2. A risk is identified that requires actions involving an organisational response, as opposed to actions that can be easily managed locally
3. Risks where actions and/or controls require significant financial spend. The trust's delegation of authority can support this decision.

There may also be similar risks that appear on multiple local registers that require an aggregated risk to be created on the Organisational Risk Register.

All risks featuring on the Organisational Risk Register should be assigned to an executive as the **Risk Owner** which ensures executive management of all organisational risks. A suitable member of the leadership team may be identified as the **Risk Handler**.

The Trust uses InPhase to record risks that feature as part of the Organisational Risk Register. It is designed to be a dynamic register where risks are added, amended, reviewed and closed on a regular basis.

The Organisational Risk Register should be reviewed by the Board, appropriate sub-committees and the Exec as determined by the terms of reference for each group. This ensures oversight to ensure:

- The right risks are being identified and reported
- Control measures are identified or where gaps are identified actions are in place
- Risks are regularly reviewed in order to achieve the target risk score
- There is a link with the Board Assurance Framework
- Resources can be allocated or priorities can be determined to support actions
- The ongoing integrity of the Risk Management Framework

4.4 Local Risk Registers

Local Risk Registers contain risks specific to individual directorates/business units as well as key corporate functions (e.g. finance, estates, IT). Each directorate/ /corporate function should maintain a local risk register and have responsibility for owning and managing the local register.

Following the escalation route below, risks contained within local registers will:

- Be scored at less than 15
- Contain actions that can be managed locally without an organisation-wide response
- Have controls/actions that have a low level of financial commitment (the department's delegation of authority limit can support this decision)

In addition to escalation from Local to the Organisational Risk Register, risks can be de-escalated from the Organisational to a Local Register if criteria is met.

The Trust uses InPhase to record risks that feature as part of the Local Risk Register. It is designed to be dynamic register where risks are added, amended, reviewed and closed on a regular basis.

Local Risk Registers will be routinely reviewed and monitored through the directorate/business unit governance structure and will also have oversight from the Patient Safety & Risk Team to ensure consistency and the approach to managing local risks is in line with the overall Risk Management Framework.

4.5 Programme/Project Risk Registers

Programme/Project Risk Registers are specific to individual programmes/projects. They are owned and led by the programme/project team and contain risks directly associated with the running of the programme/project.

Programme/Project Risk Registers may be produced within programme/project management documentation (e.g. Excel spreadsheet) or contained within InPhase, and managed through the governance structure for the specific programme/project.

An overarching risk may be added to the organisational risk register if the programme/project risks are deemed to be significant. Advice can be sought from the Patient Safety & Risk Team in relation to the escalation of Programme/Project risks.

4.6 Risk process

The Trust implements a five-stage approach to effective Risk Management:

1. Identification of the Risk
2. Assessment and scoring of the Risk
3. Identification of Risk Controls
4. Plan any additional actions
5. Monitor and Review.

These stages are described in more detail in this guidance.

4.7 Identification of the Risk

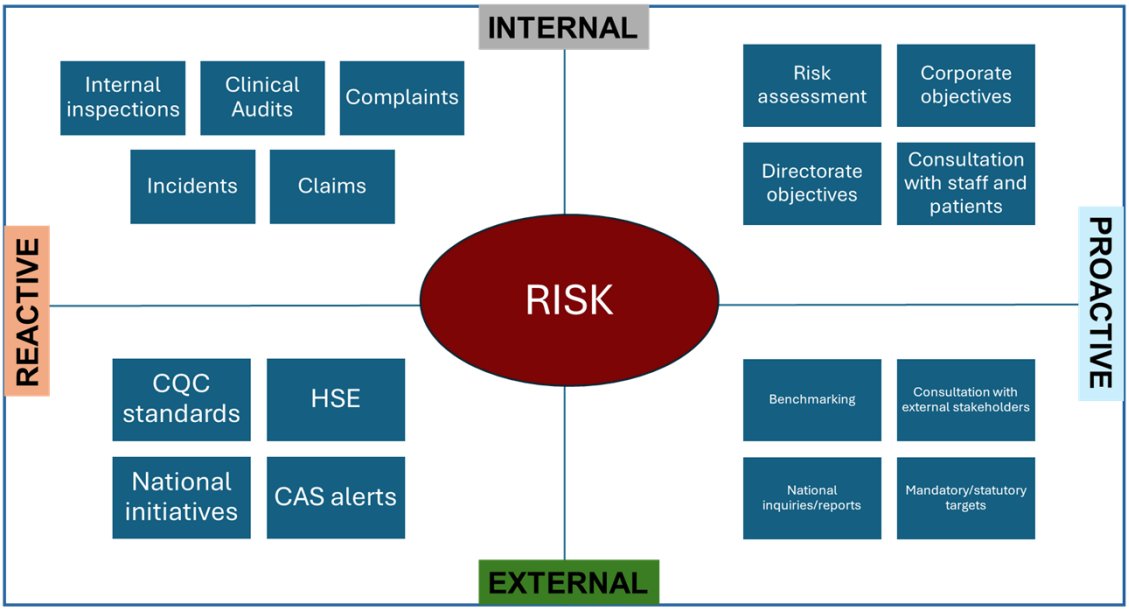
Risk is defined as a situation/event, which should it occur, will have an effect upon (i.e. threaten) the delivery of the Trust's operations or objectives.

Anyone within the Trust can identify a risk, and a recommendation on which risk register the risk features on will be made by the Head of Risk, Safety and Patient Experience.

Risk is	Risk is not
An event which **might** happen	An event (incident) that **has** happened An issue which will **definitely happen** or is **happening**

Risks can be identified from a wide-range of sources, and all staff have a responsibility to identify risks that exist within their areas of responsibility.

The following chart is not exhaustive, however provides some examples of source of risks. The identification of risks should be a dynamic process and both proactive and reactive to external and internal factors that may affect the Trust.



Local discussions when risks are identified are encouraged to:

- Attempt to separate out 'risks' from 'incidents' or 'issues'
- Avoid duplication where a risk already exists on a register
- Ensure immediate action is taken where a risk is significant

Directorates/business units and corporate functions should consider establishing a **Risk Champion** who can provide local advice and support in relation to Risk and also act as the individual who has responsibility within the area for adding the Risk to the Risk Register.

Risks should be described using the Cause, Risk, Effect model. This allows for a consistent recording of risks across the Trust and assists individuals with being able to articulate risk.

Cause	Because of 'something' (the trigger)	*"Due to…"*
Risk	Something **might** happen (the event)	*"There is a risk of/that…"*
Effect	Resulting in (the consequence)	*"Which may result in…"*

When describing a risk, there should only be **one** risk, but it may have **multiple** causes or effects.

4.8 Assessment and scoring of the Risk

Risk Type

All risks are allocated to a risk type and also a subtype. This allows for a consistent recording across the Trust and multiple risk registers, provides a basis for reporting, and also allows the Trust's risk appetite and resulting tolerance to be applied.

The following provides a summary of agreed risk types, description and subtypes. The most appropriate risk type and subtype should be selected when inputting the risk onto InPhase.

Risk Type	Description and examples	Subtypes
Estates infrastructure and environment	Risks associated with the Trust's estates infrastructure and environment, including buildings and equipment. This could include where they are is not designed, maintained or protected to prevent harm to individuals and physical assets. For example, damage to infrastructure due to a natural event such as flood, and failures of medical equipment. NOTE: not including risks associated with IT.	• Property Maintenance and Management • Environmental Impact • Estates development • Health and Safety
Finance	Risks associated with not adequately managing, monitoring and/or planning its finances in a way which fulfils financial obligations, and meets desired future funding/investment requirements. For example, fraud, financial reporting, cash flow management, economic environment	• Budgetary control • Revenue generation • Efficiency • Financial compliance and standards
Information Governance	Risks associated with information governance or data protection. For example not meeting the requirements of the Data Security and Protection Toolkit, or breaches of Data Protection.	• Data protection • Information security and cybersecurity • Data quality
Patient safety, outcomes and experience	Risks associated with causes of harm to patients and /or care does not meet the quality or availability of service expectations to deliver positive patient outcomes. For example, risks around infection prevention and clinical incident management.	• Clinical safety/quality of care • Patient experience • Clinical Research and Development

Risk Type	Description and examples	Subtypes
		• Clinical effectiveness
Regulatory & compliance	Risks associated with the failure of the Trust to recognise, adapt to, and comply with regulations and/or legislation. For example, risks around compliance with NHS performance targets / other standards, clinical regulations, and employment, data protection and H&S legislation.	• External regulatory standards • Ethics and professional standards • Legal
Information technology and digital	Risks associated with the technology infrastructure, including the hardware (like servers, computers, and network devices) and software (such as databases, applications, and systems). For example, failure or disruption to IT systems / services, and loss / theft of devices such as laptops or mobile phones. Risks to the transformation and use of digital technologies to improve or innovate processes and stakeholder experiences. For example, risks associated with the use of deep fakes, artificial intelligence, digital marketing, e-commerce and mobile platforms.	• IT infrastructure and availability • Digital transformation and innovation
Staff Safety	Risks associated with failures of the Trust to ensure the safety of staff, or compliance with Health and Safety obligations directly relating to the safety of employees.	• Occupational health and safety • Violence and aggression • Well-being
Workforce	Risks associated with not having a workforce in place with the required capacity and capabilities to deliver its strategic and operational plans. For example, risks around recruitment, retention, development, performance, and deployment.	• Recruitment and retention • Training and development • Diversity and inclusion • Employee engagement
Governance and sustainability	Risks associated with the Trust not being well governed or managed effectively to ensure sustainability of the services. For example, risks around strategic planning and management, change management, leadership, organisational / governance structure and culture, business continuity / crisis management, system working, partner collaboration, and external events such as changes to government policy / demographics, and major population health events.	• Governance structure • Strategy and planning • Stakeholder engagement and partnerships • Organisational sustainability

Risk Scoring

All risks should be assessed to determine the risk scoring. This assesses the risk against the likelihood and consequence using a 5x5 matrix (likelihood x consequence)

There are three scores applied to risks:

- **Initial Risk Score**: This is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risks and is used as a benchmark against which the effect of risk management will be measured.
- **Current Risk Score**: This is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans to mitigate the risks are developed and implemented.
- **Target Risk Score:** This is the score that is expected after the action plan has been fully implemented.

To guide scoring, a Risk Matrix has been developed. This provides a series of 'descriptors' against each 1-5 score. This is aimed to provide consistency in scoring risks across the Trust.

The Risk Matrix should be used firstly by reviewing the consequence. This is aided by the matrix containing descriptors for each score (1-5) for each Risk Type (see above).

Once the consequence is established, the likelihood should be determined.

See **Risk Matrix in Appendix A**

Likelihood scores (L)	Consequence scores (C)				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1-4	5-10	12-15	16-25
VERY LOW	LOW	MODERATE	HIGH

Risk Ownership

Ownership and day-to-day responsibility for risks will depend on whether the risk will feature on the Local Risk Register or Organisational Risk Register. This can be established once scoring is complete using the criteria above.

All Risks will have a **Risk Owner** (accountability for the risk) and a **Risk Handler** (day-to-day management of the risk and actions).

Register	Risk Owner	Risk Handler
Organisational Risk Register	• Executive lead	• Leadership team member
Local Risk Register	• Directorate General Manager • Directorate Clinical Director • Directorate Head of Nursing • Corporate Function Manager	• Business Unit Manager • Corporate Function Staff member

4.9 Identification of Risk Controls

Controls

Risks identified will usually have existing controls already in place (although they may not be sufficient or effective) as well as additional controls required.

Controls should be documented when recording the risk and we describe controls as being 'implemented' or 'not implemented'. During risk reviews, controls will be assessed for their effectiveness:

- Red – Control not implemented or control not effective
- Amber – Control implemented but only partially effective
- Green – Control implemented and effective

4.10 Plan any additional actions/controls

The Trust manages identified risks through one of the following approaches:

Treat	Terminate	Tolerate	Transfer
Control or reduce by taking action	Remove risk altogether by stopping practices/activities	Accept the current level of risk (i.e. within appetite)	Move responsibility of part/all of the risk to a third party, e.g. insurance, outsourcing

Some risks can also be seen as an opportunity, so it may be decided to **Take** the risk and use it as a positive opportunity.

Most Risks within the Trust will fall into the 'Treat' category, and therefore additional actions will be required in order to control/reduce the risk, which when implemented will become additional Controls. These additional actions should result in the Risk reaching the Target Risk Score.

When actions are completed (and become implemented controls), controls will either:

- Reduce the likelihood (most common type of controls)
- Reduce the consequence
- Reduce both the likelihood and consequence

Thinking about what the control will do on likelihood and consequence will help in working out how they will support the reduction in the risk score to the target level.

Additional actions required should be clearly documented including the target date for implementation and the person(s) responsible for the action.

Risks identified for 'Termination', 'Tolerate', or 'Transfer' should be discussed at the relevant monitoring committee and the approach formally agreed. Details of how to handle each approach in the context of whether the risk can be closed is contained below in the Risk Closure section.

4.11 Monitor and Review

Once inputted, each risk should be monitored by the Risk Owner and Risk Handler. This should include:

- Assessment of current risk score and update narrative
- Review of control effectiveness
- Updates in relation to controls (including any new controls)
- Action updates

There are two committees with specific responsibility for reviewing all new risks featuring on either Local or the Organisational Risk Register, approving risks to be closed, performing deep dives into risks and performing a 'confirm and challenge' function.

- The most relevant Exec sub-committees

- Directorate IAF meeting (for Local Risks only)

It is also necessary to review risks periodically to ensure they are still relevant, for example when:

- There has been an associated incident/near miss, or trend identified
- There has been a change in environment
- There has been a change in process
- A new procedure is proposed
- New equipment is proposed

Individual risks should be reviewed, as a minimum, at the following frequencies which are supported by the last recorded Current Risk Score. However it is recommended all risks are updated monthly.

1-4	5-10	12-15	16-25
VERY LOW	**LOW**	**MODERATE**	**HIGH**
Review at least annually	**Review at least quarterly**	**Review at least bi-monthly**	**Review at least monthly**

4.12 Risk Closure

A risk can be allocated for closure when:

- The risk is controlled to its target Risk Score and does not require monitoring, or
- It is agreed by the relevant monitoring committee that the risk cannot be controlled to the target score but still within the risk tolerance, or
- The event associated with the risk is stopped (Termination), or
- The entire risk is Transferred (e.g. via outsourcing or insurance)

The below indicates the treatment that should be applied, depending on the approach for the management of the risk.

Treat	Terminate	Tolerate	Transfer
Close risk when reaches target score or risk within tolerance (as long as risk does not require monitoring)	Once terminated, risk can be closed	Remain on register for duration of the existence of the risk	If risk no longer exists, risk can be closed

4.13 Supporting Risk

Once a risk is inputted, the following are key actions required within three working days of the risk being inputted onto InPhase:

- Review and amend/discuss with the inputter of the risk if needed, that:
  - The risk description adequately describes the risk
  - The risk is allocated to the correct risk type
  - The risk scoring is appropriate and all scores are complete
  - The risk is assigned to the correct Risk Register
  - The correct risk owner and lead has been identified
  - Controls have been identified
  - Actions have been allocated where required
- Review tolerance levels in relation to Target Score and provide support where required

If the risk features on the Organisational Risk Register, this should be scheduled for discussion at the next meeting of the relevant monitoring exec sub-committee. If the risk is for the Local register ensure this is scheduled for the next Directorate IAF meeting or Corporate Functional Meeting.

APPENDIX A – Risk Matrix

See overleaf

Risk Management Framework – Risk Matrix

Queen Victoria Hospital NHS Foundation Trust

1. Determine the consequence of the risk using the table below

Note the table contains example scenarios based on the Risk Types on a scale of 1-5. They are only a guide and not intended to cover all eventualities.

CONSEQUENCE SCORE	1	2	3	4	5
POTENTIAL IMPACT	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Estates infrastructure and environment	Minor issues with estates, infrastructure, or environmental factors that have minimal impact	Incidents affecting estates, infrastructure or environment resulting in minor disruptions or inconveniences, easily mitigated with minimal effort	Incidents affecting estates, infrastructure or environment resulting in moderate disruptions or inconveniences requiring management to prevent escalation	Significant impact on operations or environment due to major issues with estates, infrastructure or environmental factors requiring immediate actions and resource allocation	Critical incident, causing widespread damage to estates, infrastructure of the environment resulting in significant financial and operational consequences
Finance	Financial impact of £0-50k	Financial impact of £51k to £99k	Financial impact of £100k to £999k	Financial impact of £1m to £5m	Financial impact >£5m
Information Governance	Minimal risk of non-compliance with information governance policies or regulations	Limited data breach or low chance of regulatory penalties	Moderate data loss or moderate chance of regulatory non-compliance/enforcement	Significant data breach resulting in regulatory enforcement and/or reputational damage	Critical data breach, severe regulatory enforcement/penalties, damage to reputation
Patient safety, outcomes and experience	Minor injuries or discomfort requiring no medical intervention or long term harm	Minor injuries requiring medical intervention or temporary discomfort with no lasting impact on healthcare outcomes	Moderate injuries or complications requiring medical treatment but not resulting in long-term disability or significant harm	Severe injuries or adverse outcomes requiring extensive medical intervention, hospitalisation or long-term care with potential for permanent disability or significant impact on quality of life	Fatalities caused by medical error, preventable adverse event, or systemic failures in care delivery.
Regulatory & compliance	Minor deviation from regulatory requirements with minimal consequences, easily rectified	Non-compliance incidents resulting in minor regulatory scrutiny, such as warnings, manageable with existing resources	Breaches of regulatory standard leading to increased regulatory oversight, including formal investigations or inspections, requiring proactive measures to address non-compliance	Significant breach of regulatory requirements resulting in enforcement action such as fines, or legal actions, necessitating urgent remediation efforts, legal involvement and engagement with regulatory agencies	Critical regulatory compliance failure or persistent non-compliance issues resulting in escalated enforcement actions such as suspension of license, criminal charges, posing threat to Trust viability and operation.
Information technology and digital	Minor incidents affecting IT systems with minimal consequences, such as temporary network slowdowns or isolated software issues, easily resolved with existing IT support resources	System vulnerabilities, including minor outages or issues requiring planned maintenance with low impact	Disruptions to IT services causing some operational impacts, for example temporary system downtime requiring planning and operational changes	Major disruptions to IT infrastructure causing serious operational impact	Critical IT infrastructure failure to patient critical systems resulting in severe disruptions to operations/severe risk to patient safety
Staff Safety	Minor incidents affecting staff safety with negligible consequences, easily managed with existing safety protocols and resources	Safety concerns or incidents leading to minor injuries or near misses, manageable with minor disruption to safety procedures and/or training	Safety issues causing noticeable risks or injuries to staff, requiring proactive safety measures	Significant safety incidents posing substantial risks to staff well-being, requiring urgent safety interventions, equipment upgrades and stricter safety protocols	Critical safety crisis, causing serious threat to staff safety with potential to cause death or serious injury. Immediate and comprehensive safety interventions are required
Workforce	Minor incidents related to workforce management with negligible consequences, easily resolved with existing HR procedures and resources. Less than 1% variance to establishment	Challenges or issues within the workforce leading to minor disruptions or limited impact on operations. 1-5% variance to establishment	Workforce related concerns causing noticeable disruptions to operations, employee satisfaction or talent retention, requiring proactive HR interventions. 6-10% variance to establishment	Significant workforce issues resulting in substantial disruptions to operations, employee satisfaction or talent shortages, necessitating urgent HR actions and strategic workforce planning. 11-20% variance to establishment	Critical workforce crisis, posing serious threats to organisational stability, culture or talent pipeline. Immediate and comprehensive interventions essential. Over 20% variance to establishment.
Governance and sustainability	Minor events, easily managed with existing processes and resources	Challenges or shortcomings in governance or sustainability practices leading to minor setbacks or limited impacts, addressed with minimal adjustments	Governance or sustainability issues causing noticeable disruptions or risks to organisational objectives, requiring proactive measures	Significant governance or sustainability failures resulting in substantial financial, reputational, or environmental consequences, needing immediate corrective actions and enhanced monitoring	Critical governance or sustainability crisis has occurred, posing threats to the Trusts viability, reputation or sustainability agenda.

2. What is the likelihood of the consequence occurring?

What is the potential chance of the consequence from Step 1 above occurring, using the scale 1-5

LIKIHOOD SCORE	1	2	3	4	5
POTENTIAL IMPACT	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to happen	Expected to occur at least annually	Expected to occur at least every 6 months	Expected to occur at least monthly	Expected to occur at least weekly
Probability	This will probably never happen/recur. It can be assumed occurrence may not be experienced	Do not expect it to happen/recur but definite potential exists	Might happen or recur occasionally, has happened before or on occasions	Will occur again or likely it could happen	This is expected to occur frequently. Will undoubtedly happen/recur
Percentage	Less than 10%	Between 10% and 30%	Between 31% and 60%	Between 61% and 90%	Greater than 90%

NHS
Queen Victoria Hospital
NHS Foundation Trust

APPENDIX B – Risk Appetite statement from the Board

The board of Queen Victoria Hospital NHS Foundation Trust recognises that we are operating within a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. We also recognise the present challenges faced within the NHS as a whole and this has to form a backdrop to how we approach our appetite for risk.

We manage risk at QVH as part of an overall risk management framework, ensuring we have an effective process for the identification, management and monitoring of risk at all levels of the Trust. To support this, we have developed our risk appetite (the level of risk which the Trust aims to operate at in pursuit of our objectives) as well as our current risk tolerance (the level of risk which the Trust is willing to operate at).

Setting both the risk appetite and risk tolerance at the Board supports our overall approach to risk management, which helps inform decisions around how we manage risks that will exist to all areas of our operations against the constraints of the resources available to us. It will help us prioritise where we should focus our efforts; managing risk where our appetite is low, and support us to accept higher levels of risk where this is likely to give us a greater reward, particularly where this drives innovation and improvement.

We also acknowledge risk appetite can change over time and we commit to review our appetite and tolerance at least annually at a Board meeting.

There are three key principles we have adopted. Firstly that there is no single appetite. This will vary, predominantly based on the nature of the risk therefore we have described our appetite against the way we group risks into risk types and subtypes.

Secondly that we want an approach to appetite that can inform our risk management processes across the trust, and therefore we have linked our risk appetite to the existing risk scoring approach.

Lastly, we also recognise the need to retain flexibility in our overall approach and that we cannot cover all eventualities in our statements. We are therefore committed to maintaining an open dialogue around risk appetite in the context of our overall approach to effective risk management.

Jackie Smith
Trust Chair

APPENDIX C – Risk Appetite

Definitions:

Appetite	Definition	Risk Score
Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential	1-3
Cautious	Preference for safe delivery options that have a low degree of residual risk and acceptance that these may only have a limited reward potential	4-6
Open	Willing to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement/value for money	8-12
Seek	Eager to be innovative and to choose options offering higher business rewards, despite greater inherent risk	15-20
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust	25

Source: Good Governance Institute

Risk type: Estates, infrastructure and the environment

Sub-type	***Risk appetite statement***
Property maintenance and management	We will maintain a **cautious** approach to risks associated with property maintenance and management, addressing any risks with the upkeep, maintenance and management of properties and facilities management.
Environmental impact	We will be **cautious** in our approach to risks that cause adverse environment impacts, for example waste management or approach to carbon reduction
Estates development	We will **seek** all opportunities where we can develop or improve our estate for the benefit of staff and patients, for example our approach to risks associated with planning, design, construction or other infrastructure projects
Health and Safety	We have a **minimal** approach to risks associated with estates and infrastructure health and safety issues to ensure the safety of all users of our premises

Risk type: Finance

Sub-type	***Risk appetite statement***

Budgetary control	We will maintain a **minimal** approach to risks that put our financial position at risk or adversely affect the financial stability of the trust, for example variances, overspending or forecasting accuracy
Revenue generation	We will have an **open** approach to risks where the reward is revenue generating, in order to support our growth opportunities
Efficiency	We will **seek** opportunities to improve efficiency in the Trust for the benefit of staff and patients, for example in supplier management, utilisation or resource reviews
Financial compliance and standards	We will have a **minimal** approach for risks associated with financial compliance and standards, such as counter-fraud.

Risk type: Information Governance

Sub-type	***Risk appetite statement***
Data protection	We have a **minimal** approach for any risks associated with data protection including compliance with the Data Protection Act, in order to protect personal data
Information security and cybersecurity	We have a **minimal** approach to all risks affecting the security or resilience of our IT infrastructure, including systems and networks including risks associated with cybersecurity.
Data quality	We have a **cautious** approach to risks that impact on the quality of data we have within the trust, such as the accuracy, completeness and accuracy of data used in the Trust

Risk type: Patient safety, outcomes and experience

Sub-type	***Risk appetite statement***
Clinical safety/quality of care	We will have **minimal** approach for any risks that are likely to impact on patient safety and the high standards of quality care we provide to patients, for example risks associated with medical errors, falls, hospital-acquired infections or medication related incidents.
Patient experience	We will have a **cautious** approach to risks associated with patient experience, such as satisfaction of patients, waiting times or patient communication
Clinical research and development	We will have an **open** approach to risks to ensure we remain committed to research and development in pursuit of new approaches in care to benefit the patient
Clinical effectiveness	We will have a **minimal** approach to risks associated with ensuring the best possible outcomes for patient care.

Risk type: Regulatory and Compliance

Sub-type	*Risk appetite statement*
External regulatory standards	We will have a **minimal** approach to risks associated with external regulatory standards such as non-compliance with CQC regulations or other regulatory bodies
Ethics and professional standards	We will have a **minimal** approach to any risk associated with ethical or professional standards, such as conflict of interest, consent, confidentiality or misconduct
Legal	We will have a **minimal** approach to risks associated with any legal obligations or risks leading to litigation

Risk type: Information Technology and Digital

Sub-type	*Risk appetite statement*
IT infrastructure and availability	We have a **cautious** approach to any risks that threaten our ability to utilise information technology within the trust and ensure its availability, such as system outages, hardware malfunctions or inadequate backup or recovery
Digital transformation and innovation	We will **seek** opportunities to pursue digital transformation and innovation in technology which will benefit staff and patients

Risk type: Staff Safety

Sub-type	*Risk appetite statement*
Occupational Health and Safety	We will have a **minimal** approach to risks associated with occupational health hazards, such as exposure to infectious diseases, radiation safety, muscular-skeletal issues
Violence and aggression	We will have a **minimal** approach to any risks associated with preventing or managing risks of violence and aggression directed towards staff.
Well-being	We will have a **minimal** approach to any risks associated with staff well-being, for example work-related stress, mental health issues resulting from the demands of the job, staffing levels

Risk type: Workforce

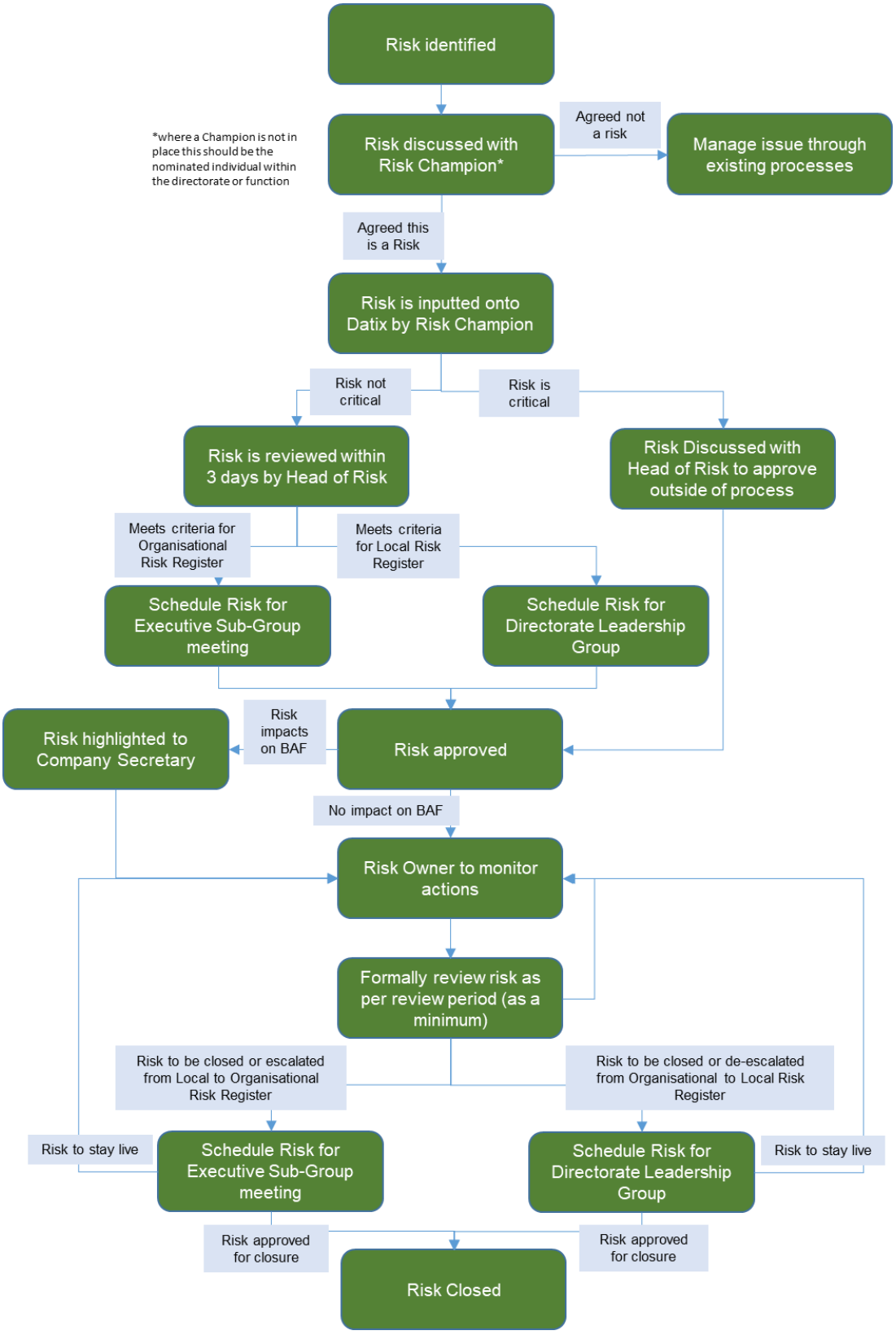
Sub-type	*Risk appetite statement*

Recruitment and retention	We will have a **open** approach to risks associated with recruitment and retention, aiming to ensure we recruit and retain high quality talent
Training and development	We will have an **open** approach to risks associated with training and development in support of colleagues progression and development
Diversity and inclusion	We will have a **minimal** approach to risks associated with diversity, equality and inclusion
Employee engagement	We will take an **open** approach to risks associated with how we engage with employees in order to drive opportunities to develop overall employee engagement

Risk type: Governance and Sustainability

Sub-type	***Risk appetite statement***
Governance structure	We have a **minimal** approach to risks associated with failures in good governance, conflict of interests or inadequate mechanisms for accountability
Strategy and planning	We will **seek** opportunities associated with strategy and planning, ensuring that we take these opportunities to develop our strategy and plans and aim for innovation and improvements in our services to patients
Stakeholder engagement and partnerships	We take an **open** approach to risks associated with partnerships and stakeholder engagement, to support our approach to system-wide partnerships in the development of current and future services
Organisational sustainability	We have an **open** approach to risks associated with our sustainability, recognising our aim for innovation and openness to change.

APPENDIX D – Risk Management Flowchart



Report cover-page					
References					
Meeting title:	Board of Directors				
04/07	12/09/2024		**Agenda reference:**	52-24	
Report title:	Board assurance framework (BAF)				
Sponsor:	Leonora May, Company secretary				
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, four current scores remain the same, three current scores have reduced, and one current score has significantly increased (physical infrastructure).				
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 August 2024				
Next steps:	NA				

Report to:	Board Directors
Agenda item:	52-24
Date of meeting:	12 September 2024
Report from:	Leonora May, Company secretary
Report author:	Leonora May, Company secretary
Date of report:	5 September 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.

We continue to work towards a revised approach to the production of the BAF both in terms of contents and presentation to improve its effectiveness.

The Board is being asked to consider the revised Risk management framework and approach to risk appetite at this 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, four current scores remain the same, three current scores have reduced, and one current score has significantly increased (physical infrastructure).

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	6	3	↓	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	20	6	↑	Apr 31	F&P	**RED**
04	**Long-term sustainability**	Chief Executive	25	8	6	↔	Nov 24	SDC	**GREEN**
05	**Compliance breach (non-clinical)**	Chief Executive	20	6	3	↓	Sep 24	F&P	**GREEN**
06	**Financial sustainability**	Chief Finance Officer	25	12	8	↔	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 BAF1 (patient services)

Risk profile

The current score has been reduced to 6 from 10 and the target score has been reduced to 3. The score has been reduced to reflect the current risk as the patient safety data and feedback demonstrate that there are significant mitigations and assurances in place. It is recognised that inherent risk is carried due to the nature of the work and that there are some gaps in assurance currently- some actions have been added to address these. The RAG rating remains at amber demonstrating that there are some issues to be monitored and addressed as demonstrated within the BAF.

Key issues/ updates

- Paper to Clinical governance group demonstrates that we will not be fully compliant with relevant NICE guidelines
- Learning from deaths annual report for 2023/24 not yet completed
- There is a need to implement a process for monitoring and reducing potential harm for long waiting patients
- There is greater confidence that staff will speak up in the moment to raise concerns if required
- There is a recognised requirement to strengthen organisational wide learning and triangulation of data
- There is a volume of work required to ensure that the estate is compliant with regulatory requirements from a quality and health and safety perspective- there is a need for close working between the CNO office and estates and facilities to agree priority of works to minimise clinical safety risks as a result of the environment (action added)

- Clinical negligence reporting demonstrates that the number of claims is reducing- previous clinical negligence claims point to a theme of lack of supervision and/ or reluctance to request more supervision- there is a need to follow up on the GMC survey and feedback from doctors in training about supervision including triangulation with Datix around supervision (action added)
- A temporary lead for medical devices is in place but there is a need for a long term plan
- Other actions added include the governance review to ensure Board to ward oversight and assurance and promoting organisational wide learning and further embedding of the clinical leadership model

Actions completed since last review

- Appointment of temporary medical devices lead
- Clinical audit annual report to the Audit and risk committee outlining assurance to be taken from the programme

Executive summary BAF 2 (workforce strategy)

Risk profile

The current score remains at 9. 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
- Trust values to launch on 17 September 2024

Actions completed since last review

- Behaviour framework developed to support launch of vision and values
- Trust values to be approved by the Board at its meeting on 12 September 2024

Executive summary BAF3 (physical infrastructure)

Risk profile

The current score has been increased to 20 and the overall assurance RAG rating is red demonstrating low confidence indicating that there are issues which need to be addressed immediately.

Key issues/ updates

- Access issues identified which create risks related to business continuity and fire safety- there is a need to urgently consider all risks associated with this issue
- Annual asbestos management survey has identified some asbestos for removal
- There is a need to identify all estates and facilities risks

- Estates team not yet fully resourced leading to potential shortfall of AP's and CP's
- Estates and facilities steering group to be re-established
- New critical suppliers procurement process in place
- Progress being made in developing a planned preventative maintenance plan
- RAAC present in one building

Actions completed since last review
- Asset list for all essential plant- complete but further work required

Executive summary BAF 4 (sustainability)
Risk profile
The current score remains at 8. The overall assurance RAG rating remains as green demonstrating high confidence which indicates that there no issues to be monitored and addressed and that the controls are effective.

Key issues/ updates
- Shortlisting of proposed patient cohort options is complete. Review of shortlist and consideration of service options to be considered at the Board seminar on 3 September 2024
- Full strategy publication delayed to November 2024 due to the pre-election period
- Longer term action added regarding implementation and delivery plan to be developed following the publication of the Trust strategy
- Uncertainty with the external factors which may have an impact on the strategy

Actions completed since last review
- Shortlisting of patient cohorts

Executive summary BAF5 (compliance breach)
Risk profile
The current score has been reduced to 6 on the basis that the likelihood has reduced due to external assurances that governance controls are effective. 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
- Auditor's annual report for 2023/24 confirms that the external auditors are satisfied that the Trust has adequate and effective governance arrangements in place and is taking appropriate action to further develop these arrangements in a range of areas
- There is a need to review all work completed to ensure that the Trust is outstanding at well led including embedding learning later in the year

Actions completed since last review
- Code of conduct for governors and process for non-compliance with the Code has been developed and was approved by the Council of Governors at its meeting on 15 July 2024

Executive summary BAF6 (financial sustainability)

Risk profile

The current score remains at 12 on the basis of satisfactory financial performance and financial planning/ budget process. The target score has been amended to 8. 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 is a need to re-establish budget holder meetings following the implementation of the new ways of working
- There is a need to develop a Trust wide efficiency programme to increase Trust productivity
- There is a need to review contract management processes including financial due diligence of new suppliers to ensure they are robust
- Financial governance training not currently in place

Actions completed since last review

- Risk management training completed
- Triangulation and validation of assumptions in financial plan

Executive summary BAF7 (information assets)

Risk profile

The current score remains at 12. 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

- Cyber security profile of the organisation is good
- The data security protection toolkit was completed in June 2024 and demonstrates that national standards are being met
- There is a need to complete a full IT system disaster recovery prior to the go live of EPR

Executive summary BAF 8 (relationships with partner organisations)

Risk profile

The current score remains at 8. The overall assurance RAG rating remains as green demonstrating high confidence which indicates that there no issues to be monitored and addressed and that the controls are effective.

Key issues/ updates

- The phase four engagement plan is in progress
- Independent review of phase three engagement complete and the feedback is positive and consistent with the previous independent review of engagement

Actions completed since last review

None- due from September 2024 onwards.

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	Q2- 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:**	14 August 2024		
Risk Handler(s)	Chief Medical Officer Chief Operating Officer	**Date Risk last formally discussed:**	27 August 2024	**Group**	Quality and safety committee

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			6		
1					

Target Score

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

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	1st line: 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) Datix reporting of issues demonstrates awareness and management of issues (August 2024, Green)	Reporting from governance groups to executive and Board sub-committees resulting in potential lack of oversight on risks 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

	Temporary lead for medical devices in place- need for long term plan Process for monitoring and reducing the potential for clinical harm for long waiting patients	Review of new medical devices by medical devices group with no issues (April 2024, Green) No patient safety incidents reported which require external oversight during last four months (August 2024, Green) 2nd line: Mandatory Training reports generated by Learning and Development Centre and shared to department heads show over 90% compliance (August 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) Clinical negligence reporting demonstrates that the number of claims is reducing (August 2024, Green) 3rd line: Patient feedback (FFT) and external surveys demonstrate Trust to be at the top of the top quartile (August 2024, Green)	Previous clinical negligence claims point to a theme of lack of supervision and/ or reluctance to request more supervision
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 Hard to recruit to posts such as sleep physiologists and ODP's	2nd Line Appraisal compliance reported by HR team on monthly basis (August 2024, Green) Low vacancy and turnover rates, Low safety incident level reporting, Safer staffing planned to actual target met each month for nursing- as shown in IQPR (August 2024, Green) Reduction in clinical negligence claims as demonstrated in report to QSC (August 2024, Green) Guardian of safe working report to Board (July 2024, Green)	GMC survey and feedback from doctors in training about supervision
3. Ongoing work to ensure we are compliant with quality and safety metrics using the CQC domains and quality statements as a benchmark which allows us to understand potential gaps and areas for development	Gap analysis against each CQC quality statement under new framework	1st Line: Looked at previous CQC inspection and identified actions needed to be completed. Some actions are now complete (August 2024, Amber)	Mitigations are being identified to reduce risks associated with the estate and being documented on the risk register

	Volume of work required to ensure that the estate is compliant with regulatory requirements from a quality and health and safety perspective	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)	Some longer term strategic level actions from past CQC inspections are in progress- expected to be completed before November 2024
4. Learning from incidents and SIs. Patient Safety and Incident Response Framework (PSIRF) policy and plan in place	There is a requirement to strengthen organisational wide learning and triangulation of data Greater confidence and evidence that staff will speak up in the moment to raise concerns is required	2nd Line: Q&S and CGG review serious incidents and Formal internal investigations as required, no issues identified (last tabled June 2024, Green) 3rd Line Quarterly quality review meeting with ICS with external review of incidents and risks with no unmitigated issues identified (August 2024, Green)	Learning from deaths annual report for 2023/24 not yet completed Reporting at Board requires triangulation of data to strengthen assurance
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 the outcomes and effectiveness executive sub-committee	2nd line: Q&S committee and Audit & Risk Committee (ARC) see the progress against clinical audit plan shows off track (February 2024, Red) Paper to clinical governance group demonstrates we may not be fully compliant with all relevant NICE guidelines (August 2024, Red)	
6. Mechanisms for staff and patients to raise concerns are in place including the new Freedom to Speak Up (F2SU) external provider, the whistle blowing policy, tell Jane, Board engagement across the organisation, staff governors and team huddles	Triangulation of feedback from different mechanisms to raise concerns and identification of themes	3rd line: Board receive bi-annual freedom to speak up reports from the freedom to speak up guardian- July report demonstrated an increase in speak ups (July 2024, Green)	Assessment of the impact of the new speaking up arrangements

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	October 2024	Chief Nurse	On track
2. 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	October 2024	CPO and Head of Risk	Date updated to October 2024
3. Clinical audit learnings to be robustly rolled out via clinical outcomes and effectiveness group with reporting to the executive committee for quality and risk and then to the Audit and risk committee	September 2024	CMO	Off track
4. Review of which external networks the Trust should be linked to	September 2024	CNO CMO	Date updated to September 2024
5. Review national standards and gap analysis resulting in action plan to mitigate (linked to Corporate risk register number 3)	October 2024	CMO, CDs	Off track- updated to October 2024
6. Assessment of all Clinical SLAs to identify areas of concern	September 2024	CFO and CMO	Off track- updated to September 2024
7. Appointment of new medical devices lead clinician	September 2024	CMO	Complete- temporary person in post, to be picked up with new CMO
8. Gap analysis against each quality statement under new CQC framework	October 2024	CNO	Off track- updated to October 2024- completed for well led

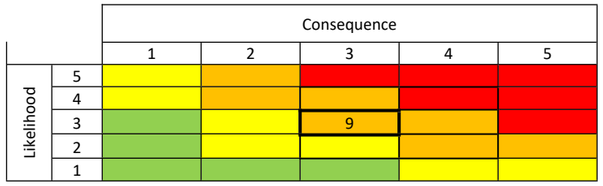
9. Clinical audit annual report to Audit and risk committee outlining assurance to be taken from the programme and outcome of clinical audits	June 2024	CMO	Complete- presented to the Audit and risk committee in June 2024
10. Triangulation of FTSU mechanisms and identification of themes	September 2024	CNO, CPO	Waiting for themes/ data to analyse- in progress
11. Assessment of how many staff do not have an up to date job description	September 2024	CPO	Not yet started
12. Close working between CNO office and estates and facilities to agree priority of works to minimise clinical safety risks as a result of the environment	September 2024	CNO, CFO	In progress
13. Follow up on GMC survey and feedback from doctors in training about supervision including triangulation with Datix around supervision	August 2024	CMO, CPO, CEO	In progress
14. Governance review to ensure ward to Board oversight and assurance and promoting organisational wide learning	October 2024	CS	In progress- review complete, implementation in progress
15. Further embedding of clinical leadership model- CD's to attend ELT, establishment of ECQR	November 2024	CNO, CMO, COO	In progress

Longer term actions (with indicative timeframe e.g. Q1 2024)	
Review to be completed by HR regarding completion and effectiveness of local and corporate inductions Review of all work completed to ensure the Trust is outstanding at well led including embedding learning	
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	Q2-24/25
✓	✓	✓	✓	✓							

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:**	13 August 2024		
Risk Handler(s)		**Date Risk last formally discussed:**	27 August 2024	**Group**	Finance and performance committee

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 Implementation of **behavioural framework** to enable culture and OD work (September 2024)	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). Local Faculty Group meetings with medical trainees / Educational Supervisors (3 times per year, Green).	New People and Culture Strategy to be reviewed through F&P and Board by September 2024 EDI network / staff networks being promoted and embedded.

	Management of **temporary staffing** use and spend (reporting to ELT September 2024)	Local Induction is already a competency. Local Induction checklist 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 (August 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 (August 2024, 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 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 (Aug 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 (Aug 24, Green). Monthly reporting on VPR to ICB (Aug 24, Green)	Lack of monthly review of staff survey actions.
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 (Aug 24, Green). 2nd Line: Bi-monthly reporting in workforce performance report to F&P and Board (Aug 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 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	1st line: Ongoing communications and engagement strategy with HoD, staff and Trust	

• **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).	There is a need to develop long term workforce planning tools to support new roles and ways of organising work. Lack of **leadership and development framework** covering talent and leadership (including cultural competence), **just culture, civility** and **high performance** team work and improvement.	(Green). Monthly MAST training reports for managers (Aug 24, Green). A draft leadership level framework is currently being produced in line with new triumvirate structure (Aug 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 (Aug 24, Green). Annual apprenticeship report (Aug 24, 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	Nov 24	CPO	Linked to overall strategy
2. Establishment of new EDI Group and re-establish staff networks and ensure embedded	Jan 25	CPO	On track – external consultants engaged to embed networks
3. Implementation of Trust vision, values and behaviour framework	Sep 24	CSO	Launching 17 Sep 24
4. Tendering of salary sacrifice and employee assistance programme	Sep 24	Deputy CPO	In progress – phased work underway
5. Design and implementation of health and wellbeing plan	Sep 24	Head of ER	On track
6. VPR implementation in line with ICB plans / case for additional support as part of business planning	Mar 25	Deputy CPO	On track
7. Design and implementation of Trust leadership and development framework	Sep 24	CPO/Head of OD	In progress
8. Succession planning for Exec team implemented	Nov 24	CPO	In progress – as part of overall strategy
9. Development of workforce planning tools and training	Jan 25	CPO/Head of OD	Work underway with Allocate

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

- Development / implementation of behavioural framework (September 2024)
- Development of sub-strategies within People Strategy, Inc.:
  - Resourcing
  - Wellbeing strategy
  - Talent Management and Succession planning
  - Medical Education strategy
  - Library and Knowledge Service Strategy

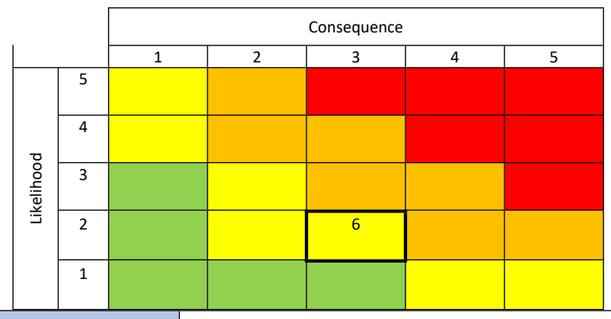
- Embedded processes for medium and long term workforce planning with links to transformation

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	Q2-24/25
✓	✓	✓	✓	✓							

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:**	14 August 2024		
Risk Handler(s)	Associate Director of Estates and Facilities	**Date Risk last formally discussed:**	27 August 2024	**Group**	Finance and performance committee

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 2024/25 agreed in response to six facet survey (undertaken every 5 years by independent surveyor)	Agreed funding for full maintenance schedule	1st line: Draft 5 year plan has been produced and being reviewed. Monthly reviews demonstrate good progress being made (August 2024, Green) 2nd line: Backlog maintenance schedule for 2024/25 is being reviewed monthly with Finance and good progress is being made (August 2024, Green) Summarised backlog maintenance reporting to capital programme group (CPG) monthly	

		demonstrate some challenges with procurement (August 2024, Amber) Estates and facilities reporting to F&P (quarterly) covers a status update on the backlog maintenance plan progress which demonstrates challenges with resources (August 2024, 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, some of which remain outstanding (August 2024) Annual Asbestos Management Survey to identify high risk areas for removal has identified some asbestos for removal (July 2024, Amber)	Estates team to create a spreadsheet to show service, name of AE, contract period and reporting arrangements Estates to provide a summary report to F&P to highlight any exceptions arising from the AE annual reports Action plan required from asbestos and all AE annual reports
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 Training for staff on SOPs		Internal review of effectiveness of standard operating procedures (Long term action once the SOPS have been updated) Estates and facilities steering group to be re-established
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 including access issues (refer to longer term actions) Training for staff regarding business continuity plans for estates (refer to longer term actions)	3rd line: Annual EPRR assurance report to QSC/ FPC and Board demonstrates substantial compliance (July 2024, Green)	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)	Some formal Contract Management processes now in place (refer to longer term actions)	1st line: Regular service reviews with critical suppliers (August 2024, Green)	Estates team to create schedule for quarterly service review meetings in 2024/25
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 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 estates leadership team highlights issues related to accuracy of data(August 2024, Red)	Asset register is currently being undertaken by external company- to be completed before the end of August 2024 Micad CAFM system has been purchased Reporting progress on PPM to FPC quarterly- to be established
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		3rd line: Review of PAM submission by NHSE (expected October 2024)	Summarised PAM results to be routinely reviewed and reported by the Estates team to F&P
8. Roles and responsibilities defined and documented within the estates team	Estates team not yet fully resourced leading to possible shortfall of AP's and CP's	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	There is a need to fully consider all risks associated with recently highlighted access issue There is a need to identify all estates and facilities risks	1st line: Estates leadership team sighted on risks and actions plans being developed	Lack of assurance that estates and facilities risks are identified and being addressed

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	ADEF	Complete but further work required- expected by end of August 2024
2. SOP review and development of training programme for 2024 for estates team	October 2024	ADEF	Ongoing – target date amended to October 2024
3. Estates team to create a spreadsheet to show service, name of AE, contract period and reporting arrangements	September 2024	ADEF	On target
4. Estates to provide a summary report to F&P to highlight any exceptions arising from the AE annual reports	October 2024	ADEF	AE process not managed and reports not completed. New AE's being appointed. Target date amended for reporting to FPC in October 2024
5. Commence summarised reporting of PAM results to F&P	October 2024	ADEF	New PAM to be developed for October 2024 deadline
6. Create comprehensive list of critical suppliers with support from procurement team	December 2024	ADEF	Not yet completed, ongoing work

7. A need to identify and fully consider all estates and facilities risks, including those related to access	August 2024	ADEF	Urgent action for completion before the end of August 2024
8. Action plan required from asbestos and all AE annual reports	November 2024	ADEF	Not yet started
9. Estates and facilities steering group to be re-established	October 2024	ADEF	In progress

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- compliance manager interviews scheduled
- 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 – work started
- Reporting on the status of BCP reviews / tests to the monthly estates and facilities steering group and Emergency Planning Lead – not yet started- need to link with emergency planning lead to review emergency planning
- 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 to be recruited
- Internal review of effectiveness of standard operating procedures – ongoing to be reviewed in line with policies

Links to Corporate Risk Register	6 - Major incident

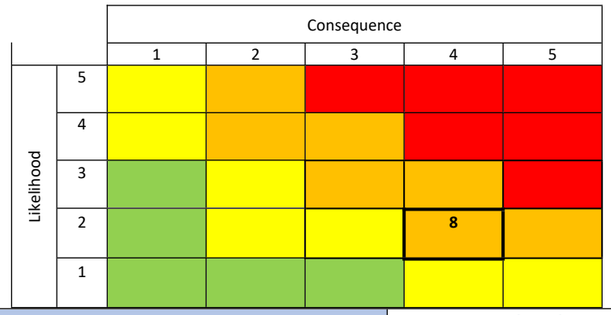
KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1 – 23/24	Q2 – 23/24	Q3 – 23/24	Q4 – 23/24	Q1 – 24/25	Q2- 24/25
✓	✓	✓	✓	✓							

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 specialist services for patients, reduction in staff morale, challenges with recruitment and retention, loss of community employment and local facilities	

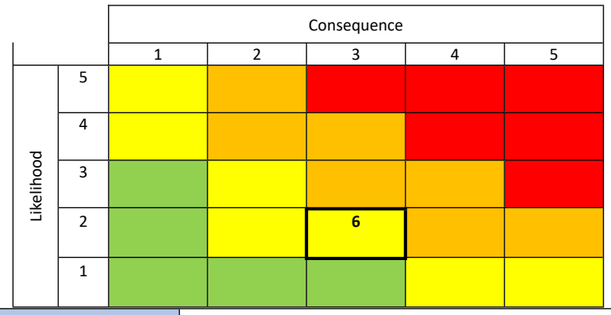
Responsible committee	Strategic Development Committee	**Date Risk Added:**	September 2023		
Principal Exec – Risk Owner	Chief Executive Officer	**Date Risk last reviewed:**	13 August 2024		
Risk Handler(s)	Chief Strategy Officer	**Date Risk last formally discussed:**	21 August 2024	**Group**	Strategic Development Committee

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. Detailed strategy development framework and milestone roadmap setting out key milestones and actions. Weekly monitoring of plan within strategy function to ensure delivery and initiate any required actions to variance 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)	Shortlisting of patient cohorts complete. Review of shortlist and consideration of service options to be reviewed at board seminar 3 September 2024 Full strategy to be approved November 2024	1st line: Strategy updates provided to the Strategic development Committee on a monthly basis demonstrating progress to date which is currently on track (July 2024, Green) 3rd line: Oversight of strategy development by the ICB of high level options board paper who are supportive of the approach (June 2024, Green)	None

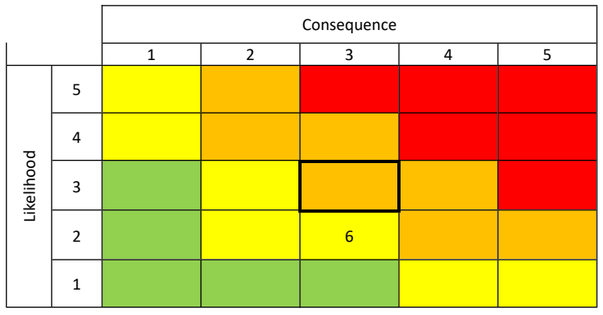
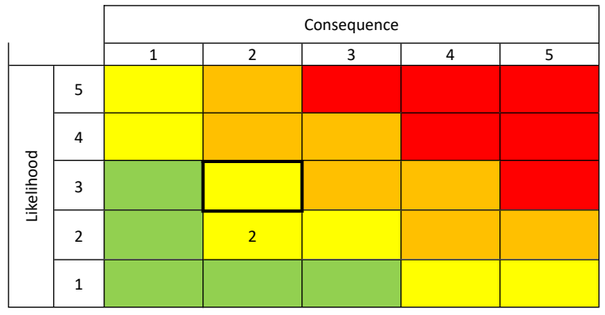
2. Clear and robust internal governance arrangements for decision making aligned to strategy objectives have been agreed by Chief Executive Officer / Board Chair and documented. This includes monthly Strategic Development Committee meetings to oversee strategic development and provide assurance and advice to the Board.	None	2nd line: Annual committee effectiveness review completed for the Strategic Development Committee. Thes results of the review demonstrate that the SDC is delivering in line with its terms of reference. (July 2024, Green).	None
3. 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	None (assurances in place as part of budgeting process captured within BAF Risk 6 Financial Sustainability)	None
4. 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. Shortlisting clinical options to be reviewed at board seminar 3 September 2024 (longlisting options appraisal complete)	September 2024	CSO	Delayed due to pre-election requirements – target date amended Clinical options review to be presented to the Board at its seminar on 3 September 2024
2. 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)			
3. Implementation and delivery plan following the publication of the trust strategy			

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	Q2-24/25
	✓	✓	✓	✓							
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:**	16 August 2024		
Risk Handler(s)	Company Secretary	**Date Risk last formally discussed:**	27 August 2024	**Group**	Finance and performance committee

Initial Score	Current Score	Target Score
		

Direction of travel since last review		Target date	September 2024
		Risk tolerance	To be added

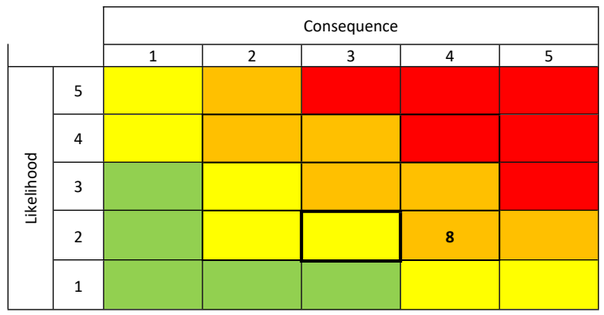
Controls (what are we doing about risk)	Gaps in Controls (where are we failing to put systems in place)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
1. Governing documents including Trust Constitution, Standing orders, Standing financial instructions, Scheme of delegation, Terms of reference and policies (non-clinical)	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) (June 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 (August 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. Ongoing work to ensure that we can benchmark against the CQC well led quality statements which allows us to understand potential gaps and areas for development	Continuous improvement framework Well embedded risk management 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		3rd line:	Benchmarking date from freedom to speak up service

		Board received report from independent freedom to speak up guardian- demonstrated increased number of speak ups (July 2024, Green)		
Immediate Actions		**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. 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		September 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
2. 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		October 2024	CPO and HoR	Policy actions contained within BAF1. Off track – delayed due to ongoing work associated with policies and governance framework. Date updated to October 2024
3. Review of all work completed to ensure the Trust is outstanding at well led including embedding learning		December 2024	CS	
4. Implement continuous improvement framework		September 2024	CSO	On track
5. Code of conduct for governors to be updated		July 2024	CS	Complete- approved by governors in July 2024
6. Review of Trust wide Corporate Governance and implementation of new framework		September 2024	CS	On track
7. 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	Q2-24/25
✓	✓	✓	✓	✓							
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:**	14 August 2024		
Risk Handler(s)	Deputy Chief Finance Officer	**Date Risk last formally discussed:**	27 August 2024	**Group**	Finance and performance committee

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: Business plan 2024/25 reviewed by FPC and Board shows break even position planned (July 2024, Green) 3rd line: Progress updates and outputs are reported to the system shows break even and is agreed within system control total (July 2024, Green) Internal audit – review of planning process for 2023/24 completed May 23 (3rd line, Green- note this was an advisory review so no audit opinion was issued, but findings support a Green rating).	To link the medium term financial plan with the Trust Strategy when approved
2. Monthly financial reporting scrutinised by finance team, ELT, FPC, Board and ICS Sussex		2nd Line: Integrated quality and performance report M3 demonstrates delivery of the financial plan (August 2024, Green) 3rd line: Internal Audit - Financial Management with reasonable assurance opinion (Q2 2023, Amber) Monthly review of financial position submissions to ICS Sussex and NHSE. No issues have been raised with financial sustainability (July 2024, Green)	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	Following the implementation of the new Trust structure, the budget holder meetings need to be redesigned and reestablished	1st line: Finance team keep a log of budget holder meetings to ensure regular oversight. Log shows not all budget holder meetings have been reestablished (August 2024, Amber) 2nd line: Monthly IQPR meetings provide assurance that budget holder meetings have occurred, and the financial position is understood. Not yet fully embedded sufficiently (August 2024, Amber)	
4. Directorate IQPR meetings 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	Delays in production of directorate IQPR data packs means they have not been available until September 2024 and therefore meetings have used Trust wide data. Directorate packs currently being established with support from Real World Health	1st and 2nd line: Executive review of directorate data in IQPR meetings and reporting to the Executive leadership team. Not yet using directorate specific data (August 2024, Amber)	

5. Financial policies and procedures in place (including standing orders and standing 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	2nd line: Compliance against SO's, SFI's and SoD reported to the Audit and risk committee annually- last report shows that the Trust complied during 2023/24 (March 2024,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. Waiver report to committee shows high level of waivers (June 2024, Green)	
6. Staff training - Training for budget holders on the management of budgets, understanding of financial planning, financial governance.	Budget holder training not yet started, training packs need updating to support current financial requirements of the Trust. A roll out plan in place and agreed with ARC	2nd line: List of budget holder training completed kept by finance team. Shows that budget holder training has not yet started. (August 2024, Red)	Review of budget holder training completion rates
7. 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	2nd line: Internal audit report on contract management shows partial assurance (2023/24, Amber)	
8. 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
3. Rollout of Risk Management Training	July 2024	Interim Risk Project Lead	Training complete
4. Triangulation and validation of assumptions in financial plan	May 2024	Chief Finance Officer	Complete for 2024/25- ongoing action for each year
5. Financial plan to be linked to new trust strategy	November 2024	CFO	Delayed due to pre-election requirements
6. Introduce focused programme delivery for all efficiencies identified through business planning	November 2024	CFO, COO	On track- work in progress
7. Following the implementation of the new Trust structure, the budget holder meetings need to be redesigned and reestablished	September 2024	CFO	On track

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

- Identify opportunities for income growth as part of system collaboration - opportunities for 2025/26 to be identified (Q4 2024/2025)
- Develop a Trust wide efficiency programme to increase Trust productivity (Q4 2024/25)

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	Q2-24/25
✓	✓	✓	✓	✓							

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** 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. Digital services policies and procedures (Information governance, information technology and security) in place. Reviewed annually to ensure updates made in line with agreed timescales. 2. Trude wide policy administration in place to ensure policies are kept up to date and reviewed in a timely way	Not all staff adhere to the policies and / or know the details of them A need to enhance the information asset register	<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

		3rd line: Data security protection toolkit completed annually which is reviewed by the Trust's external auditors. Last completion in June 2024 demonstrates national standards being met (June 2024, Green)	
3. Annual mandatory information governance and data security training in place. Mandatory training reports in place and circulated by OD team for monitoring compliance	None	2nd line: Monthly reporting of compliance internally produced by L&D team and issued to service mangers for following up non-compliance shows (Green) L&D produce a snapshot mandatory report as part of the annual DSPT submission to NHSE (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 (June 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	Need improvement plan for communications to continuously identify gaps in training and awareness Undertake internal phishing and spam email exercises	None	To provide progress report on communications plan to IMT once agreed Reporting on phishing and spam exercises
6. Ongoing security updates, reactive vulnerability scanning and penetration testing – remediation plans monitored through IMT group and SIRO. Enhanced proactive monitoring SIEM tool being put in place.	None	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	A full IT system disaster recovery to be undertaken prior to the go live of the EPR.	3rd Line: External / third party provider tabletop digital business continuity exercise with feedback report provided to CIO with IMT having oversight of remediation plans. Completed 5/6, Amber as results	Full IT system disaster recovery test yet to be undertaken

		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. 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 Digital Strategy to be approved at the November Board	Final strategy to be approved following approval of the Trust Clinical Strategy (Action 4)

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track)
1. IG training to be included within integrated assurance framework deployment	July 2024 October 2024	DPO	Date updated to October 2024
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
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	November 2024	CDIO / CFO	Due to go to November Board meeting for approval
5. Board development dates for cyber security training	February 2024	CFO / CDIO	Completed
6. Continuous improvement plan for data security awareness	October 2024	CDIO	Not yet started
7. Improvements to the information asset register	March 2025	CDIO	Not yet started

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

- Plan a full business continuity exercise – Completed
- Data migration, data quality strategy to be drafted under the EPR programme strategy (Q4 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	Q2- 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	

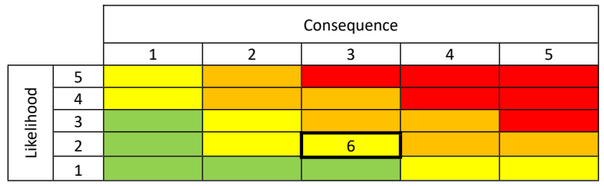
Responsible committee	Strategic Development Committee	**Date Risk Added:**	September 2023		
Principal Exec – Risk Owner	Chief Executive Officer	**Date Risk last reviewed:**	13 August 2024		
Risk Handler(s)	Chief Strategy Officer	**Date Risk last formally discussed:**	21 August 2024	**Group**	Strategic Development Committee

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. 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 and demonstrates that the plan is on track for delivery and engagement feedback is being captured (August 2024, Green) 2nd line: Phase 4 engagement plan on track. Verbal engagement updates to continue to be reported to SDC on a monthly basis demonstrate that work is on track. (July 2024, Green) 3rd line:	Independent review of phase 3 engagement to be provided to the Strategic Development Committee

		Independent review of phase 3 engagement complete. Report provides positive assurance regarding engagement activities undertaken (June 2024, 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	2nd Line: CEO Board update includes high level updates on system relationships. Latest update demonstrated development of system leadership roles and QVH support to the system (July 2024, Green) Quarterly Provider Assurance meetings with ICB and NHSE in place (April 2024, Green). June 2024 meeting stood down as full assurance received by ICS	None identified
3. The trust executive continue to build 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	None	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. (July 2024, Green)	None identified

Immediate Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Develop partnership strategy	November 2024	CSO	Delayed due to pre-election requirements and delay to overall strategy
2. Phase four of engagement plan to be completed	October 2024	CSO	
3. Independent review of phase 3 engagement to be presented to the Strategic Development Committee	September 2024	CSO	
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:	12/09/2024		**Agenda reference:**	**53-24**	
Report title:	Assessment of estates risks and issues				
Sponsor:	Maria Wheeler, Chief Finance Officer				
Author:	Claire Lowe, Interim Director of Estates and Facilities Adrian Lee, Director of Estates and Facilities				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the Board with an update on estates issues and risks.				
Summary of key issues	• Fire safety- issues with compliance highlighted following the Fire Safety Enforcement Notice received • Asbestos- an initial inspection commissioned in June 2024 which is still underway has identified some issues to address which will require a management plan • RAAC- Reinforced Aerated Autoclaved Concrete has been identified in location 58 (medical photography)- independent engineer survey and advice to relocate before April 2025 • Ventilation- ventilation systems on site are not Health Technical Memorandum (HTM) compliant • Electrical infrastructure- some infrastructure is end of life and without fixed wire testing regime in place (uninterrupted power supply new installation complete) • Boilers- heating systems not fit for purpose to support winter months • Outpatient's department floors- new flooring required to ensure safe to use (two first floor rooms taken out of use as the floor cannot be repaired) • Outpatient's department roof- roof replaced earlier in the year and issues remain Re standing water • Theatres 1-10 roofs- design issues are causing water pooling across the whole roof • Therapy building- wall heave and footings (no immediate safety issue) • Trees- a number to be removed for safety reasons • Access- access to north west of the site for emergencies and key deliveries				
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:	BAF3- physical infrastructure				
Corporate risk register:	Local and organisational related risks set out within issues log				
Regulation:	Health Technical Memorandum (HTM)				
Legal:	NA				
Resources:	Various resources required to manage issues and risks				

Assurance route				
Previously considered by:	Finance and performance committee			
	Date:	27/08/2024	Decision :	Escalate to Board
Next steps:	Regular updates on progress to the Finance and performance committee			

Report to: Board Directors
Agenda item: 53-24
Date of meeting: 12 September 2024
Report from: Maria Wheeler, Chief finance officer
Report author: Adrian Lee, Associate Director of Estates and Facilities
Claire Lowe, Interim Director of Estates and Facilities
Date of report: 2 September 2024
Appendices: None

Estates risks and issues

Introduction

This report seeks to brief the Board on current issues and risks related to the Trust's estate.

Executive summary

There are a number of issues and risks which are being monitored related to the Trust's estate. These are largely due to the age of the infrastructure and some are legacy issues which are now being addressed.

At the beginning of the this year, senior estates officers were appointed and have since started a full assessment of the site to understand issues and risks and ensure that mitigating actions are in place.

The full assessment is ongoing and the findings to date are set out within this report. Where urgent issues have been identified, work has been undertaken to reduce the risks. Regular updates to the Finance and performance committee and Board will continue as the assessment progresses.

The key findings of the assessment to date are set out below. These are:

- Fire safety
- Asbestos
- Ventilation
- Identification of RAAC
- Electrical infrastructure
- Boilers / Heating
- Building condition
- Trees

Fire Safety

West Sussex Fire & Rescue Service (WSFRS) visited on 22 January 2024 for a routine inspection, following which a Fire Safety Enforcement Notice was issued to the Trust to ensure discrepancies were addressed. This followed their previous visit

in March 2023 and their subsequent letter of discrepancies. The fire service have been pleased with work completed to date to address discrepancies. Although most of the work was completed before 3 June 2024 in line with the enforcement notice, the fire dampers work is running beyond the original deadline to fully complete. The full extent of the works needed was discovered following the full initial survey and the fire service granted an extension.

Asbestos
An initial inspection has identified some asbestos on site. Independent asbestos experts are currently undertaking a detailed re inspection. The inspection will cover every building on the site in detail, including a thorough assessment of the condition of the asbestos and the risk it poses. The Trust will receive a full report from the asbestos experts from which a detailed management plan will be prepared. No areas of immediate concern have been highlighted to date.

Reinforced Aerated Autoclaved Concrete (RAAC)
In March 2024, an independent survey of all buildings at QVH was commissioned to identify the presence of Reinforced Aerated Autoclaved Concrete (RAAC). It identified that it was present in Location 58 which is currently used for medical photography.

A number of controls are being implemented which includes preventing access to the roof, ensuring that there are no roof leaks and maintaining visual inspections of the building. The relocation plan of the service to the Rowntree building is being developed and costed. The service will be relocated before April 2025 as previously reported to the Board.

The Trust will make an application to the NHSE RAAC team for funding for this work including demolition of the existing Medical Photography building. A short form business case will be developed and presented to the Board for approval.

Ventilation
The ventilation systems on site are not Health Technical Memorandum (HTM) compliant. Urgent action has been taken in order to improve compliance and make the environment as safe as possible for patients and staff. This includes ductwork cleaning in theatres and ward areas which have mechanical ventilation. Air handling units will be installed within the radiology department before the end of September 2024. Longer term, chillers will be installed within theatres and extensive work will be required in order to meet full compliance and ventilation compliance will be an essential requirement of all estate upgrade schemes in line with the Estates strategy going forward.

Electrical infrastructure
Some of our electrical infrastructure is at end of life and without fixed wire testing regimes in place. There are risks related to failure of the sites electrical systems and that emergency lighting may not function as needed.

This issue is being closely monitored and work has started to install monitoring equipment to understand maximum demand and peak times. A full survey of electrical infrastructure will be completed and a 100% fixed wire testing regime is being established.

Boiler /Heating
Some of our boilers are not fit for purpose to support the Trust through winter months. A temporary boiler will be installed to support resilience through the winter

months whilst an action plan to install an energy centre on site to support a permanent solution is developed.

Building condition

- Outpatient department floors- new flooring is required to ensure rooms are safe to use. Temporary repairs have been completed where it has been possible. Two of the first floor rooms have been taken out of use as the floors are unrepairable.

- Outpatient department roof- there is standing water on the roof which needs to be addressed to prevent leaks. The roof was replaced earlier this year. The team are working through long term solutions.

- Theatres 1 -10- there is standing water on the roofs which needs to be addressed to prevent leaks and infection risks. Water is being pumped off of the roof daily whilst a long term solution is developed.

- Building One (therapies)- has structural issues due to wall heave and the building moving on it footing. This is not an immediate safety issue but brickwork is being monitored to ensure that there is no significant movement. A long term solution is being developed.

Trees

A tree survey has been commissioned to ensure compliance with Mid Sussex Tree Protection Orders (TPO's). This has highlighted a number of trees which need to be removed for safety reasons. This will be completed before the end of September 2024 and new trees will be planted. A tree management plan will be commissioned to ensure that trees are protected where there are no safety issues.

Recommendation

The Board is asked to **note** the issues highlighted and associated risks.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024		**Agenda reference:**	**54-24**	
Report title:	Trust Constitution updates				
Sponsor:	Leonora May, Company Secretary				
Author:	Leonora May, Company Secretary				
Appendices:	Appendix one- V11 draft Trust Constitution				
Executive summary					
Purpose of report:	This report seeks approval from the Board to make changes to the Trust's Constitution.				
Summary of key issues	• S18.1.7 has been updated to make clear that a person may not become or continue to become a member of the Council of Governors if they have previously been removed as a QVH governor • S18.17 has been added to include an express provision for the Chair to suspend a governor if they consider there to be a reason why the person may not continue to be a governor as set out within the Constitution. It should be noted that notwithstanding a lack of express provision, the Chair has the ability to suspend a governor in their capacity as Chair • S18.18 has been added to include a provision which states that a governor may not stand for re-election or be reappointed while they are suspended • S21.6 has been updated to make clear that the Chair may, in exceptional circumstances, call a meeting of the Council of Governors in line with the model Constitution • S25 has been updated to correct the name of the Governor steering committee as set out within its updated terms of reference • S26 has been updated to include the Deputy Lead Governor role				
Recommendation:	The Board is asked to approve the Trust's Constitution.				
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:	BAF5- compliance				
Corporate risk register:	None				
Regulation:	None				
Legal:	NHS Act 2006 Health and Social Care Act 2012				
Resources:	None				
Assurance route					
Previously considered by:	Council of Governors				
	Date:	July 2024	Decision:	Approved	
Next steps	New Constitution to come into effect immediately Published on Trust's website				

Report to:	Board of Directors
Agenda item:	54-24
Date of meeting:	12 September 2024
Report from:	Leonora May, Company Secretary
Report author:	Leonora May, Company Secretary
Date of report:	5 September 2024
Appendices:	Appendix one: V11 draft Trust Constitution

Trust Constitution updates

Introduction

This report seeks approval from the Board to make changes to the Trust's Constitution. Changes to the Trust's Constitution require approval from the Council of Governors and the Board of Directors. The Council of Governors approved the changes to the Trust's Constitution at its meeting on 15 July 2024 subject to including the Deputy Lead Governor role within S26. This change has been made.

During a dispute between the Trust and a public governor regarding Requirements imposed on the public governor, it became apparent that there were some discrepancies within the Trust's Constitution and areas where the Constitution differed from the NHS foundation trust model Constitution. These changes seek to rectify that in line with legal advice sought and received by the Trust.

Executive summary

- S18.1.7 has been updated to make clear that a person may not become or continue to become a member of the Council of Governors if they have previously been removed as a QVH governor

- S18.17 has been added to include an express provision for the Chair to suspend a governor if they consider there to be a reason why the person may not continue to be a governor as set out within the Constitution. It should be noted that notwithstanding a lack of express provision, the Chair has the ability to suspend a governor in their capacity as Chair

- S18.18 has been added to include a provision which states that a governor may not stand for re-election or be reappointed while they are suspended

- S21.6 has been updated to make clear that the Chair may, in exceptional circumstances, call a meeting of the Council of Governors in line with the model Constitution

- S25 has been updated to correct the name of the Governor steering committee as set out within its updated terms of reference

- S26 has been updated to include the Deputy Lead Governor role

Recommendation

The Board is asked to **approve** the changes to the Trust's Constitution.

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital
NHS Foundation Trust

(A Public Benefit Corporation)

Constitution

(updated as per the Health and Social Care Act 2012)

Document control sheet		
Document title		Queen Victoria Hospital NHS Foundation Trust Constitution
Version	1	Agreed by the Council of Governors at a meeting held in public on 16 April 2013
Version	2	Amended by the Council of Governors at a meeting held in public on 19 June 2014
Version	3	Amended to incorporate the 2014 Model Election Rules, as notified to the Council of Governors at a meeting held in public on 11 December 2014
Version	4	Amended by the Council of Governors at a meeting held in public on 8 October 2015 • Provisions 18.1.5 and 18.1.7 Council of Governors – disqualification and removal • Provision 38.1 Board of Directors – disqualification
Version	5	Amended by the Council of Governors at a meeting held in public on 21 April 2016 • Annex 1 – The public Constituency
Version	6	Approved by the Board of Directors at its meeting on 6 July 2017 and by the Council of Governors at the Trust's AGM on 31 July 2017 • References to Chairman are now shown as Chair • Reference to both male and female gender shown throughout the documentation. • Following agreement by the Council of Governors at its meeting on 20 October 2016, the title Governor Representative to the Board has been changed to Lead Governor. • At the same meeting, Council agreed that the roles of Lead governor and Vice-Chair should be amalgamated; the Constitution has been revised to reflect this change.
Version	7	Approved by the Board of Directors at its meeting on 07 November 2019 and by the Council of Governors at its meeting on 13 January 2020. • Wording of S18.1 amended to reflect wording of S.11, making it clear that an individual who satisfies criteria for membership of one constituency shall not become or continue as a member of any other constituency
Version	8	Approved by the Board of Directors at its meeting on 07 January 2021 and by the Council of Governors at its meeting on 11 January 2021. • Amendment to S16.6 and Annex 3 (CoG vacancies) • Amendments to 17.1 and 17/2 to ensure consistency • Amendment concerning processing of membership applications • Amendment to GSG Terms of Reference (S.25) • Amendment to wording of paragraph 4.2 'exercisable' from 'exercised' • Updating of pronouns.

Version	9	Approved by the Board of Directors at its meeting on 05 August 2021 and by the Council of Governors at its meeting on 19 July 2021. • Rescinding amendments to GSG Terms of Reference (S.25) agreed in January 2021.
Version	10	Approved by the Council of Governors at its meeting on 21 February 2022 and by the Board of Directors at its meeting on 3 March 2022. • Lead governor: amendment to interpretation and definitions. • Lead governor: amendment to section 26.1 • Lead governor: amendment to sections 26.2 and 26.3 • Lead governor attendance at Board of Directors meetings: Amendment to section 39.6 • Chairing of Council of governor meetings: Amendment to section 21.14
Version	10a	Correction of administrative error, numbering of section 18
Version	10b	Correction of administrative error to remove the text in section 21.15 and correct numbering of section 21.15 to section 22
Version	11	Approved by the Council of Governors at its meeting on 15 July 2024 and by the Board of Directors at its meeting on 12 September 2024. • Amendments to S18.1.7amendment to make clear that a person may not become or continue to be a governor if they have previously been removed as a QVH governor • Amendments S18.17 to include express provision for Chair to suspend a governor • Addition S18.18 to include a provision which states a governor may not stand for re-election or be reappointed whilst they are suspended • Amendments S21.6 to make clear that the Chair may call a meeting of the Council of Governors • Amendments S25 to update the name of the Governor steering committee • Amendments S26 to include reference to Deputy Lead Governor role

Preamble

This document is the Constitution for the Queen Victoria Hospital NHS Foundation Trust.

An NHS Foundation Trust is a Public Benefit Corporation authorised under the National Health Service Act 2006 (the 2006 Act) to provide goods and services for the purposes of the health service in England. A Public Benefit Corporation is a body corporate which is constituted in accordance with Schedule 7 of the 2006 Act. The Constitution provides, inter alia, for the Trust to have Members, Governors and Directors, and determines who may be eligible for Membership and how Governors and Directors are appointed and defines their respective roles and powers. Further, Members of the Trust may attend and participate at public meetings of the Trust, vote in elections of, and stand for election for, the Council of Governors, as provided in this Constitution.

The NHS Constitution is a Department of Health publication and establishes the principles and values for staff and patients. It sets out the rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve. It also sets out responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

TABLE OF CONTENTS

1 Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act or as amended by the Health and Social Care Act 2012.

References in this Constitution to legislation include all amendments, replacements or re-enactments made and include all subordinate legislation made thereunder.

Headings are for ease of reference only and are not to affect interpretation.

Words importing the singular shall import the plural and vice-versa.

All annexes referred to in this Constitution form part of it.

In this Constitution:

the 2006 Act is the National Health Service Act 2006 (as amended);

the 2012 Act is the Health and Social Care Act 2012;

Accounting Officer means the person who, from time to time, discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;

Affiliate Member means anyone under the age of 18 or who lives outside the areas specified in Annex 1 as the area for the Public Constituency who shall receive information about the Foundation Trust but who shall not be entitled to vote in Governor elections;

Annual Accounts means those accounts prepared by the Foundation Trust in accordance with paragraph 25 of Schedule 7 to the 2006 Act;

Annual Governors' Meeting is defined in paragraphs 21.3 and 27.1 of this Constitution;

Annual Members' Meeting is defined in paragraph 28 of this Constitution;

Annual Report means a report prepared by the Foundation Trust in accordance with paragraph 26 of Schedule 7 to the 2006 Act;

Appointed Governors means a Local Authority Governor or Partnership Governor;

Appointments Committee means a committee comprised of Governors for the purpose of carrying out activities and functions in accordance with its terms of reference;

Area of the Foundation Trust means an area specified in Annex 1 as an area for a Public constituency;

Audit Committee means a committee of the Board of Directors established in accordance with paragraph 47 of this Constitution;

Auditor means the Auditor of the Foundation Trust appointed by the Council of Governors in accordance with paragraph 46 of this Constitution;

Board of Directors means the Board of Directors of the Foundation Trust, constituted in

accordance with this Constitution;

Chair means the person appointed in accordance with this Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Foundation Trust as a whole. The expression "the Chair" shall include the Deputy Chair or any other Non-Executive Director appointed if the Chair or Deputy Chair is absent or is otherwise unavailable;

Chief Executive means the Chief Executive of the Foundation Trust;

Clear Day means a day of the week not including a Saturday, Sunday or public holiday;

Close Family Member means either a:

a) Spouse;

b) Person whose status is that of "Civil Partner" as defined in the Civil Partnerships Act 2004 or a co-habitee;

c) Child, step child or adopted child;

d) Sibling;

e) Parent; or

f) Nephew, niece or cousin;

Conflict shall have the meaning ascribed to "Conflict" in paragraph 40.11.1 of this Constitution;

Constitution means this Constitution and all annexes to it;

Council of Governors means the Council of Governors as constituted in accordance with this Constitution and which has the same meaning as the Council of Governors in paragraph 7 of Schedule 7 to the 2006 Act;

Deputy Chair means the Deputy Chair of the Foundation Trust appointed in accordance with paragraph 36 of this Constitution;

Director means a member of the Board of Directors;

Directors' Code of Conduct means the Code of Conduct for Directors of the Foundation Trust, as adopted by the Foundation Trust and as amended from time to time by the Board of Directors, to which all Directors must subscribe;

Disclosure and Barring Service means the Executive Agency of the Home Office to which the Secretary of State has delegated his/her functions under Part V of the Police Act 1977 in relation to applications for criminal records certificates and enhanced criminal record certificates as established by section 87(1) of the Protection of Freedoms Act 2012;

Elected Governor means a Public Governor or a Staff Governor;

Executive Director means an executive member of the Board of Directors of the Foundation Trust;

Financial Year means each successive period of 12 months beginning with 1 April and ending with 31 March;

Forward Plan means the document prepared by the Foundation Trust in accordance with paragraph 27 of Schedule 7 to the 2006 Act;

Foundation Trust means the Queen Victoria Hospital NHS Foundation Trust;

Governor means a member of the Council of Governors;

Governors' Code of Conduct means the Code of Conduct for Governors of the Foundation Trust, as adopted by the Foundation Trust and as amended from time to time by the Council of Governors, to which all Governors must subscribe;

Lead Governor means the governor nominated by the Trust to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code and as set out in the role description and personal specification.

Governors Steering Group means a group of Governors chosen by the Council of Governors and chaired by the Vice-Chair of the Council of Governors that supports the work of the Council of Governors and the phrase "GSG" shall be construed accordingly;

Health Service Body shall have the meaning ascribed to "NHS Body" in Section 275 of the 2012 Act;

Interested Director shall have the meaning ascribed to "Interested Director" in paragraph 40.11.1 of this Constitution;

Licence means the licence granted to the Foundation Trust under Section 88 of the 2012 Act;

Local Authority Governor means a member of the Council of Governors appointed by one or more Local Authorities whose area includes the whole or part of the area of the Foundation Trust;

Meeting Chair means the person presiding over a meeting, committee or event;

Member means a Member of the Foundation Trust and the term "Membership" shall be construed accordingly;

Membership Strategy means the document of that name which describes the Foundation Trust's strategy to set up systems and processes to establish, maintain and develop its Membership;

Model Election Rules means the rules set out in Annex 4 of this Constitution;

Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act;

Nomination and Remuneration Committee means a committee constituted in accordance with paragraph 37;

Non-Executive Director means a Non-Executive Director of the Foundation Trust;

Officer means an employee of the Foundation Trust or any other person holding a paid appointment or office with the Foundation Trust;

Partnership Governor means a member of the Council of Governors other than a Public Governor, a Staff Governor or a Local Authority Governor;

Partnership Organisation means an organisation that may appoint a Partnership Governor and which is listed in Annex 3 of this Constitution;

Principal Purpose means the purpose set out in Section 43(1) of the 2006 Act;

Public Constituency is defined in paragraph 8 of this Constitution;

Public Governor means a member of the Council of Governors elected by Members of the Public Constituency;

Registered Dentist means a fully registered person within the meaning of the Dentists Act 1984 who holds a licence to practise under that Act;

Registered Medical Practitioner means a fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practise under that Act;

Registered Midwife means a fully registered person within the meaning of the Nurse and Midwifery Order 2001 (SI 2001/253);

Registered Nurse means a fully registered person within the meaning of the Nurse and Midwifery Order 2001 (SI 2001/253);

Regulatory Framework means the 2006 Act, the Constitution and the Licence;

Replacement Governor is defined in paragraph 16.4 of this Constitution;

Secretary means a person whose function shall be to provide advice on corporate governance issues to the Board of Directors, Council of Governors and the Chair and monitor the Foundation Trust's compliance with the Regulatory Framework. The Secretary shall be appointed and removed by the Chief Executive and Chair of the Foundation Trust acting jointly;

Senior Independent Director means a Non-Executive Director appointed in accordance with paragraph 36 of this Constitution;

Sex Offenders' Order means either:

a) a Sexual Offences Prevention Order made under Section 104 or Section 105 of the Sexual Offences Act 2003; or

b) an Interim Sexual Offences Prevention Order made under Section 109 of the Sexual Offences Act 2003; or

c) a Foreign Travel Order made under Section 114 of the Sexual Offenders Act; or

d) a Risk of Harm Order made under Section 123 of the Sexual Offences Act 2003; or

e) an Interim Risk of Sexual Harm made under Section 126 of the Sexual Offences Act 2003;

Sex Offenders' Register means the notification requirements set out in Part 2 of the Sexual Offences Act 2003, commonly known as the Sex Offenders' Register;

Staff Constituency is defined in paragraph 9 of this Constitution;

Staff Governor means a member of the Council of Governors elected by the Members of the Staff Constituency; and

2 Name

2.1 The name of the Foundation Trust is the Queen Victoria Hospital NHS Foundation Trust (the "Foundation Trust").

3 Principal Purpose

3.1 The Principal Purpose of the Foundation Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Foundation Trust does not fulfil its Principal Purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Foundation Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Foundation Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better carry on its Principal Purpose.

4 Powers

4.1 The powers of the Foundation Trust are set out in the 2006 Act.

4.2 All the powers of the Foundation Trust shall be exercisable by the Board of Directors on behalf of the Foundation Trust.

4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

4.4 In performing its NHS functions, the Foundation Trust shall have regard to the NHS Constitution. For the purpose of this paragraph, "NHS functions" means functions under an enactment which is a function concerned with, or connected to, the provision, commissioning or regulation of NHS services and "NHS services" means health services provided in England for the purposes of the health service under Section1(1) of the 2006 Act.

5 Other purposes

5.1 The Foundation Trust shall operate for the public benefit and aspire to the highest standards of public service, including respect for the rights of individuals and the environment. The Foundation Trust will operate effectively, efficiently and economically and invest any surpluses in its future.

5.2 The Foundation Trust shall, as appropriate, involve itself in education, training and research activities, in furtherance of its Principal Purpose.

6 Membership and constituencies

6.1 The Foundation Trust shall have Members, each of whom shall be a Member of one of the following constituencies:

6.1.1 the Public Constituency; or

6.1.2 the Staff Constituency.

7 Application for Membership

7.1 An individual who is eligible to become a Member of the Foundation Trust may do so on application to the Foundation Trust.

7.2 Subject to paragraph 9.5 below, applicants for Membership of the Foundation Trust must complete a form prescribed by the Chief Executive or the Secretary.

7.3 All Members of the Foundation Trust shall be under a duty to notify the Secretary of any change in their particulars which may affect their entitlement as a Member.

7.4 It shall be the responsibility of Members to ensure their eligibility and not that of the Foundation Trust.

7.5 Anyone under the age of 18 or who lives outside the area specified in Annex 1 as the area for the Public Constituency and who wishes to become a Member of the Foundation Trust shall become an Affiliate Member of the Foundation Trust. An Affiliate Member shall receive information sent to all Members about the Foundation Trust but shall not be entitled to vote in Governor elections.

8 Public Constituency

8.1 An individual who lives in the area specified in Annex 1 as the area for the Public Constituency may become or continue as a Member of the Foundation Trust.

8.2 Those individuals who live in the area specified for the public constituency are referred to collectively as the Public Constituency.

8.3 The minimum number of Members in the Public Constituency is specified in Annex 1.

8.4 The Secretary shall, on receipt of an application and subject to being satisfied that the applicant is eligible, ensure the applicant's name is entered into the Foundation Trust's register of Members at which point they shall become a Member of the Foundation Trust.

8.5 The Secretary may require any individual to supply supporting evidence to confirm eligibility.

8.6 The Secretary will endeavour to complete the membership application process within 20 working days; when a governor election has been announced membership applications will be processed within 5 working days of all supporting evidence being made available by the applicant.

9 Staff Constituency

9.1 An individual who is employed by the Foundation Trust under a contract of employment with the Foundation Trust may become or continue as a Member of the Foundation Trust provided:

9.1.1 he/she is employed by the Foundation Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months;

9.1.2 he/she has been continuously employed by the Foundation Trust under a contract of employment for at least 12 months; and

9.2 Those individuals who are eligible for Membership of the Foundation Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

9.3 The minimum number of Members in the Staff Constituency is specified in Annex 2.

9.4 For the purposes of paragraph 9.1 above, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Foundation Trust.

9.5 An individual who is eligible to become a Member of the Staff Constituency under paragraph 9.1 above, and who is invited by the Foundation Trust to become a Member of the Staff Constituency, shall become a Member of the Staff Constituency without an application being made, unless he/she informs the Foundation Trust that he/she does not wish to do so.

10 Membership

10.1 The Foundation Trust shall at all times strive to ensure that, taken as a whole, its actual Membership of the Public Constituency is representative of those eligible for Membership of the Foundation Trust.

10.2 The area set out for the Public Constituency shall have regard to the need for those eligible for such Membership to be representative of those to whom the Foundation Trust provides services.

11 Restriction on Membership

11.1 An individual who is a Member of a constituency shall not, while Membership of that constituency continues, be a Member of any other constituency.

11.2 An individual who satisfies the criteria for Membership of the Staff Constituency shall not become or continue as a Member of any constituency other than the Staff Constituency.

11.3 An individual must be at least 18 years old to become a Member of the Foundation Trust.

11.4 An individual shall not become or continue as a Member of the Foundation Trust if:

11.4.1 he/she has been confirmed as an habitual and/or vexatious complainant in accordance with the Foundation Trust's policy for handling complaints; or

11.4.2 he/she has been deemed to have acted in a manner detrimental to and

contrary to the interests and values of the Foundation Trust or has failed to agree to and abide by the values of the Foundation Trust.

12 Expulsion from Membership

12.1 If a Member is found to be in contravention of paragraph 11 above, a resolution to expel them shall be considered by a committee comprising the Chair, the Lead Governor and the Secretary.

12.2 The committee (as set out above) shall consider the complaint, taking such steps as it considers appropriate to ensure that the Member's point of view is heard.

12.3 Where a Member is deemed by the committee to be in contravention of paragraph 11, the Member shall be suspended immediately and the committee's recommendation shall be taken to the next general meeting of the Council of Governors for approval. The Member shall be duly informed.

12.4 At the general meeting of the Council of Governors at which the committee's recommendation to expel a Member is considered, the Council of Governors shall be at liberty to either:

12.4.1 agree with the committee's recommendation, by a three quarters majority vote of those Governors present, and expel the Member immediately; or

12.4.2 remove the Member's suspension with immediate effect should the Council of Governors not agree with the committee's recommendation.

12.5 In either case, the Member shall be duly informed of the decision of the Council of Governors.

12.6 No person who has been expelled from Membership in accordance with these provisions shall be re-admitted as a Member except by a resolution carried by the votes of three quarters of the members of the Council of Governors present and voting at a general meeting in favour of the individual concerned being re-admitted.

13 Termination of Membership

13.1 A Member shall cease to be a Member on:

13.1.1 death; or

13.1.2 resignation by notice in writing to the Secretary;

13.1.3 ceasing to fulfil the requirements of paragraphs 8, 9 or 11 of this Constitution or being expelled in accordance with in paragraph 12 above.

14 Council of Governors – composition

14.1 The Foundation Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

14.2 The composition of the Council of Governors is specified in Annex 3.

14.3 The members of the Council of Governors, other than the Appointed Governors, shall

be chosen by election by their constituency.

14.4 The number of Governors to be elected by each constituency is specified in Annexes 1 and 2.

14.5 More than half of the members of the Council of Governors shall be Governors from the Public Constituency.

15 Council of Governors – election of Governors

15.1 Elections for elected members of the Council of Governors shall be conducted using the first past the post method in accordance with the Model Election Rules.

15.2 The Model Election Rules, as published from time to time by the Department of Health and which may be varied from time to time, form part of the Constitution. The current Model Election Rules are attached at Annex 4.

15.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of the Constitution for the purposes of paragraph 53 of this Constitution (Amendment of the Constitution).

15.4 An election, if contested, shall be by secret ballot.

15.5 A person may not vote at an election or stand for election as an Elected Governor unless, within the specified period in the Model Election Rules, he/she has made a declaration in the form specified in paragraph 15.6. It is an offence to knowingly or recklessly make a declaration which is false in a material particular.

15.6 The specified form of declaration referred to in paragraph 15.5 above regarding the declaration to stand for election as an Elected Governor shall be as set out on the nomination paper referred to in rule 12 of the Model Election Rules and shall also state as follows:

15.7 *"I declare that, to the best of my knowledge, I am eligible to stand for election to the Council of Governors for the seat named in Section 2 of this form. I declare that, to the best of my knowledge, I am not de-barred from standing for election by any of the provisions detailed at Section 3 of this form. I declare that I have stated details of any political membership and financial interests I have in the Foundation Trust at Section 4 of this form. I declare that I am a member of the Foundation Trust and that I have attended a pre-election Governor awareness training session or equivalent, as agreed by the Company Secretary. I understand that if any of these declarations are later found to be false, I will, if elected, lose my seat on the Council of Governors and may also have my Membership withdrawn."*

16 Council of Governors – vacancies

16.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of a term of office, the provisions set out below will apply.

16.2 Where the vacancy arises amongst the Elected Governors, the Council of Governors shall be at liberty either:

16.2.1 to call an election to fill the remainder of the unexpired term of office where it is in excess of one year; or

16.2.2 to invite the next highest polling candidate for that seat at the most recent election or (where relevant) by-election, who is willing to take office, to fill the seat for the remainder of the unexpired term of office where it is in excess of one year. If that candidate does not accept to fill the vacancy, it may be offered to the next highest polling candidate until the vacancy is filled; or

16.2.3 where no reserve candidate is available or willing to fill the vacancy, to call an election; or

16.2.4 to leave the seat vacant until the next scheduled elections are to be held where the unexpired term of office is one year or less.

16.3 When deciding on a course of action, the Council of Governors must always ensure that the aggregate number of Governors who are Public Governors on the Council of Governors always remains in the majority.

16.4 Where the vacancy arises amongst the Appointed Governors, the Secretary will request the relevant Partnership Organisation to appoint a Replacement Governor, in line with the eligibility criteria set out for Governors at paragraph 18 and Annex 5, to hold office for the remainder of the unexpired term of office. The Partnership Organisation shall agree the appointment of a Replacement Governor with the Secretary within three months of being notified.

16.5 The validity of any act of the Council of Governors is not affected by any vacancy among the Governors or by any defect in the appointment of any Governor.

16.6 Where a vacancy arises on the Council of Governors amongst the Public Governors for reason of the expiry of a term of office, the provisions relating to such a vacancy set out in Annex 3 will apply.

17 Council of Governors – tenure

17.1 All governors may hold office for a term of up to three years

17.2 All governors may hold office for a maximum of two terms

17.3 A governor shall be eligible for re-election or re-appointment at the end of his/her term subject to 17.2 (above)

17.4 An Elected Governor shall cease to hold office if he/she ceases to be a member of the constituency by which he/she was elected.

17.5 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her.

17.6 Any Governor shall cease to hold office if he/she is disqualified for any of the reasons set out in the constitution.

18 Council of Governors – disqualification and removal

18.1 In line with section 11.1, an individual who is a member of a constituency shall not, while membership of that constituency continues, be a member of any other constituency. In addition, the following may not become or continue as a member of the Council of Governors:

18.1.1 He/she is a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

18.1.2 in the case of an Elected Governor, he/she ceases to be a Member of the relevant constituency by which he/she was elected;

18.1.3 in the case of an Appointed Governor, the appointing organisation withdraws their sponsorship of him/her;

18.1.4 he/she is under 18 years of age at the date at which he/she is nominated for election or appointment;

18.1.5 he/she is a Director of the Foundation Trust, or an executive director, non-executive director or Chair of another NHS foundation trust, or other Health Service Body (unless they are appointed by an appointing organisation which is an NHS body);

18.1.6 he/she is a governor of another NHS foundation trust and there presents a conflict of interest with the affairs of the Foundation Trust which cannot be resolved;

18.1.7 he/she has been a Director of the Foundation Trust in the preceding five years prior to the date of his/her nomination to stand as an Elected Governor, or in the case of an Appointed Governor, the date of his/her appointment;

18.1.8 subject to paragraphs 18.7 and 18.8 below, he/she is incapable by reason of his/her mental disorder, illness or injury of managing and/or administering his/her property and/or affairs;

18.1.9 prior to putting himself/herself forward for consideration as an Elected Governor or Appointed Governor, he/she has

- failed to register as a member of the Foundation Trust
- has registered but failed to allow sufficient time for his/her application to be processed (ie. five working days) prior to the date of a governor awareness training session (pre-election event);
- failed to attend a pre-election or pre-appointment governor awareness training event, the purpose of which is to ensure that prospective Governors are made fully aware of the responsibilities and duties of a Governor and the commitments that the role entails, prior to the individual standing for office as a Governor;

18.1.10 he/she has refused, without reasonable cause, to undertake any training which the Foundation Trust and/or Council of Governors requires all Governors to undertake;

18.1.11 he/she is a person who, by reference to information revealed by a Disclosure and Barring Service check, is considered by a committee comprising the Chair, Lead Governor and Secretary to be inappropriate on the grounds that his/her appointment might adversely affect public confidence in the Foundation Trust or otherwise might bring the Foundation Trust into disrepute;

18.1.12 he/she has failed any other relevant identity or other check carried out by the Foundation Trust;

18.1.13 he/she has failed to sign and deliver to the Secretary a statement in the form required by the Foundation Trust confirming acceptance of the Governors' Code of Conduct;

18.1.14 he/she has failed to make, or falsely makes, any declaration required by paragraph 15.6 of this Constitution;

18.1.15 he/she has been declared by the Council of Governors to be an habitual and/or vexatious complainant;

18.1.16 the relevant Partnership Organisation which he/she represents ceases to exist;

18.1.17 he/she has been expelled or removed from the post of governor from the ~~f~~Foundation ~~t~~Trust or another NHS foundation trust; or

18.1.18 he/she is an active member of a body or organisation with policies or objectives such that his/her membership thereof would likely cause the Foundation Trust to be in breach of its statutory obligations or to bring the Foundation Trust into disrepute.

18.2 Further circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

18.3 Where a person has been elected or appointed to be a Governor and he/she becomes disqualified under provisions set out paragraph 18 or Annex 5, he/she shall notify the Secretary in writing of such disqualification as soon as is practicable and, in any event, within ten Clear Days of first becoming aware of those matters which rendered him/her disqualified.

18.4 If it comes to the notice of the Secretary at the time of his/her taking office or later that the Governor is so disqualified, the Secretary shall immediately declare that the Governor in question is disqualified and notify him/her in writing to that effect as soon as is practicable.

18.5 Upon dispatch of any such notification, a Governor's tenure of office, if any, shall be terminated immediately and the Secretary shall cause his/her name to be removed from the register of members of the Council of Governors. From that point, the individual shall immediately cease to be or act as a Governor.

18.6 If a Governor is found to be incapable, by reason of mental disorder, illness or injury, of managing and/or administering his/her property and/or affairs for the purposes of paragraphs 18.1.8 above, a committee comprising the Chair, Secretary, and Lead Governor shall be convened.

18.7 The committee (as set out above) shall consider the Governor's circumstances, taking such steps as it considers appropriate to ensure that the Governor's views are understood.

18.8 Where the committee deems that the Governor is incapable, by reason of mental disorder, illness or injury, of managing and/or administering his/her property and/or affairs, he/she shall be immediately suspended from office. The Governor shall be duly

informed.

18.9 The committee shall make a recommendation to the next general meeting of the Council of Governors that the Council of Governors should either:

18.9.1 temporarily suspend the Governor from office until such time the Council of Governors, in its absolute discretion, considers the Governor to be capable of managing and/or administering his/her property and/or affairs; or

18.9.2 disqualify the Governor from office where the Council of Governors in its absolute discretion, considers him/her to be incapable of managing and/or administering his/her property and affairs.

18.10 At the general meeting of the Council of Governors at which the committee's recommendations are considered, a resolution shall be approved by not less than three quarters of the members of the Council of Governors present and voting, to either:

18.10.1 temporarily suspend the Governor from office for an agreed, specified period; or

18.10.2 disqualify the Governor from office; or

18.10.3 remove the suspension of the Governor, should the Council of Governors not agree with the committee's recommendation.

18.11 In considering whether an individual is incapable by reason of mental disorder, illness or injury of managing and/or administering his/her property and/or affairs, the committee (described above) shall take into account the provisions of the Mental Capacity Act 2005, or any statutory modification thereof, and shall be entitled to take appropriate professional advice from internal Foundation Trust advisors and/or external advisors as necessary.

18.12 If a Governor fails to attend three consecutive meetings of the Council of Governors in any Financial Year, his/her tenure of office is to be terminated immediately unless the Council of Governors is satisfied by a three quarters majority of those members of the Council of Governors present and voting at a meeting of the Council of Governors that:

18.12.1 the absence was due to a reasonable cause; and

18.12.2 the Governor will be able to start attending meetings of the Council of Governors again within such a period as the other Governors consider reasonable.

18.13 Notwithstanding the provisions of paragraph 18.12 above, if a Governor fails to attend three out of four consecutive meetings of the Council of Governors and he/she has previously been the subject of a decision in his/her favour under paragraph 18.10 above, the Governor's tenure of office is to be terminated immediately.

18.14 A Governor shall vacate his/her office immediately if:

18.14.1 he/she is considered to have acted in a manner inconsistent with the values of the Foundation Trust or in a manner detrimental to or contrary to:

18.14.1.1 the interests of the Foundation Trust; or

18.14.1.2 the Licence; or

18.14.1.3 the Governors' Code of Conduct; or

18.14.2 he/she has failed to declare an interest as required by the Constitution or he/she has spoken or voted at a meeting on a matter in which he/she has an interest contrary to the Constitution. For the purpose of this paragraph, "interest" includes a relevant and material interest, or a pecuniary, personal or family interest, whether that interest is actual or potential and whether than interest is direct or indirect; or

18.14.3 he/she is adjudged to have acted in a manner inconsistent with the values of the Foundation Trust or in a manner detrimental to it by a majority of not less than three quarters of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

18.15 A Governor whose office is terminated subject to ~~the~~ paragraph~~s~~ 18.14 above shall not be eligible to stand for re-election or re-appointment to the Council of Governors for a period of three years from the date of his/her removal from office or the date on which any appeal against his/her removal from office is disposed of, whichever is the later.

18.16 A Governor may resign from office at any time during the term of that office by giving notice in writing to the Secretary. Where possible and appropriate, a resigning Governor should agree a notice period with the Secretary prior to resigning from office.

18.17 If the Chair considers that the grounds for removal set out in paragraphs 18.1, 18.2 or 18.14 may apply to a Governor, the Chair may immediately suspend the Governor for a period to be determined by the Chair,

~~**18.16**~~**18.18** A Governor may not stand for re-election or be reappointed while they are suspended in accordance with this paragraph 18.

19 Council of Governors – duties of Governors

19.1 The general duties of the Council of Governors are:

19.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

19.1.2 to represent the interests of the Members of the Foundation Trust as a whole and the interests of the public.

20 Council of Governors – skills and knowledge

20.1 The Foundation Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as Governors.

21 Council of Governors – meetings of Governors

Admission of the Public

21.1 Meetings of the Council of Governors shall be open to members of the public. Members

of the public and representatives of the press may be excluded from a meeting for special reasons as set out in Annex 6.

Calling Meetings

21.2 Subject to paragraph 29 below, the Council of Governors is to meet at least four times per year. Meetings are to be held at such times and places as the Council of Governors may determine.

21.3 One of the Council of Governors' meetings shall be an annual meeting held no later than 30 September in each year when the Council of Governors is to receive and consider the Annual Accounts and any report of the Auditor on them and the Board of Directors is to present to the Council of Governors the Annual Report (the "Annual Governors' Meeting").

21.4 For the purposes of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting of the Council of Governors.

21.5 The Council of Governors may invite the Chief Executive, members of the Board of Directors or a representative of the Auditor or other advisors to attend and speak at a meeting of the Council of Governors.

21.6 The Chair of the Foundation Trust may, in exceptional circumstances, call a meeting of the Council of Governors at any time. ~~after a requisition for that purpose, signed by at least half of the whole number of Governors, has been presented to him/her at the Foundation Trust headquarters. If the Chair does not call a meeting within ten Clear Days after such a requisition has been presented to him/her, half the Governors or more may call a meeting.~~If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of members of the Council of Governors, or if without so refusing the Chair does not call a meeting within fourteen days after a requisition to do so, then the members of the Council of Governors may forthwith call a meeting provided they have been requisitioned to do so by more than 50% of the members of the Council of Governors.

Notice of meetings and agenda

21.7 Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine.

21.8 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Governor, by post or electronically.

21.9 Agendas shall be sent to Governors five Clear Days before the meeting and supporting papers, whenever possible, shall be despatched no later than three Clear Days before the meeting, save in an emergency and with the agreement of the Chair.

21.10 In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Governors and no such business shall be transacted at the meeting other than that specified in the notice.

21.11 Want of service of the notice on any Governor shall not affect the validity of the meeting. A notice of the meeting shall be presumed to have been served one day after posting or, in the case of a notice being sent electronically, on the date of transmission.

21.12 The Council of Governors shall agree the dates of general meetings of the Council of Governors in advance which shall be publicised through reasonable and appropriate means.

Conduct of meetings

21.13 The Chair of the Foundation Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 34 below) or, in his/her absence the Deputy Chair (appointed in accordance with the provisions of paragraph 36 below), or in his/her absence one of the Non-Executive Directors shall preside at meetings of the Council of Governors and be the Meeting Chair.

21.14 If the Meeting Chair has a conflict of interest in relation to the business being discussed, then the Deputy Chair shall chair that part of the meeting. Should the Deputy Chair not be present then one of the other non-executive directors shall chair that part of the meeting.

21.15 Governors' behaviour at meetings (and generally as a representative of the Foundation Trust) is expected to be exemplary. Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion and the decision of the Meeting Chair on questions of order, relevancy, regularity and any other matters shall be final.

21.16 The names of the Meeting Chair and Governors present at the meeting shall be recorded in the minutes.

Voting

21.17 Every question at a meeting of the Council of Governors shall be determined by a majority of votes of the Governors present and qualified to vote. In the case of the number of votes for and against a motion being equal, the Meeting Chair shall have a casting vote.

21.18 Every Governor must make an annual declaration that he is qualified to vote at meetings of the Council of Governors. He/she will do so in the form specified below:

Declaration to the Secretary of the Queen Victoria Hospital NHS Foundation Trust

Elected Governors

"I hereby declare that I am, at the date of this declaration, a member of the [Public / Staff] Constituency, and I am not prevented from being a member of the Council of Governors by reason of any provision of paragraph 8 of Schedule 7 to the 2006 Act or the Constitution."

Appointed Governors

"I hereby declare that I am at the date of this declaration a properly Appointed Governor and I am not prevented from being a member of the Council of Governors by reason of

any provision of paragraph 8 of Schedule 7 to the 2006 Act or the Constitution."

21.19 A Governor may not vote at a meeting of the Council of Governors unless, prior to the meeting, he/she has made the declaration referred to in paragraph 21.19 above.

21.20 Each Governor must also notify the Secretary as soon as possible and provide a further declaration at any subsequent meeting if his/her circumstances have changed.

21.21 All Governors shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of Governors.

21.22 All questions put to the vote shall, at the discretion of the Meeting Chair, be determined by oral expression or by a show or hands. A paper ballot may be used if the majority of Governors present so request.

21.23 If half of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

21.24 If a Governor so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

21.25 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

Electronic Communication

21.26 The Council of Governors may agree that Governors can participate in its meetings by telephone, video or computer link or other such agreed means. Participation in a meeting in this manner shall be deemed exceptional but shall constitute presence in person at the meeting. Express approval from the Meeting Chair must be sought in advance.

21.27 Further provisions which apply in these circumstances are set out in Annex 7.

Content and length of speeches

21.28 Approval to speak at meetings shall be given by the Meeting Chair. This includes Governors, Members, members of the public or press, Officers or any other person in attendance at a meeting.

21.29 Speeches must be directed to the matter, motion or question under discussion or to a point of order.

21.30 Unless, in the opinion of the Meeting Chair, it would not be desirable or appropriate to limit speeches on any topic to be discussed, having regard to its nature complexity or importance, no proposal, speech nor any reply, may exceed three minutes.

21.31 In the interests of time, the Meeting Chair may, in his/her absolute discretion, limit the number of replies, questions or speeches which are heard at any one meeting.

Quorum

21.32 Any meeting of the Council of Governors requires a quorum of at least half of the total number of Governors to be present, with a majority of those present being Public Governors.

21.33 No business shall be carried out at a meeting which is not quorate.

21.34 If the Meeting Chair or a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (paragraphs 22, 40 and Annex 8), he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next agenda item.

21.35 If at any meeting of the Council of Governors, there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for a period of at least five Clear Days. The Secretary shall give notice of the date, time and place of the adjourned meeting and, notwithstanding paragraph 21.34 above, upon re-convening, those present shall constitute a quorum.

Committees and groups

21.36 The Council of Governors may appoint committees or groups consisting of its members to assist it in carrying out its functions but may not delegate any of its powers or functions to them. A committee or group so appointed may appoint its own working groups.

21.37 These committees or groups may include Directors or Officers of the Foundation Trust and/or outside advisors to help them in their tasks.

22 Council of Governors – Conflicts of interest of Governors

22.1 If a Governor has a relevant and material interest, or a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose the nature and extent of that interest to the members of the Council of Governors as soon as he/she becomes aware of it.

22.2 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, the Governor must make a further declaration before the Foundation Trust enters into the transaction or arrangement.

22.3 This paragraph does not require a declaration of an interest of which the Governor is not aware or where the Governor is not aware of the transaction or arrangement in question.

22.4 A Governor need not declare an interest if:

22.5 it cannot reasonably be regarded as likely to give rise to a conflict of interest; or

22.6 to the extent that the Governors are already aware of it.

22.7 Any interests raised by the Governors in this way shall be recorded in the register of

interests of the Governors.

22.8 Further provisions as to the circumstances in which a Governor must declare a conflict of interest are set out in Annex 8.

23 Council of Governors – remuneration, travel and other expenses

23.1 Governors are not to receive remuneration from the Foundation Trust provided that this shall not prevent remuneration of Governors by their employer.

23.2 Subject to any Foundation Trust policy on the payment of expenses, the Foundation Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Foundation Trust. These shall be published in the Annual Report.

24 Referral to Monitor's panel for advising Governors

24.1 In this paragraph, the "Panel" means a panel of persons appointed by Monitor to which a Governor of the Foundation Trust may refer a question as to whether the Foundation Trust has failed or is failing:

24.1.1 to act in accordance with the Constitution; or

24.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

24.2 A Governor may refer a question to the panel only if more than half of the members of the Council of Governors present and voting approve the referral at a general meeting of the Council of Governors.

25 Governors' Steering ~~Group~~ Committee (GSc~~G~~)

25.1 The purpose of the Governors' Steering Committee~~Group~~ is to:

25.1.1 support and facilitate the work of the Council of Governors and make recommendations to it on any aspects of its work;

25.1.2 facilitate communication between the Council of Governors and the Board of Directors;

25.1.3 provide advice and support to the Chair, Chief Executive and the Secretary;

25.1.4 initiate appropriate reviews and reports on matters within the remit of the Council of Governors; and

25.1.5 actively engage the Governors in adding value to the Foundation Trust.

25.2 The GSC~~G~~ shall have authority to form working groups to facilitate the work of the GSC~~G~~ and to support any recommendations it may make to the Council of Governors.

25.3 The GSC~~G~~ shall meet as regularly as it considers necessary to fulfil its obligations. It shall report to the Council of Governors as required.

25.4 Members of the GSC~~G~~ shall be chosen by the Council of Governors and the GSC~~G~~

shall be chaired by the ~~Vice-Chair of the Council of Governors~~Lead Governor.

25.5 The GS~~c~~C shall invite others to attend its meetings as it considers appropriate and as the need arises.

26 Lead Governor

26.1 In accordance with a process approved by the Chair after consulting the Council of Governors, the Secretary will administer the nomination procedure for a Lead Governor.

26.2 The Council of Governors may appoint a Deputy Lead Governor. The secretary will administer the nomination procedure for a Deputy Lead Governor.~~(not used)~~

26.3 (not used)

27 Meeting of the Council of Governors to consider the Annual Accounts and Reports

27.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors (the "Annual Governors' Meeting"):

27.1.1 the Annual Accounts;

27.1.2 any report of the Auditor on them; and

27.1.3 the Annual Report.

28 Annual Members' Meeting

28.1 The Foundation Trust shall hold an annual meeting of its Members (the "Annual Members' Meeting"). The Annual Members' Meeting shall be open to all members of the public.

28.2 In addition to the obligations set out in paragraph 28.3 below, the Council of Governors shall present to each Annual Members' Meeting:

28.2.1 a report on steps taken to secure that, taken as a whole, the actual Membership of the Public Constituency is representative of those eligible for such Membership;

28.2.2 the progress of the Membership Strategy; and

28.2.3 any changes to the Membership Strategy.

28.3 At least one member of the Board of Directors must attend each Annual Members' Meeting and present the following documents:

28.3.1 the Annual Accounts;

28.3.2 any report of the Auditor on them;

28.3.3 the Annual Report.

29 Combined Meetings of Members and Governors

29.1 The Foundation Trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 27.1 above with the Annual Members' Meeting (paragraph 28).

30 Special Members' Meetings

30.1 Notwithstanding any provisions contained in this Constitution regarding meetings of the Council of Governors, the Annual Members' Meetings or meetings of the Board of Directors, the Board of Directors or the Council of Governors may resolve to call special meetings of the Foundation Trust for the benefit of its Members (a "Special Members' Meeting") for the purpose of providing Members with information and to offer Members an opportunity to provide feedback to the Foundation Trust.

30.2 Special Members' Meetings are open to all Members of the Foundation Trust, Governors, Directors and representatives of the Auditor and any external consultant as well as members of the general public and representatives of the press unless determined otherwise.

30.3 Notwithstanding the provisions of paragraph 30.2 above, the Board of Directors or Council of Governors may invite to attend a Special Members' Meeting any experts or advisors whose attendance they consider to be in the best interests of the Foundation Trust.

30.4 Arrangements for the Special Members' Meeting shall be carried out in accordance with arrangements for meetings of the Council of Governors except that the quoracy shall be as follows:

30.4.1 Chair (or Deputy Chair);

30.4.2 at least one Member from the Staff Constituency; and

30.4.3 at least one Member from the Public Constituency.

31 Board of Directors – composition

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

31.2 The Board of Directors is to comprise:

31.2.1 the following Non-Executive Directors:

31.2.1.1 a Chair; and

31.2.1.2 at least four other Non-Executive Directors.

31.2.2 the following Executive Directors:

31.2.2.1 a Chief Executive (who shall be the Accounting Officer);

31.2.2.2 a Finance Director; and

31.2.2.3 at least two other Executive Directors.

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

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

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

31.6 The validity of any act of the Foundation Trust is not affected by any vacancy among the Directors or by any defect in the appointment of any Directors.

32 Board of Directors – general duty

32.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Foundation Trust so as to maximise the benefits for the Members of the Foundation Trust as a whole and for the public.

33 Board of Directors – qualification for appointment as a Non-Executive Director

33.1 A person may be appointed as a Non-Executive Director only if he/she:

33.1.1 is a Member of the Public Constituency, and

33.1.2 he/she is not disqualified by virtue of paragraph 38 or Annex 5 below.

34 Board of Directors – appointment of the Chair and other Non-Executive Directors

34.1 The Council of Governors at a general meeting of the Council of Governors shall appoint the Chair of the Foundation Trust and the other Non-Executive Directors, taking into account the views of the Board of Directors on the qualities, skills and experience required for each position.

34.2 The Chair and the Non-Executive Directors shall be appointed for a period of office of up to three years. Any term beyond six years will be subject to annual re-appointment.

34.3 Non-Executive Directors shall be appointed in accordance with a process agreed by the Appointments Committee on behalf of the Council of Governors.

34.4 An existing Non-Executive Director, nearing the end of his/her term, shall be considered for a further term of office, subject to the following:

34.4.1 a satisfactory appraisal that he/she continues to be effective;

34.4.2 he/she continues to demonstrate commitment to the role;

34.4.3 he/she is willing to complete a further term of office;

34.4.4 he/she is not precluded by paragraph 34.2 by virtue of time already served as a Non-Executive Director.

34.5 Should the Appointments Committee decide to advertise externally for a Non-Executive Director, a specification shall be drawn up and approved by the Appointments Committee that shall set out the personal and professional qualities needed.

34.6 Where paragraph 34.5 applies, the Appointments Committee shall follow a process which involves advertising for the vacancy, shortlisting against the specification and interviewing candidates. In the case of appointing a Non-Executive Director, the interview panel will include at least one Public Governor and the Chair. In the case of appointing the Chair, the interview panel will include at least one Public Governor and the Senior Independent Director.

34.7 Recommendations for appointment shall be taken to the next general meeting of the Council of Governors for formal appointment.

35 Board Directors – suspension and removal of the Chair and other Non-Executive Directors

35.1 Removal of the Chair or another Non-Executive Director shall require the approval of three quarters of the members of the Council of Governors.

35.2 During any meeting of the Council of Governors at which the Chair may be suspended or removed, the Senior Independent Director shall preside, or if the Senior Independent Director is absent from the meeting or is absent temporarily on the grounds of a conflict of interest, another Non-Executive Director shall preside.

35.3 Suspension or removal of the Chair or another Non-Executive Director shall require a resolution to be submitted by three quarters of the members of the Council of Governors and sponsored by at least one Governor.

35.4 The Governor sponsoring the resolution shall set out in writing the reasons in support of the resolution. At the meeting of the Council of Governors where the resolution is to be considered and voted upon, the Chair or other Non-Executive Director, who is the subject of the resolution, shall be given the opportunity to respond to the reasons given. If the individual fails to attend the meeting without due cause, the meeting may proceed in their absence. The decision to proceed in these circumstances shall be at the sole discretion of the Meeting Chair.

35.5 In making the decision to remove the Chair or another Non-Executive Director, the Council of Governors shall take into account the results of the annual appraisal concerning the individual in question. The Council of Governors shall also remove or suspend a Non-Executive Director in consultation with the Chair (if the matter concerns another Non-Executive Director) or the Senior Independent Director (if the matter concerns the Chair).

35.6 If any resolution to suspend or remove either the Chair or another Non-Executive Director is not approved at the meeting of the Council of Governors where the matter was considered, no further resolution can be put forward to suspend or remove such Non-Executive Director, or the Chair, which is based on the same reasons, within twelve calendar months of the date of the meeting at which the resolution was considered.

35.7 Suspension is a temporary measure which shall be used to prevent the Chair or a Non-Executive Director from exercising his or her functions pending the completion of an investigation or removal from office.

35.8 The Council of Governors may use the power of suspension in the following circumstances:

35.8.1 where the Foundation Trust is in receipt of information which gives cause for concern about the Chair or a Non-Executive Director continuing to hold office because of its effect on the reputation of the Trust or on the integrity of the individual in question;

35.8.2 where there is sufficient evidence to warrant removal from office but before removal takes effect; or

35.8.3 where there is an allegation of fraud or other impropriety or other alleged misconduct that would require the Chair or a Non-Executive Director to be suspended to protect patients, staff or public funds.

36 Board of Directors – appointment of the Senior Independent Director and Deputy Chair

36.1 A Senior Independent Director shall be appointed by the Board of Directors in consultation with the Council of Governors.

36.2 A Non-Executive Director appointed as the Senior Independent Director shall be the Senior Independent Director for a period consistent with his/her existing term of office as a Non-Executive Director.

36.3 Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Secretary.

36.4 The Senior Independent Director may also fulfil the role of the Deputy Chair.

36.5 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive Directors as Deputy Chair, who may be the Senior Independent Director.

36.6 If the Chair is unable to discharge his/her functions as a Chair of the Foundation Trust, the Deputy Chair will be the “acting Chair” until such time as the Chair is able to discharge his/her functions as Chair or a new Chair is appointed by the Council of Governors in accordance with paragraph 34 above.

37 Board of Directors – appointment and removal of the Chief Executive and other Executive Directors

37.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

37.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

37.3 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

37.4 The Foundation Trust shall establish a committee of Non-Executive Directors and the

Chief Executive to decide the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors (the "Nomination and Remuneration Committee"). When deciding the remuneration and allowances, and the other terms and conditions of office of the Chief Executive, the membership of the Nomination and Remuneration Committee shall not include the Chief Executive.

38 Board of Directors - disqualification

38.1 The following may not become or continue as a member of the Board of Directors:

38.1.1 either:

a. an executive or non-executive director or governor of another NHS foundation trust, or

b. an executive or non-executive director of another Health Service Body, or

c. an executive or non-executive director of a body corporate

which presents a conflict of interest with the affairs of the Foundation Trust which cannot be resolved;

38.1.2 someone who is incapable by reason of his/her mental disorder, illness or injury of managing and/or administering his/her property and/or affairs. In considering whether an individual is incapable by reason of mental disorder, illness or injury of managing and/or administering his/her property and/or affairs, the provisions of the Mental Capacity Act 2005, or any statutory modification thereof, shall be taken into account. Further internal or external advice shall be sought where necessary;

38.1.3 an individual who has refused, without reasonable cause, to fulfil any training requirement established by the Board of Directors;

38.1.4 a person who is the subject of a disqualification order made under the Company Directors' Disqualification Act 1986;

38.1.5 on the basis of disclosures obtained through an application to the Disclosure and Barring Service, he/she is not considered suitable by the Chair; or

38.1.6 someone who has failed to sign and deliver to the Secretary a statement in the form required by the Foundation Trust confirming acceptance of the Directors' Code of Conduct.

38.2 Further circumstances in which an individual may not become or continue as a member of the Board of Directors are set out in Annex 5.

39 Board of Directors – meetings

39.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public and representatives of the press may be excluded from a meeting for special reasons as set out in Annex 6.

39.2 The Board of Directors may agree that Directors can participate in its meetings by

telephone, video or computer link or other such agreed means. Participation in a meeting in this manner shall be deemed exceptional but shall constitute presence in person at the meeting.

39.3 Further provisions which apply in these circumstances are set out in Annex 7.

39.4 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

39.5 In the case of an equality of votes at a meeting of the Board of Directors, the Chair (or Meeting Chair as may be) shall have a casting vote.

39.6 (not used)

40 Board of Directors – Conflicts of interests of Directors

40.1 The duties that a Director of the Foundation Trust has by virtue of being a Director include in particular:

40.1.1 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;

40.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

40.2 The duty referred to in sub-paragraph 40.1.1 is not infringed if:

40.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

40.2.2 the matter has been authorised in accordance with the Constitution.

40.3 The duty referred to in sub-paragraph 40.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

40.4 In sub-paragraph 40.1.2, "third party" means a person other than:

40.4.1 the Foundation Trust; or

40.4.2 a person acting on its behalf.

40.5 If a Director of the Foundation Trust has in any way a relevant and material interest or a direct or indirect interest in a proposed transaction or arrangement with the Foundation Trust, the Director must declare the nature and extent of that interest to the other Directors. This shall be recorded in the register of interests of the Directors.

40.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

40.7 Any declaration required by this paragraph must be made before the Foundation Trust enters into the transaction or arrangement.

40.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

40.9 A Director need not declare an interest:

40.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

40.9.2 if, or to the extent that, the Directors are already aware of it;

40.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered by:

40.9.3.1 a meeting of the Board of Directors; or

40.9.3.2 a committee of the Directors appointed for the purpose under the Constitution.

40.10 Any interests raised by the Directors in this way shall be recorded in the register of interests of the Directors.

40.11 A matter shall have been authorised for the purposes of paragraph 40.2.2 if:

40.11.1 The Directors, in accordance with the requirements set out in this paragraph [40.11], authorise any matter or situation proposed to them by any Director which would, if not authorised, involve a Director (an "Interested Director**"**) breaching his/her duty under paragraph 40.1.1 above to avoid conflicts of interest (a "Conflict**"**).

40.11.2 Any authorisation under this paragraph will be effective only if:

40.11.2.1 the matter in question shall have been proposed by any Director for consideration in the same way that any other matter may be proposed to the Directors under the provisions of this Constitution or in such other manner as the Directors may determine;

40.11.2.2 any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interested Director; and

40.11.2.3 the matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

40.11.3 Any authorisation of a Conflict under this paragraph may (whether at the time of giving the authorisation or subsequently):

40.11.3.1 extend to any actual or potential conflict of interest which may reasonably be expected to arise out of the Conflict so authorised;

40.11.3.2 provide that the Interested Director be excluded from the receipt of documents and information and the participation in discussions (whether at meetings of the Directors or otherwise) related to the Conflict;

40.11.3.3 provide that the Interested Director shall or shall not be an eligible Director in respect of any future decision of the Directors in relation to any resolution related to the Conflict;

40.11.3.4 impose upon the Interested Director such other terms for the purposes of dealing with the Conflict as the Directors think fit

40.11.3.5 provide that, where the Interested Director obtains, or has obtained (through his/her involvement in the Conflict and otherwise than through his/her position as a Director of the Foundation Trust) information that is confidential to a third party, he/she will not be obliged to disclose that information to the Board of Directors, or to use it in relation to the Foundation Trust's affairs where to do so would amount to a breach of that confidence; and

40.11.3.6 permit the Interested Director to absent himself/herself from the discussion of matters relating to the Conflict at any meeting of the Directors and be excused from reviewing papers prepared by, or for, the Directors to the extent they relate to such matters. Where the Directors authorise a Conflict, the Interested Director will be obliged to conduct himself/herself in accordance with any terms imposed by the Directors in relation to the Conflict.

40.11.4 Where the Directors authorise a Conflict, the Interested Director shall be obliged to conduct himself/herself in accordance with any terms imposed by the Directors in relation to the Conflict.

40.11.5 The Directors may revoke or vary such authorisation at any time, but this will not affect anything done by the Interested Director, prior to such revocation or variation in accordance with the terms of such authorisation.

40.11.6 A Director is not required, by reason of being a Director to account to the Foundation Trust for any remuneration, profit or other benefit which he/she derives from or in connection with a relationship involving a Conflict which has been authorised by the Directors (subject in each case to any terms, limits or conditions attaching to that authorisation) and no contract shall be liable to be avoided on such grounds.

40.12 Subject to paragraph 40.13 below if a question arises at a meeting of Directors or of a committee of Directors as to the right of a Director to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting, be referred to the Chair whose ruling in relation to any Director other than the Chair is to be final and conclusive.

40.13 If any question as to the right to participate in the meeting (or part of the meeting) should arise in respect of the Chair, the question is to be decided by a decision of the

Directors (other than the Chair) at that meeting, for which purpose the Chair is not to be counted as participating in the meeting (or that part of the meeting) for voting or quorum purposes.

40.14 Further provisions as to the circumstances in which a Director must declare a conflict of interest are set out in Annex 8.

41 Board of Directors – remuneration and terms of office

41.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors. These shall be published in the Annual Report.

41.2 Subject to any Foundation Trust policy on the payment of expenses, the Foundation Trust may pay travelling and other expenses to members of the Board of Directors at rates determined by the Foundation Trust.

42 Registers

42.1 The Foundation Trust shall have:

42.1.1 a register of Members showing, in respect of each Member, the constituency to which he/she belongs;

42.1.2 a register of members of the Council of Governors;

42.1.3 a register of interests of the Governors;

42.1.4 a register of Directors; and

42.1.5 a register of interests of the Directors.

42.2 The Secretary shall be responsible for compiling and maintaining the registers which may be kept in either paper or electronic form. Admission to or removal from any register shall be in accordance with the provisions of this Constitution. The Secretary shall update registers with new or amended information as soon as is practical.

43 Admission to and removal from the registers

Register of Members

43.1 The Secretary shall maintain a register of Members in two parts.

43.2 Part one, which shall be the register referred to in the 2006 Act, shall include the name of each Member and the Constituency to which they belong and this shall be open to inspection by the public in accordance with paragraph 45 below.

43.3 Part two shall contain all the information from the application referred to in paragraph 7 and shall not be open to inspection by the public nor may copies or extracts from it be available to any third party (save to the extent that copies or extracts from it be made available to any third party appointed to the Foundation Trust to maintain the register of the Members and to conduct elections in accordance with the provisions of paragraph 15).

43.4 Notwithstanding the provisions of paragraphs 44.1 to 44.3 (inclusive), the Foundation Trust shall extract such information as it needs in aggregate to satisfy itself that the actual Membership of the Foundation Trust's Public Constituency is representative of those eligible for Membership and for the administration of the provisions of this Constitution.

Register of members of the Council of Governors

43.5 The register of members of the Council of Governors shall list:

43.5.1 the name of each Governor;

43.5.2 their category of membership of the Council of Governors (Public, Staff, Local Authority or Partnership Governor);

43.5.3 an address through which they can be contacted, which may be the Secretary;

43.5.4 the dates of his/her terms of office including start and end date, or date of his/her resignation/removal.

Register of interests of the Governors

43.6 The register of interests of the Governors shall contain:

43.6.1 the names of each Governor;

43.6.2 whether he/she has declared any interests and, if so, the interests declared in accordance with this Constitution;

43.6.3 the dates of his/her terms of office including start and end date, or date of his/her resignation/removal.

Register of Directors

43.7 The register of Directors shall list:

43.7.1 the name of each Director;

43.7.2 their capacity on the Board of Directors;

43.7.3 address through which they can be contacted, which may be the Secretary;

43.7.4 the dates of his/her terms of office including start and end date, or date of his/her resignation/removal.

Register of interests of the Directors

43.8 The register of interest of the Directors shall contain:

43.8.1 the name of each Director;

43.8.2 whether he/she has any declared any interests and, if so, if the interests declared in accordance with this Constitution;

43.8.3 the dates of his/her terms of office including start and end date, or date of his/her resignation/removal.

44 Registers – inspection and copies

44.1 The Foundation Trust shall make the registers specified in paragraph 43 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations, including, for the avoidance of doubt, the Public Benefit Corporation (Register of Members) Regulations 2004 (SI2004/539).

44.2 The Foundation Trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member of the Foundation Trust, if the Member so requests.

44.3 So far as the registers are required to be made available:

44.3.1 they are to be available for inspection free of charge at all reasonable times; and

44.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

44.4 If the person requesting a copy or extract is not a Member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

45 Documents available for public inspection

45.1 The Foundation Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times and on its website:

45.1.1 a copy of the current Constitution;

45.1.2 a copy of the latest Annual Accounts and of any report of the Auditor on them; and

45.1.3 a copy of the latest Annual Report.

45.2 The Foundation Trust shall also make the following documents relating to a special administration of the Foundation Trust available for inspection by members of the public free of charge at all reasonable times and on its website:

45.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

45.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

45.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;

45.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

45.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

45.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

45.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

45.2.8 a copy of any final report published under section 65I (administrator's final report);

45.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act;

45.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

45.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy or extract.

45.4 If the person requesting a copy or extract is not a Member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

46 Auditor

46.1 The Foundation Trust shall have an Auditor.

46.2 The Audit Committee shall make recommendations to the Council of Governors on the appointment of the Auditor.

46.3 In appointing the Auditor, the Council of Governors shall have regard to the recommendations of the Audit Committee.

46.4 The Council of Governors shall appoint or remove the Auditor at a general meeting of the Council of Governors.

46.5 The Accounting Officer shall ensure that the Auditor carries out his/her duties in accordance with Schedule 10 to the 2006 Act.

47 Audit Committee

47.1 The Foundation Trust shall establish a committee of Non-Executive Directors as an Audit Committee to review the establishment of an effective system of internal control and risk management, and to perform such monitoring and reviewing and to carry out other such functions as are appropriate.

48 Accounts

48.1 The Foundation Trust must keep proper accounts and proper records in relation to the accounts.

48.2 Monitor may with the approval of the Secretary of State give directions to the Foundation Trust as to the content and form of its accounts.

48.3 The accounts are to be audited by the Foundation Trust's Auditor.

48.4 The Foundation Trust shall prepare in respect of each Financial Year Annual Accounts in such form as Monitor may with the approval of the Secretary of State direct.

48.5 The functions of the Foundation Trust with respect to the preparation of the Annual Accounts shall be delegated to the Accounting Officer.

49 Annual Report, Forward Plans and other non-NHS work

49.1 The Foundation Trust shall prepare an Annual Report and send it to Monitor.

49.2 Each Annual Report shall give:

49.2.1 information on any steps taken by the Foundation Trust to ensure that (taken as a whole) the actual Membership of the Public Constituency is representative of those eligible for such Membership;

49.2.2 information on the remuneration of the Directors and on the expenses of the Governors and the Directors;

49.2.3 the information on the impact that income received by the Trust, otherwise than from the fulfilment of the Principal Purpose, has had on the provision of goods and services for those purposes; and

49.2.4 such other information as may be prescribed by Monitor.

49.3 The Foundation Trust shall give information as to its forward planning in respect of each Financial Year to Monitor.

49.4 The Forward Plan shall be prepared by the Board of Directors.

49.5 In preparing the Forward Plan, the Directors shall have regard to the views of the Council of Governors.

49.6 Each Forward Plan shall include information about:

49.6.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Foundation Trust proposes to carry on, and

49.6.2 the income it expects to receive from doing so.

49.7 Where a Forward Plan contains a proposal that the Foundation Trust carry on an activity of a kind mentioned in sub-paragraph 49.6.1, the Council of Governors must:

49.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Foundation Trust of its Principal Purpose or the performance of its other functions; and

49.7.2 notify the Directors of the Foundation Trust of its determination.

49.8 The Trust's total income in any financial year is made up of: (a) income attributable to its principal purpose as provided in paragraph 3.1 above; plus (b) income attributable to the provision of goods and services for any other purposes ("non NHS income"). If the Trust in any Financial Year proposes to increase its non NHS income and this would result in the non NHS income as a proportion of its total income increasing by 5% or more, then the Trust may implement the proposal only if more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve its implementation.

50 Instruments

50.1 The Foundation Trust shall have a seal.

50.2 The seal shall not be affixed except under the authority of the Board of Directors.

51 Indemnity

51.1 Members of the Council of Governors, the Board of Directors, the Secretary and other Officers of the Foundation Trust who act honestly and in good faith shall not have to meet out of their own personal resources any personal civil liability which is incurred in the execution or purported execution of their functions save where they have acted recklessly. Any costs arising in this way shall be met by the Foundation Trust.

51.2 The Foundation Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Council of Governors, Board of Directors, Secretary and other Officers.

51.3 The Foundation Trust may take out insurance either through the NHS Litigation Authority or otherwise in respect of Directors' and Officers' liability, including liability arising by reason of the Foundation Trust acting as a corporate trustee of an NHS charity.

52 Disputes between the Council of Governors and the Board of Directors

52.1 Subject to paragraph 24 above, in the event of a dispute between the Council of Governors and the Board of Directors:

52.1.1 in the first instance, the Chair, on the advice of the Secretary and other such advice as the Chair may see fit to obtain, shall seek to resolve the dispute;

52.1.2 if the Chair is unable to resolve the dispute, he/she shall appoint and chair a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute;

52.1.3 if the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

52.2 The dispute resolution procedures set out in this paragraph do not preclude the Governors from referring the matter to a panel of persons appointed by Monitor as set out in paragraph 24 (above). In these circumstances, the dispute must relate to a question about the Trust failing or failure to act in accordance with the Constitution or in accordance with provision made by or under Chapter 5 of the 2006 Act and must otherwise satisfy the conditions set out in paragraph 24.

53 Amendment of the Constitution

53.1 The Trust may make amendments of its Constitution only if:

53.1.1 more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve the amendments;

53.1.2 more than half of the members of the Board of Directors present and voting at a meeting of the Board of Directors approve the amendments.

53.2 Amendments made under paragraph 53.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

53.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Foundation Trust):

53.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment to the Members; and

53.3.2 the Foundation Trust must give the Members an opportunity to vote on whether they approve the amendment.

53.4 If more than half of the Members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Foundation Trust must take such steps as are necessary as a result.

53.5 Amendments by the Foundation Trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

54 Mergers etc. and Significant Transactions

54.1 The Foundation Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

54.2 The Foundation Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Foundation Trust present and voting approve entering into the transaction.

54.3 A "Significant Transaction" is a transaction which meets any of the following criteria:

Ratio	Description	Percentage
Assets	The Gross Assets subject to the transaction divided by the gross assets of the Trust.	>25
Income	The income attributable to: • the assets; or • the contract associated with the transaction divided by the income of the Trust.	>25
Consideration to total Trust Capital	The Gross Capital of the company or business being acquired/divested divided by the Total Capital of the Trust following completion, or the effects on the Total Capital of the Trust resulting from a transaction.	>25

For the purposes of this paragraph:

"Gross Assets" is the total of fixed assets and current assets;

"Gross Capital" equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets; and

"Total Capital" of the Trust equals taxpayers' equity.

54.4 Notwithstanding the above provisions and for the avoidance of doubt, a Significant Transaction does not include:

54.4.1 a transaction pursuant to: Sections 56, 56A 56B and 57A of the 2006 Act; or

54.4.2 any contracts in place from time to time with Horsham and Mid Sussex Clinical Commissioning Group (or its successor organisation) on behalf of Kent Surrey and Sussex Clinical Commissioning Groups (or their successor organisations), any other Clinical Commissioning Groups and/or the NHS Commissioning Board.

54.5 Any transaction which meets any of the criteria set out in paragraph 54.3 shall be notified to the Council of Governors if the percentage is in excess of 10% but less than 25%.

ANNEX 1 – THE PUBLIC CONSTITUENCY

(Paragraph 8)

PUBLIC CONSTITUENCY OF THE FOUNDATION TRUST

NAME OF CONSTITUENCY	AREA	MIMIMUM NO. OF MEMBERS	NO. OF GOVERNORS
Kent, Surrey, East and West Sussex and South London	The electoral wards of: Kent County Council West Sussex County Council East Sussex County Council Surrey County Council Medway Unitary Authority Brighton and Hove City Council London Borough of Croydon London Borough of Kingston London Borough of Merton London Borough of Richmond London Borough of Sutton London Borough of Bexley London Borough of Bromley London Borough of Greenwich London Borough of Lambeth London Borough of Lewisham London Borough of Southwark London Borough of Wandsworth	200	20

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraph 9)

STAFF CONSTITUENCY OF THE FOUNDATION TRUST

DESCRIPTION OF MEMBERS	MINIMUM NO. OF MEMBERS	NO. OF GOVERNORS
Staff employed by Queen Victoria Hospital NHS Foundation Trust as set out in paragraph 9.1 of the Constitution	50	3

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraph 14)

COMPOSITION OF THE COUNCIL OF GOVERNORS OF THE FOUNDATION TRUST

Governor Type	Governor Description	No. of Governors
Elected	Public	**20**
Elected	Staff	3
Total of Elected Governors		**23**
Appointed (Local Authority)	Local Authority – West Sussex County Council	1
Appointed (Partnership Organisation)	East Grinstead Town Council	1
Appointed (Partnership Organisation)	The League of Friends	1
Total of Appointed Governors		**3**
Total Number of Governors		**26**

VACANCIES ARISING ON THE EXPIRY OF A GOVERNOR TERM OF OFFICE

Where a term of office for a Public Governor expires, the Trust will ordinarily hold an election for the relevant public constituency with the duly elected Public Governor for that constituency taking office on the expiry of the existing Public Governor's term of office.

Where requested by the Board for good reason, the Council of Governors shall consider a request to delay such an election for a period of 12 months. Any further period of delay shall only be with the further approval of the Council of Governors and for such period as they may determine. Any votes on such proposals to be by a majority of the Council of Governors voting. Good reasons for a delay include, but are not limited to, the following:

- The effects of a pandemic or other health or civil emergency (or government guidance on the holding of elections for foundation trusts); or
- Anticipated transactions involving the Trust under any of sections 56 (mergers), 56A (Acquisitions) or 57A (dissolution) of the 2006 Act within the forthcoming 12 months.

The request for a delay by the Board and the approval by the Council of Governors may occur at any time prior to the expiry of any relevant existing Public Governor's term of office.

When considering such a request, the Council of Governors must take into account that the Trust must always ensure that the aggregate number of Governors who are Public Governors on the Council of Governors always remains the majority of Governors on the Council of Governors. The request shall be granted where a majority of the Council of Governors voting approve.

Where an election for a Public Governor constituency occurs following any period of delay approved by the Council of Governors, the election thereafter will be for a term ending on the date that the term would have ended but for the delay to the election.

In the case of elections delayed in 2020 by virtue of the pandemic (and prior to these provisions appearing in the Constitution), the election for each Public Governor constituency will be for a term ending on the date that the term would have ended but for the delay to the election.

The validity of any act of the Council of Governors is not affected by any vacancy among the Governors or by any defect in the appointment of any Governor.

ANNEX 4 – THE MODEL ELECTION RULES

(Paragraph 15)

MODEL ELECTION RULES FOR ELECTIONS TO THE COUNCIL OF GOVERNORS

1. Interpretation

1.1 In these rules, unless the context otherwise requires: “2006 Act” means the National Health Service Act 2006;

“corporation” means the public benefit corporation subject to this constitution; “council of governors” means the council of governors of the corporation; “declaration of identity” has the meaning set out in rule 21.1;

“election” means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

“e-voting” means voting using either the internet, telephone or text message; “e-voting information” has the meaning set out in rule 24.2;

“ID declaration form” has the meaning set out in Rule 21.1; “internet voting record” has the meaning set out in rule 26.4(d);

“internet voting system” means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

“lead governor” means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

“list of eligible voters” means the list referred to in rule 22.1, containing the information in rule 22.2;

“method of polling” means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

“Monitor” means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

“numerical voting code” has the meaning set out in rule 64.2(b) “polling website” has the meaning set out in rule 26.1;

“postal voting information” has the meaning set out in rule 24.1;

“telephone short code” means a short telephone number used for the purposes of submitting a vote by text message;

“telephone voting facility” has the meaning set out in rule 26.2; “telephone voting record” has the meaning set out in rule 26.5 (d); “text message voting facility” has the meaning set out in rule 26.3; “text voting record” has the meaning set out in rule 26.6 (d);

“the telephone voting system” means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;
“the text message voting system” means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

“voter ID number” means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

“voting information” means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll
Close of the poll	By 5.00pm on the final day of the election

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the

purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4 STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) The date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and is to prepare a nomination form for signature at the request of any member of the corporation, but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing, as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of

these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who

casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e- voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates, the

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held.

(*"declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope; ("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,

(d) contact details of the returning officer, ("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e- mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity; in order to be able to cast his or her vote;

(c) specify:

(i) the name of the corporation
(ii) the constituency, or class within a constituency, for which the election is being held.
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,
(vi) the date and time of the close of the poll, and
(vii) the contact details of the returning officer;
(viii)

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held,
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) instructions on how to vote and how to make a declaration of identity,
(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that

comprises of:

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)1

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form “disqualified”,

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot

paper, and

(c) place the ID declaration form in a separate packet

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it“ disqualified” and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"ballot document" means a ballot paper, internet voting record, telephone voting record or text voting record.

"continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X",

"non-transferable vote" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any

mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"stage of the count" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"transferred vote" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"transfer value" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) The use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of

such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(i) ballot papers that have been returned; and
(ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules

and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44 Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by

reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot

paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark,
(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,
(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
(c) which is unmarked or rejected because of uncertainty, shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,
(b) by more than one mark, is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and
(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and
(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45 First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47 Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1 (a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the

quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub- parcel of ballot documents referred to in rule STV47.5 (a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at: a transfer value calculated as set out in rule STV47.4(b), or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred,
(c) whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote when credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest

surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non- transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49 Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled, the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub- parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub- parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents, (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub- parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he/she has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:
  (i) the total value of votes, or
  (ii) the total transfer value of votes transferred to each candidate,
(b) add that total to the previous total of votes recorded for each candidate and record the new total,
(c) record the value of non-transferable votes and add that value to the previous non- transferable votes total, and
(d) compare:
  (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
  (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the

lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51 Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he/she obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51 Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is

found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7 FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10, available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS

Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation, and give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule STV44.1,
(f) the number of rejected text voting records under each of the headings in rule STV44.3, available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and
(c) give public notice of the name of each candidate who he or she has declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with “rejected in part”,
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records, and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,
or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed

pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,
the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –
  (i) any rejected ballot papers, including ballot papers rejected in part,
  (ii) any rejected text voting records, including text voting records rejected in part,
  (iii) any disqualified documents, or the list of disqualified documents,
  (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage, by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect

any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and
(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9 DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the Chair of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and,

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and

respond to questions, as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and
(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the

purposes of this Part.

PART 11 QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as Monitor may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If Monitor requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 Monitor may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iii) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 – ELIGIBILITY AND DISQUALIFICATION CRITERIA FOR GOVERNORS AND DIRECTORS

(Paragraphs 18 and 38)

1.1 A person may not become or continue as a member of the Council of Governors or the Board of Directors if:

a) he/she has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

b) he/she has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it;

c) he/she has within the preceding five years has been convicted anywhere in the world of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her;

d) he/she has, within the preceding two years, been dismissed (otherwise than by reason of redundancy or ill health) from any paid employment within a Health Service Body;

e) his/her tenure of office as the Chair or director of a Health Service Body has been terminated on grounds that his/her appointment is not in the interest of the health service, for non-attendance at meetings or for non-disclosure of a material interest;

f) he/she is a member of a Local Authority Health Overview and Scrutiny Committee;

g) he/she is a member of a Health and Wellbeing Board;

h) he/she is a member of Health Watch (nationally or locally);

i) he/she is the subject of a Sex Offenders' Order and/or his/her name is included in the Sex Offenders' Register;

j) he/she is a person who is included in any barred list established under the Safeguarding Vulnerable Groups Act 2006;

k) he/she is a Close Family Member of a Governor or Director of the Foundation Trust;

l) he/she has failed to repay (without good cause) monies properly owed to the Foundation Trust;

m) he/she has demonstrated aggressive or violent behaviour (such as verbal assault, physical assault, violence or harassment) at any NHS hospital, NHS premises or NHS establishment, or against the Foundation Trust's employees or other persons who exercise functions for purposes of the Foundation Trust whether or not in circumstances leading to his/her removal or exclusion from any NHS hospital, premises or establishment.

ANNEX 6 – CONDUCT OF MEETINGS OF THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

(Paragraphs 21 and 39)

1.1 Members of the public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors and the Board of Directors except in circumstances where a special resolution is passed that members of the public and representatives of the press shall be excluded from a meeting.

1.2 The reasons for passing such a resolution shall be due to the sensitive or confidential nature of the discussion which might include information relating to:

a) employees, former employees or applicants;

b) occupiers or former occupiers of accommodation provided by or at the expense of the Foundation Trust;

c) patients or service users;

d) information relating to the financial or business affairs of a particular person.

1.3 Further, the Council of Governors or the Board of Directors, as the case may be, may resolve that:

a) in the interests of public order, the meeting should be adjourned, for a reasonable, specified period, to enable the meeting to complete business without the presence of the public or the press; or

b) publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

c) there is another special reason, which shall be stated in the resolution, which requires that members of the public and representatives of the press be excluded.

1.4 Matters to be dealt with, following the exclusion of the public and representatives of the press, shall be confidential to the Governors or the Directors as the case may be. Members of the Council of Governors, Board of Directors, Officers and/or others in attendance at the request of the Chair shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chair.

1.5 The Chair may exclude any member of the public or representative of the press from a meeting of the Council of Governors or the Board of Directors, as the case may be, if he/she considers that they are interfering with or preventing the proper conduct of the meeting.

1.6 Nothing in this Constitution requires the Council of Governors or the Board of Directors, as the case may be, to allow members of the public and representatives of the press to record proceedings in any manner whatsoever other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Chair or the Meeting

Chair.

ANNEX 7 – MEETINGS OF THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS ANNEX 7 – ELECTRONIC COMMUNICATION

(Paragraphs 21 and 39)

1.1 In exceptional cases, arrangements can be made for Governors or Directors to participate in meetings of the Council of Governors or the Board of Directors, as the case may be, by telephone, video or computer link or other such agreed means.

1.2 In these circumstances the following provisions apply:

a) "Communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

b) A Governor or Director, as the case may be, in electronic communication with the Chair and all other parties to a meeting of the Council of Governors or the Board of Directors or of a committee thereof shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he/she has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

c) A meeting at which one or more of the Governors or Directors, as the case may be, attends by way of electronic communication is deemed to be held at such a place as the Governors or Directors, as the case may be, shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Governors or Directors, as the case may be, attending the meeting are physically present, or in default of such a majority, the place at which the Chair of the meeting is physically present.

d) Meetings held in accordance with this paragraph are subject to paragraph 21.32. For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

e) The minutes of a meeting held in this way must state that it was held by electronic communication and that the Governors or Directors, as the case may be, were all able to hear each other and were present throughout the meeting.

ANNEX 8 – CONFLICTS OF INTEREST OF GOVERNORS AND DIRECTORS

(Paragraphs 22 and 40)

1.1 Interests which should be regarded as “relevant and material” for Governors and Directors are set out below:

a) directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies); or

b) ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or the Foundation Trust; or

c) significant or controlling share in organisations likely or possibly seeking to do business with the NHS or the Foundation Trust; or

d) a position of authority in a charity or voluntary organisation in the field of health or social care; or

e) any connection with a voluntary or other organisation contracting for NHS or Foundation Trust services or commissioning NHS or Foundation Trust services; or

f) any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Foundation Trust, including but not limited to lenders of banks.

1.2 For the avoidance of doubt, they shall be included in the relevant register of interests of the Governors or the Directors, as the case may be.

1.3 A "family interest" is an interest of a Close Family Member of a Governor or Director which, if it were the interest of that Governor or Director, would be a personal or pecuniary interest of his/hers.

1.4 If Governors or Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Secretary. Influence rather than immediacy of the relationship is more important in assessing the relevance of an interest.

1.5 There shall be arrangements for excluding Governors and Directors from discussion or consideration of matters in which they have a “relevant or material” interest.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024	**Agenda reference:**	**55-24**		
Report title:	Vision, values and key strategic objectives				
Sponsor:	Abigail Jago – Chief Strategy Officer				
Author:	Kathy Brasier - Deputy Chief Strategy Officer				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of the report is for the Board to **APPROVE** the refreshed QVH vision, values and key strategic objectives (KSO).				
Summary of key issues	As part of the strategy development programme QVH has worked in conjunction with an independent provider to refresh the trust vision and values. The process included wide engagement with staff through both face to face workshops and online groups to support co-production. In conjunction with this work, the Trust KSO's have also been refreshed in line with the Trusts strategy development programme. This includes; • A focus on verb orientated objectives to support the ability for measurement • Care delivery to be expanded to patients, families and the population • An objective to reflect the refreshed ambition for innovation and improvement • An objective setting out the importance of our people as the trust's greatest asset • A shift from a financial based objective to that of a wider ambition in terms of delivering sustainable services • The inclusion of an objective that reflects the priority of collaboration The vision, values and objectives have been discussed and supported in the hospital leadership team (which includes triumvirate multi-disciplinary leadership teams, clinical and corporate leaders), Executive Leadership Team meetings, two Board seminars and the Strategic Development Committee. Internal and external stakeholder engagement has continued since April 2023 at the start of the Trusts strategic journey and will continue throughout this process to implementation and beyond.				
Recommendation:	The Board is asked to **approve** the Trusts vision, values and key strategic objectives, taking note of the engagement undertaken				
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:	BAF4				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Board seminars (4/4/24 and 26/6/24). ELT (6/5/24), Extraordinary Executive Leadership Team (1/7/24) , Hospital Leadership Team (15/7/24) Strategic Development Committee (28/5) and (24/7)				
	Date:	24/07/24	SDC Decision:	Recommendation for approval to trust board	
Next steps:	Board to **approve** the preferred option for the trusts refreshed vision, values and KSO's				

Report to:	Board of Directors
Agenda item:	55-24
Date of meeting:	12/09/2024
Report from:	Abigail Jago – Chief Strategy Officer
Report author:	Kathy Brasier - Deputy Chief Strategy Officer
Date of report:	27 August 2024
Appendices:	None

Vision, values and key strategic objectives

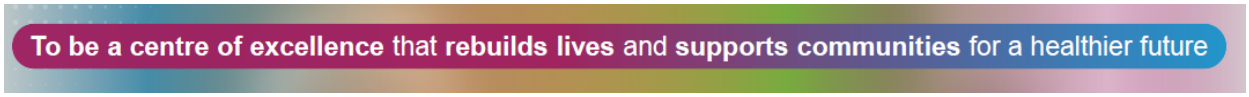
Introduction

As part of the QVH strategy development programme the trust vision, values and strategic objectives have been revisited and revised to align with the new strategy. These have been developed based on a number of engagement activities and will be central to our continuous improvement approach.

Vision and values

The vision and values have been co-produced with staff through an engagement process including face to face and online workshops. This work builds upon feedback from the wide engagement with stakeholders throughout the strategy development programme including patient focus groups.

Following much discussion, at a variety of forums, including; staff engagement workshops, hospital leadership team meeting, board seminars, executive leadership team sessions, the preferred vision statement is as follows:

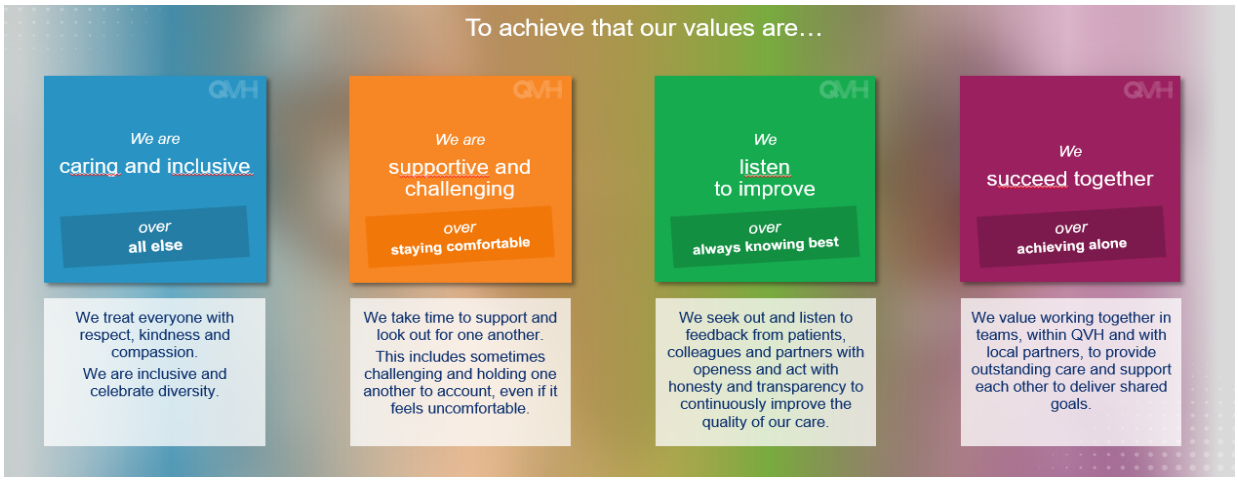


It is proposed that this is the preferred statement due to rationale which include the following key factors:

- Reference to QVH as a centre of excellence in line with the strategic intent agreed at Board in January 2024
- Reference to rebuilding lives to reflect the role of QVH in regard to reconstruction and associated services
- Reference to supporting communities for a healthier future to align with the hybrid model and commitment to supporting the health of communities served by QVH

In regard to trust values, as an organisation it is important that we are driven by our values as this determines our culture. Our culture is key to ensure that we can all care for our patients and each other to enable the best patient care and to succeed as individuals, teams and an organisation.

Following consideration from staff and leadership team the following values are proposed. A behaviours framework has been developed with staff representatives to support the embedding of our values.

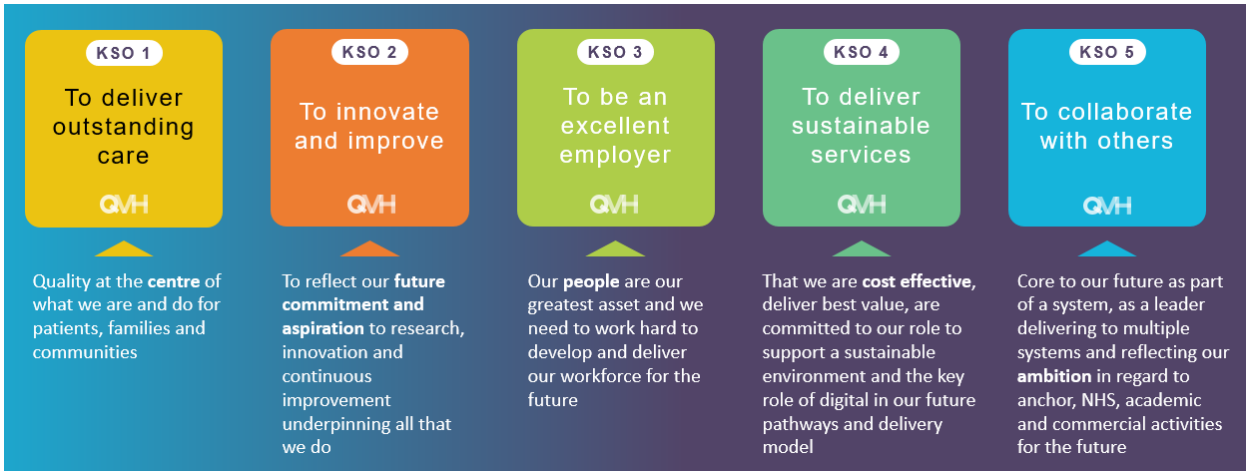


Key Strategic Objectives (KSO)

Work has also been underway to refresh the trust key strategic objectives (KSO's) to align with the future strategic ambitions. The objectives have been developed taking into account peer benchmarking with the following changes:

- A focus on verb orientated objectives to support the ability for measurement against delivery
- Care delivery (KSO1) to be expanded to patients, families and the population
- An objective (KSO2) to reflect the refreshed ambition for both innovation and improvement
- An objective (KSO3) setting out the importance of our people as the trust's greatest asset
- A shift from traditional financial based objective to that of a wider ambition in terms of delivering sustainable services (KSO4)
- The inclusion of an objective that reflects the priority of collaboration (KSO5)

The proposed key strategic objectives are as follows:



Recommendation

The **Board** is asked to **APPROVE** the proposed vision, values and key strategic objectives, taking **NOTE** of the engagement undertaken to date, with both internal and external stakeholders.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024		**Agenda reference:**	**56-24**	
Report title:	Integrated Quality and Performance Report				
Sponsor:	Kirsten Timmins, Chief Operating Officer				
Author:	Suzanne Cliffe, External Consultant				
Appendices:	Integrated Quality and Performance Report Month 3 slide pack				
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 3 (June) 2024/25) and a narrative update on Month 4 (July 2024/25).				
Summary of key issues	KSO 1 – no areas of concern noted KSO 2 – CQC Inpatient Survey results show the trust recognised by patients as the top trust in the country for the inpatient care provided KSO 3 – risk to delivery of >65 week wait RTT National target of zero by the end of September 2024. Increasing size of the waiting list and providing support by treating long waiting patients from across the NHS Sussex system will add to the challenges of meeting RTT targets. KSO 4 – finance position on plan at Month 4 achieving a break-even position KSO 5 – review of the use of agency in nursing and corporate functions to reduce the use of temporary staff and support recruitment into substantive roles Highlight reports are included for each of the five major projects for 2024/25 and no significant concerns are reported.				
Recommendation:	The Board is requested 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 and embed the new reporting format				
Assurance route					
Previously considered by:	ELT, Finance and Performance Committee, Quality and Safety Committee				
	Date:	30/07/2024, 27/08/2024, 28/08/2024	Decision:	N/A	
Next steps:	Embed the monthly reporting processes				

Report to:	Board of Directors
Agenda item:	56-24
Date of meeting:	12/09/2024
Report from:	Kirsten Timmins, Chief Operating Officer
Report author:	Suzanne Cliffe, External Consultant
Date of report:	04/09/2024
Appendices:	Integrated Quality and Performance Report (IQPR) M3

Integrated Quality and Performance Report

Introduction

In line with the Integrated Assurance Framework, the Integrated Quality and Performance Report (IQ&PR) brings 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.

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. For those metrics not being met, further information is provided on the issues and the actions being taken.

June/July 2024 Performance

This paper highlights the key areas from within the Month 3 report updated for the Month 4 position where relevant. Further detailed information is included in the attached Month 3 report.

There was a further period of industrial action that straddled the end of June and the start of July 2024 that resulted in the cancellation of appointments and reduced activity, and this is reflected in the data. In addition, the trust has started to support the wider NHS Sussex system with their aim to reduce the number of long waiting patients with the transfer of some patients to be treated at QVH.

KSO 1 Outstanding Patient Care

There are no areas of concern being raised in Month 3 or Month 4 with no never events or serious patient safety incidents reported.

KSO 2 World Class Clinical Services

The CQC Inpatient survey carried out in November 2023 with adult patients who stayed at least one night in hospital was published recently. The trust was recognised by the patients as the top trust in the country for the inpatient care provided.

Feedback from a recent Healthwatch visit has raised some areas for review regarding access to services on the trust's site. These are currently being discussed and a plan will be developed to address the areas highlighted.

KSO 3 Operational Excellence

RTT - The trust had 55 patients >65 weeks reported at Month 4 against an internal target of 59. >78 week waits continue to reduce with just 1 reported at Month 4.

However, the trust is currently predicting that it is unlikely to meet the >65 week wait national target of zero waits at the end of September 2024.

The increase in the numbers on the waiting list continues to be an area of concern, particularly for the non-admitted pathway. In addition, performance is affected by supporting the NHS Sussex system with the treatment of long waiting patients transferred to QVH (to date 155 patients have been transferred).

Cancer – (reported a month in arrears). Faster Diagnosis Standard continues to meet the target and >62 days target was met in M3. >31 days was not met and the >62 backlog increased to 57 including 15 patients waiting >104 days against an internal target of 3 patients.

Diagnostics (DM01) – the target of 95% has been met for the last three months mainly due to the sustained improvement within sleep services.

Theatre Productivity – performance against the capped target of 85% is at 82% for Month 4 and remains below the target. A work programme has been established to address utilisation and patient flow to improve productivity.

KSO 4 Financial Sustainability
For Month 4 the trust remained at breakeven and with a forecast to achieve a break-even position at year end.

Capital spend is currently behind plan mainly due to slippage on the Electronic Patient Record and Community Diagnostic Centre schemes.

KSO 5 Organisational Excellence
The use of agency staff is being reviewed within the nursing and corporate areas alongside current vacant posts to support recruitment into substantive roles and reduce the reliance on temporary staff.

Following the recruitment of a Wellbeing and Inclusion Manager, priorities and plans are being scoped for the next twelve months.
A behaviours framework has been developed and is to be launched in September 2024 alongside the revised trust vision and values.

Major Projects 2024/25

KSO 2 World Class Clinical Services
To implement and optimise an on-site Local Anaesthetic Unit – the programme has now resumed and an assessment of the next steps is being made

KSO 3 Operational Excellence
To deliver the Community Diagnostic Centre programme – delays in confirming the service model and agreeing schedules for accommodation has led to slippage in the programme from delivery by March 2025 to December 2025

To deliver the Sussex Pathology Network Programme –The Laboratory Information System (LIMS) project is now delayed until 2025 due to wider issues across the system

To deliver Year 1 of the Electronic Patient Record – the programme is now underway engaging with the organisation

KSO 5 Organisational Excellence
To design and implement a systematic continuous improvement approach across the organisation - the programme is now underway with the agreed partner and a Head of Continuous Improvement has been appointed. A comms and engagement plan is in place, a board development session is planned for early September 2024 and the first cohort for initial training is planned for the end of September 2024.

Recommendation
The Board is asked to **NOTE** the Month 3 Integrated Quality and Performance Report and the updated position at Month 4.

NHS
Queen Victoria Hospital
NHS Foundation Trust

Integrated Quality and Performance Report

Month 3 – June 2024

QVH

Integrated Quality and Performance Report - Scorecard

Queen Victoria Hospital NHS Foundation Trust

Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	LCL	UCL	Summary
Breakeven YTD	Jun 24	£0.0m			£0.0m	£0.0m				
RTT > 65 Weeks	Jun 24	0			69	51	73.80	39.79	107.81	Common cause - no signficant change
% Overall FFT Recommendation Rate	Jun 24	90%			94.8%	95.4%	95.81	93.87	97.76	Common cause - no signficant change
Ethnicity recording	Jun 24	95%			79.3%	79.6%	79.56	75.61	83.51	Common cause - no signficant change
Smoking Status	Jun 24	95%			98.2%	98.3%	84.98	79.26	90.71	Special cause improving

Major Projects

Major Project	This Month	OverallStatus	Last Month	Summary
Electronic Patient Record		Risk to delivery of plan		Significant change programme required
To deliver the Community Diagnostic Centre programme		Off track but mitigations in place		Work now progressing well
To deliver the Sussex Pathology Network Programme		Off track but mitigations in place		Part of wider system project
To design and implement a systematic quality improvement approach across the organisation		On track		Progressing well
To implement and optimise an on-site Local Anaesthetic Unit		Paused		Project manager being recruited

Integrated Quality and Performance Report - Summary

NHS
Queen Victoria Hospital
NHS Foundation Trust

Overview

June 2024
There was a further period of industrial action of junior doctors during the last week of June 2024 and the first two days of July 2024 resulting in the cancellation of appointments and reduced activity. This impacted revenue, reducing income and increasing costs. No further industrial action by junior doctors is planned.
To support the Sussex system in reducing long waits, the trust has agreed to take some long waiting patients for both OMFS and Ophthalmology to be treated at QVH. This is likely to impact performance going forward and plans are being developed to ensure that this can be tracked.

KSO 1 Outstanding Patient Experience
There have been no never events or serious patient safety incidents reported for June 2024. All metrics reported are improving or at consistent levels.

KSO 2 World Class Clinical Services
Work continues to progress the identification of meaningful patient reported outcomes in a wider range of sub-specialty areas.

KSO 3 Operational Excellence
For RTT the overall waiting list is continuing to increase and work is underway to fully understand the dynamics of the list.
>65-week waits are above target due to anticipated complexity of cases and a combination of factors puts delivery of the September 2024 target of zero >65 week waits at risk.
The cancer Faster Diagnosis Standard and the 62 day cancer standard were met for May 2024 although the 31-day standard was not met.
The 95% diagnostic target continues to be met due to the improvement in sleep performance.
Outpatient productivity is at 44% against the 46% target and this is an area of focus for continual improvement.
Theatre productivity (capped) achieved 85.3% against the 85% target.

KSO 4 Financial Sustainability
The trust achieved a break-even position for Month 3 in line with plan and the forecast is to achieve the year end break-even position. Industrial action impacted both income and costs with an increase in agency costs over the pay bill cap.

KSO 5 Organisational Excellence
A strengthening of workforce controls and processes is underway with an improvement in the time to hire seen. There is a focus on high cost and long term agency usage with a view to converting where possible to substantive employment or bank.
The People Promise Manager commenced in June 2024 to review and embed the Seven elements of the National People Promise, the Wellbeing and Inclusion Manager is now in post and the Coordinator role starts in August 2024, and there is work with the EDI partner and the ICB EDI lead to support staff network engagement, all of which will support staff experience.

Integrated Quality and Performance Report - Major Projects

June 2024
Major Projects

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. A new Project Manager is being appointed.

KSO 3 Operational Excellence
To deliver the Community Diagnostic Centre programme – there has been an increase in pace around the programme. Demand and capacity modelling in progress.
To deliver the Sussex Pathology Network Programme – this is a programme for multiple projects being implemented simultaneously and QVH is a member organisation. There is significant activity being undertaken to progress these projects. The Laboratory Information System (LIMS) project is now behind plan and presents operational and cost pressures for the trust.
To deliver Year 1 of the Electronic Patient - this project carries significant risk for delivery given the scale of the programme and the trust's digital maturity. However, there is considerable progress in the establishment of the initial elements of the programme including engagement with the wider organisation

KSO 5 Organisational Excellence
To design and implement a systematic quality improvement approach across the organisation - work is underway with the agreed partner including development of plans to engage with the wider 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

CareQuality Commission

The Queen Victoria Hospital (East Grinstead)

CQC overall rating

Good

23 May 2019

KSO1 Outstanding Patient Care - Summary

NHS
Queen Victoria Hospital
NHS Foundation Trust

Overview

Quality and safety is our priority, KSO1 provides the evidence to show how we have delivered safe and compassionate care for our patients.
There have been zero never events or serious patient safety investigations reported in month 3.
We have had zero reported falls, and 1 category 2 pressure ulcer which is currently being reviewed.
There have been zero infection control concerns this month, and patient complaints have reduced slightly from 6 in May to 3 in June
The Trust's Quality Account was submitted in June and is available to the public on the Trust's website.
The Board Assurance Framework has been updated and all risks both corporate and local have been reviewed to ensure mitigation's and actions are maintained.

Positive Assurance/Improvements

Oliver McGowan training compliance continues to improve from 89.5% in May to 90.4% in June
Complaint numbers have fallen in Month 3 and we continue to respond to complaints within our target.
Quality 'watch' metrics remain within the expected limits.

Challenges

Results of Mental Capacity Audit have revealed increased need for training and understanding of the Act which is being addressed by the MCA lead

Meeting Health and Safety Executive guidance for the use of Entonox in clinical areas.

Mitigations and Actions

Develop action plan for Mental capacity training.

Task and finish group set up, Entonox removed from areas where not used regularly, health surveillance of staff administering Entonox being explored.

KSO1 Outstanding Patient Care - Scorecard

Queen Victoria Hospital NHS Foundation Trust

Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	UCL	LCL	Summary
Ethnicity recording	Jun 24	95%			79.3%	79.6%	79.56	83.51	75.61	Common cause - no signficant change
Smoking Status	Jun 24	95%			98.2%	98.3%	84.98	90.71	79.26	Special cause improving
Falls per 1,000 Occupied Bed Days	Jun 24	7			0.0	3.4	3.67	11.83	-4.49	Common cause - no signficant change
Hospital Aquired PU Per 1,000 Occupied Bed Days	Jun 24	0			1.2	1.1	0.55	2.29	-1.18	Common cause - no signficant change
% Complaints Responded On Time	Jun 24	70%			90.0%	100.0%	90.21	103.29	77.13	Common cause - no signficant change
Safer Staffing Compliance	Jun 24	90%			99.9%	99.6%	99.48	100.80	98.16	Common cause - no signficant change
Number of Open CAS Alerts	Jun 24				2	2	1.60	3.03	0.17	Common cause - no signficant change

Metric	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Number of Complaints	9	3	6	5	7	7	4	7	1	2	12	6	3
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient safety incident investigations	0	0	0	0	0	0	0	0	0	0	1	0	0
Mortalities	1	0	0	0	0	0	0	0	0	0	0	0	0
Hospital Acquired CDI, MRSA, E.Coli, MSSA	0	0	0	2	0	1	0	0	0	0	0	1	0
Oliver McGowan Training Compliance				16.5%	41.0%	53.0%	67.6%	75.4%	80.5%	83.0%	87.5%	89.4%	90.5%

Latest Data Refresh: **7/29/2024 8:00:16 AM** Latest Commentary Refresh: **7/30/2024 7:04:06 AM**

KSO1 Outstanding Patient Care

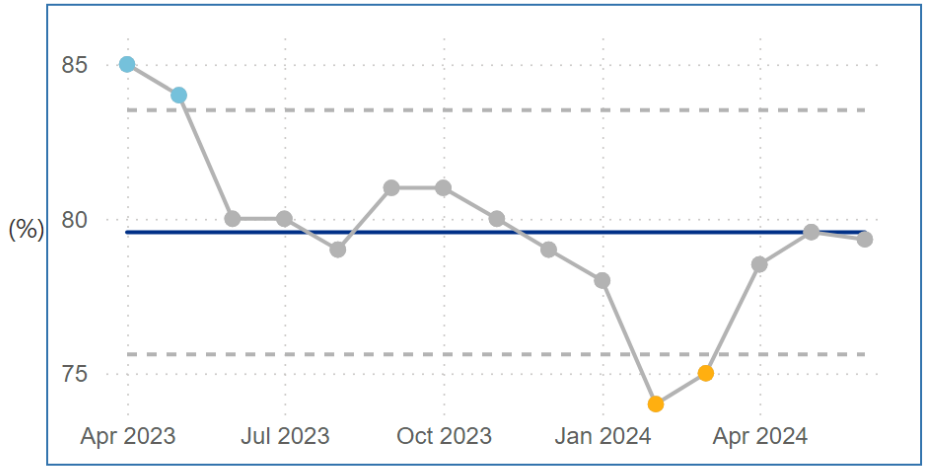
Queen Victoria Hospital NHS Foundation Trust

Ethnicity recording

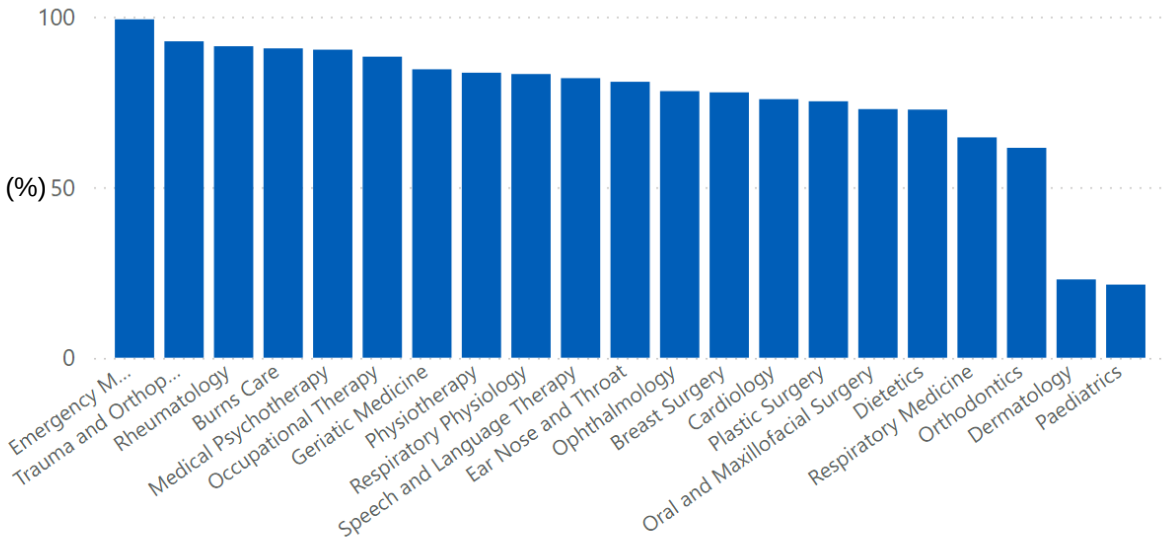
Reporting Month: Jun 24

Executive Lead: CNO

1.Historic trend data



Actual
79.3%
Internal Target
95%
National Target
95%
SPC
Common Cause
Consistent Fail



3.Top Contributors

A baseline has been established from existing measures for ethnicity, defining what to measure and the point of capture.

4.Action Plan

Actions	Target Date
Capture data only once for multi patient visits	September 2024
Identify areas where capturing data is going well, lessons learnt	September 2024

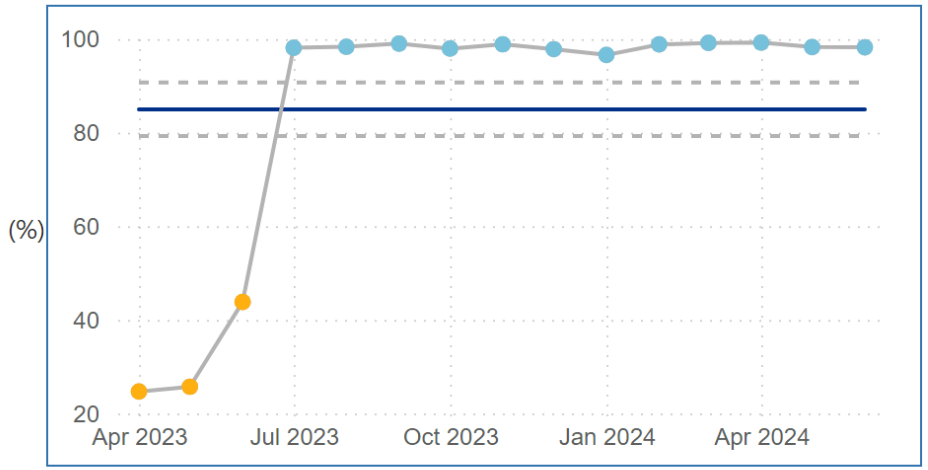
KSO1 Outstanding Patient Care

Queen Victoria Hospital NHS Foundation Trust

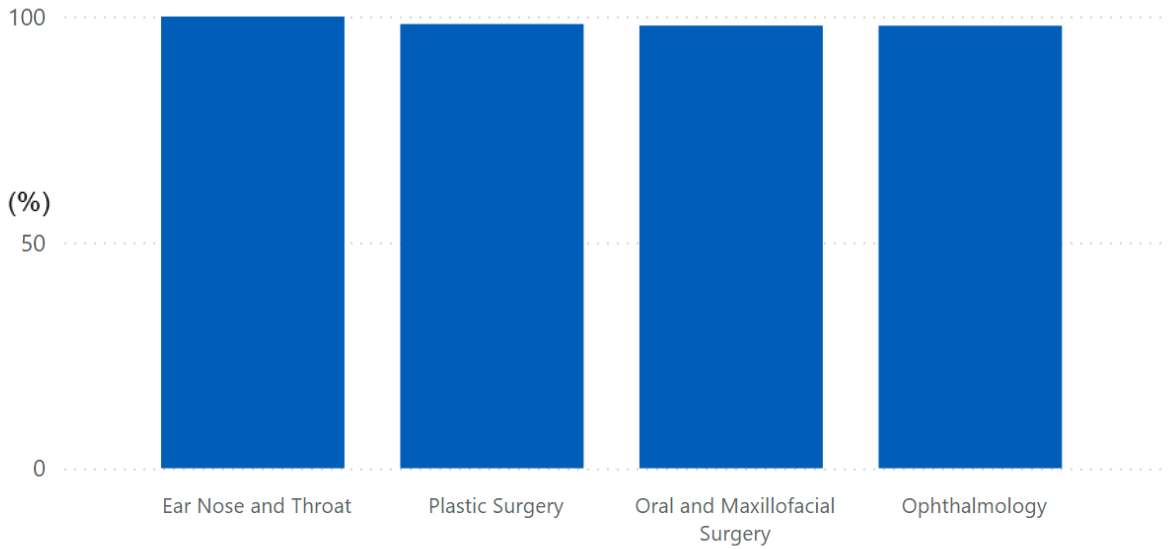
Smoking Status

Reporting Month:	Jun 24	Executive Lead:	CNO

1.Historic trend data



Actual
98.2%
Internal Target
95%
National Target
95%
SPC
Improving - Improvement High
Consistent Fail



3.Top Contributors

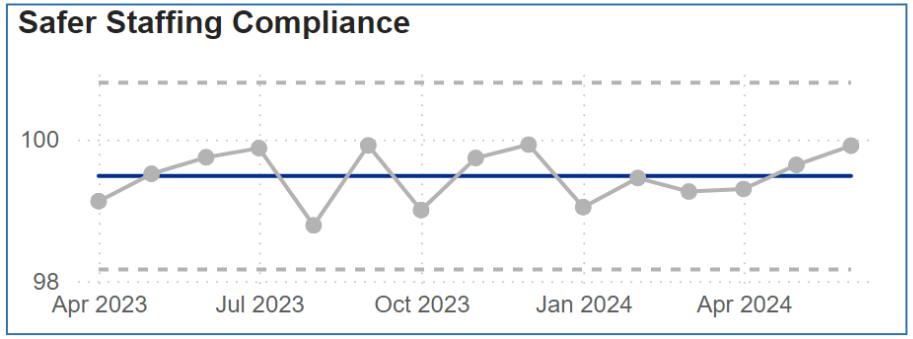
Capturing data when due for an admissions only and not for outpatient visits.

4.Action Plan

Actions	Target Date
Identify appropriate metrics to capture data	September 2024

KSO1 Outstanding Patient Care - Watch Metric

Queen Victoria Hospital NHS Foundation Trust



Actual	SPC
99.9%	Common Cause
Internal Target	Consistent Pass
90%	
National Target	
90%	

Day	Planned Staff			Actual Staff				Planned Staff			Actual Staff			Night
	RN	NA	HCA	RN	NA	HCA		RN	NA	HCA	RN	NA	HCA	
	5537	299	2455	5537	299	2444	Total Hours	4416	104	1311	4416	103.5	1311	
				100.0%	100.0%	100.0%	% Planned Hrs Met				100.0%	100.0%	100.0%	
			8292			8280	Total Hrs Planned & Actual - Combined Reg & Support			5831			5830.5	
						99.9%	% Planned Hrs Met - Combined Reg & Support						100.0%	

Current Position	Issues	Actions & Timelines
Meeting local levels of safe staffing. Currently deploying staff flexibly across the wards. No incidents linked to unsafe staffing levels	No issues.	6 monthly safe staffing review being carried out and will be reported at September Board.

Latest Data Refresh: **7/29/2024 8:00:16 AM** Latest Commentary Refresh: **7/30/2024 7:04:06 AM**

Integrated Quality and Performance Report

Queen Victoria Hospital NHS Foundation Trust

KSO2 World Class Clinical Services
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 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

Patient Related Outcome Measure (PROM)

2024/25 Major Projects

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

CareQuality Commission

The Queen Victoria Hospital (East Grinstead)

CQC overall rating

Good

23 May 2019

QVH

KSO2 World Class Clinical Services - Summary

Queen Victoria Hospital NHS Foundation Trust

Overview

The teams continue to produce good outcomes although the evidence is stronger in some areas. Work continues to progress the identification of meaningful patient reported outcomes in a wider range of sub-speciality areas.

Research strategy is being finalised to ensure that we continue to be world leading, and teams are supported to be innovative.

Microbiology engagement continues to be good with plans for a new audit to assess the impact of the virtual ward rounds later in the year.

Positive Assurance/Improvements	Challenges	Mitigations and Actions
Good Outcomes – evidenced well in some subspecialties – peer reviewed publications and registry data. Formal reporting metrics to be identified Better clinical engagement with Antimicrobial Stewardship from QVH teams and Microbiologist. Appointment of antimicrobial pharmacist. Updated prescribing app to reflect QVH caseload	Not all subspecialties have obvious benchmarking opportunities / patient reported outcome measures so teams will need to be inventive and develop metrics Documentation of decision making and discussions with microbiologist	Directorate teams to consider outcome measures and develop an action plan to work towards these. 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	Summary
% Overall FFT Recommendation Rate	Jun 24	90%			94.8%	95.4%	95.81	93.87	97.76	Common cause - no signficant change
Overall FFT Response Rate	Jun 24	25%			19.7%	19.2%	21.53	13.28	29.77	Common cause - no signficant change
FFT Recommendation Rate - Inpatients	Jun 24	90%			100.0%	99.5%	99.70	97.98	101.41	Common cause - no signficant change
FFT Response Rate - Inpatients	Jun 24	25%			41.3%	34.2%	44.90	28.20	61.60	Common cause - no signficant change
FFT Recommendation Rate - Inpatients Children	Jun 24	90%			97.2%	100.0%	99.08	95.12	103.03	Common cause - no signficant change
FFT Response Rate - Inpatients Children	Jun 24	25%			34.0%	20.0%	28.60	4.47	52.72	Common cause - no signficant change
FFT Recommendation Rate - MIU	Jun 24	90%			90.5%	91.4%	92.66	85.34	99.97	Common cause - no signficant change
FFT Response Rate - MIU	Jun 24	25%			19.8%	17.6%	21.69	14.16	29.22	Common cause - no signficant change
FFT Recommendation Rate - Outpatients	Jun 24	90%			94.5%	95.3%	95.46	94.53	96.38	Special cause worsening
FFT Response Rate - Outpatients	Jun 24	25%			16.2%	16.2%	17.36	13.02	21.69	Common cause - no signficant change
Readmissions< 30 Days	Jun 24	2%			2.6%	2.5%	2.33	0.54	4.13	Common cause - no signficant change
VTE Risk Assessment	Jun 24	95%			97.7%	97.7%	97.61	93.47	101.75	Common cause - no signficant change

Latest Data Refresh: **7/29/2024 8:00:16 AM** Latest Commentary Refresh: **7/30/2024 7:04:06 AM**

KSO2 World Class Clinical Services - Annual Goal

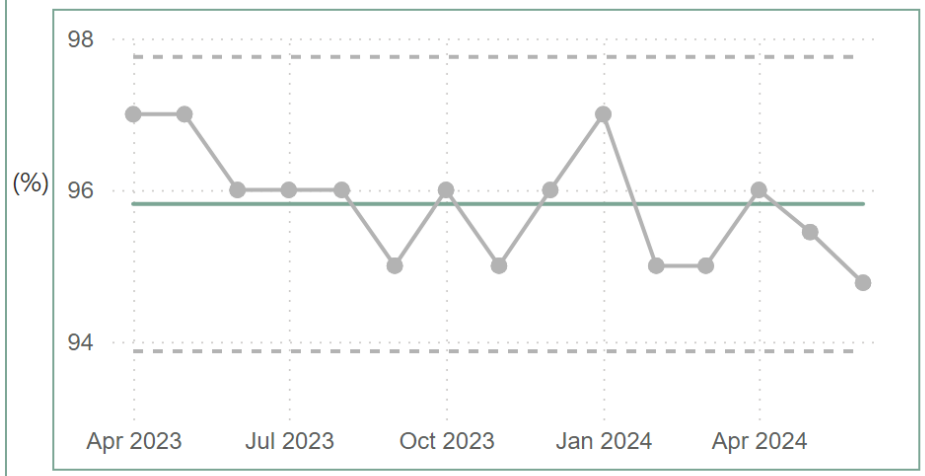
Queen Victoria Hospital NHS Foundation Trust

% Overall FFT Recommendation Rate

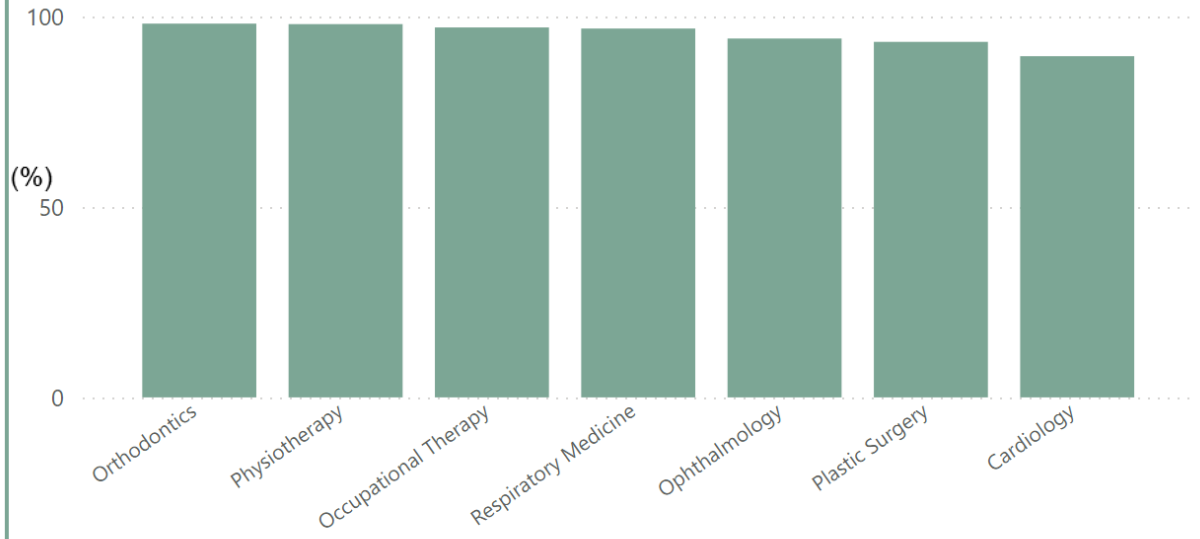
Reporting Month: Jun 24

Executive Lead: CNO

1.Historic trend data



Actual
94.8%
Internal Target
90%
National Target
90%
SPC
Common Cause
Consistent Pass



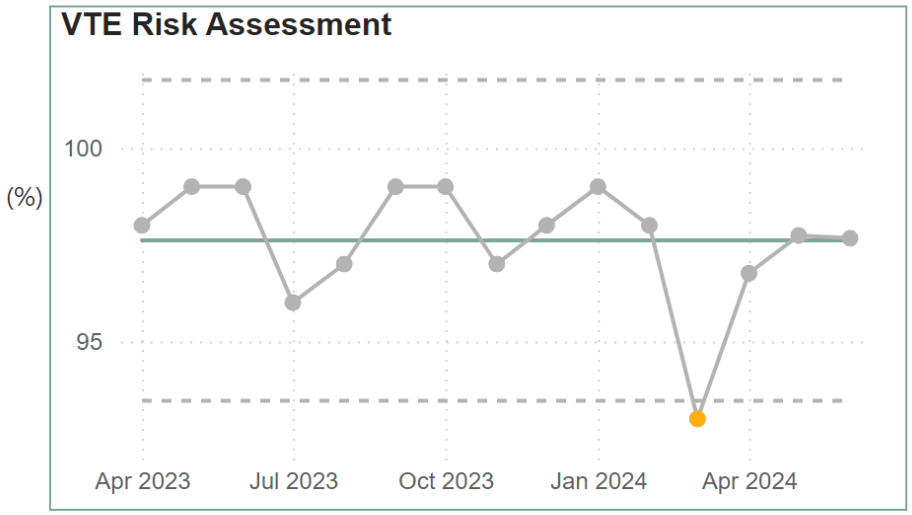
3.Top Contributors

Friends and Family test scores remain above target with positive responses for both inpatients and outpatients

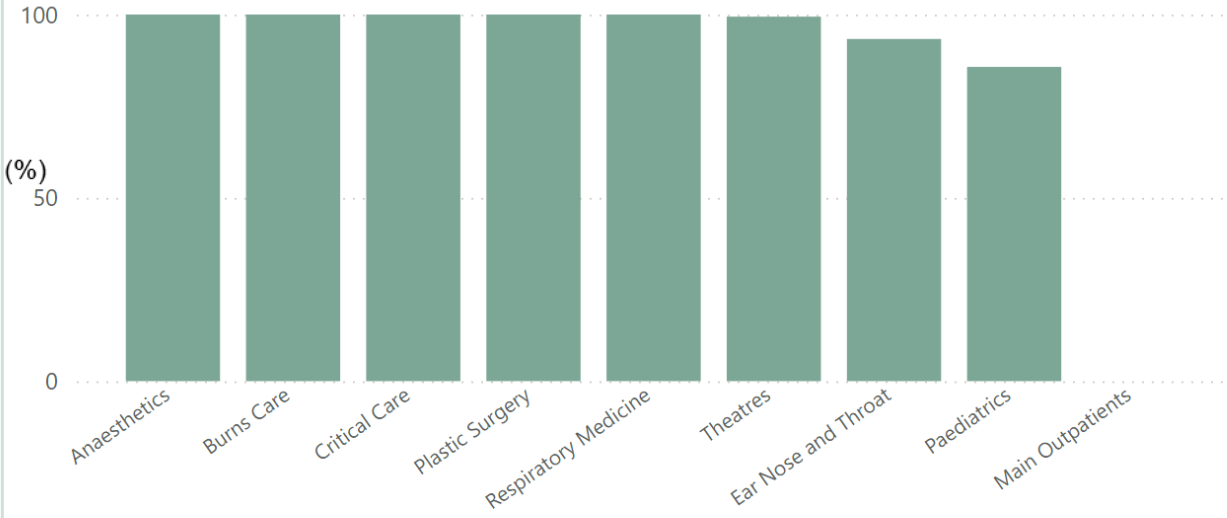
4.Action Plan

	Actions	Target Date
0	No Narrative	No Narrative

KSO2 World Class Clinical Services - Watch Metric



Actual
97.7%
Internal Target
95%
National Target
95%
SPC
Common Cause
Inconsistent



Current Position	Issues	Actions & Timelines
Achieving 97% - above target	Nil of note	Keep under review

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KSO2 World Class Clinical Services – 2024/25 Major Projects

Queen Victoria Hospital NHS Foundation Trust

Local Anaesthetic Unit	Executive Lead: CNO Lead: CMO	Reporting Month: Jun 24	Overall Status: Amber

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-late April 2024	April 2024	Post implementation review carried out. Learning incorporated in future plans.
Phase 2 – feasibility study	April 2024	May 2024	Phase 2 paused.

	Risks / Issues	Description	Mitigating Action
	Feasibility of the site	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 study	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 of the project	The cost of the project may exceed available funding	Consider other options and if there is a need to value engineer.
	Alignment with overall Trust estate strategy	The project needs to fit within the trust's overall estates strategy	

Integrated Quality and Performance Report

Queen Victoria Hospital NHS Foundation Trust

KSO3 Operational Excellence

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 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)*

CareQuality Commission

The Queen Victoria Hospital (East Grinstead)

CQC overall rating

Good

23 May 2019

QVH

KSO3 Operational Excellence - Summary

NHS
Queen Victoria Hospital
NHS Foundation Trust

Overview

RTT performance: Challenges remain as the waiting list continues to increase; programme of work underway to understand waiting list dynamics; significant efforts to eliminate long waiting patients over 65 and 78 weeks continue. Performance will be impacted from M4 onwards as patients from across the Sussex system are treated at QVH. Challenges continue with anaesthetic availability and the impact of industrial action in M3.

Cancer performance: FDS and 62d performance achieved national standard in M2. 31d did not achieve target reporting 91% and the >62d backlog remained static. Main challenges affecting cancer performance include a large seasonal increase in skin cancer referrals, patient complexity particularly for H&N and shortfalls in workforce capacity against the increased demand. Forward look into M3 suggests cancer performance is likely to maintain compliance with 62d and FDS targets.

Diagnostics (DMO1): Diagnostic performance has achieved the 95% target for the second consecutive month. Largely impacted by sustained improvement in Sleep Services (91.6%).

Outpatient productivity: Improving performance against the 46% target reporting 44% in M3; work ongoing to increase internal data visibility and understand areas of opportunity.? Outpatient transformation is an area of focus from Q2 onwards.

Theatre productivity: Performance achieved target reporting 85.3% (capped). A detailed action plan is being developed; this is a major area of focus and progress will be monitored through the theatre productivity group.

Positive Assurance/Improvements

- Cancer FDS continues to exceed target
- Cancer 62 day performance achieved target in M2; 86.8% against the 85% standard
- Diagnostic (DMO1) performance achieved target in M3 reporting 96.7%
- Theatre utilisation has achieved the GIRFT target reporting 85.3% (capped)
- Consistently exceeding the 4 hour performance target for MIU, reporting 98.8% against the 95% target.
- Achieved 96.5% of the value weighted activity plan for M3

Challenges

- RTT wait list continues to increase; stock take underway with detailed action plan to improve RTT management
- Sustained shortfalls in RTT validation workforce risking delayed clock stops and increased PTL size
- Large seasonal increase in skin cancer referrals outstripping current capacity and taking priority over routine RTT
- Late tertiary referrals continue to make up a large portion of the cancer >62d backlog (49% in M3)
- Continued anaesthetic staffing availability challenges affecting general anaesthetic activity delivery in all services, although improved since M2

Mitigations and Actions

- Outsourced programme of work identified to review and validate the entire RTT PTL
- Review of elective governance structure to ensure clear structure, purpose, responsibilities and deliverables against elective recovery goals
- Elective waiting list reporting and analysis improvement work commenced
- Utilising IS capacity for routine patients to release capacity for oncology and urgent RTT. Also exploring expansion of the teledermatology service
- Working collaboratively across services to prioritise capacity for long waiting RTT patients where possible
- Pathway analyser in progress to ascertain bottlenecks in complex H&N cancer pathways
- Anaesthetic capacity and demand review completed; recruitment ongoing with successful locum appointment in M4 and further consultant recruitment starting in M6 to fill vacancy
- Theatre utilisation action plan is being developed as a major area of focus

KSO3 Operational Excellence - Scorecard

NHS Queen Victoria Hospital NHS Foundation Trust

Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	UCL	LCL	Summary
RTT > 65 Weeks	Jun 24	0			69	51	73.80	107.81	39.79	Common cause - no signficant change
RTT 18 Week Wait Performance	Jun 24	92%			61.9%	62.6%	60.91	63.51	58.31	Common cause - no signficant change
RTT Waiting List	Jun 24				18925	18506	17,662.73	18,257.43	17,068.03	Special cause worsening
RTT >78 Weeks	Jun 24	0			1	4	8.20	18.27	-1.87	Common cause - no signficant change
% Income Vs Plan	Jun 24	100%			95.8%	99.6%	99.22	118.87	79.58	Common cause - no signficant change
Cancer 28 Day FDS	May 24	75%			87.5%	86.0%	85.35	93.41	77.28	Common cause - no signficant change
Cancer 31 Days	May 24	96%			91.0%	92.5%	86.24	98.84	73.64	Common cause - no signficant change
Cancer 62 Days	May 24	85%			86.8%	81.8%	78.38	103.09	53.68	Common cause - no signficant change
Cancer Waits > 62 Days	Jun 24	32			45	45	54.47	75.34	33.60	Common cause - no signficant change
Cancer Waits > 104 Days	Jun 24	3			8	6	12.93	22.24	3.62	Common cause - no signficant change
Diagnostics 6 Week Waits Performance	Jun 24	95%			96.7%	94.9%	85.17	93.92	76.41	Special cause improving
MIU 4 Hour Performance	Jun 24	95%			98.8%	99.0%	99.50	100.40	98.60	Common cause - no signficant change
% of 1st & Outpatient Procedure Appointments	Jun 24	46%			44.5%	44.4%	43.77	45.79	41.75	Common cause - no signficant change
Theatre Elective Utilisation- QVH Site (Capped)	Jun 24	85%			85.3%	82.7%	82.13	86.91	77.35	Common cause - no signficant change

KSO3 Operational Excellence - Annual Goal

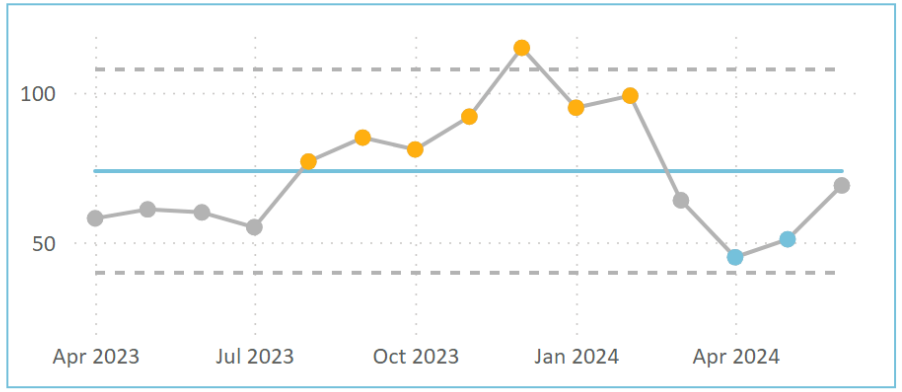
Queen Victoria Hospital NHS Foundation Trust

RTT > 65 Weeks

Reporting Month: Jun 24

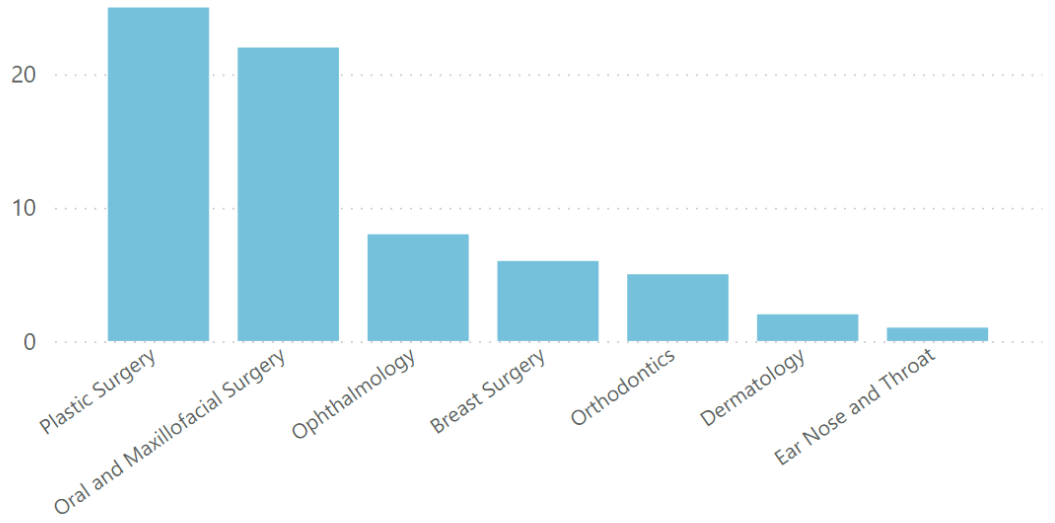
Executive Lead: COO

1.Historic trend data



National	Sussex ICB	QVH
0.75%	2.49%	0.28%

Actual	69
Internal Target	59
National Target	0
SPC	
Common Cause	
Inconsistent	



3.Top Contributors

There was an expected increase in the 65 week position due to anticipated complexity of cases; M3 internal trajectory was not met.

Forward look for M4 anticipates a decrease in 65 week breaches, although meeting the M4 trajectory will be challenged by the below contributors.

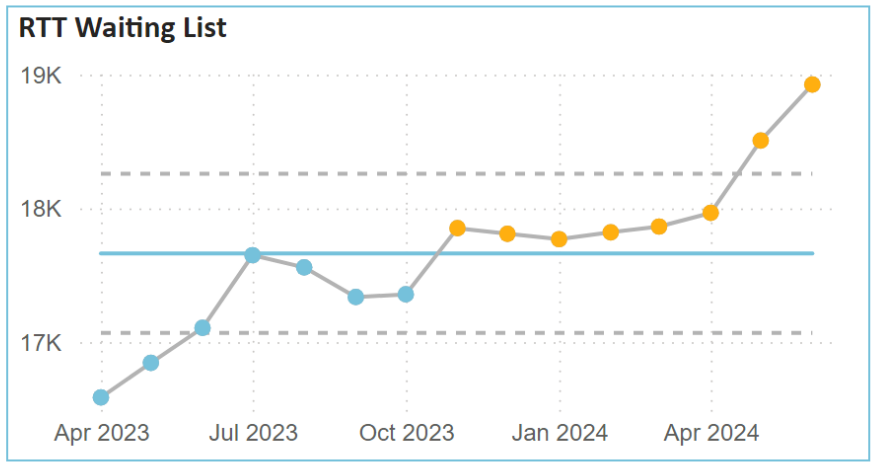
Maxillofacial (OMFS), Corneo, Breast and Mohs (Skin) identified as at-risk areas

1. Reduction in capacity run rate from M1 driven by lower levels of additional activity from the loss of WLI sessions
2. Anaesthetic workforce availability
3. Late tertiary referrals and the impact of taking mutual aid patients from across the system

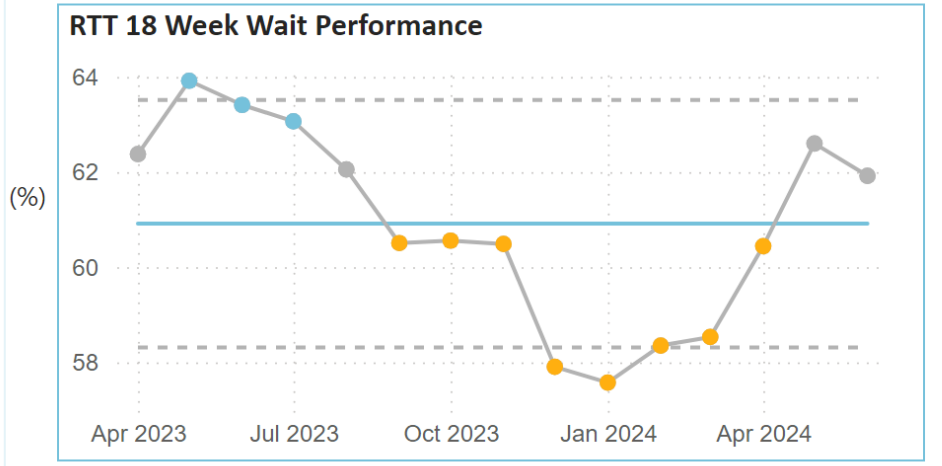
4.Action Plan

Actions	Target Date
1. Plans progressing to increase complex Mohs capacity through the local anaesthetic unit. Increased IS capacity at Worthing Dermatology Service for Mohs cohort in place from M3.	Ongoing
Continued reallocation of theatre lists to services with most clinically urgent patients. Additional Saturday capacity scheduled in M4 and M5 to support the OMFS at risk cohort.	Ongoing
2. Capacity and demand review of the anesthetic workforce completed and shared with clinical director and chief people office, demonstrating shortfall in budgeted establishment to deliver sufficient GA capacity.	M3
In the meantime, continued use of bank, agency and additional duties where possible, alongside successful recruitment within establishment of a locum, in post from M4. Further consultant recruitment scheduled from M5 to cover vacancy.	M4 / M5
3. Improving oversight and understanding of impact of tertiary referrals through increased data quality and reporting. Protecting capacity for longer waiting mutual aid patients where the referring provider is responsible for reporting the wait time, affecting capacity to treat existing patients on the QVH wait list.	Ongoing

KSO3 Operational Excellence - Watch Metric



Actual
18925
Internal Target
National Target
SPC
Worsening - Concern High
(Blank)



Actual
61.9%
Internal Target
92%
National Target
92%
SPC
Common Cause
Consistent Fail

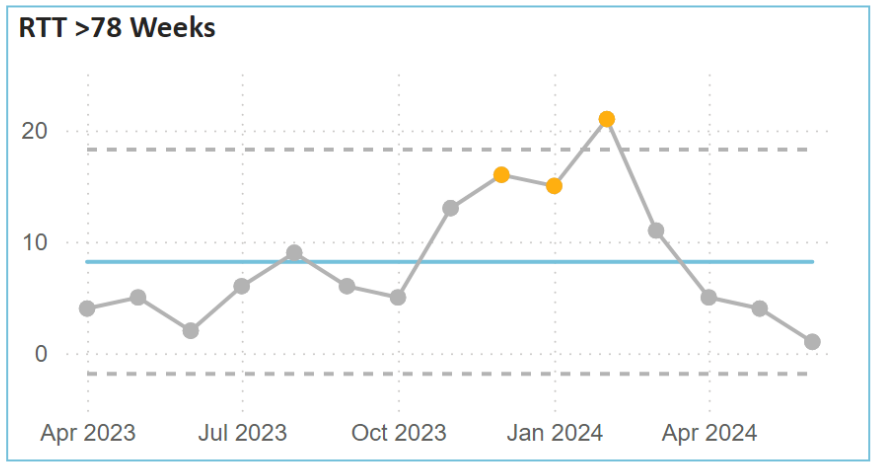
RTT 18 Week Wait Performance: look back 2024-05-01

National	Sussex ICB	QVH
58.23%	49.31%	62.61%

Current Position	Issues	Actions and timescales
Total WL size continues to increase, primarily driven by Maxillofacial, Orthodontics and Sleep, with non-admitted pathways being the largest area of growth. Review underway of waiting list dynamics to understand detailed actions required to give assurance of the Trust's RTT waiting list management Performance is affected by supporting the Sussex system with treating long waiting OMFS and Ophthalmology patients through both mutual aid and full patient transfers (FPT); started in M3 with 86 FPTs M3 industrial action caused loss of 14 theatre sessions, and 79 outpatient appointments (13 new, 66 follow up), as well as loss of un-booked capacity once IA was announced.	Reduction in clock stops against a static rate of clock starts. Impacted by outpatient follow up capacity challenges, lack of QVH RTT validation workforce, Sleep consultant absence (planned and unplanned) and temporarily out of use orthognathic diagnostic equipment delaying pathway progression.	Standing up additional outpatient capacity where possible, plans to increase QVH validation staff cohort, sleep consultant recruitment underway with interviews in M5 and additional appointed consultant starting in M6. Exploring use of IS for orthognathic diagnostics whilst QVH equipment is reviewed.
	Increase in cancer referrals which take priority over routine RTT referrals; particularly affecting Skin	Additional weekend clinics scheduled where possible while a longer-term solution for outpatient capacity is explored, including potential expansion of the tele-dermatology service. Continued use of IS providers for routine RTT to release oncology capacity.
	QVH and offsite data quality due to sustained shortfalls in onsite and offsite RTT validation workforce risking delayed clock stops and increased waiting list size	Outsourced programme of work identified in M4 to review and validate the entire RTT PTL, subject to costings. Successful appointment of a dedicated RTT spoke site validator to allow greater process control; expected to be in post by M6
	Current elective governance structure requires review and modernisation	Review governance framework commenced in M4 with the aim to ensure clear structure, purpose, responsibilities and deliverables against elective recovery goals. Detailed action plan in place which encompasses all elements of waiting list management improvement, with an assurance report due for the Board in M5.

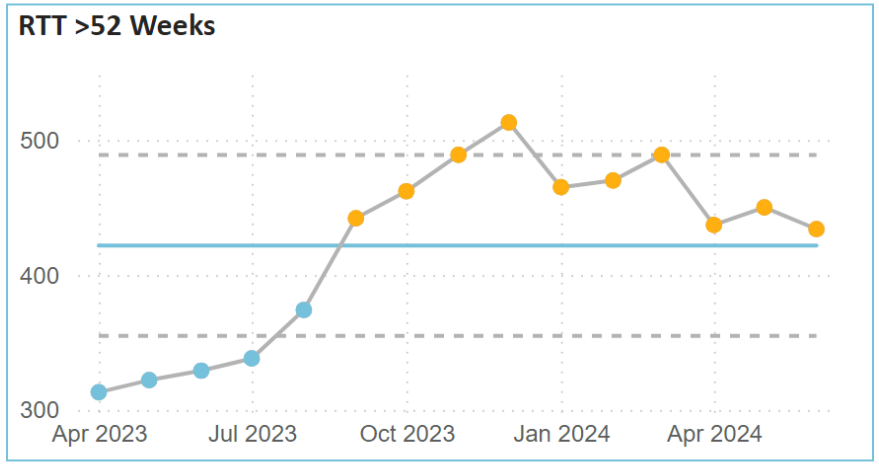
KSO3 Operational Excellence - Watch Metric

Queen Victoria Hospital NHS Foundation Trust



RTT >78 Weeks: look back 2024-05-01

Actual	Internal Target	National Target	SPC
1	0	0	Common Cause Inconsistent



Actual	Internal Target	National Target	SPC
434	734	734	Worsening - Concern High Consistent Pass

National	Sussex ICB	QVH
0.05%	0.26%	0.02%

Current Position	Issues	Actions and timescales
78 week waits Reporting 1 breach in M3 due to a medical delay related to patient sickness; this patient has since been treated in M4 Forward look for M4 is 2 patients breaching 78 weeks; one Orthodontic patient affected by patient sickness with a provisional treatment date offered in M6, subject to fitness. The second patient was referred to the Sleep service at 77 weeks; negotiations are ongoing with referring provider regarding breach reporting, plans to commence the care pathway in M4 subject to diagnostic outcome. Patients waiting over 78 weeks are reported weekly with assurance provided to both the Chief Operating Officer and the Sussex ICB **52 week waits** Stable position reporting 434 in M3. This will be an increased area of focus from M7 onwards following elimination of the 65-week cohort. BAU actions continue to ensure robust monitoring of the 52-week cohort and pathway progression, alongside improvement workstreams to review PTL meeting management processes.	Reduction in capacity run rate from M1 driven by lower levels of additional activity from the loss of WLI sessions	Working collaboratively across services to prioritise capacity for longest waiting patients where possible
	Patient initiated delays including short term sickness	Ensuring patient choice delays are managed appropriately and consistently in line with the Elective Access Policy which is currently in review. Applying active monitoring codes where appropriate, with clinical oversight.

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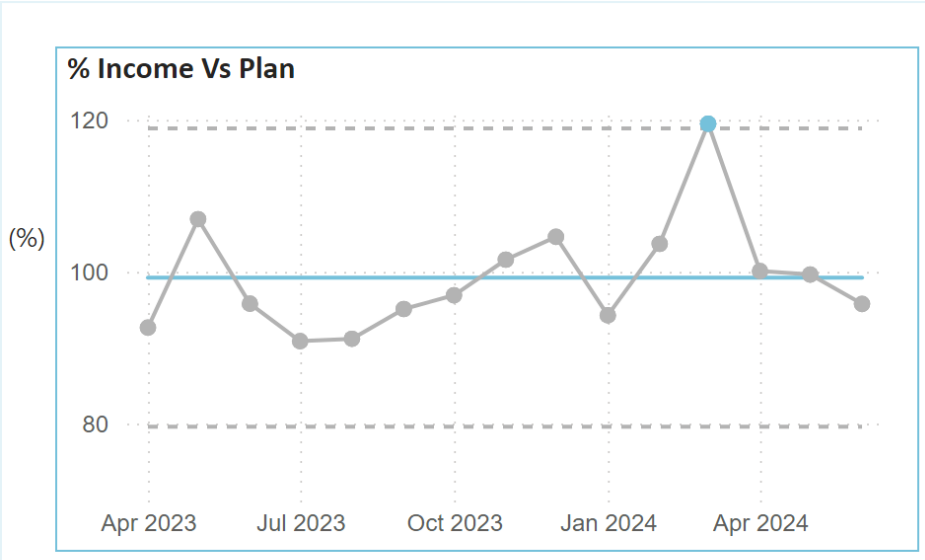
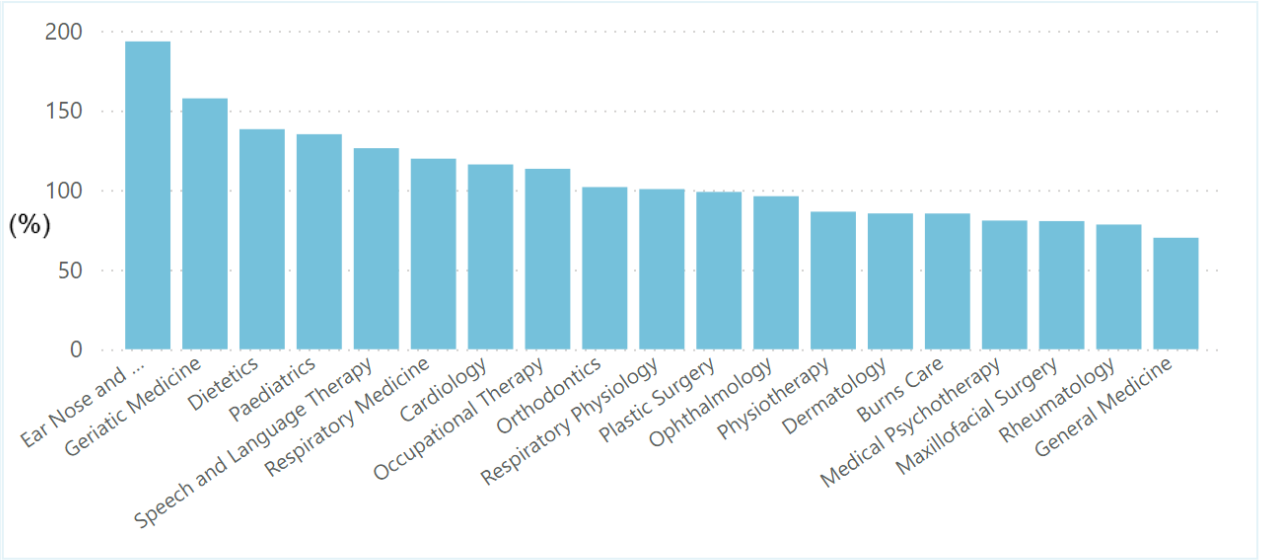
Queen Victoria Hospital NHS Foundation Trust



Actual
95.8%
Internal Target
100%
National Target
SPC
Common Cause
Inconsistent



Current Position	Issues	Actions & Timelines
Reporting 96.5% of plan in M3 (VWA).	Run rate of anaesthetic staff availability continues to result in loss of theatre activity. 23 cases cancelled due to inability to cover anaesthetic gaps in M3, and 40 cases converted to local anaesthetic due to lack of general anaesthetic cover.	Capacity and demand review of the anesthetic workforce completed. Continued use of bank, agency and additional duties where possible, alongside successful recruitment within establishment of a locum, in post from M4. Additional consultant recruitment scheduled from M5 to cover vacancy.
Reporting 93% admitted (daycase and elective) and 102% outpatient (new patient and outpatient procedure) against plan (VWA).		
Industrial action estimated to have contributed to 2% of the overall underperformance with the majority of the impact seem in the admitted activity.	Industrial Action – A total of 14 theatre sessions lost in M3 and loss of outpatient capacity. Cancellation of 14 operations, 13 new patient appointments and 66 follow up appointments, however this does not reflect the full extent of capacity lost as services ceased booking when industrial action dates were announced.	1 additional all day Saturday maxillofacial theatre list planned in M4 and 2 in M5. Theatre list allocations being revised to ensure capacity is directed towards services in line with demand.
Significant levels of planned and unplanned leave in some services contributing to further underperformance.		

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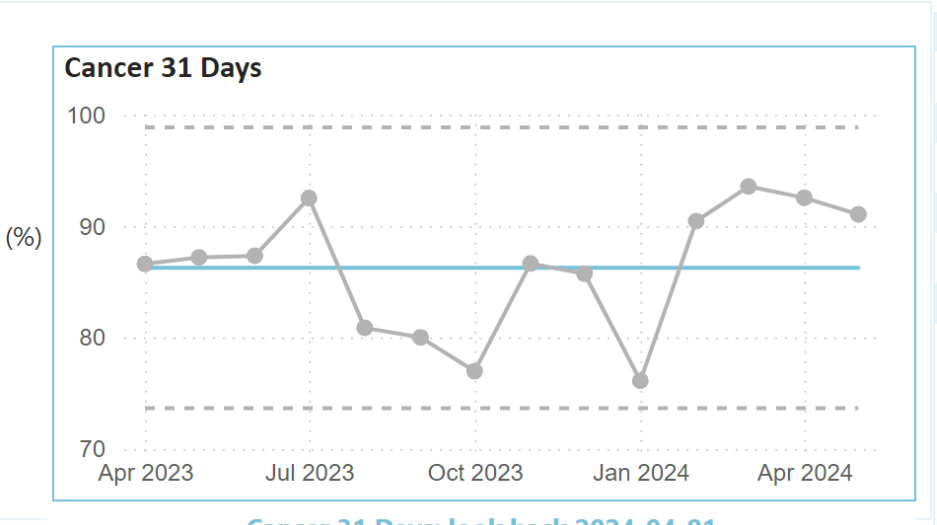
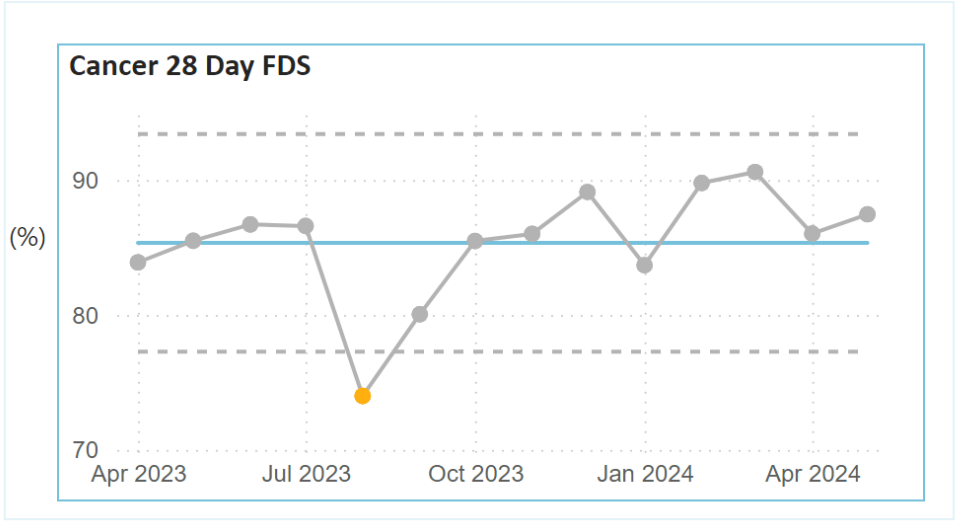
KSO3 Operational Excellence - Watch Metric

Queen Victoria Hospital NHS Foundation Trust



Actual
91.0%
Internal Target
96%
National Target
96%
SPC
Common Cause
Inconsistent

Cancer 31 Days: look back 2024-04-01



Actual
87.5%
Internal Target
75%
National Target
75%
SPC
Common Cause
Consistent Pass

National	Sussex ICB	QVH
89.16%	80.24%	92.52%

Current Position	Issues	Actions and timescales
31-day performance Underperformance in M2 reporting 91.9%, which is a 1.5% deterioration from previous month. Specialty performance; Skin 90.6%, Head & Neck 83.3% and Breast 100%. Impacted by Skin subsequent treatments; SLNB capacity issues. 31D DTT passed for Skin for M2 at 100%.	Sentinel Lymph Node Biopsy (SLNB) capacity and pathway challenges	Working with IS providers to provide additional SLNB capacity; in place from M2. Sending around 8-10 patients monthly who fit eligibility criteria, those not suitable are seen at QVH
	Staff capacity and skill mix	Skin: moving less complex patients to alternative lists in the local anaesthetic unit to protect capacity of consultants able to see more complex patients including SLNB
Faster Diagnosis Standard (FDS) The Trust achieved FDS with a performance of 87.5% in May. Meeting the submitted trajectory and Mar-25 target. Specialty performance: Skin 87.6%, Head & Neck 87.5% Unvalidated M3 position remains compliant with the Mar-25 target but is unlikely to achieve the submitted trajectory due to temporary IT system challenges impacting timely results letters.	The most common causes of FDS breaches were Outpatient Capacity (25), Administrative Delay (18) and Delay to Diagnostic Test by Health Care Provider (19). Administrative delays predominantly relate to results letter delays.	Closely monitoring FDS at the PTL and specialty meetings to enable proactive pathway management. Root cause analysis of the IT system challenges will be presented to the Quality & Safety Committee.
	Large increase in the number of Skin cancer referrals received; demand is greater than current capacity.	Increasing outpatient capacity to meet higher demand; reviewing a longer-term solution which includes potential expansion of the tele-dermatology service.

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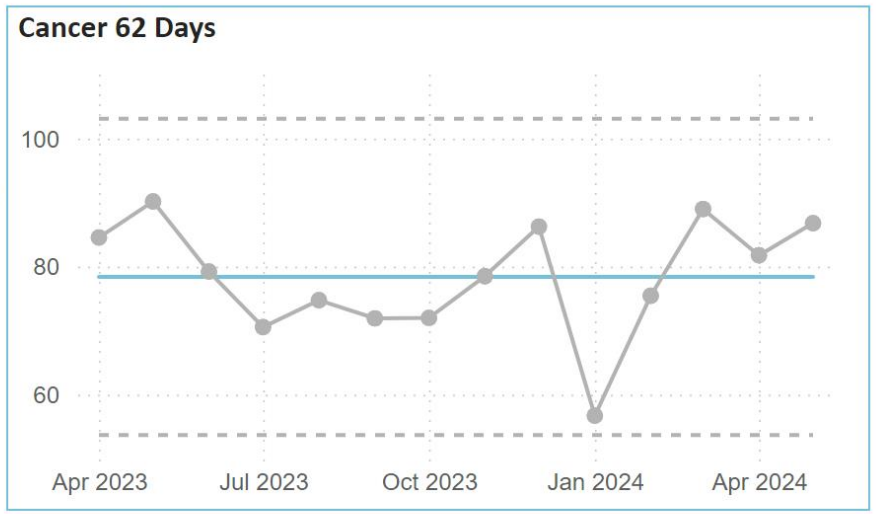
KSO3 Operational Excellence - Watch Metric

Queen Victoria Hospital NHS Foundation Trust



Actual
86.8%
Internal Target
85%
National Target
85%
SPC
Common Cause
Inconsistent

National	Sussex ICB	QVH
66.6%	62.2%	81.75%

Current Position	Issues	Actions & Timelines
Increase in month reporting 86.8%. Meeting the national standard, submitted trajectory and Mar-25 target.	Skin workforce capacity shortfalls	Recruitment of speciality doctor to replace capacity lost in M9 of 23/24, start date pending visa processes
Likely to continue to meet national standard in M3, subject to final validations with other providers; also predicting to achieve submitted trajectory and Mar-25 target.	H&N workforce capacity shortfalls	Recruitment underway for a locum consultant aiming to be in post from M7
	Complex case mix in H&N	Pathway analyser in progress to ascertain pathway bottlenecks

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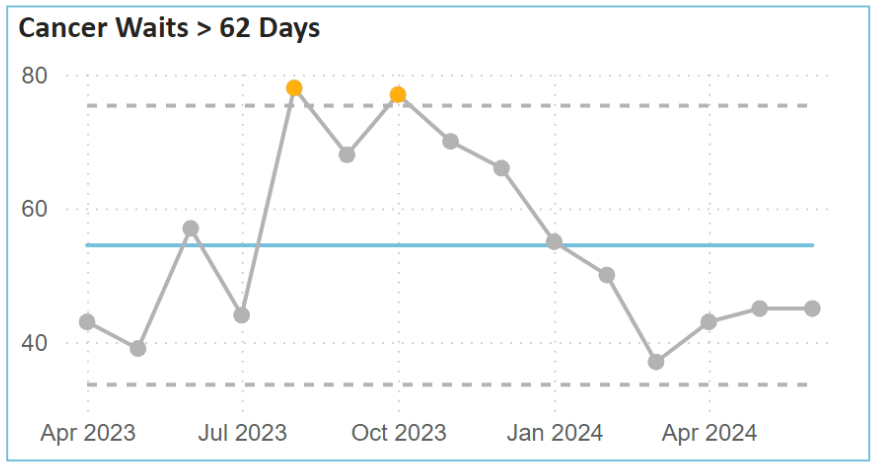
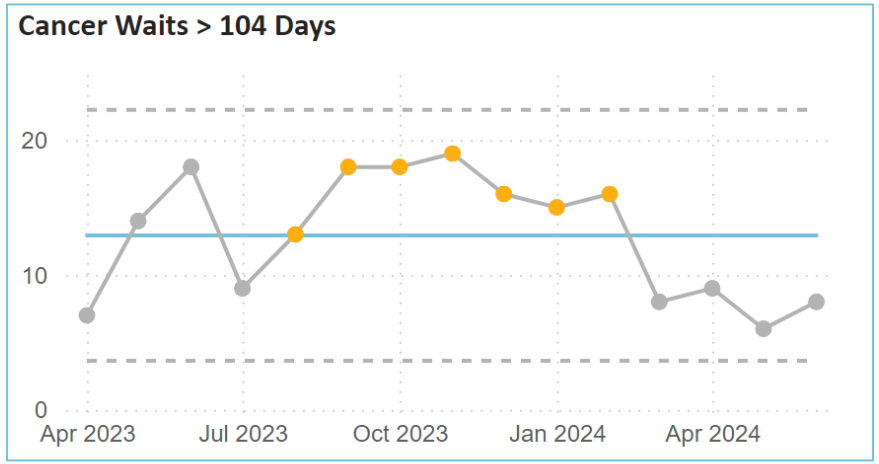
KSO3 Operational Excellence - Watch Metric



Actual
45
Internal Target
32
National Target
32
SPC
Common Cause
Consistent Fail



Actual
8
Internal Target
3
National Target
3
SPC
Common Cause
Consistent Fail

Current Position	Issues	Actions & Timelines
Reporting 45 patients in M3; no change from M2.	Late tertiary referrals (>38 days) make up 49% of the backlog in M3	Regular meetings with Kent Integrated Dermatology Service to monitor and address late referrals
Reporting a decrease in the number of patients waiting over 62 Days as a proportion of the PTL from 7.1% to 6.4% due to the increase in the size of the PTL.	High volume of complex pathways with patients having inpatient stays at other hospitals or being too unwell to accept a treatment date	Continued focus on patients over 62 days at twice weekly patient tracking meetings; patients are discussed at an individual level to monitor pathway progression and minimise delays.
Specialty performance: Skin (29), Head & Neck (9), Breast (5), Other (2). Skin and H&N have seen a reduction in patients.		
Patients waiting over 104 days are included in the 62 day backlog; in M3 there were 8 patients over 104 days, an increase of 2 patients, impacted by an increase in skin.		

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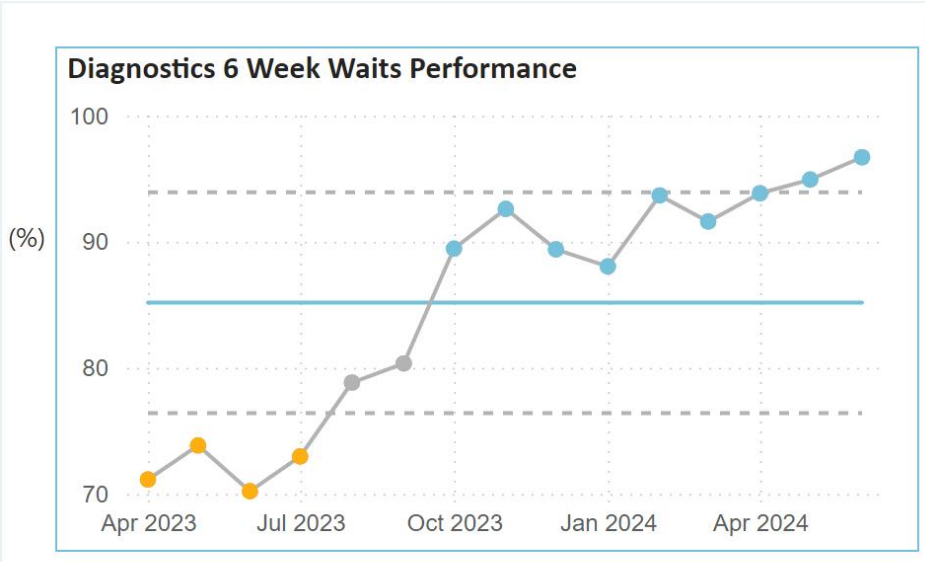
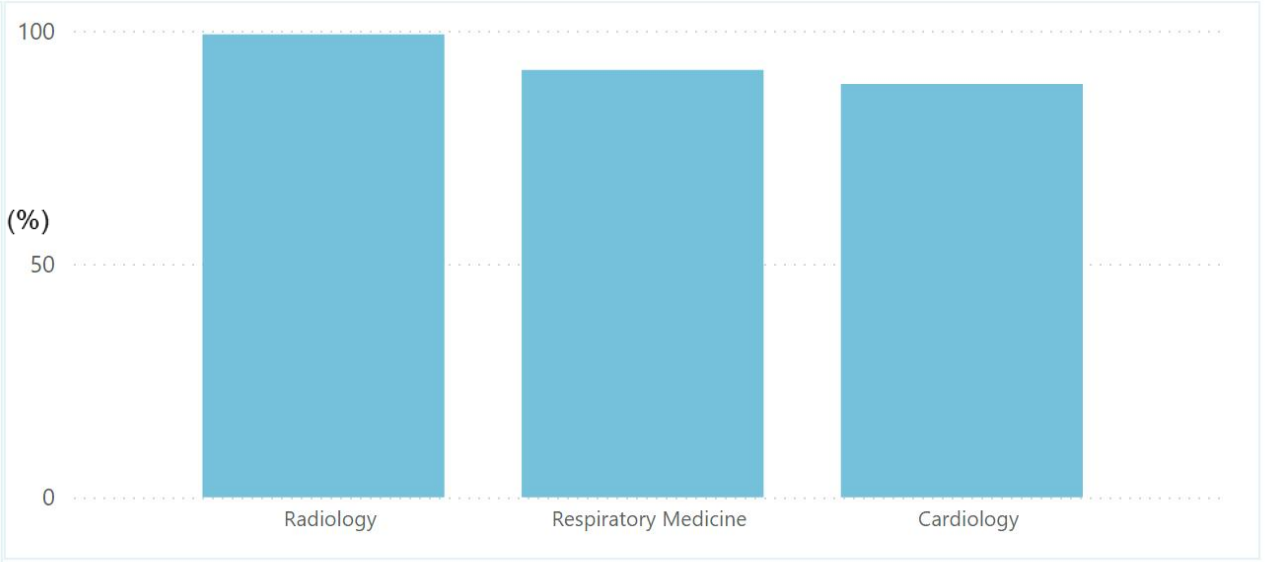
KSO3 Operational Excellence - Watch Metric

Queen Victoria Hospital NHS Foundation Trust



Actual
96.7%
Internal Target
95%
National Target
95%
SPC
Improving - Improvement High
Consistent Fail



National	Sussex ICB	QVH
77.92%	79.58%	94.92%

Current Position	Issues	Actions & Timelines
Diagnostic performance has achieved target for the second consecutive month, reporting 96.7% in M3		
Impacted by sustained improvement in Sleep: 91.6% with 43 patients >6 weeks; a 36% reduction on previous month	Sleep - consultant clinic capacity, as well as increasing referral rate; currently 600+ per month	Scheduling additional clinics where possible. Recruitment underway for two new (potentially full-time) consultants, a third part-time consultant starts in M6. Revised pathways – electronic triage and process revision to be implemented from M5.
Radiology diagnostic performance remains high reporting 99.2%	Radiology - sonographer shortage, a local and national issue. Upcoming maternity leave will challenge ultrasound biopsy lists	Bank and agency solutions are in place from M4. Recruitment ongoing for a locum radiologist.

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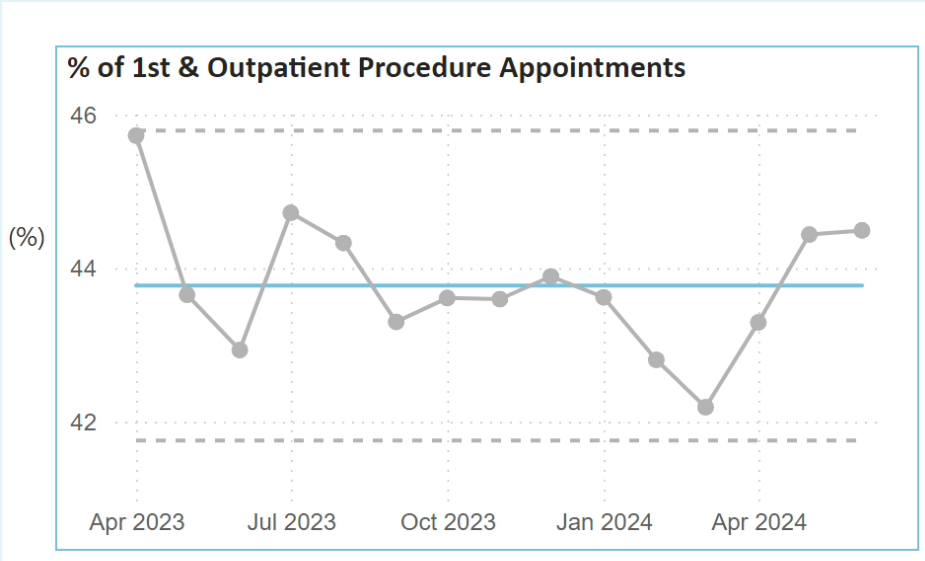
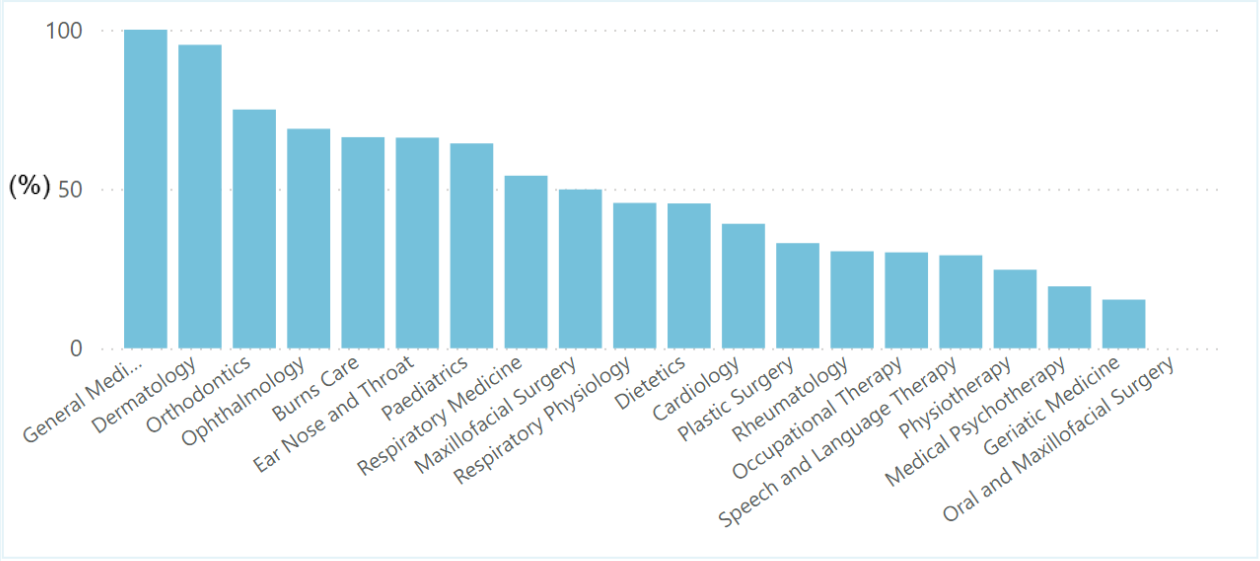
KSO3 Operational Excellence - Watch Metric

Queen Victoria Hospital NHS Foundation Trust



Actual
44.5%
Internal Target
46%
National Target
46%
SPC
Common Cause
Consistent Fail



Current Position	Issues	Actions & Timelines
Reporting 44.5% in M3, up from 43% in previous month	Insufficient internal data visibility to be able to identify opportunity areas for improving first appointments and outpatient procedures at specialty and clinic level	Development of the internal reporting mechanism remains in progress; further fine tuning required throughout M4
The outpatient transformation programme will be a key area of focus from Q2 onwards		Finalising methodology to calculate new patient to follow up ratios at specialty level to enable identification of areas where first appointments could be increased
PIFU performance continues to improve reporting 2.3% in M3, with the anticipated effect of reducing follow ups of low clinical value to release additional first appointment capacity.		
Work underway to improve outpatient DNA rates in opportunity areas such as physiotherapy and hand therapy to free up capacity to clear backlogs and reduce wait times.		

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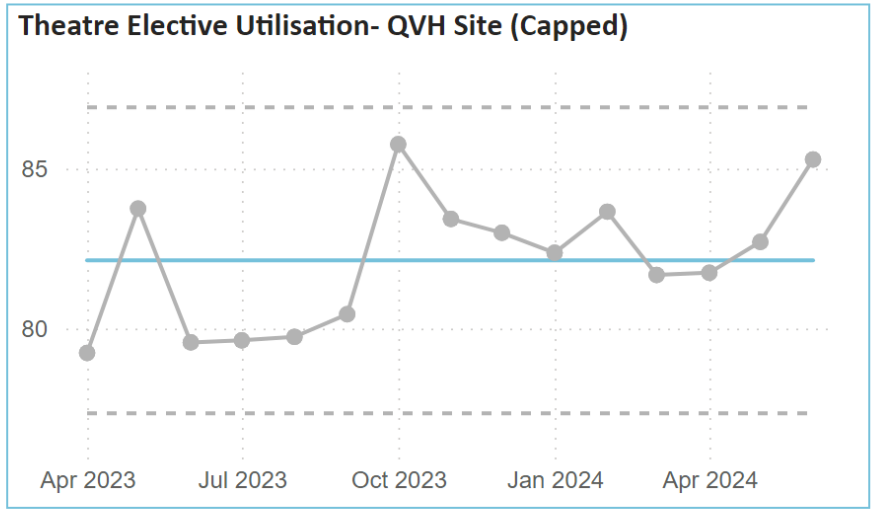
KSO3 Operational Excellence - Watch Metric

Queen Victoria Hospital NHS Foundation Trust



Actual
85.3%
Internal Target
85%
National Target
85%
SPC
Common Cause
Inconsistent

Measure	Performance	Variation	Assurance
Theatre Productivity - % of Cancellations on the Day	5.00		
Elective Late Starts (Mins)	13.00		
Elective Early Finishes(Mins)	14.00		
Daycase Rate (%)	80.10	H	F
Theatre Elective Utilisation- QVH Site (Capped)(%)	85.28		
Elective Theatre Utilisation (Uncapped) (%)	89.00		

Current Position	Issues	Actions & Timelines
The utilisation figure reported above is capped which measures the total amount of planned time used, excluding overruns and unplanned extensions.	Cancellations on the day (COTD)	New process introduced from M4 to allow daily feedback at service level on key theatre performance metrics
Changes to the capped calculation may be expected in the coming months as our internal methodology is aligned with recently released NHSE data quality measures.		New process within Skin implemented from M4 to address the largest COTD reason: operation not required due to lesion not present
Capped utilisation has improved in month to 85.3%; achieving target despite M3 industrial action with 14 sessions lost.	Underutilised lists, particularly Skin, OMFS, Orthognathic and Cataract lists	A detailed theatre utilisation action plan is being developed in M4 using A3 methodology to address areas of underperformance; this is a major area of focus and progress will be monitored through the theatre productivity group
Continued engagement with the GIRFT Further Faster programme with a particular attention on theatre productivity and ophthalmology list utilisation.		Plans to pilot increasing the number of cataract cases per list from M4, subject to patient complexity and clinical appropriateness. Also applying learning from IS ophthalmology centers to improve patient flow

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KSO3 Operational Excellence – 2024/25 Major Projects

Queen Victoria Hospital NHS Foundation Trust

Deliver the Community Diagnostic Centre Programme	Executive Lead: Tania Cubison Lead: Fiona Lawson	Reporting Month: Jun 24	Overall Status: Amber

The QVC CDC programme is progressing. There has been an increase of pace around the programme. The demand and capacity model, the business case and the planning application have all progressed. 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	Dec 2025	Dec 2025	New programme team in situ have reviewed the programme timelines. Completion of the new build expected in Dec 2025.
Increase referrals and activity	Ongoing	Ongoing	Demand and capacity model to be completed by Aug 24.
Develop additional Clinical pathways	Ongoing	Ongoing	To further develop clinical pathways for Patients to access.

Risks / Issues	Description	Mitigating Action
Insufficient demand in activity.	Threat to viability of overall programme through insufficient demand in activity.	Conversations in the system to confirm sufficient demand needed for CDC sand ensuring that provider operating models reflect the full use of CDCs.
Budget constraints	Insufficient funds to deliver the programme may lead to value engineering to keep the project within available capital resources which reduce some of the planned functionality in some clinical services.	Work underway to consider the costings. If financial gap continues to be identified, further work ongoing to reengineer the design to fit within capital resource available

KSO3 Operational Excellence – 2024/25 Major Projects

Queen Victoria Hospital NHS Foundation Trust

To deliver the Sussex Pathology Network Programme	Executive Lead: Tania Cubison Lead: Fiona Lawson/Rachael Liebmann	Reporting Month: Jun 24	Overall Status: Amber

The Sussex Pathology Network (SPN) Programme has multiple projects progressing concurrently with QVH as a member organisation: LIMS – QVH implementation is delayed until September 2025 due to wider SPN issues re. harmonisation. Activities requiring significant input from lab staff are approaching. This resource is currently unfunded and presents operational and cost pressures to BAU and risk of further delay if the activity is not completed within allocated timescales. Order Comms – The project plan continues to be refined in liaison with the supplier and stakeholders. Technical working group progressing towards HLD; reviewing resource requirements for the build. Timescales to align with LIMS deployment. Digital Histopathology – Work continues to progress the QVH Digital Histopathology business case. The project team are still in discussion with SECTRA and VisioPharm to refine the requirement with quotations due this month. There remains potential for central funding to help with revenue costs. SPN to confirm later this month. Achievement of digital histopathology will require both capital and revenue commitment from QVH budgets. Managed Services Contract (MSC) – Bidders have submitted initial draft responses to the Technical Specifications, which are now being reviewed by the relevant teams to draw out agenda items for the Dialogue sessions. The Dialogue sessions will be held between 22nd July and 2nd Aug. SPN (S7) Target Operating Model (TOM) – Work has continued on reworking the OBC and all agreed options wave now been included in the document. Quality Workstream – Work to identify quality documentation/SOPs in scope has been completed. QMIS SOC has been approved at SPOF and will continue through network and Trust governance. The position statement for PQAD has been approved and an action plan is being taken to SPOF for endorsement. Workforce – the short-term workforce strategy was approved at the steering group and was included on June's SPOF agenda. Position statements identifying the barriers to underrepresented group and also for EDI impact assessment to Training & Development, were also approved.

Milestones	Planned Date	Actual/Forecast Date	Commentary
Digital Histo workstream - Preparation of POAP for initial review by ELT	July 2024	TBC	On Target
LIMS workstream - Agree Project Plan	End July 2024	TBC	On Target
LIMS workstream - complete Clinical Safety Case Report (dependant on CSO Consultancy	End July 2024	TBC	On Target
TOM workstream - Financial modelling for remaining options to be completed	July 2024	TBC	On Target
Quality workstream - Harmonise document control and change control processes	July 2024	TBC	On Target
MSC workstream - dialogue sessions	July 2024	TBC	On Target
MSC workstream - Pre-submission of technical specifications received form bidders	July 2024	TBC	On Target

Risks / Issues	Description	Mitigating Action
Underspend of allocated network funding	There is a risk that there could be an underspend against the MOUs.	Plan spend in line with project delivery. UHSx / ESHT to escalate potential underspend to SROs to enable mitigations to be taken forward. SPN project team to assess impact for subsequent years implementation. Major Projects Narrative History Report a bug
Evolution of programme	realign to new service design. Delay on decision making may occur if stakeholders over consider the future requirements and subsequently impact project delivery.	Accept a level of uncertainty and that future changes may be needed. Avoid closing future opportunities, where possible, but not at risk of delivering project benefits (ie within time and financial constraints)
Network Commercial structure not defined	Risk to delivery of Programme if a commercial structure is not agreed across SPN	Development of Network Formation Case for Change. Maintain Legal advice on network formation development. Early engagement and socialisation of case for change at Trust level
Capacity of Trust resource	Risk to delivery of programme against timeline due to Trust resource capacity in key areas e.g. Clinical, Operational, Digital	SPN working collaboratively with trusts to agree additional roles to support project delivery, building backfill resource into business case. Divisions to prioritise programme. Financial split as per MOU (QVH only 1% and also no Path IT team creates additional resource pressure)
Risk to progression of Programme if Programme Team resource not in place	Failure to deliver projects and overall programme if limited Network co-ordination in place, leading to failure to realise benefits anticipated through networking	Future planning for programme team resource requirements beyond 24/25. Review priorities of programme alongside resource capacity, with constant review

KSO3 Operational Excellence – 2024/25 Major Projects

Queen Victoria Hospital NHS Foundation Trust

Electronic Patient Record	Executive Lead: COO Lead: CDIO	Reporting Month: Jun 24	Overall Status: Amber
	FOT FY: TBC FY Budget: TBC	YTD Spend: TBC YTD Budget: TBC	Variance TBC

The EPR Programme is a significant, multi-year programme and is of a significant scale requiring wide engagement of teams and a transformation process. The commencement of the programme has now taken place and the development of the detailed plans, the personnel required and the communication with the wider organisation is now underway.
There are four key workstreams
- Transformation: Some roles within the EPR team are still to be recruited to and plans are in place although this does represent a current risk to the programme
- Build: This workstream is on track with Altera training for the team taking place
- Assurance: The clinical governance assurance process is being developed as part of the wider governance structure
- Technology: This workstream is on track with meetings with partners and implementation of the test environments

Milestones	Planned Date	Actual/Forecast Date	Commentary
Formal EPR kick-off meeting	12 June 2024	12 June 2024	Completed - 26 attendees plus programme leads
Creation of Project Initiation Document	31 July 2024		
Revised governance structure to be agreed	31 July 2024		

Risks / Issues	Description	Mitigating Action
R003	Risk around release on internal resources required to assist with project, and potential problems linked with back-filling 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 startegy and deliver with support from wider EPR programme resources and trust staff.
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 startegy (in PID) to define data to be migrated, resolve quality issues prior to migration, this is to be resourced and planned.

KSO4 Financial Sustainability

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

2024/25 Annual goals

1.Break even position

KSO4 Financial Sustainability - Summary

Queen Victoria Hospital NHS Foundation Trust

Overview

- At the close of June 2024, the Trust was delivering its break-even plan and had a cash balance of £8.7m. The forecast is for the achievement of the Trust's break-even plan.
- The actual pay award for consultants is reflected in the financial position along with the expected income. An assumption that the overall pay increase across all staff will be a 2.1% increase. As pay awards are confirmed the costs and income will be reflected.
- Activity levels have been good although industrial action did impact on Month 3 income. The Elective Recovery Fund (ERF) has been calculated using the 2019/20 baseline as a 12-month average resulting in £0.7m favourable income.
- Industrial action has seen additional costs and reduced income in Month 3. A pay impact estimation of £0.2m and lost income of £0.1m have been included in the position.
- Trust agency spend increased in Month 3 and is £0.8m YTD which reflects 4.9% of the pay bill which is above the 3.2% cap. The Trust is working on ways to reduce agency usage and converting agency staff to permanent or bank.
- Efficiency plans of £6.5m are included in the position and it has been confirmed there is (at present) no additional efficiency requirement.
- The Trust's capital plan for the year is £17.5m and includes capital spend associated with the receipts from the sale of land. At Month 3 it is £2.4m under spent.
- The plan was updated in Month 3 and therefore the in month figures contain YTD updates in the plans resulting in higher variances than normal. This will return to normal in Month 4.

Positive Assurance/Improvements	Challenges	Mitigations and Actions
The Trust is delivering the break even position YTD at Month 3	Delivery of the the £1.2m stretch target and ERF	Put an efficiency steering group into place
The Trust is delivering its activity plan to deliver 125% by the end of the year although industrial action is impacting on the income.	To deliver the activity and increase productivity across the Trust. In order to deliver the target activity needs to remain high	Monitor activity in the Trust monthly review meetings and driver productivity in theatres.
The Trust agency spend is £0.8m YTD which reflects 4.9% of the pay spend.	To reduce the monthly agency spend and remain within the annual agency cap of 3.2%	Recruitment to vacancies and conversation of agency staff to bank or fixed term contracts.

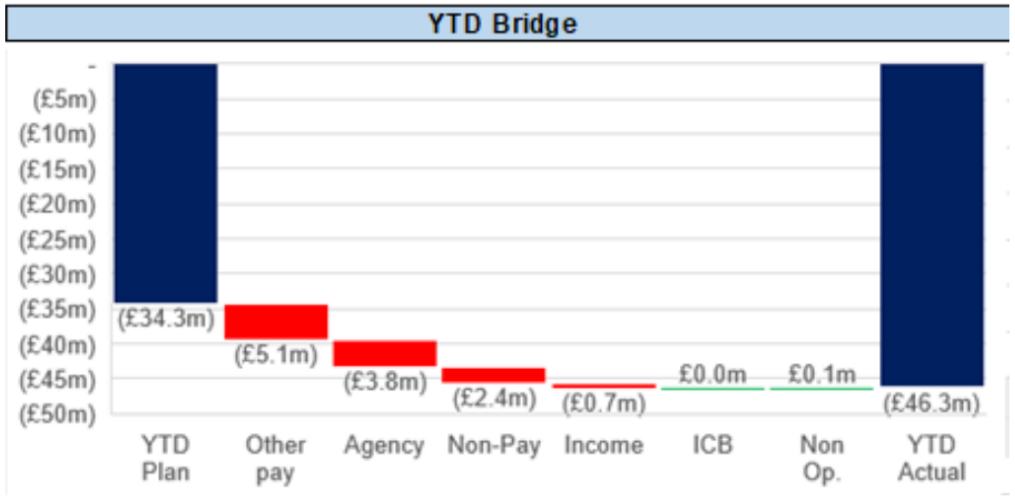
KSO4 Financial Sustainability - Scorecard

Queen Victoria Hospital NHS Foundation Trust

Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	LCL	UCL	Summary
Breakeven YTD	Jun 24	£0.0m			£0.0m	£0.0m				
Cash At Bank YTD	Jun 24				£8.7m	£6.4m				
Capital Spend YTD	Jun 24	£2.95m			£0.5m	£0.2m				
Efficiencies YTD	Jun 24	£1.32m			£1.3m	£0.9m				
BPPC (NHS & Non-NHS) Volumes	Jun 24	95%			90.8%	93.9%				
BPPC (NHS & Non-NHS) Values	Jun 24	95%			90.7%	91.7%				
Agency Spend Less than 3.2% of Total Pay Bill	Jun 24	£0.34m			£0.8m	£0.5m				

Sussex System Financial Summary

Org	Surplus/(Deficit) by Organisation				
	YTD Plan	YTD Actual	YTD Variance Favourable/(Adverse)		Full Year Plan
ESHT	(£8.7m)	(£13.6m)	(£4.9m)	(3.0%)	(£11.7m)
QVH	-	£0.0m	£0.0m	0.0%	-
SCFT	(£1.7m)	(£1.7m)	-	-	-
SPFT	(£6.3m)	(£6.7m)	(£0.5m)	(0.4%)	(£18.6m)
UHSx	(£17.7m)	(£24.3m)	(£6.6m)	(1.8%)	(£26.5m)
Provider Total	**(£34.3m)**	**(£46.3m)**	**(£12.0m)**	**(1.6%)**	**(£56.8m)**
ICB	-	£0.0m	£0.0m	0.0%	-
System Total	**(£34.3m)**	**(£46.3m)**	**(£11.9m)**	**(1.2%)**	**(£56.8m)**



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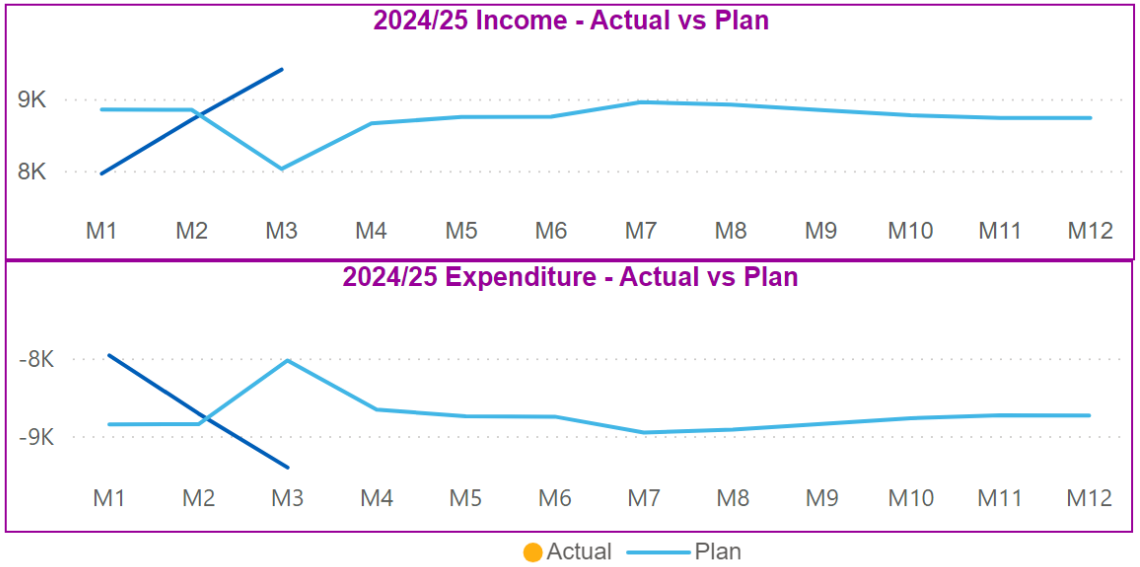
KSO4 Financial Sustainability - 24/25 - Annual Goal

Queen Victoria Hospital NHS Foundation Trust

Breakeven YTD



Reporting Month: Jun 24

Executive Lead: CFO

2.Stratified data

Breakeven	Annual Target	Forecast Outturn
Income & Expenditure	£	£
Cash at bank	£14.3m	£14.3m
Capital Spend	£17.5m	£17.5m
Efficiencies	£6.5m	£6.5m
Value	95%	95%
Volume	95%	95%

3.Top Contributors

Value weighted activity achievement in Month 1 was 120%.

Month 2 Value Weighted Aactivity achievement was 117% compared to the 19/20 activity baseline. ERF activity income increased by circa £240k from Month 1 even though the months had the same number of working days,. This was against a higher baseline in Month 2 of 19/20 compared to Month 1

4.Action Plan

Actions	Target Date
Set up activity profile for delivering the income plan	01/07/2024
Set up efficiencies programme group to monitor and deliver the Trusts forecast.	01/07/2024

KSO4 Financial Sustainability - 24/25 - Watch Metric

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 3 2024/25											
Income and Expenditure											
	In Month £'000				Year to Date £'000				Forecast Outturn £'000s		
	23/24	**Plan**	**Actual**	**Variance**	**23/24**	**Plan**	**Actual**	**Variance**	**Plan**	**Forecast**	**Variance**
Income											
Patient Activity Income	7,897	7,804	9,077	1,273	23,246	25,062	25,750	688	102,198	102,198	0
Other Operating Income	244	223	331	108	882	666	985	319	2,654	3,364	710
Total Income	7,520	8,027	9,408	1,381	24,128	25,728	26,735	1,007	**104,852**	**105,562**	**710**
Pay											
Substantive	(5,046)	(4,859)	(5,351)	(492)	(14,095)	(15,782)	(15,360)	422	(65,837)	(65,837)	0
Bank	(358)	(330)	(267)	63	(950)	(988)	(984)	4	(3,950)	(3,950)	0
Agency	(130)	(122)	(360)	(238)	(419)	(335)	(848)	(513)	(1,275)	(1,275)	0
Total Pay	(4,866)	(5,311)	(5,978)	(667)	(15,464)	(17,105)	(17,192)	(87)	**(71,062)**	**(71,062)**	**0**
Total Non-Pay	(2,548)	(2,152)	(2,873)	(721)	(8,373)	(6,929)	(7,911)	(982)	**(32,576)**	**(33,286)**	(710)
					0	0	0	0	0	0	0
Total Non Operational Expenditure	(129)	(587)	(579)	8	(360)	(1,763)	(1,700)	63	(1,491)	(1,491)	0
Total Expenditure	(7,543)	(8,050)	(9,430)	(1,380)	(24,197)	(25,797)	(26,803)	(1,006)	(105,129)	(105,839)	(710)
Surplus/(Deficit)	**(23)**	**(23)**	**(22)**	**1**	**(69)**	**(69)**	**(68)**	**1**	**(277)**	**(277)**	**0**
Technical Adjustments	23	23	23	0	69	69	69	0	277	277	0
Adjusted Surplus / (Deficit)	0	0	1	1	0	0	1	1	0	0	0

Current Position	Issues	Actions & Timelines
The Trust position at Month 3 is for a breakeven position	The plan contains an addtional stretch target of £1.2m and efficiencies that increase later in the year.	Work to increase productivity and deliver additional efficiencies
Industrial action has increased the costs at Month 2 by an estimated £0.2m and reduced income by £0.1m	Industrial action is not in the plan so has an adverse impact on the trusts ability to deliver the break even plan	Collect the information and submit it in order to receive available reimbursement. Monitor activity to increase productivity to offset the reduced income.
Agency spend is £0.8m which is 4.9% of pay spend	Agency cap is 3.2% annually so agency spend needs to reduce to a level below cap to achieve full year 3.2%	Recruitment to vacant posts and conversion of agency to bank and fixed term contracts

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KSO4 Efficiencies - 24/25 - Watch Metric

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 3 2024/25											
Efficiency											
	In Month £'000				Year to Date £'000				Forecast Outturn £'000s		
	23/24	Plan	Actual	Variance	23/24	Plan	Actual	Variance	Plan	Forecast	Variance
Non-Pay NHS Subcontracted		187	187	0		562	562	0	2,250	2,250	0
Non-Pay non-NHS Subcontracted		183	183	0		549	549	0	2,200	2,200	0
Pay - Agency		21	21	0		54	54	0	250	250	0
Non-Pay - Procurement (excl Drugs)		22	22	0		66	66	0	260	260	0
Pay - Establishment Reviews		29	29	0		89	89	0	350	350	0
Income - Additional Productivity		0	0	0		0	0	0	1,200	1,200	0
Total		**442**	**442**	**0**		**1,320**	**1,320**	**0**	**6,510**	**6,510**	**0**

Current Position	Issues	Actions & Timelines
The Trust is delivering its efficiency programme	A need to provide greater levels of backup on the delivery of the programme and whether schemes are recurrent or non-recurrent	Put in new software to monitor the efficiency programme across teh Trust. This is being populated and should be in use for Month 6
The Trust needs to deliver the additional productivity income target	Activity is higher than plan in order to deliver other efficiencies. This means that productivity needs to be maintained and increased in order to increase the income further. This is a significant increase on previous years	monitoring in the monthly directorate meetings and by the income and contracting team

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KSO4 Capital Spend - 24/25 - Watch Metric

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 3 2024/25											
Capital Spend											
	In Month £'000				Year to Date £'000				Forecast Outturn £'000s		
	23/24	Plan	Actual	Variance	23/24	Plan	Actual	Variance	Plan	Forecast	Variance
IT		59	25	(34)		168	61	(107)	710	710	0
Medical Equipment		50	0	(50)		100	119	19	600	600	0
Estates Maintainance		120	20	(100)		290	87	(203)	1,437	1,437	0
Estates Other		83		(83)		251	0	(251)	994	994	0
EPR		399	65	(334)		898	139	(759)	4,787	4,787	0
CDC		559	5	(554)		1,218	75	(1,143)	6,706	6,706	0
Other Capital		0		0		0	0	0	2,250	2,250	0
Total		**1,270**	**115**	**(1,155)**		**2,925**	**481**	**(2,444)**	**17,484**	**17,484**	**0**

Current Position	Issues	Actions & Timelines
Spend year to date is £481k against a plan of £2.9m	Greatest variance is CDC spend, this is a risk for this financial year	Discussion on brokerage are underway
EPR spend is £759k behind budget	Original phasing suggested higher resource onboard, will catch up in September with phase 2 payment to Altera	Reviewing resource budget this year to rephase forecast
CRL is £500k behind budget	Conversion of POs to invoice and GRN, commitments are to target	Procurement are contracting to an agreed plan for major spend on radiology and theatres. Estates work is due to be on target by end of Q2

Integrated Quality and Performance Report

Queen Victoria Hospital NHS Foundation Trust

KSO5 Organisational Excellence

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 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: There has been a reduction in time to hire from M2 to M3. With the introduction of new processes and support for managers to raise vacancies and the ongoing workforce controls meeting we have seen a 7 day reduction to 54.10 days against a KPI of 53 days. Work is continuing with Occupational health to improve and speed up this element of the process which is often cited as a delay to the process.
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. Two competency changes have been identified and new requirements have been communicated to staff.
Apprenticeship Levy: Annual report in production for July 2024. Consideration for new policy/guidelines for widening participation (incl. apprenticeships) to be scoped Autumn 24/25. From 1 July 24, existing staff who undertake an apprenticeship as part of their career development will be paid either their existing pay point or the rate paid to other apprentices, whichever is the higher (subject to some eligibility criteria). This impacts on 2 apprentices at QVH and wages are currently being addressed.
Medical Education: At the Junior Doctors Forum the results of the junior doctors awards were announced, with trainees also recognised at the staff awards. Feedback was generally positive, although issues with being allocated time to complete mandatory training were raised, which would be fed back to the relevant department for action.
Employee Relations: Throughout June there were 15 employee relations cases; this included, 2 investigations, 2 informal and 2 formal conduct management cases, 1 informal grievance and 3 formal open grievance cases, 1 informal dignity and respect and 2 formal cases ongoing, 1 open engagement process, and 1 formal redeployment.

Positive Assurance/Improvements

- All permanent staff MAST compliance improved and remained above 90% target (92.8%)
- Local Induction reporting tool available online for managers
- Positive feedback from Anaesthetics and Plastics medical trainees at LFG
- Improvements in place to assure supervision for trainee doctors in plastic surgery.
- No trainee doctor exception reports received in May.
- Reduction of 7 days in time to hire.
- Work with finance colleagues ongoing to align establishment to 1165 WTE
- Overall vacancy rate is 3.3%, significantly below our 8% target

Challenges

- 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 remains 1.1 day above KPI
- Bank use remains high in some areas
- Agency use remains high at 28.11 WTE in M3 compared to 26.4 WTE in M2
- Vacancy rate has increased slightly from 2.9% in M2 to 3.3% in M3
- Minimal reduction in bank usage to 80.95 WTE

Mitigations and Actions

- 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
- Workforce profile and modelling underway to review staffing levels / activity commencing with Nursing
- Recruited to a Wellbeing and Inclusion Manager role and Wellbeing and Inclusion Coordinator role
- People Promise Manager has commenced in M3 to review and embed the 7 elements of the National People Promise
- Strengthening of workforce controls process underway, alongside regular review of high cost and long term agency usage

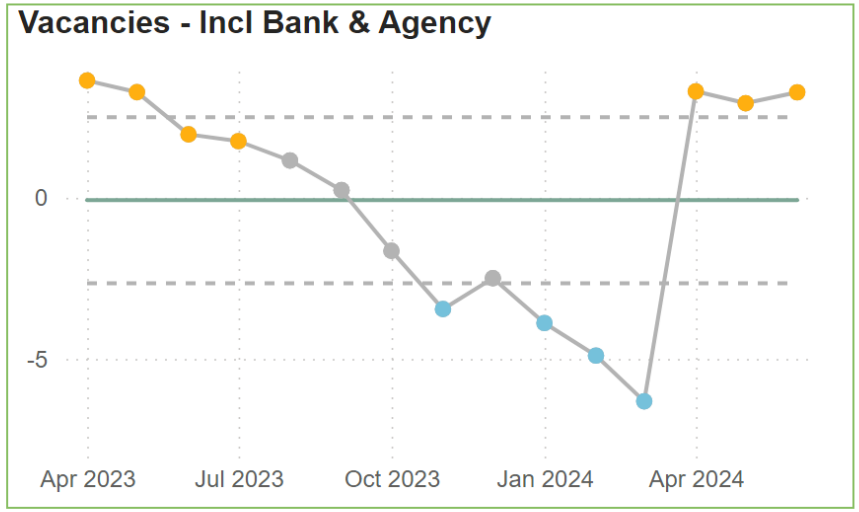
KSO5 Organisational Excellence - Scorecard

NHS
Queen Victoria Hospital
NHS Foundation Trust

Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	LCL	UCL	Summary
Vacancies - Staff In Post	Jun 24	8%			9.1%	8.9%	30.71	20.63	40.78	Special cause improving
Vacancies - Incl Bank & Agency	Jun 24	8%			3.3%	2.9%	-0.08	-2.66	2.49	Special cause worsening
Average Time To Hire - Days	Jun 24	80			54.1	61.7	58.31	36.97	79.66	
Turnover Rate - Rolling 12 months	Jun 24	10%			11.9%	12.0%	12.45	11.50	13.40	Common cause - no signficant change
Sickness Absence Rate - Rolling 12 months	Jun 24	3%			3.7%	3.5%	3.74	3.59	3.89	Special cause improving
Appraisal Rate	Jun 24	90%			81.3%	81.2%	84.32	82.02	86.62	Special cause worsening
Statutory & Mandatory Training Compliance	Jun 24	90%			92.8%	92.1%	92.69	91.86	93.52	Common cause - no signficant change
Agency Usage In Month (WTE)	Jun 24				28.1	26.4	18.59	12.12	25.06	Special cause worsening
Bank Usage In Month (WTE)	Jun 24				81.0	82.9	82.33	70.43	94.22	Common cause - no signficant change

Latest Data Refresh: **7/29/2024 8:00:16 AM** Latest Commentary Refresh: **7/30/2024 7:04:06 AM**

KSO5 Organisational Excellence - Watch Metric

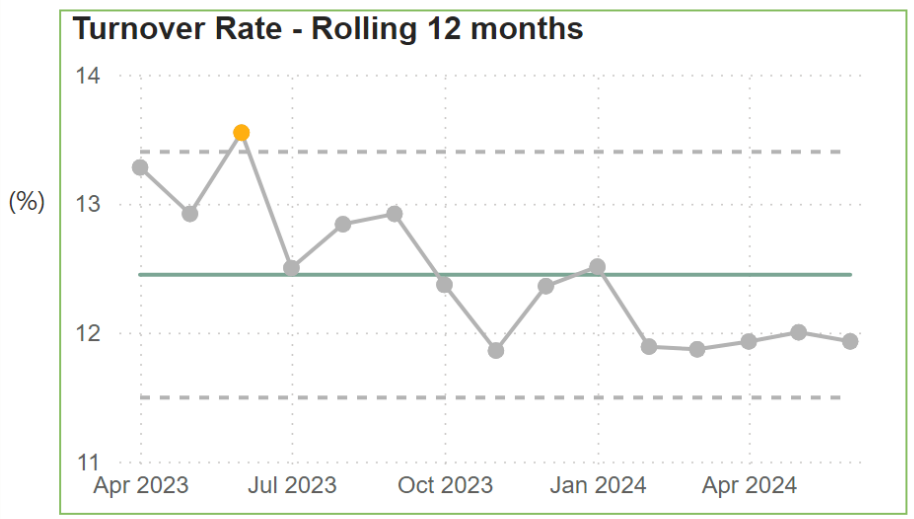


Actual
3.3%
Internal Target
8%
National Target
8%
SPC
Worsening - Concern High
Consistent Pass

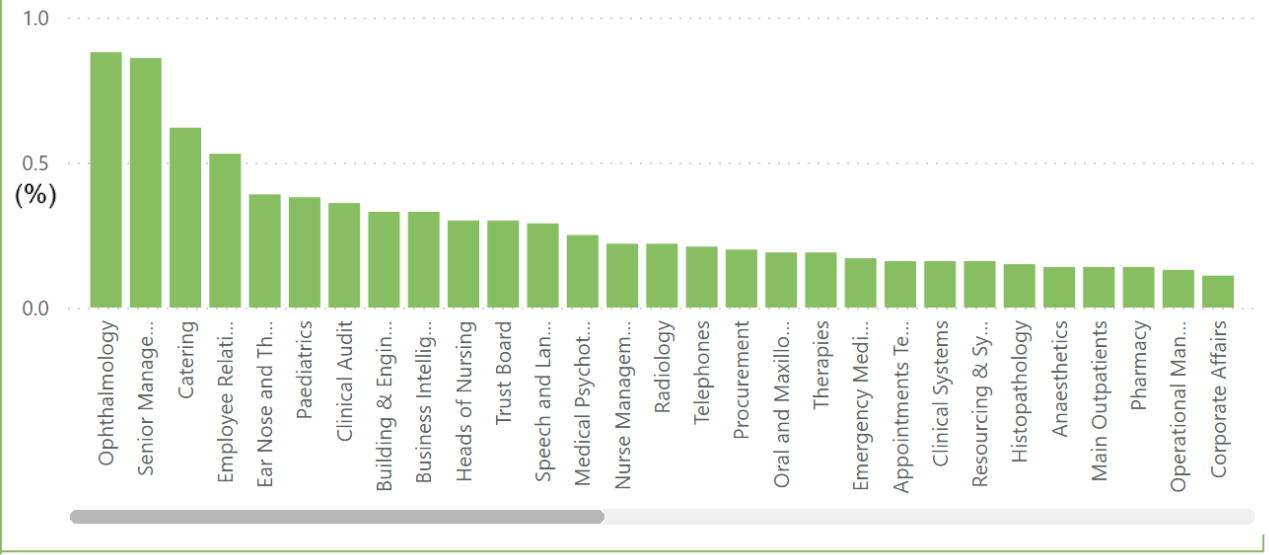
Current Position	Issues	Actions & Timelines
• The trust establishment has been re-based in M3 following reconciliation with finance and submitted plan for 2024-25 to NHS Sussex • Overall trust establishment is 1165.73 for 2024-25 • The re-base of establishment for 2024-25 has led to vacancy levels increasing compared to M12 2023-24	• Overall vacancy level has increased to 3.3% in M3 from 2.9% in M2	• Trust vacancy control process being reviewed to ensure correct levels of control in place and efficient in application • Monthly establishment control meeting between workforce and finance in place to ensure correct embedding of new establishment across ESR and ledger • Work has been undertaken between Workforce and Finance to ensure accurate reconciliation of establishment has taken place and aligned to submitted plan, with appropriate phasing throughout 2024-25

KSO5 Organisational Excellence - Watch Metric

Queen Victoria Hospital NHS Foundation Trust



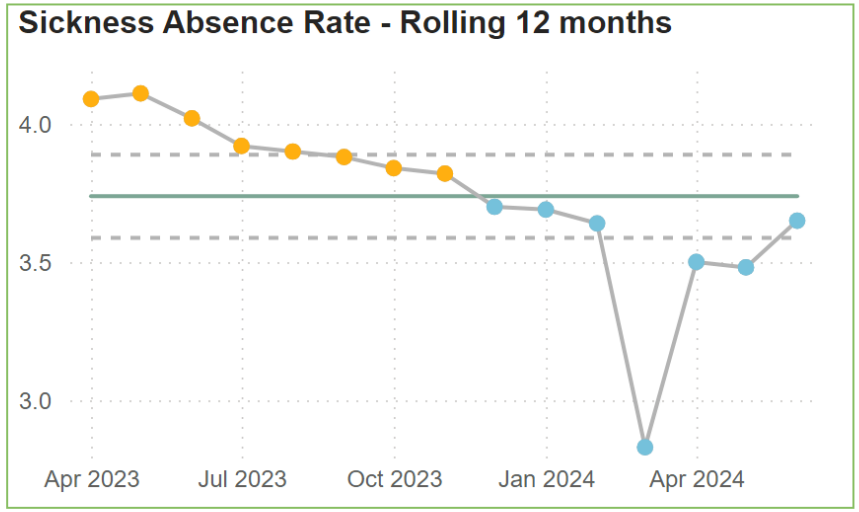
Actual
11.9%
Internal Target
10%
National Target
10%
SPC
Common Cause
Consistent Fail



Current Position	Issues	Actions & Timelines
• The trust establishment has been re-based in M3 following reconciliation with finance bringing turnover down to 11.93% in M3 compared to 12.00% in M2 • Reduction in starters to 5.19 with increase in leavers at 10.36 in June 2024		• New People Promise Manager commenced in M3 looking at retention of staff against the 7 pillars of the national People Promise • Review being undertaken into exit interview process to better capture the reasons why staff leave

KSO5 Organisational Excellence - Watch Metric

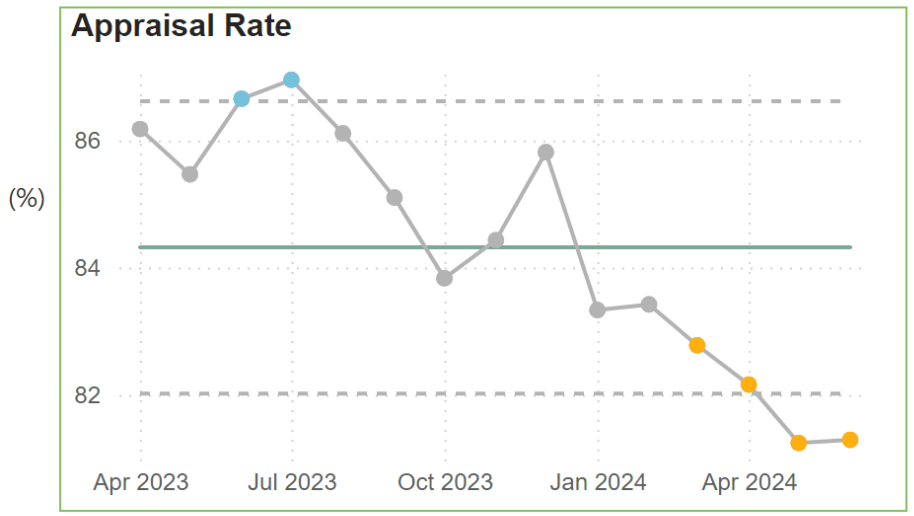
Queen Victoria Hospital NHS Foundation Trust



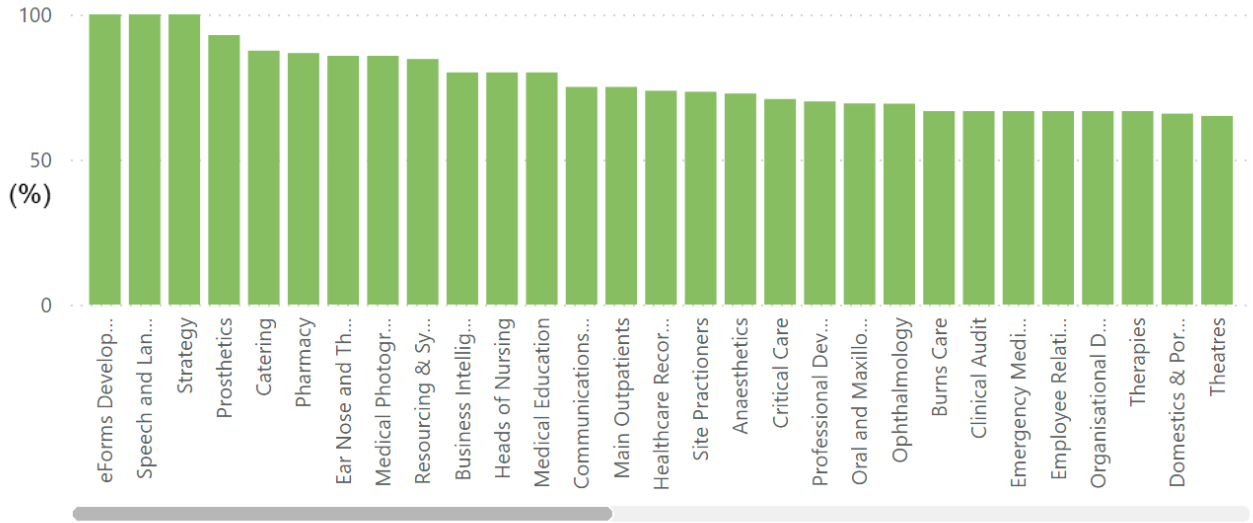
Actual
3.7%
Internal Target
3%
National Target
3%
SPC
Improving - Improvement Low
Consistent Fail

Current Position	Issues	Actions & Timelines
• Marginal increase to 3.65% in June compared to 3.48% in May to 54.10 against KPI of 53.	• Long term sickness absence was most significant in Chief Medical Officer directorate whereas short term was most prevalent in Commerce & Finance and Perioperative Services in June	• Employee Relations team continue to monitor long term sickness absence and trigger points in line with the Supporting Health in the Workplace Policy and advise managers appropriately

KSO5 Organisational Excellence - Watch Metric



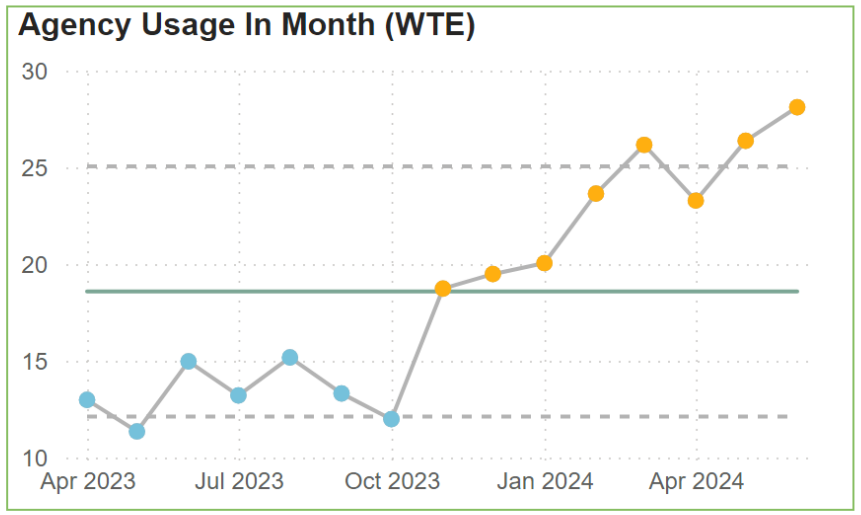
Actual
81.3%
Internal Target
90%
National Target
90%
SPC
Worsening - Concern Low
Consistent Fail



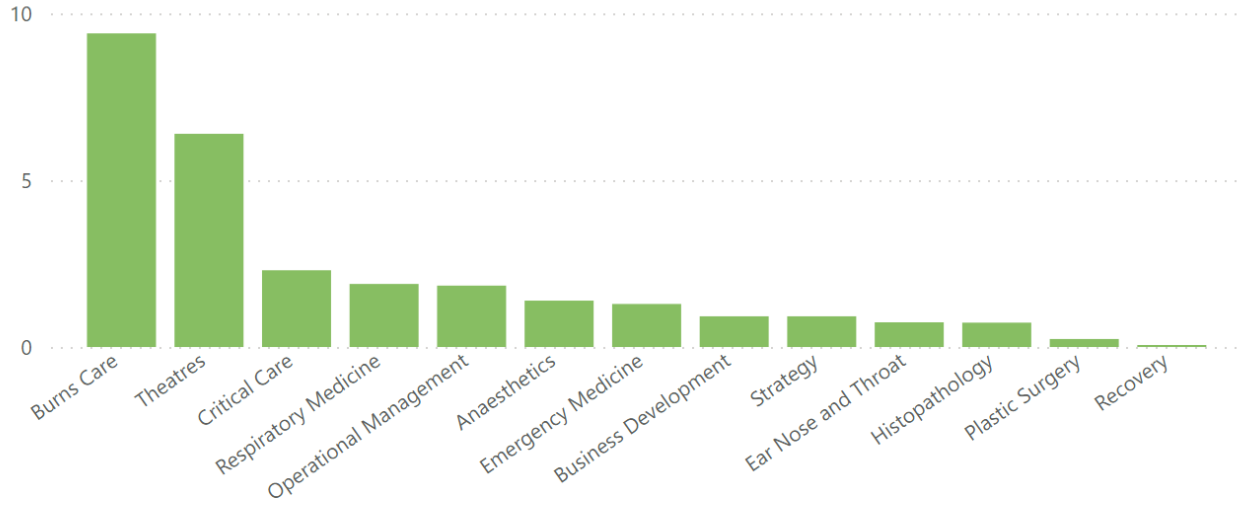
Current Position	Issues	Actions & Timelines
• Overall appraisal rate is below 90% KPI (81.3%) down 0.86% from M2 (Mid-month this is now 83.30%). The number of appraisals expired more than 3-months ago has increased to 109 (up from 100 in May 2024)	• Medical & Dental compliance dropped by 8.8% (79.89%) which has affected the overall compliance. • Investigation has shown some managers are failing to notify workforce services of appraisal completion in a timely manner, or if at all	• Organisational Development & Learning (OD&L) is liaising with Medical Education Manager as to best approach to address compliance shortfall for Medical & Dental staff • OD&L has produced in-depth analysis of appraisal compliance and contacted and scheduled meetings with areas of particular concern to identify issues and promote completion. As of 19/07/24 overall compliance has increased to 83.30% • Connect article email will be produced to promote appraisal process and importance in July 2024. • Compliance is raised at triumvirate meetings monthly. • Where staff are over 3 months out of date, these are highlighted via an in-depth report to managers to ensure compliance levels are increased. • Introduction of Manager Self Service through ESR will enable managers to oversee compliance levels, complete appraisal documentation online and log compliance in real time – this is work in progress

KSO5 Organisational Excellence - Watch Metric

Queen Victoria Hospital NHS Foundation Trust



Actual
28.1
Internal Target
National Target
SPC
Worsening - Concern High
(Blank)



Current Position	Issues	Actions and Timelines
June 2024 Agency usage in month • Increase in Agency usage in June at 28.11 WTE compared to 26.37 WTE in May • Trust reporting a YTD position of 4.9% of total pay attributed to Agency staff against a target of 3.2% and above plan	• Highest agency usage in M3 within Peri-Operative Care at 10.14 WTE and Plastics and Burns at 9.64 WTE • Nursing and Midwifery highest staff group usage at 17.31 WTE • Admin and Clerical accounts for 3.68 WTE agency usage	• Live reporting exercise with Chief Nurse to look at high agency usage within nursing area and review process of booking and head room locked into nursing shifts. • Monthly review of top 10 High-Cost Agency to be undertaken by CPO • Engagement with managers in areas of high agency usage to understand drivers and ensure recruitment into substantive posts is actively being undertaken
June 2024 Bank usage in month • Reduction in M3 at 80.95wte compared to 82.93 in M2	• Highest bank usage in Perioperative services at 25.30 WTE followed by Core Clinical and Community at 15.88 WTE • Highest bank usage staff group was Admin & Clerical at 27.21 WTE followed by Nursing & Midwifery at 22.63 WTE	• Engagement with managers in areas of high bank usage to understand drivers and ensure recruitment into substantive posts is actively being undertaken • Live reporting exercise with Chief Nurse to look at high bank usage within nursing area and review process of booking and head room locked into nursing shifts.

KSO5 Organisational Excellence – Culture

Queen Victoria Hospital NHS Foundation Trust

Coaching:
Pilot Coaching skills for managers programme ran in Jun 24. Based on feedback, minor tweaks being made, and further dates will be advertised to staff. The senior triumvirate leadership team has also been offered Coaching skills training in Sept 24 as part of their development.
NHS Elect workshops:
Workshops have been agreed with NHS Elect for delivery across 2024/25 to all staff. A session for Teaming & Psychological Safety has taken place. with two further dates to be advertised. NHS Elect sessions will also be delivered for the Triumvirate Senior Leadership team as part of their development programme - these are currently being developed in partnership with NHS Elect and QVH organisational development team.
Local and Corporate Induction:
A new online reporting tool has been developed and promoted to managers at QVH to record local induction completion. OD&L will monitor and report on completion. New Corporate induction ran 1 July 24. This will be continually reviewed and updated based on upcoming changes and will move to the 2nd Monday of every month from September 24 to allow access to larger training facilities.
Library:
Meeting scheduled on 22 July with Kent Surrey and Sussex Library Knowledge Services arranged to ensure QVH are aligned to the Library Quality and Outcomes Framework (LQOIF) and meeting the outcomes and 16 essential indicators. The Trust will be rated on our achievements so far and will be required to develop a Service Improvement Plan for any areas identified as needing improvement.
Health and Wellbeing:
The new Wellbeing and Inclusion Manager has commenced in July 24 and it is anticipated that a Wellbeing and Inclusion Coordinator will commence in Aug 24 to support delivery of health & wellbeing and EDI actions. Wagestream, a financial wellbeing platform, has launched giving staff access to flexible pay, alongside a number of other key benefits including salary and shift tracking, budgeting, financial education, savings and debt advice with support.
Equality, Diversity and Inclusion:
We continue to work 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, Gender Pay Gap and Ethnicity Pay Gap reports have been completed for 23/24 with the reports approved at the Finance and Performance Committee in June and will go to Board in September 2024 before publication.
Medical Education:
LEEP 2 was delivered to the second cohort of leadership delegates with excellent feedback received. A well-received session on providing effective feedback and managing challenging conversations was delivered for educational supervisors.
Violence Prevention and Reduction:
Trust VPR group has completed its first annual review of data and progress to be presented to Health and Safety Group in July. A new policy has been developed and is being consulted along with a clear SOP for staff and managers. Since commencing the work in August 2023 the Trust has seen an increase in 30% compliance against the national standards with a further stretch target for 24-25.

KSO5 Organisational Excellence – 2024/25 Major Projects

Queen Victoria Hospital NHS Foundation Trust

Quality Improvement	Executive Lead: CSO Lead: Deputy CSO	Reporting Month: Jun 24	Overall Status: Green

Project milestones on track.
Formal contract in place.
Weekly Task and Finish Group established, with monthly Steering Group and oversight meetings arranged.
Training naming conventions approved, awaiting formalised approved branding of QVH programme.
Readiness assessment in progress..
Initial communication activities commenced.

Milestones	Planned Date	Actual/Forecast Date	Commentary
Awaiting formal contract award to be issued	24 June 2024	24 June 2024	This has now been raised, awaiting PO
Kick off planning meeting with partner	12 June 2024	12 June 2024	Completed
CI training naming conventions to be agreed	9 July 2024	9 July 2024	Completed
Awaiting interviews for substantive Head of CI	31 July 2024	31 July 2024	In progress
Readiness assessment to be completed	31 July 2024	31 July 2024	In progress
CI branding to be approved	20 August 2024	20 August 2024	In progress

Risks / Issues	Description	Mitigating Action
Programme leadership capacity	Delay to recruitment of substantive improvement post	Interim in place and recruitment in progress.
Organisational engagement	Risk of a lack of engagement	Engagement plan in progress with initial activities identified

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

Latest Data Refresh: **7/29/2024 8:00:16 AM** Latest Commentary Refresh: **7/30/2024 7:04:06 AM**

Integrated Quality and Performance Report - Glossary

NHS
Queen Victoria Hospital
NHS Foundation Trust

Abbreviation	Definition
AHP	Allied Health Professionals
BAF	Board Assurance Framework
BPPC	Better Practice Payment Code
BU	Business Unit
CD	Clinical Director
CDC	Community Diagnistic Centre
CDEL	Capital Departmental Expenditure Limit
CDI	Clostridium difficile infection
CEO	Chief Excutive Officer
CFO	Chief Financial Officer
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COO	Chief Operating Officer
COTD	Cancellations on the Day
CPO	Chief People Officer
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRL	capital resource Limit
CSO	Chief Strategy Officer
DATIX	Reporting system for reporting clinical incidents
DM01	Diagnostic waiting times and activity
DNA	Did Not Attend
DSU	Day Surgery Unit
EDI	Equality, Diversity and Inclusion
ENT	Ear Nose and Throat
EPR	Electronic Patient Record
ER	Employee Relations

Abbreviation	Definition
ESR	Electronic Staff Record
F2SU	Freedom to Speak Up
FBC	Full Business Case
FDS	Faster Diagnosis Standard
FFT	Friends and Family Test
GA	General Anaesthetic
GIRFT	Getting It Right First Time
GM	General Manager
HoD	Head of Department
ICB	Integrated Care Board
ICE	Integrated Clinical Environment
ICS	Integrated Care System
IP	Inpatients
IPACT	Infection Prevention and Control Training
KPI	Key Performance Indicator
KSO	Key Strategic Objective
LAU	Local Anaesthetic Unit
LEEP	Leadership through Education for Excellent Patient Care
LIMS	Laboratory Information Management System
MAST	Mandatory and Statutory Training
MIU	Minor Injuries Unit
MRSA	Methicillin-resistant Staphylococcus Aureus
MSC	Managed Service Contract
MSSA	Meticillin Sensitive Staphylococcus Aureus
NHSE	NHS England
NICE	National Institute for Health and Care Excellence

Abbreviation	Definition
OBC	Outline Business Case
OH	Occupational Health
OIP	Outline Implementation Plan
OMFS	Oral and Maxillofacial surgery
OPD	Outpatients Department
OPPROC	Outpatient Procedure
PAS	Patient Administration System
PDC	Public Dividend Capital
PID	Project Initiation Document
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Related Outcome Measures
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QI	Quality Improvement
QNET	Queen Victoria Hospital's intranet
QP	Quality Priority
RTT	Referral to Treatment
SDP	Shared Delivery Plan (NHS Sussex)
SPC	Statistical Process Control
SPN	Sussex Pathology Network
TMJ	Temporomandibular Joint Dysfunction
VPR	Violence Prevention Reduction
VWA	Value Weighted Activity
WRED	Workforce Disability equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024	**Agenda reference:**	**57-24**		
Report title:	Audit & risk committee assurance report				
Sponsor:	Paul Dillon-Robinson, committee Chair				
Author:	Paul Dillon-Robinson, committee Chair Ellie Simpkin, Governance manager				
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	- Sustained progress is being made on the development of the Trust's Risk Management Framework and Board Assurance Framework, within the integrated assurance framework. - The proposed risk management framework and risk appetite policy for the Trust have been reviewed by the committee and are recommended to the Board for approval. - Work continues to monitor the Trust's Tactical Measures Programme. The committee will monitor progress on an exception basis, but stresses the importance of embedding financial control. - The number and value of contract waivers has decreased since June 2024, but needs to be kept under control. The committee will continue to monitor the impact of the action being to improve contract management across the Trust. - The committee was pleased to note that management have positively engaged with the internal audit of the planned waiting list and that the recommendations arising from the review are almost complete				
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:					
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	57-24
Date of meeting:	12 September 2024
Report from:	Paul Dillon-Robinson, committee Chair
Report author:	Paul Dillon-Robinson, committee Chair Ellie Simpkin, Governance manager
Date of report:	4 September 2024
Appendices:	None

Sub-committee assurance report
Audit & risk committee - 4 September 2024

Key agenda items

- **Risk management framework update**
- **Risk appetite policy**
- **Ward to Board governance**
- **Integrated Care System risk update**
- **Standards of business conduct policy refresh**
- **External Auditor's annual report 2023/24 (including VFM commentary)**
- **Annual report to council of governors on external audit effectiveness**
- **Internal audit progress report including the outcome of the review of the Planned Waiting List**
- **Local Counter Fraud progress report**
- **Financial assurance**
- **Review of contract management – update on actions**
- **Procurement regulations - update**
- **Grip & control - Tactical Measures Programme - update**

Alert

- The committee was pleased to note the sustained progress being made with the development of Trust's Risk Management Framework and Board Assurance Framework whilst noting the status of the Integrated Care System risk management. The committee emphasised the importance of how risk management and assurance must be embedded within the culture of the organisation and the need to ensure they are appropriately linked into the integrated assurance framework.
- Work continues to monitor the Trust's Tactical Measures Programme, to ensure "grip and control" over finances, although this is still work-in-progress. The committee stressed the importance of maintaining financial grip and control measures and ensuring that they are operating effectively. The committee will continue to monitor the implementation of the action plan on an exception reporting basis.

Assure

- The committee reviewed the revised leadership governance structure which will address some of the remaining recommendations arising from the Trust's Well Led review and strengthen ward to board governance. The Trust's leadership will need to ensure that the various committee / meeting bodies work effectively.
- The internal audit of the Trust's planned waited list received a partial assurance opinion, however, the committee was pleased to note that management have positively engaged with work and that the

recommendations arising from the review are almost complete. The actions being taken have been reviewed and discussed by the Quality & safety committee and Finance & performance committee.
- The number and value of contract waivers approved has decreased since June 2024, but needs to be kept under control. The committee received an update on the work which is being led by the Head of Procurement to improve procurement and contract management across the Trust and will continue to monitor the impact of the action being taken as work progresses.
- The External Auditor's annual report for 2023/24 has confirmed that the external audit opinion on the 2023/24 financial statements was an unqualified opinion and that no significant weaknesses were identified in the 2023/24 Value for Money assessment. This report is now available on the Trust's website and will be presented to the AGM on 16 September 2024.
- The internal audit review of the Trust's self-assessment against the Data Security Protection Toolkit has resulted in a substantial assurance outcome.

Advise
- The proposed risk management framework and risk appetite policy for the Trust have been reviewed by the committee and are recommended to the Board for approval.
- Changes to the Standards of business conduct policy, tightening it in line with comments from the local counter fraud specialist, were approved.
- The committee recorded its thanks to the Interim Deputy Director of Strategic Finance and Interim Risk Project Lead for the significant contributions they have made during their time with the Trust.

Risks discussed and new risks identified
- The development of system-wide risks is being overseen by the NHS Sussex Committee in Common. Governance and Risk leads across Sussex will be considering how these system risks can be aligned with provider risk registers and Board Assurance Frameworks. The committee would like to see the Trust more explicitly address these risks within the short term.

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024	**Agenda reference:**	**58-24**		
Report title:	Quality & safety committee assurance report				
Sponsor:	Shaun O'Leary, committee Chair				
Author:	Shaun O'Leary, committee Chair Ellie Simpkin, Governance manager				
Appendices:	Appendix one: 6 monthly nursing workforce review report to QSC (for information)				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	- The committee reviewed information regarding the clinical negligence claims settled by the Trust between 1 April 2019 and 31 March 2024. There is no statistical significance in terms of claims per service when aligned with activity levels. Supervision when undertaking procedures has been identified as a key theme on which the committee will be seeking further assurance. - The committee is assured that Learning from Patient Safety Events (LfPSE) framework has been implemented and is becoming embedded within the Trust with good reporting levels being maintained. - The committee has considered the Bi Annual Safe Staffing and Nursing Workforce Review and is assured of the safe staffing levels within inpatient areas within the Trust, in line with national guidance. - Robust discussion was had on the development of the new clinical harm process to include identification of high-risk cohorts. The committee will be reviewing the impact of the work and the lessons learnt at a seminar session later in the year. - The quarter one milestones for the delivery of the Trust's chosen Quality Priorities for 2024/25 have been achieved. - The committee has undertaken its annual effectiveness review and will be considering any specific actions arising from the review at its September 2024 seminar session.				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	The committee maintains oversight of BAF 01 patient services.				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	58-24
Date of meeting:	12 September 2024
Report from:	Shaun O'Leary, committee Chair
Report author:	Shaun O'Leary, committee Chair Ellie Simpkin, Governance manager
Date of report:	29 August 2024
Appendices:	Appendix one: 6 monthly nursing workforce review report to QSC (for information)

Sub-committee assurance report
Quality & safety committee – 27 August 2024

Key agenda items

- **Clinical Negligence Claims**
- **Committee effectiveness review (full)**
- **Integrated Quality and Performance Report**
- **Quality Priorities 2024/25 – quarter one**
- **Review of Board assurance framework (BAF)**
- **Patient Safety Incident Response Framework: Patient safety overview & update**
- **Clinical Harm Reviews / Waiting list management**
- **Bi Annual Safe Staffing and Nursing Workforce Review**

Alert

- The committee reviewed information regarding the clinical negligence claims settled by the Trust between 1 April 2019 and 31 March 2024. Supervision when undertaking procedures has been identified as a key theme and the committee will be seeking further assurance on the action being taken to monitor and address this.
- The Trust has undertaken a provider assurance review in response to the National NHS Infected Blood Inquiry. Of the 11 recommendations relevant to QVH, the organisation has been rated as assured for seven, partly assured for three and not assured for one. Plans are in place to address the areas of partial and non-assurance which will be monitored and reported to the committee.

Assure

- The committee has reviewed the Trust's Integrated Quality and Performance Report for month three. All quality watch metrics remain within expected limits and there are no infection control concerns. Action is being taken to address the low response rate to the Friends & Family Test for the outpatient department.
- Clinical negligence claims have been triangulated with other forms of feedback from patients and relatives and DATIX reports. There is no statistical significance in terms of claims per service when aligned with activity levels.
- The committee is assured that Learning from Patient Safety Events (LfPSE) framework has been implemented and is becoming embedded within the Trust with good reporting levels being maintained.
- The committee received a report summarising the outcome of the work undertaken to review the Trust's waiting list management processes. Robust discussion was had on the development of the new clinical harm process to include identification of high-risk patient cohorts. The committee will be

reviewing the impact of the work and the lessons learnt at a seminar session later in the year.

- The committee has considered the Bi Annual Safe Staffing and Nursing Workforce Review and is assured of the safe staffing levels within inpatient areas within the Trust, in line with national guidance. This report is included as an appendix to this report for information.
- The Q1 milestones for the delivery of the Trust's chosen Quality Priorities for 2024/25 have been achieved.
- The committee has undertaken its annual effectiveness review. The results were positive, recognising that the challenges brought about by what has been a significant period of change in the executive leadership. The ways in which the integrated reporting was introduced were discussed. The committee heard that the intention is for the triumvirate clinical leadership structure to support evidence-based assurance reporting. The committee will be considering any specific actions arising from the review at its September 2024 seminar session. The results will be reported to the Board in March 2025 as part of its annual effectiveness review.

Advise

- At its seminar session in September 2024 the committee will receive an update on the changes to the corporate governance structures and consider the influence of the triumvirate leadership on shaping patient safety and quality assurance.

Risks discussed and new risks identified

- The committee reviewed BAF 01 (patient services). The reduction of the current risk score from 10 to 6 and the reduction of the target score to 3 was discussed. The committee supports the rescoring which recognises the inherent risk due to the nature of the work and the mitigations which are currently in place.

Recommendation

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

Report cover-page					
References					
Meeting title:	Executive Leadership Team / QSC				
Meeting date:	27/8/2024	Agenda reference:			
Report title:	Bi Annual Safe Staffing and Nursing Workforce Review				
Sponsor:	Jane Dickson, Chief Nurse				
Author:	Liz Blackburn, Deputy Chief Nurse				
Appendices:	1. National Quality Board requirements and self-assessment				
Executive summary					
Purpose of report:	The workforce review comes to the Quality and safety committee for **assurance** as to the nurse safe staffing levels within inpatient areas within the Trust. It is the responsibility of the Chief Nurse to advise the Board on safe staffing levels for nursing in line with national guidance and for the board to see evidence of this assurance. It is then a requirement for the board to be sighted on the deployment of those planned staffing levels monthly and this is included in the IQPR.				
Summary of key issues	The workforce paper outlines : • Safe staffing levels can be evidenced across inpatient areas • Tools used to undertake this review are Safer Nursing Care Tool which is based on the Shelford Model, care hours per patient day and how we benchmark against “Model Hospital” data • The manner in which services are delivered, such as day case and overnight activity and the fluctuations in occupancy, requires flexibility in deploying staff with significant reliance on professional judgement • This professional judgement is applied at a number of touch points through the day • Data from a number of additional sources such as Incidents, complaints and patient feedback are then used to triangulate and provide additional assurance • Trust rated top in CQC inpatient survey including specific question about numbers of nursing staff to provide care • No requirement for additional resources for inpatient areas with the current activity levels Further work required: • It is also noted within this paper that the current strategic review of services will likely impact on volumes of activity, occupancy and how services are structured and this will require a further review of nursing staff numbers at that time • Within scope of this review are inpatient areas only and a review of nurse staffing requirements and reliance on temporary staffing in non- inpatient areas will from part of the further review when strategic direction is agreed • The projected future risk of high numbers of colleagues reaching potential retirement age in certain areas most notably theatres with recommendations for actions to be explored now				
Recommendation:	Quality and Safety committee is requested to **review** the report and the **assurance** within it				
Action required	Approval	Information N	Discussion N	**Assurance Y**	Review N

Link to key strategic objectives (KSOs):	**KSO1: Y**	**KSO2: Y**	**KSO3: Y**	**KSO4: Y**	**KSO5: Y**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	Links to all 5 KSOs				
Corporate risk register:					
Regulation:	Health & Social Care Act 2008 and National Quality Board Guidance				
Legal:	As above				
Resources:	No additional resources identified within this report				
Assurance route					
Previously considered by:					
	Date:		Decision:	Approved to go forward to Board	
Next steps:	To be shared at September Board meeting within QSC highlight report				

Bi Annual Safe Staffing and Nursing Workforce Review

1. Purpose

The purpose of this paper is to provide an overview of safe nurse staffing levels including right staff, right skills, right place. These include establishment reviews, workforce planning, new and developing roles, and recruitment and retention to comply with requirements set out by: NHS England/ Improvement (NHSE/I), the National Quality Board (NQB) and the Care Quality Commission (CQC). The Chief Nursing Officer (CNO) is responsible for ensuring that there is optimal nurse staffing levels to patient acuity and dependency in all inpatient areas of the organisation and provides a six monthly review to present to the board for assurance.

2. Background

All NHS Trusts are required to deploy sufficient, suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively, National Quality Board (NQB) *Safe and sustainable and productive staffing.* Both the Francis Inquiry and the Berwick report outlined ways in which the NHS can improve care and raised the issue of staffing levels. The Francis report found that inadequate staffing levels at Mid Staffordshire led to the poor quality of care.

The National Institute for Health and Care Excellence (NICE) published a safe staffing for nursing in adult inpatient wards in acute hospitals guideline (SG1) in 2014, with its aim to ensure that patients receive the nursing care they need, regardless of the ward, time of the day, or the day of the week.

The QVH have five inpatient areas with a total of 60 beds (this includes 2 inpatient paediatric beds). The use of the Safer nursing care tool (SNCT) which is based on the Shelford Model, allows us to calculate clinical staffing requirements built on patients' needs (acuity and dependency), together with professional judgement, to make safe staffing decisions.

3. National Overview

There are approximately 47,000 nursing vacancies in the NHS in England alone, accounting for over 10% of the total nursing workforce. Factors that are contributing to this shortage include:

- Aging Workforce: A significant portion of the NHS nursing staff is nearing retirement age (approximately 25% of nurses are over 50 years old).
- Training and Education: Training positions and capacity of educational institutions do not currently meet the demand for this.
- International Recruitment: Brexit has had an impact on the NHS's ability to recruit nurses from European countries, tighter immigration policies have made it more challenging and less attractive for international nurses to work in the UK.
- Workplace Stress and Burnout: The intense job pressures, exacerbated by the COVID-19 pandemic, have raised turnover rates by causing high rates of exhaustion and mental health problems among nurses.

The 2023/24 priorities and operational planning guidance outlines the ongoing need to recover our core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future. It establishes three key tasks across the NHS:

Train: growing your own workforce through increased education, training, apprenticeships and alternative routes into health care roles.

Retain: improving culture and leadership across NHS organisations to better support staff throughout their careers.

Reform: improving productivity by ensuring staff have the right skills in using new technologies that provide patients with the care that they need. Expanding enhanced, advanced and associate roles

to offer modernised careers, emphasising on the skills needed to care for patients with multimorbidity, frailty or mental health needs.

4. Establishment reviews and budget setting

Our budgets and establishments have been reviewed with the Finance team for the financial year 2024/25.

The SNCT of safe staffing deployment has been applied across the adult inpatient areas with professional judgement and reference to national standards where the model alone cannot be relied upon, for example Burns (Burns Care Standards 2022) and Critical care (BACCN Standards for Nurse Staffing in Critical Care 2009).

Nationally it is agreed that Registered Nurse to patient ratios in the day should be no more than a ratio of 1:8 in adult inpatient ward settings that are non-specialist. Ross Tilley and Margaret Duncombe ward (C-Wing) fall within this criteria and the deployment of staff within the budgets responding to differing occupancies and theatres cases is deployed at 1:8. Critical care requires a nurse to patient ratio of 1:1 when patient acuity is at level 3, and a ratio of 1:2 for level 2 patients. The Burns ward have a nurse to patient ratio of 1:3 as per the Burns care standards, and H&N have a ratio of 1:4. The planned to actual deployment is measured daily and reported monthly is against the agreed nurse to patient ratios.

The table below summarises the application of SNCT across the adult inpatient areas.

Ward	Capacity	SNCT recommended safe staffing WTE incl headroom (incl HCSW)	Budgeted WTE 2024/25 (incl HCSW)	Budgeted WTE 2024/25 incl Bank & agency (incl HCSW)	Variance SNCT vs budget	Average occupancy based on midnight bed state
Burns (incl EBAC)	6 *	27.05	22.07	26.11	-0.94	72%
Canadian-Wing	MD – 15 RT – 24 Combined - 39	59.64	42.58	45.94	-13.70	50%
Critical Care Unit (CCU)	5 (3 level 3 beds, 2 level 2/1)	27.02	23.43	25.72	-1.3	47%
Head and Neck Unit	8	14.31	12.88	12.88	-1.43	45%

* This excludes 2 additional beds which are ring-fenced for the rehabilitation of burns patients who are not requiring hospital inpatient care but do require therapy input.

Ward	Capacity	SNCT recommended safe staffing WTE incl headroom (incl HCSW)	Budgeted WTE 2024/25 (incl HCSW)	Budgeted WTE 2024/25 incl Bank & agency (incl HCSW)	Variance SNCT vs budget	Average occupancy based on midnight bed state

Peanut (incl PAU)	9 (incl 2 inpatient)	22.42	17.22	19.02	-3.38	20%

Paediatric care is provided in Peanut ward, this is predominantly day case activity with two overnight beds available and staffed as required using a twilight shift and the flexibility of staff. The SNCT is used to staff the ward alongside guidance from the RCN which stipulate one registered nurse for every three children aged under two years at all times on general wards and one nurse per every four children aged over two. This is achieved with our current staffing model and skill mix. All of our registered staff have either degree or diploma level training in paediatric nursing.

When reviewing this data, the board should note the following points:

- The SNCT can only be entirely applied to the head neck unit, all the other inpatient areas require a degree of professional judgement due to the volume of day case activity, co-located outpatient areas and national standards.
- The SNCT is also calculated on 100% occupancy and the evidence demonstrates the inpatient wards are not running at 100% at midnight.
- Where there is evidence that the recommended SNCT safe staffing levels are not met by the budgeted establishment, the occupancy data supports the ability to apply a flexible approach.
- Both Burns and Peanut ward run outpatient clinics within their clinical footprint and utilising the same pool of staff therefore professional judgement on safe staffing levels is integral to calculating the WTE required.
- C Wing is comprised of two wards with a shared staffing establishment, deployed over both wards. Due to the flexibility of the workforce and the variability in occupancy, staff are deployed to maintain safe staffing and patients are at times combined on one ward to maintain safety.
- Use of bank and agency to manage the peaks and troughs of activity ensures the Trust can maintain safety.
- Bed occupancy fluctuates significantly through the week and between day and night. The frequent reviews throughout the day and flexibility of rostering enables safe staffing levels to be maintained at all times.
- If occupancy is to increase, C Wing may require an increase in funded establishment.

The following table outlines our budgeted, contracted and actual WTE from May 2024:

Ward	**Budgeted WTE 2024/25 incl Bank & agency**		**Contracted WTE in May 2024**		**Actual WTE used in May 2024**	
	Registered	Unregistered	Registered	Unregistered	Registered	Unregistered
Burns (inc EBAC)	18.62	7.49	16.96	5.52	19.38 *	9.68 *
C-Wing	32.41	13.53	28.36	12.29	28.68	13.02
CCU	19.93	5.79	15.99	4.89	18.31	4.25
H&N	10.36	2.49	7.99	2.39	8.95	2.39
Peanut (inc PAU)	14.07	4.95	12.95	2.40	14.28	2.99

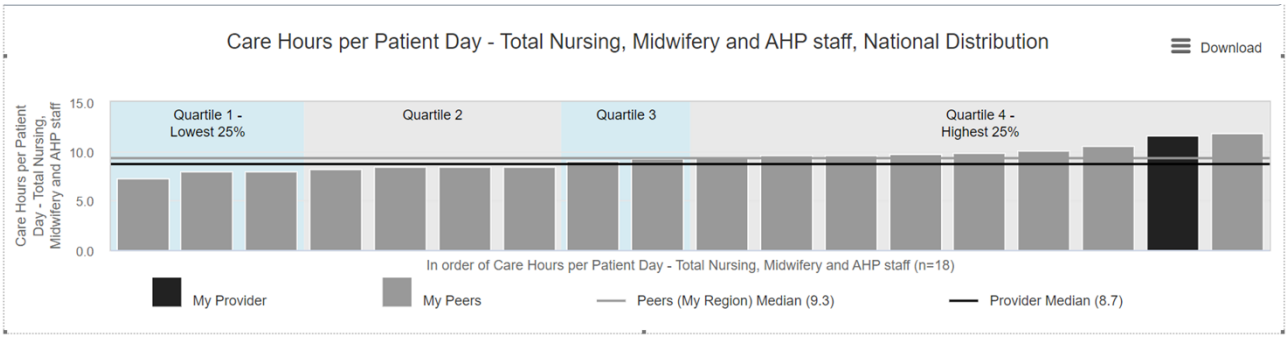
* Additional registered and unregistered staff used for a complex patient whose length of stay is over a year. This does not include deployment of RMN agency support.

There are four points throughout the day where staffing and safety is reviewed, at 08.00, 10.00, 15.00 and 20.00 via the site handover and bed meetings chaired by the Site Practitioner team with multidisciplinary input.

The Heads of Nursing attend the 08.00 handover and the 15.00 bed meeting giving further assurance that safe staffing, appropriate deployment of staff and planned staffing for the next 24 hours is achieved. Monthly review of actual staffing against planned is carried out and triangulated against incidents raised via DATIX and safer nursing metrics and complaints data.

5. Care Hours per Patient Day (CHPPD), Safe Care and safe staffing metrics

This is benchmarked nationally through the NHSE/I 'Model Hospital' against our region. We are above the national benchmark due to the specialist nature of our work.



Source - Model Hospital

When the above aggregate is reviewed at individual patient areas the ranges are in line with staffing requirements and national guidelines for example Critical care 1:1 nurse to patient ratios :

Critical Care	26– 38 CHPPD
Head and Neck	9-12 CHPPD
Burns	9- 16 CHPPD
Margaret Duncolme	5-7 CHPPD
Ross Tilley	5-7 CHPPD

6. Train

Ring fencing our nursing apprenticeships within our Professional Development budget has allowed us to plan our nursing establishments, support our staff in career development and be proactive in looking at new ways of working. We have supported 7 staff to undertake apprenticeships, 5 have been following the trainee nursing associate (TNA) route, and 2 have progressed their TNA training to the registered nurse degree apprenticeship.

2023/24 NHSE CPD funding has supported over 500 opportunities for NMC and HCPC registrants to access over 73 specialist workshops, conferences, group study days and post graduate modules. All applicants are managed through the QVH funding panel and align to the individual's personal development plan.

QVH continues to support CPD through specialist training opportunities. 57 training workshops and study days were delivered in the last 12 months. 15 where critical incident and upskilling simulation sessions across the organisation.

QVH was awarded the National Preceptorship for Nursing "Quality Mark" for the multi professional development programme and policy. We supported employees 'return to practice' as registered NMC nurse. In addition there are a number of internationally educated QVH employees in Healthcare Support Worker roles who are receiving support to gain NMC registration.

7. Retain

We continue to have good retention of staff and low turnover rates. Turnover for nursing is at 7.85% compared to Trust overall of 11.9%.

We have continued to utilise the 'new starter' premium, implemented in when vacancy rates were greater than 20%, this acted as an incentive to apply, in response to challenges such as public transport, location and proximity to other hospitals that attract additional premiums. This scheme has significantly reduced our vacancy rate and requires review.

The work experience programme provides an opportunity for local students to experience what a career in the NHS may offer and has a good uptake in attendance.

Below is the leaver and starter information for the nursing workforce, this includes all new starters, leavers, those who have increased or decreased their hours and those who have moved from a bank contract to a permanent one. Our turnover rate has fallen by nearly 1% over the past six months.

8. Reform

We continue to develop our registered nurses to ensure that they have the right skills to undertake the care required. Our critical care nurses undertake the Critical care pathway at level 6, the Burns nurses undertake the Burns module at level 6 or 7 currently be accessed via Bristol University, they are also required to attend the Emergency Management of Severe Burns (EMSB). The Trsut run a number of internal study days which reflect our three core services of Plastics, Maxillofacial, and Corneo surgery. All staff are encouraged to attend these days as part of their induction.

9. Triangulating staffing deployment and Incident Reporting

There were eight incidents reported via datix during this period (Apr 2023 – Mar 2024) in relation to staffing. These incidents are always reviewed by Heads of Nursing and actions taken in response. Four incidents reported unsafe staffing due to acuity of patients on CCU and H&N, on investigation staffing levels did meet both safe staffing and the BACCN guidance. Two incidents related to deployment of staff to other inpatient areas in order to maintain safe staffing. One related to lack of staff for a twilight shift on Peanut ward, patient was not onsite and was referred on. Safe staffing levels were maintained during the industrial action which was reported on datix. A review of patient safety incidents over the past twelve months have not identified staffing levels as a factor in the root cause of the incident.

Feedback from patients (FFT) is reviewed monthly and this consistently shows extremely high levels of satisfaction with care. The CQC inpatient survey annual results have just been received and QVH came top in the country, and with questions specifically about nurses patients felt nurses answered questions in ways they could understand, included patients in conversations about their care, and patients felt there were enough nurses on duty to care for them.

10. Retirements

The table below indicates the numbers registered Nurses/theatres practitioners who could retire in the next 5 years. Included is anyone aged 50 and over for any NMC registered staff and anyone 55 and over for any HCPC registered staff. This is currently 82 staff and is the equivalent of 60.86 WTE. Of note, this includes staff who have already retired and returned to work.

	Burns	CCU	Corneo	C-Wing	H&N	MIU	OPD	Peanut	Site	Specialist	Theatres (inc pre-assess)
Band 5		1	1	1			3	3		1	12
Band 6	4	3	1	2	1		2	3		5	19
Band 7			2		1	3	1		5	5	
Band 8a										2	
Band 8b											
Band 9 or above										1	
Totals	**4**	**4**	**4**	**3**	**2**	**3**	**6**	**6**	**5**	**14**	**31**
WTE	3.52	2.71	3.07	1.92	2	2.48	3.84	4.77	3.69	9.59	23.27

Sourced - ESR

Theatres has a high number of staff who meet the retirement criteria, the focus is on developing our existing staff through apprenticeships to meet the staffing requirements. Each area monitors on a yearly basis their staff who are currently on any flexible and agile working contracts. HR provide up to date data on who is eligible for retirement and each area lead ensures that there is timely recruitment in these roles.
This projection of retirees in the table above points to a requirement for specific workforce planning to ensure we have adequately trained theatre staff. Work is underway with CPO and external universities to scope out what, in addition to the drive for apprenticeships in this area, this may/ should look like.

11. Maternity Leave and Sickness

5.72 WTE registered nurses are currently on maternity leave, data taken on 31st March 2024.

The data below demonstrate the sickness rates in the registered and unregistered nursing workforce. The 12 month sickness rate has been above our KPI of 3% throughout the year. The health and well-being of staff is reviewed at appraisals, one to one meetings and return to work conversations, and new roles such as Professional Nurse Advocate (PNA) has been used to provide restorative supervision for staff.

Trust Workforce KPIs	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Compared to previous month
12 month sickness rate	4.57%	4.60%	4.66%	4.41%	4.43%	4.38%	**4.25%**	↓
Monthly sickness absence %	5.11%	5.39%	6.09%	5.20%	4.87%	3.30%	**3.25%**	↓

Source - ESR

12. Assurance

The last 12 months have seen a slight decrease in the sickness rate. All sickness absence is managed as per Trust policy. The health and wellbeing of all our staff remains a key priority. The Trust continues to support staff mental and physical health through appropriate referrals, communications and well-being initiatives.

Bank and agency usage flexes in line with sickness absence and patient acuity.

The monthly safe staffing data is reported at Clinical Governance Group (CGG) and provides an overview of nursing safe staffing for inpatient areas and the site team. The data maps actual staffing against planned staffing. This is also included in the IQPR that will be discussed at Board.

During this process we have benchmarked against the NQB recommendations (appendix 1) and is assured that QVH is meeting these recommendations.

13. Recommendations

The Board is asked to:

- note that we deploy safe staffing levels in all our inpatient areas
- note that we meet the benchmarks recommend by RCN, ICS and NICE
- note the staffing levels and skill mix are effectively reviewed
- note the vacancy rates and actions to recruit
- note that future strategy and changes to services may enable changes to staffing deployment that deliver greater efficiency
- note that increasing occupancy may require an increase in establishment in certain services

Liz Blackburn Deputy Chief Nurse July 2024

Appendix 1

National Quality Board requirements and self-assessment

Recommendation	Current Position March 2024
Boards take full responsibility for the quality of care to patients and as a key determinant of quality take full and collective responsibility for nursing care and care staffing capacity and capability	The Board has a process in place for setting and monitoring nursing levels, with the Quality and Safety Committee receiving detailed ward/ department report for all areas where we treat patients. This information is triangulated with risk team and DATIX each month to look for early warning triggers and emerging themes .The Board receives nursing workforce reports and an update on staffing levels and quality at every public board.
Processes are in place to enable staffing establishments to be met on a shift to shift basis	Nursing acuity and capacity is reviewed four times per day in the ward areas. This information is presented at the twice daily bed meeting where senior clinical and operational staff manages the patient flow for electives and trauma. Nursing and care staff can be reallocated at the start or during a shift and local escalation process is embedded. Heads of Nursing are visible in the clinical areas. Daily oversight of planned versus actual staffing levels by Chief or Deputy Chief Nurse.
Evidence based tools are used to inform nursing and care staffing capability and capacity	All ward areas use safer nursing care tool- acuity and dependency tool. Application of specialty specific national guidance to support establishments and professional judgement. NEWS2 safety assessment tool transferred to electronic e-Obs version in September 2020 and provides another layer of assurance about workforce deployment.
Clinical and managerial leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns	Datix reporting system is established and used. 'Tell Nicky' – confidential email to Chief Nurse. Trust policies e.g. Whistleblowing. Quality review visits, weekly ward manager meetings. Freedom to Speak up Guardian in post with six monthly updates to Board.
Multi-professional approach is taken when setting nursing and care staffing establishments	Workforce review undertaken by the Deputy Chief Nurse in conjunction with the executive leadership team (ELT). Changes to establishments have been made only after consultation with ELT and trust staff.
Nurses and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	There is 22% uplift within the ward establishments to cover sickness, mandatory and statutory training and leave. Ward managers are accountable for their budgets and have monthly meeting with the HoN and finance. All ward managers have supervisory time to undertake management duties.
At each public board an update on workforce information, staffing capacity and capability is discussed six monthly with a nursing establishment review	The Chief Nurse provides updates on workforce in the quality report at every public board.
Information is clearly displayed about nurses	All ward areas have status boards in public areas stating expected number and actual number of nurses and care staff on duty. When there are variations on this, the ward manager will

and care staff on duty in each ward on each shift.	review and escalate via agreed processes to ensure safe staffing maintained. The Chief Nurse will review this escalation and triangulate with safer care metrics and complaints data to ensure staffing levels allow provision of quality care
Providers take an active role in securing staff in line with workforce requirements	Staff are supported to undertake specialist modules for development and enhanced care. Recruitment process are being streamlined.
Commissioners actively seek assurance that the right people with the right skills are in the right place at the right time with the providers with who they contract.	Chief Nurse meets on a regular basis with the ICB Chief Nurse and Quality leads. Staffing levels discussed at these meeting. The commissioners are aware of the nurse staffing levels and the actions the trust is taking to optimise recruitment and retention.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/09/2024		**Agenda reference:**	**59-24**	
Report title:	Finance & performance committee assurance report				
Sponsor:	Peter O'Donnell, committee Chair				
Author:	Peter O'Donnell, committee Chair Ellie Simpkin, Governance manager				
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	- The Trust will not meet its target of achieving zero patients waiting over 65 weeks by the end of September 2024. - Progress is being made in line with expectations to address the fire safety matters across the site, however, new areas of risk due to the condition of the estate are still being identified. - Concerns were raised by the committee over the Trust's capacity to deliver on all major projects whist meeting key operational targets - The committee has received a summary of the work which has been undertaken to review and improve the Trust's waiting list management processes. This will be an ongoing area for oversight for the committee. - Workforce key performance indicators including staff sickness and mandatory and statutory training compliance remain positive. The Trust is maintaining its break-even position in month and forecast for year end. - Risks due to weaknesses in contract management remain a concern for the committee. - The new Estates team are continuing to review all areas of estates and are finding a number of significant longstanding issues that need to be addressed. - The committee reviewed the draft People and Culture Strategy and recommends it to the Board for approval.				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	The committee maintains oversight of BAF 02, 03, 05, 06 and 07				
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:	59-24
Date of meeting:	12 September 2024
Report from:	Peter O'Donnell, committee Chair
Report author:	Peter O'Donnell, committee Chair Ellie Simpkin, Governance manager
Date of report:	28 August 2024
Appendices:	None

Sub-committee assurance report
Finance & performance committee – 27 August 2024

Key agenda items

- **Integrated Quality and Performance Report**
- **Review of Waiting List Management**
- **Apprenticeship Levy annual report 2023/24**
- **Final 2024/25 Sussex system financial plan**
- **Estates update**
- **Major projects update**
- **CDC site location options**
- **People & culture strategy**
- **Board Assurance Framework**
- **Sterile Services Contract Award**
- **CPAP Respiratory Therapy Services Contract Award**

Alert

- The Trust will not meet its target of achieving zero patients waiting over 65 weeks by the end of September 2024. This is due to the impact of industrial action, availability of anaesthetists as well as a number of patients being on complex care pathways. The Trust is also supporting the Sussex system by taking on some additional long waiting patients. The committee was reassured that all patients have been reviewed by the Chief Medical Officer for clinical harm. The committee has requested further analytics on this area.
- There are challenges in cancer performance due to a seasonal increase in skin cancer referrals and patient complexity for head and neck cancer. The 31-day cancer performance standard was not achieved in month three and the 62-day back log remains static.
- Progress is being made in line with expectations to address the fire safety matters across the site, review asbestos compliance and address the presence of Reinforced Aerated Autoclaved Concrete (RAAC), however, the committee was informed that new areas of risk due to the condition of the estate are still being identified. The committee has requested that a comprehensive plan and budget to address the issues identified is prepared for the next meeting, along with a breakdown of the areas yet to be assessed. Discussion was also had on the actions being taken to improve assurance reporting to the Board on estates matters.
- Discussion was had on the importance of robustness of contract management across the Trust. The committee is aware that this matter is being looked at by the Audit & Risk Committee.
- Major projects, e.g. Electronic Patient Record and the Community Diagnostic Centre, are all taking more time to mobilise than planned. Concerns were raised by the committee over the Trust's capacity to deliver on all major

projects alongside other critical priorities and operational delivery and it has been suggested that the executive team review resources and priorities.
- Spend on agency staff has increased from month two to 4.9% in month three. A trajectory to reduce spend to 3.2% is being developed and the committee will receive an update at its next meeting on the success of the action and controls which are being put in place
- The Sussex ICB financial position for month three was significantly behind plan.

Assure
- The Trust achieved the 95% target for Diagnostics (DMO1) performance in month three due to a sustained improvement in sleep services. The Faster Diagnosis Standard and 62-day cancer performance standards were met in month two and will likely be maintained in month three. The Trust has maintained achievement of the 85% Getting it Right First Time (GIRFT) standard for QVH theatre utilisation.
- The committee received an update on the new ambition to increase the proportion of cancers diagnosed at stage 1 and 2 by 2028 and was pleased to note that the Trust has exceeded the 80% stage completeness in the dataset submissions for 2023.
- The committee received a report summarising the outcome of the work which has been undertaken to review the Trust's waiting list management processes. An action plan has been developed which will be an ongoing area for oversight for the committee.
- Workforce key performance indicators including staff sickness and mandatory and statutory training compliance remain positive. There has been a reduction in time to hire; work to reduce this further continues.
- There has been an improvement in appraisal rates to 84.36% in August 2024. The committee has asked to receive exception reports on any long standing overdue appraisals.
- The Trust's library & knowledge service has received a positive report following its recent inspection by NHS England.
- The Trust is maintaining its break-even position in month and forecast for year end and efficiency targets are being delivered. Further information on the phasing of the plan was requested.

Advise
- The Apprenticeships and levy spend annual report 2023/24 was received and noted.
- The committee reviewed the draft People and Culture Strategy and, subject to the refinement of the prioritisation of the strategy milestones and the development of the message as to what is unique to QVH, recommends it to the Board for approval.
- The proposed site locations for the new build QVH Community Diagnostic Centre were considered.
- The committee has made recommendations to the Board for the approval of the award of the sterile services contract (subject to confirmation that full consideration has been given to the contract duration) and the CPAP respiratory therapy services contract.

Risks discussed and new risks identified
- The BAFs for key strategic risks 02, 03, 05, 06, 07 have been reviewed. The committee agreed with the suggestion that the current score for BAF 03 (physical infrastructure) should be reviewed as it did not reflect the mitigating actions which are being undertaken.

- Discussion was had on the risks to the organisation due to the condition of the estate, the mitigations in place and the further planned actions.
- Risks due to weaknesses in contract management remain a concern for the committee.
- The ability to deliver against major project milestones is also highlighted by the committee as a risk for the Trust.

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