

Bundle Public Board 6 March 2025

Agenda attachments

A – Front cover PUBLIC

B – Membership FINAL

C – Register

D – Agenda public-6 March 2025 FINAL

122.2
5 Welcome, apologies and declarations of interest

Jackie Smith, Trust Chair

123.2
5 Draft minutes of the public meeting held on 16 January 2025

Jackie Smith, Trust Chair

Approval

123-25 Minutes- PUBLIC Board meeting- 16 January 2025 DRAFT V1

124.2
5 Matters arising and actions pending from previous meeting

Jackie Smith, Trust Chair

Review

124-25 PUBLIC Matters arising

125.2
5 Patient story

Edmund Tabay, Chief Nursing Officer

Discussion

126.2
5 Chair's report

Jackie Smith, Trust Chair

Assurance

126-25 Chair's report final V2

127.2
5 Chief Executive's report

Abigail Jago, acting Chief executive officer

Assurance

127-25 CEO's report Feb 2025 Final

128.2
5 Board of Directors work programme 2025/26

Jackie Smith, Trust Chair

Approval

128-25 Board work programme 2025-26

128-25.1 BoD work programme 2025-26 DRAFT V4

129.2
5 Establishment of People committee

Helen Edmunds, Chief people officer

Leonora May, Company secretary

Approval

129-25 People committee

129-25.1 Appendix one- PC ToR 2025-26 DRAFT V1

129-25.2 Appendix two- RoP SoD DRAFT V1

129-25.3 Appendix three- Standing orders DRAFT V1

130.2
5 Annual review of Register of sealing

Leonora May, Company secretary

Information

130-25 Annual report on the use of the Trust seal

130-25.1 Land sale completion documents

131.2
5 Organisational risk register

Leonora May, Company secretary

All executive directors

Assurance

131-25 Organisational risk register final

131-25.1 Risk – Reports – Risk Register Export V2

- 132.2
5 Integrated quality performance report
QVH financial position update incl. ratification of revisions to capital allocation – Jon Bell, interim Chief finance officer
Kirsten Timmins, Chief operating officer
Assurance
132-25 M9 IQPR Board 03 2025v2
132-25.1 M9 IQPR v2
132-25 Capital Forecast paper V2
- 133.2
5 Premises assurance model (PAM)
Abigail Jago, acting Chief executive officer
Claire Lowe, interim Director of estates and facilities
Approval
133-25 PAM board paper – Feb 2025
133-25.1 PAM Submission 2024.pptx – Final Version (002)
- 134.2
5 Equality Diversity and Inclusion (EDI) annual report 2023/24
Helen Edmunds, Chief people officer
Approval
134-25 Annual Equalities Report 2023-24 Public Board
134-25.1 Annual Equalities report 2023-24
- 135.2
5 Emergency Preparedness Resilience and Response annual assurance
Kirsten Timmins, Chief operating officer
Assurance
135-25 EPRR Annual Report to Board
135-25.1 Core Standards Assurance 2024 Outcome Letter_QVH V4
- 136.2
5 Audit & risk committee assurance
Paul Dillon-Robinson, Non-executive director and committee Chair
Assurance
136-25 ARC assurance report to Board March 2025 FINAL
- 137.2
5 Quality & safety committee assurance
Shaun O’Leary, Non-executive director and committee Chair
Assurance
137-25 QSC assurance report Board March 2025 FINAL
- 138.2
5 Financial, workforce and operational performance assurance
Peter O’Donnell, Non-Executive Director and committee Chair
Assurance
138-25 FPC assurance report to Board March 2025 FINAL
- 139.2
5 Any other business (by application to the Chair)
Jackie Smith, Trust Chair
Discussion
- 140.2
5 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

Business Meeting of the Board of Directors

Thursday 6 March 2025

Session in PUBLIC

10.00-12.00

Education centre (location 40), QVH



**MEMBERSHIP
BOARD OF DIRECTORS
March 2025**

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
	-	Jo Emmanuel
Acting Chief Executive Officer	-	Abigail Jago
Chief Medical Officer	-	Tamara Everington
Chief Nursing Officer	-	Edmund Tabay
Interim Chief Finance Officer	-	Jon Bell
Chief Operating Officer	-	Kirsten Timmins

In full attendance (non-voting):

Associate Non-Executive Directors	-	Aleema Shivji
	-	Vivek Chaudhri
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 (volunt)								
Jackie Smith Trust Chair	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	Non-Executive Director at OneFamily	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
Jo Emmanuel Non-Executive Director	Nil	Independent consultancy work for different NHS bodies for mental health, none directly linked to QVH	Nil	School governor for West St Leonards primary academy school	Nil	Nil	Nil	Nil

Abigail Jago Acting Chief Executive Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Tamara Everington Chief Medical Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Jon Bell Interim Chief Finance Officer	Nil	Nil	Nil	Trustee of Association of Coloproctology of Great Britain and Ireland	Advisor to software start up (Match+ CE Ltd) developing software for use in the NHS Advisor to the Tavistock and Portman NHS Foundation Trust	Nil	Nil	Nil
Edmund Tabay Chief Nursing 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
Aleema Shivji Associate Non-Executive Director	Director of 5 Westborne Villas Freehold Ltd and 5 Chatham Place Freehold Ltd	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Vivek Chaudhri Associate Non-Executive Director	Director of Global AI Leaders Network Director of Purposeful AI	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							
Jackie Smith Trust Chair	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
Jo Emmanuel Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tamara Everington Chief Medical Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jon Bell Interim Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Edmund Tabay Chief Nursing Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Abigail Jago Acting Chief Executive 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
Aleema Shivji Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Vivek Chaudhri Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Business meeting of the Board of Directors
Thursday 6 March 2025
10.00-12.00

Agenda: session held in public

WELCOME

122-25	Welcome, apologies and declarations of interest <i>Jackie Smith, Trust Chair</i>
--------	--

STANDING ITEMS		Purpose
123-25	Draft minutes of the public meeting held on 16 January 2025 <i>Jackie Smith, Trust Chair</i>	<i>Approval</i>
124-25	Matters arising and actions pending from previous meetings <i>Jackie Smith, Trust Chair</i>	<i>Review</i>
125-25	Patient story <i>Edmund Tabay, Chief nursing officer</i>	<i>Discussion</i>
126-25	Chair's report <i>Jackie Smith, Trust Chair</i>	<i>Assurance</i>
127-25	Chief Executive's report <i>Abigail Jago, acting Chief executive officer</i>	<i>Assurance</i>

GOVERNANCE, STRATEGY & RISK

128-25	Board of Directors work programme 2025/26 <i>Leonora May, Company secretary</i>	<i>Approval</i>
129-25	Establishment of People committee <i>Helen Edmunds, Chief people officer</i> <i>Leonora May, Company secretary</i>	<i>Approval</i>
130-25	Annual review of Register of sealing <i>Leonora May, Company secretary</i>	<i>Information</i>
131-25	Organisational risk register <i>Leonora May, Company secretary</i> <i>All executive directors</i>	<i>Assurance</i>

PERFORMANCE

132-25	Integrated quality and performance report QVH financial position update including ratification of revisions to capital allocation (<i>Jon Bell, interim Chief finance officer</i>) <i>Kirsten Timmins, Chief operating officer</i>	<i>Assurance</i>
--------	--	------------------

133-25	Premises assurance model (PAM) <i>Abigail Jago, acting Chief executive officer</i> <i>Claire Lowe, interim Director of estates and facilities</i>	<i>Approval</i>
ANNUAL REPORTS		
134-25	Equality diversity and inclusion (EDI) annual report 2023/24 <i>Helen Edmunds, Chief people officer</i>	<i>Approval</i>
135-25	Emergency Preparedness Resilience and Response <i>Kirsten Timmins, Chief operating officer</i>	<i>Assurance</i>
COMMITTEE ASSURANCE REPORTS		
136-25	Audit & risk committee assurance <i>Paul Dillon-Robinson, Non-executive director and committee Chair</i>	<i>Assurance</i>
137-25	Quality and safety committee assurance <i>Shaun O'Leary, Non-executive director and committee Chair</i>	<i>Assurance</i>
138-25	Financial, workforce and operational performance assurance <i>Peter O'Donnell, Non-Executive Director and committee Chair</i>	<i>Assurance</i>
MEETING CLOSURE		
139-25	Any other business (by application to the Chair) <i>Jackie Smith, Trust Chair</i>	<i>Discussion</i>
MEMBERS OF PUBLIC		
140-25	Questions from members of the public <i>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.</i> <i>Jackie Smith, Trust Chair</i>	

Document:	Minutes (DRAFT)	
Meeting:	Board of Directors (session in public) 10.00-12 noon 16 January 2025 Education Centre, QVH	
Present:	Jackie Smith (JS)	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)
	Jon Bell (JB)	Interim Chief finance officer (voting)
	Tamara Everington (TE)	Chief medical officer (voting)
	Edmund Tabay (ET)	Chief nursing officer (voting)
	Kirsten Timmins (KT)	Chief operating officer (voting)
	Helen Edmunds (HE)	Chief people officer (non-voting)
	Abigail Jago (AJ)	Acting Chief executive officer (voting)
In attendance:	Leonora May (LM)	Company Secretary (minutes)
	Liz Blackburn (LB)	Deputy Chief nursing officer
	Allison Hunter (AH)	Strategy and improvement project support officer [item 96-25]
	Jackie Doherty (JDo)	Freedom to speak up guardian, The Guardian Service [item 99-25]
	Derek Mcilroy (DM)	The Guardian Service [item 99-25]
Apologies:	James Lowell (JL)	Chief executive officer
Members of the public:	3 members of public, 6 members of staff and 14 governors	
93-25	Welcome, apologies and declarations of interest The Chair opened the meeting welcoming members of the Board, including ET and JB to their first Board meeting and those observing the meeting including 14 governors, Jo Emmanuel who will be joining the Trust as the clinical Non-executive director and Aleema Shivji and Vivek Chaudhri who will be joining the Trust as associate Non-executive directors. The Chair reminded those observing the meeting that they were not invited to participate in discussions and that there will be an opportunity for governors to ask questions at the end of the meeting. Apologies were received from JL and AJ is acting Chief executive officer. LB was in attendance to represent nursing as this is ET's first week in the Chief nursing officer role. JB confirmed that he has submitted some declarations of interest since the register of interests was published. He confirmed that none of these are conflicting with items on the agenda. There were no further additional declarations of interest other than those already recorded on the register of interests.	
94-25	Draft minutes of the public meeting held on 14 November 2024 The Board agreed that the minutes of the public Board meeting held on 14 November 2024 are a true and accurate record of that meeting and approved them on that basis.	
95-25	Matters arising and actions pending from previous meetings The Board noted: - There is one overdue action (EDI annual report 2023/24) which is due to be presented at the March 2025 meeting. HE confirmed that national data from NHSE is not yet available which is the reason for the delay; she proposed, and the Board agreed that it would be appropriate for the Trust report to be compiled and presented	

	to the Finance and performance committee in February 2025 and the Board in March 2025 with national data to follow as an addendum - Three actions have been closed since the last meeting - The written update related to clinical harm reviews for H2 patients
96-25	Staff story The Board welcomed AH who had joined the meeting to share her experience of being a member of staff at QVH. AH shared that she joined QVH in 2021 as an Executive assistant. It was a steep learning curve but she was able to attend many meetings and build her understanding of how the Trust operated. She was also given opportunities through her personal development plan to go out to clinical areas and learn about services. In 2023 she joined the strategy team and played a pivotal role in strategy engagement with internal and external stakeholders. Since joining the team she has had many opportunities to learn and enhance her skillset. She referred to a key challenge as being changes to milestones but the strategy team were able to work as a team and support one another well. AH described the great mentorship she had received from senior members of staff since joining the strategy team. A Board member asked AH what the key challenges were transitioning into the NHS. AH described lengthy processes and numerous back to back meetings which are a challenge. The Board thanked AH for sharing her story.
97-25	Chair's report JS presented the Chair's report to the Board. She highlighted that: - Seven new public governors had joined the Council of Governors in December 2024, many of whom were observing today's meeting. The Board extended a welcome to them - Jo Davis stood down as a staff governor in November 2024. She extended thanks to Jo for her contribution as a staff governor - There are a number of organisational challenges which the Board are focussed on and which will be priority areas for discussion today. These are operational challenges, financial challenges, and challenges related to strategic projects - The Strategic development committee met in December 2024 and agreed that the committee should continue to exist for at least one year to oversee the delivery and implementation of the strategy The Board noted the contents of the report.
98-25	Chief Executive's report AJ presented the report to the Board, taking it as read. She brought the good news stories regarding theatres and inpatient survey results to the Board's attention. She reported that there are some areas where there are significant risks which should be the Board's focus for the meeting. She described these as: - The Trust's financial position and a risk that the Trust will not achieve a breakeven position at year end - Some of the Trust's projects are going well but there are significant challenges too, specifically related to the electronic patient record (EPR) roll out which requires considerable further work - There is a risk to the Trust's long waiting position. The Trust has an ambition to get to zero over 65 week waits before the end of the financial year and further work is required to understand if this is achievable - There is ongoing estates challenges, specifically relating to the Trust's boiler systems. AJ reported that the estates team have worked extremely hard to ensure

	the heating and hot water systems can continue to run and extended thanks to them. The team continue to progress estates critical infrastructure work The Board extended thanks to the estates team for all of their work to mitigate issues with the boiler, particularly over the Christmas period. The Board acknowledged the system challenges relates to finance and waiting lists and the need for QVH to continue to support system partners. Discussion was had regarding the next steps for the QVH strategy 2025-2030 and the Board highlighted the importance of the development of the financial strategy. JB confirmed that this is being developed; meetings had been held with the Finance and performance committee Chair to set out the plan for the long term financial model and the team are working towards having a draft in place by May 2025. The planning guidance for 2025/26 is key and expected shortly. In response to a question, AJ outlined the priorities for Q4. She explained that the team are in the process of developing the implementation plan aligned to national priorities and planning guidance, system priorities, quality priorities and local challenges including the financial position. This will be discussed by the Board at its seminar in February 2025. The Board acknowledged a number of challenges related to progress with major projects. A Board member questioned whether there is adequate project management support given these common challenges. In response, AJ confirmed that the project management resource is being reviewed on an ongoing basis and that there may be some areas which require different resources. She suggested a need to be clear about priorities and focus from a project management and corporate team perspective. The Finance and performance committee will have sight of the broader resourcing plan. The Board acknowledged a wider issue regarding priorities and a need for the executive team to provide assurance that the organisation is not trying to do too much at the same time, given challenges with change management and change excellence and the need to improve in these areas. It was suggested that there may be difficult choices in the months ahead regarding what should be stopped versus prioritised and that the Board would support this approach. Discussion was had regarding culture. A Board member asked how work to address cultural issues related to non-compliance is feeding into wider cultural work streams. HE responded, acknowledging that there are cultural challenges across the organisation which can be seen with behaviour and compliance issues. She thought that these are not new challenges, but staff are now feeling safe to speak up and understand how to. She highlighted the importance of taking action when staff speak up and embed learning. She explained that a Cultural transformation steering group has been established and the Board will start its work on culture in February 2025 with a diversity 'MOT'. She emphasised the importance of cultural change work being driven from all angles. The Board acknowledged that responsibility for culture sits with the Board, and that it is for the Board to set the tone and describe behaviours and model leadership for others to follow. The Board agreed that the next step should be an assessment of the organisational culture to enable the Board to understand the gap between where it is now and where it needs to be in line with the values and behaviour framework previously agreed by the Board. ACTION HE The Board noted the contents of the report.
99-25	Freedom to speak up (FTSU) guardian report [JDo and DM joined the meeting] JDo presented the report to the Board, highlighting that:

	- The report covers up until the end of November 2024, as the December 2024 report has not been produced yet. This data will be available in the next report - The number of speak ups is increasing and there have been 20 cases up to the end of November 2024 - There has been an improvement in the number of cases which those who have spoken up are happy to escalate but there is still a reluctance from staff to use their name which suggests that there is still work to do to ensure staff feel safe Discussion was had regarding other speaking up avenues. PDR confirmed that the Audit and risk committee had recently received an update with limited assurance and doubts about how effective other measures are. TE highlighted that almost daily, significant issues are being raised through various speaking up routes, many of which reflect that the organisation has previously had a high degree of tolerance for behaviours which would not be acceptable in a modern day workplace. The Board acknowledged this point and thanked TE for raising it. In response to a question, JDo confirmed that a case is never closed until the person confirms that they do not require further support so time to close cases will vary. During December 2024, around four cases were closed. In response to a question about staff networks, HE confirmed that this remains a priority but attendance is not yet high enough to form groups which thrive. EDI champions have come forward. The Board agreed that the networks need to be valuable and make a difference for staff and agreed the importance of continued engagement in this area as well as facilitating staff attendance at meetings of the groups. The Board thanked JDo for the update, noting the contents of the report including the fact that no safety concerns have been raised.
100-25	Organisational risk register LM presented the report to the Board as read, highlighting that: - The highest scoring risks on the register currently relate to compliance with governing documents, mental capacity assessments for patients and estates critical infrastructure - Each of the Board sub-committees have had sight of the organisational risk register and the risks relevant to their remit in recent meetings. The Audit and risk committee has received an update on the implementation of the Risk management framework and will oversee the effectiveness. The scores for the risks related to the fire alarm and boiler systems have been reduced since presented to the Finance and performance committee due to mitigations in place In response to a question, AJ confirmed that the risk related to electrical cabling is not new and that work on the mitigating actions is on progress and on track. Discussion was had regarding the risk related to the Trust's breakeven position and the Board expressed the view that the current score may not be reflective of the true level of risk. JB agreed to revisit this score. ACTION JB A Board member sought reassurance that if the Trust's boiler system were to fail, the mitigations in place would ensure that there is no impact to patient and/ or staff safety. AJ agreed to provide an update on the mitigating actions and current position outside of the meeting. ACTION AJ The Board noted the contents of the report, acknowledging that the Trust is currently carrying a high level of risk.

101-25

Integrated quality and performance report

The executive team presented the report highlighting the following:

- KSO3 (operational performance): KT reported that the waiting times within Sussex are challenged; as the Trust does not provide urgent and emergency care, it is supporting the wider Sussex system with waiting lists. The Trust has received 110 patient transfers and has reported an increase in the number of patients waiting more than 52 weeks. She reported that the deterioration is due to the prioritisation of cancer patients, providing system support and the Trust's own challenges related to breast and skin. For month 8, the Trust has reported seven patients waiting over 78 weeks and 47 patients waiting over 65 weeks, 21 of these being transferred from the wider Sussex system. KT anticipated that the Trust's long waiting position will deteriorate in January and February 2025. KT reported that the Trust is not meeting its 125% activity target which is driving an income deficit
- KSO1 and KSO2 (patient experience and clinical services): LB reported that there are no concerns on quality metrics. TE reported that there has been an increase in all cancers since Covid-19, and increase in demand on all NHS services, particularly urgent and primary care. She expressed the view that the Trust has work to do to ensure that the Trust can be responsive in meeting needs of patients on waiting list, particularly within the outpatients department
- KSO4 (financial performance): JB reported that the Trust's 2024/25 operating and financial plan had a very challenging cost improvement plan target and assumed an increase in activity part way through the year. During month 8 the Trust has not met the activity level and there has been pressures on pay and non-pay spend. The Trust had been able to breakeven by releasing non-recurrent reserves but there is an underlying deficit position. It is likely that some income benefit during Q4 will materialise and it is therefore possible that the Trust may meet its breakeven position, however the Board should note the underlying deficit position due to not meeting income targets and pay and non-pay pressures. The financial outlook into next year will be very challenging
- KSO5 (organisational excellence): HE reported that the Trust remains focussed on reducing agency spend. The staff survey closed in November 2024 and the team are working through the results. The response rate was 57% which is similar to the previous year

The Board considered and discussed the updates as follows:

- A Board member asked how many 65 week waiting patients there is likely to be at the end of March 2025. In response, AJ confirmed that more detailed work is required to understand the best and worst case scenarios and provide an accurate forecast
- KT was asked whether there are any prosthetics patients waiting more than three years. KT agreed to report back to the Board with this information. **ACTION KT**
- The Board acknowledged that the Trust is not meeting its activity plan for 2024/25 which is driving a financial deficit position
- Discussion was had regarding the Trust's financial position and the Board acknowledged the underlying deficit position. It was thought that there had been a lack of transparency in previous reporting, as Board members were not aware that the Trust's breakeven position was being achieved by releasing accruals. It was agreed that there must be learning from this
- Board members agreed that the activity plans for 2025/26 must be realistic and achievable, even if that demonstrates a deficit. JB shared the view that next year will be extremely challenging and that the Trust should focus on finding innovative ways to maintain corporate functions whilst lowering costs
- Discussion was had regarding the response rate to the staff survey and Board members suggested that there is a need to increase engagement in order to increase the response rate. It was suggested that engagement focus on staff understanding why it matters and what action will be taken as a result

	The Board noted the contents of the report.
102-25	Electronic patient record (EPR) project update KT presented the report to the Board. She reported that work is ongoing to understand the financial position of the project. She highlight the enormity of the project for the Trust and its resources; the right skills were required in order to deliver it and the team have been in place since late 2024. There have been some variances to the original business case and at the time of writing the report there was thought to be a £3.8m financial gap. She proposed that a revised business case summary is presented back to the Finance and performance committee and Board setting out the changes and seeking approval for the potential rephrasing. The Board agreed that the project requires a reset. It was suggested that it is currently failing which raises questions about the original business case not being robust. Board members highlighted the need for transparency regarding benefits in the revised business case, noting that these will unlikely be financial. TE recognised the challenges whilst highlighting the improvements that the EPR will bring to patient care. She reported that staff are deeply engaged in the transition and that the Trust is on the threshold of delivering a core component which will transform clinical care. The Board noted a compliance issue with the Scheme of delegation, with a contract with a value of more than £1m being approved outside of the Board. The Board: - Noted the update regarding the issues and risks related to the EPR programme, specifically finance, governance and benefits realisation - Noted the variances to the full business case - Supported the development of a revised business case summary for the programme
103-25	National inpatient survey results LB presented the report to the Board, reporting that the QVH has scored top in the country for the national inpatient survey. She explained that although the Trust has done very well, there are still areas which could be further improved and these will be addressed. The Board noted an improvement in patient food. The Board noted the contents of the report and congratulated all involved in achieving the results.
104-25	Audit and risk committee assurance PDR presented the committee assurance report to the Board. He reported that the committee held an additional meeting in November 2024 focussed on the internal control environment and compliance issues. All Board members attended the meeting. The Trust will need to disclose in its Annual governance statement for 2024/25 the issues with the control environment and the external auditors will comment on this. The committee will monitor the work to rectify the position. The contract management internal audit follow up has provided limited assurance and the committee will continue to monitor progress in this area. The Board noted the contents of the report.
105-25	Quality and safety committee assurance

	SOL presented the committee assurance report to the Board. He reported that the committee had spent time at its last meeting understanding the status of quality impact assessments which have slipped in terms of routine application. The committee were assured by work underway to rectify this position. The committee are assured that patient safety investigations are thorough but acknowledge a need to improve the quality and speed of investigations and final assessments. The committee received the medicines management annual report for 2023/24 and were pleased to note no moderate or severe harm during the period. The Board noted the contents of the report.
106-25	Financial, workforce and operational performance assurance POD presented the report to the Board. He reported that the capital plan is behind and that the committee will receive a plan for this to be spent before the end of the financial year. The committee have sought further assurance that those patients waiting over 65 weeks are being communicated with and that clinical harm reviews are being undertaken. This matter has been referred to the Quality and safety committee. The committee has asked for an in depth review of the Bognor Community diagnostic centre (CDC) given that it is currently rated as red and there is limited assurance regarding delivery. The Board noted the contents of the report
107-25	Any other business (by application to the Chair) There was no further business and the meeting closed.
108-25	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 asked the following questions and the following responses were given. Question Is the theatres module one of the financial challenges related to the EPR project? Response KT confirmed that the theatres module was within the original business case and budget. Question Why has the EPR clinical advisory group only just been established? Response KT confirmed that the whole team has changed, with a new team being brought in with the right expertise to deliver. The group has been established as quickly as possible. Question How much are junior medical staff engaged with cultural transformation work? Response TE confirmed that junior medical staff are engaged with in a systematic way. There is a forum in place as well as the freedom to speak up guardian and opportunities for support and feedback. Question Why did we not know about the Bognor Community diagnostic centre (CDC)? Response

	JS confirmed that the Trust's Chief Executive Officer was asked by the system to take the lead on developing this; work is in progress to understand the current position. Question Does the staff survey follow a 'one size fits all' approach or is there adaptations for clinical staff, for example? Response HE explained that the survey is national so there is no opportunity to adopt it for specific staff groups.
--	---

Matters arising and actions pending from previous meetings of the Board of Directors - PUBLIC								
ITEM	MEETING Month	REF.	TOPIC	AGREED ACTION	OWNER	DUE	UPDATE	STATUS
1	September 2024	50-24	EDI	EDI annual report 2023/24 to be presented to the Board as soon as possible to ensure continued oversight of areas of concern. The report should include analysis of data and a view from the CPO as well as actions which will make a difference	HE	16 January 2025 6 March 2025	November 2024: Verbal update at meeting December 2024: National data not available, report to be presented to March 2025 Board meeting March 2025: report on agenda	CLOSED
2	January 2025	98-25	Culture	Assessment of the organisational culture to be completed to enable the Board to understand the gap between where it is now and where it needs to be in line with the values and behaviour framework previously agreed by the Board	HE	8 May 2025		NOT YET DUE
3	January 2025	100-25	Financial position	Review risk score for organisational risk related to the Trust's breakeven position at year end	JB	6 March 2025	March 2025: Verbal update at meeting	PENDING
4	January 2025	100-25	Boiler system	Provide an update on mitigating actions and current position outside of the meeting	AJ	6 March 2025	January 2025: AJ provided an update outside of the meeting confirming that the fact we had lost boilers in a number of plant rooms, and we were at risk of not being able to heat the hospital in 80% of clinical areas. This was given a risk rating of 25. With the hire boiler now on site the likelihood of not having heating has been mitigated down to a 15, as the likelihood has now changed. The consequence has not changed as the failure of the hire boiler would still close the hospital. The new rating is where we are today with all the mitigations already in place.	CLOSED
5	January 2025	101-25	Performance	Confirm whether there are any prosthetics patients waiting more than three years for treatment	KT	6 March 2025	February 2025: The prosthetics department has confirmed there are no patients waiting more than three years for treatment.	CLOSED

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/03/2025	Agenda reference:	126-25		
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	- During March 2025, the Board and Council of Governors will complete their annual effectiveness reviews - Public governor vacancies will be held until the next election in 2026. The staff governor vacancy will be filled for the remainder of the term - I would like to welcome Jo Emmanuel, Aleema Shivji and Vivek Chaudhri to their first Board meeting - This will be Karen Norman's last Board meeting and I would like to extend my thanks and thanks on behalf of the whole Board for all that she has done for the Trust during her six year tenure as Non-executive director and more recently the senior independent director				
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: <i>Outstanding patient experience</i>	KSO2: <i>World-class clinical services</i>	KSO3: <i>Operational excellence</i>	KSO4: <i>Financial sustainability</i>	KSO5: <i>Organisational excellence</i>
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 of Directors
Agenda item: 126-25
Date of meeting: 06 March 2025
Report from: Jackie Smith, Trust Chair
Report author: Jackie Smith, Trust Chair
Date of report: 20 February 2025
Appendices: None

Chair's report

Council of Governors

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

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

During March/ April 2025, we will be holding an all-day training and development day for all of our governors, following the first event held in May 2024 which was welcomed by governors in supporting them to discharge statutory responsibilities.

During March 2025, the Council of Governors will complete its annual effectiveness review, the outcome of which will be reported to the Council of Governors at its meeting in April 2025.

At its meeting in January 2025, the Council of Governors agreed to hold public governor vacancies until the next public governor election during 2026. The Council of Governors agreed that the remainder of the vacant staff governor term should be filled by the next highest polling candidate from the staff governor election in 2023. I will confirm appointment to this post once the process is finalised.

Board of Directors

Key concern areas for the Board include the Trust's financial position, operational challenges, progress made against major projects and cost improvement plans for 2025/26 following the publication of the planning guidance for next year which is challenging.

I would like to welcome Jo Emmanuel, Aleema Shivji and Vivek Chaudhri to their first Board meeting. Jo joined the Board in January as our clinical Non-executive director in succession of Karen Norman. Aleema and Vivek joined the Board in January as our Associate Non-executive directors.

This will be Karen Norman's last Board meeting and I would like to extend my thanks and thanks on behalf of the whole Board for all that she has done for the Trust during her six year tenure as Non-executive director and more recently the senior independent director. Russell Hobby will take over from Karen as senior independent director.

We will shortly be going out to recruitment for a Non-executive director with recent and relevant financial experience who will Chair our Audit and risk committee in succession of Paul Dillon-Robinson whose second and final term as a Non-executive director ends in September 2025.

The membership and Chairing arrangements of the Board sub-committees will be reviewed in light of these Board personnel changes and the proposed establishment of the People committee.

Our Chief executive officer, James Lowell, left the Trust during February 2025 to take up a secondment opportunity as Chief Delivery Officer at NHS Hampshire and Isle of Wight Integrated Care Board for six months. During this time, Abigail Jago will be the acting Chief executive officer. I would like to express thanks on behalf of the Board to James for everything he has done for our organisation and the communities we serve during his time in the role, and to Abigail for stepping into the acting Chief Executive role.

During March 2025, the Board will complete its annual effectiveness review, the outcome of which will be discussed by the Board at its meeting in March 2025.

Other activities

I continue to meet regularly with the Chair of NHS Sussex and engage with NHSE. We have recently discussed the potential removal of the Trust's additional licence conditions, given that the relationship between the Board and Council of Governors has much improved.

Since the last Board meeting, Non-executive colleagues have visited the outpatients department, the radiology department and the site practitioners. I am pleased to say that governors are increasingly taking up the offer to join Non-executive directors on service visits.

The Strategic development committee last met in December 2024 following the publication of the organisational strategy. The committee will meet next on 26 March 2025 following which I will submit an assurance report to the Board.

Recommendation

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

Report cover-page

References

Meeting title:	Board of Directors		
Meeting date:	06/03/2025	Agenda reference:	127-25
Report title:	Chief Executive Officer (CEO) report		
Sponsor:	Abigail Jago, Acting Chief Executive Officer		
Author:	Diane Talbot, Business Manager to CEO, Michelle Baillie, Associate Director of Communications, Engagement and Charity, Leonora May, Company Secretary		
Appendices:	None		

Executive summary

Purpose of report:	This report outlines the main developments since the last public Board meeting to bring to the boards attention.				
--------------------	--	--	--	--	--

Summary of key issues	- The Trust continues to report an in month breakeven position and is forecasting to breakeven at year end, however the underlying position remains challenged and there is a risk to achieving breakeven. The underlying position to Month 9 has increased to a deficit of £2.1m which has been mitigated using non-recurrent funding. Income continues behind plan and there is a further risk related to specialist commissioning income that could further deteriorate the position. - The planning guidance and changes to elective funding for 2025/26 poses significant challenge to providers and the ability for QVH to submit a breakeven plan for 2025/26. - The Board has approved a plan to reallocate capital underspend to address priority medical equipment and digital resourcing. - The trust has shared a forecast of 50 patients waiting greater than 65 weeks at the end of March. Work continues to reduce this position further and the current position is an improved forecast of 39 patients. - The Fire Enforcement notice issued on 1 February 2024 was lifted following a final review with West Sussex Fire & Rescue Service (WSFRS) on 30 January 2025. Fire compliance remains a priority and WSFRS will revisit within 12 months. - The key risks to the Trust meeting its key strategic objectives are the financial position, operational challenges and the estate infrastructure including boilers, heating systems and electrical infrastructure. - Work is ongoing to strengthen governance control and compliance. - Work continues to address risks associated with key strategic programmes in particular Electronic Patient Record (EPR) and the Community Diagnostic Centre (CDC) programmes.				
-----------------------	---	--	--	--	--

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: <i>Outstanding patient experience</i>	KSO2: <i>World-class clinical services</i>	KSO3: <i>Operational excellence</i>	KSO4: <i>Financial sustainability</i>	KSO5: <i>Organisational excellence</i>

Implications

Board assurance framework:	All
Organisational risk register:	None
Regulation:	None
Legal:	None
Resources:	Resource impact as identified within the report.

Assurance route

Report to: Board Directors
Agenda item: 127-25
Date of meeting: 06 March 2025
Report from: Abigail Jago, Acting Chief Executive Officer
Report author: Diane Talbot, Business manager to CEO
Date of report: 26 February 2025
Appendices: None

Acting Chief executive officer (CEO) report

Executive summary

This report outlines the main developments since the last public Board meeting on 16 January 2025 to bring to the Boards attention.

Alert

- **Finance update**

At Month 9, the Trust continues to report a breakeven position and is forecasting to breakeven at year end, however the underlying position remains challenging and there is a risk to achieving breakeven at year end. The underlying position for the year to Month 9 has increased to a deficit of £2.1m which has been mitigated using available non-recurrent measures. Income continues to deliver below plan year to date and there is a risk related to the income from specialist commissioners that could further deteriorate the position if not resolved by year end. The executive and directorate leadership teams continue to progress a number of actions to improve the run rate in the remaining weeks of the year, with weekly review meetings held with directorate leads.

Key issues within next year's plans are the scale of the exit underlying position and the level of required cost reduction.

The Board has approved a plan to reallocate capital underspend to address priority medical equipment and digital requirements and procurement of the agreed assets is progressing, with the capital budget expected to be fully utilised by the end of March 2025.

The Trust is working on the finance, operating and workforce plans for 2025/26 with a final submission date of the 27 March 2025.

- **65 week wait**

The trust reported an increase in the number of patients waiting over 65 weeks in Month 9, with 26 of the 73 patients being transfers from within the wider Sussex system. The Trust has shared a forecast of 50 patients over 65 weeks at the year end, with continued work underway to reduce this position further, with the current forecast improved to 39 patients. This cohort includes patients requiring complex breast reconstruction surgery.

- **Bognor Community Diagnostic Centre (CDC) / QVH CDC**

QVH is currently leading two CDC developments. Since the last board meeting two detailed stocktakes have taken place in regard to both programmes. Intervention is underway to strengthen governance and programme leadership across both programmes.

Bognor CDC Programme governance is being reset following a change from a new build (following cost implications of Environment Agency requirements) to a now planned refit

proposal within the university campus. This programme of work is a priority within West Sussex Place and reflects a partnership across the NHS and the University of Chichester.

The planning application for the CDC on the QVH site at East Grinstead was submitted on 31 January 2025. The build construction is out to tender and will inform the business case which will then be submitted for board approval.

- **EPR**

An EPR business case summary has been developed to review the current position of the programme. This considers the following key areas:

- Original forecast spend and delivery milestones as approved in the Full Business Case (FBC) in March 2024.
- Key factors and variances that have occurred subsequent to the approval of the FBC.
- Current programme status.
- Analysis of the key options available to the Trust:
- A high-level assessment of the key benefits as set out in the original Full Business Case and risk to delivery of benefits.

Whilst the paper is going through the approvals process, the programme team is continuing to work towards the first phase milestone.

Assure

- **Reinforced autoclaved aerated concrete (RAAC)**

Work started to refurbish Rowntree on 10 February 2025. Medical Photography will move into their new location at end of March and then the existing medical photography building will be demolished by end of April. Full funding has been approved by NHSE RAAC team. (£1.3M)

- **Fire notice update**

The Enforcement notice issued on 1 February 2024 was lifted following a final review with West Sussex Fire & Rescue Service (WSFRS) on 30 January 2025. Fire safety remains a priority to ensure compliance. WSFRS will visit again within 12 months.

- **Pagers**

The contract for a new paging system and a four year maintenance contract has been signed and implementation progressing.

- **Organisational culture**

Organisational culture is a key focus currently. There is an increase in staff speaking up in relation to their experience at work and where they have experienced poor behaviours between staff and across teams. Learning from investigations is being embedded to support future processes. Listening sessions continue with staff, led and supported by the wellbeing and organisational development team, with 1:1 and team development interventions taking place. The Cultural Transformation Steering Group met for the first time on the 26 February 2025.

Advise

- **Performance**

Waiting times for patients across Sussex remain challenged, yet the system support and focus across all trusts on those patients waiting over 65 weeks is showing an improved position across the Sussex system.

Key highlights for the Board regarding QVH's performance over and above highlights above as follows:

- RTT performance remains in line with the national benchmark yet deteriorated slightly in Month 9 given the focus on treating the long waiting patients.
- The Trust continues to meet the 4 hour urgent and emergency care standard and the performance targets for cancer Faster Diagnosis standard and 62 days.
- The trust's diagnostics position deteriorated from 92.3% in Month 8 to 89.1% in Month 9. This was primarily driven by capacity constraints in sleep services.
- Agency spend as a % of our pay bill is 3.4% against an NHS Sussex target of 3.2%. Agency usage has reduced by 5.1 Whole Time Equivalent (WTE) in Month 9, bank usage has decreased by 9.15 WTE.

Risk

The key risks to the Trust meeting its key strategic objectives are:

- the Trust's financial position including 2024/5 year end underlying financial position, level of required cost reduction and national changes to the funding of elective care
- estate critical infrastructure (including boiler and heating systems and electrical infrastructure)
- the ability to deliver and maintain the maximum waiting standards for patients awaiting planned care including waits over 65 weeks and requirements within the new planning guidance

Following the publication of the organisational strategy 2025-2030, the Board recognised that the risks which make up the Board assurance framework are due a refresh to provide a realistic view of the most fundamental strategic risks and key controls to support mitigation. The Board had an initial discussion about this in its seminar in December 2024 and work has started on developing a new Board assurance framework.

Work continues across all key areas to improve control and compliance. This includes the weekly workforce control panel, temporary staffing reduction oversight group and monthly financial controls review meeting.

Strategy

In February we held a patient, staff and volunteer workshop to develop ideas and individual preferences on how to develop and design an easy read version of our *QVH strategy 2025-2030* document. Following this successful event we have collated all of the feedback and are now working to develop the end product.

The development of the strategy implementation plan is underway, ensuring collaborative working with executive colleagues to develop a Trust overarching annual priorities operational plan. This document is designed to include all elements of the Trusts operational, financial and strategic ambitions over the coming year taking into consideration the recently published operational planning guidance 2025/26 and system priorities. The plan also supports the phased delivery of key milestone within the approved enabling strategies including; anchor, health inequalities, green, people and culture and digital for 2025/26. Priorities will be aligned to financial capabilities.

Continuous Improvement

The *QVH Way* continuous improvement programme is ongoing and on track. There are now 12 improvement huddles in place across the organisation, with a further four planned by the end of March 2025, with a virtual board option being trialled in both the coding and strategy teams. The huddles are beginning to be embedded in both clinical and non-clinical areas, where staff led improvements are taking place. Benefits realisation will be critical to the

programme moving forwards, linking with Project Management Office (PMO) to understand the impact of the programme across the trust. As part of the roll out of The QVH Way, 22 members of staff have received yellow belt training, where they are undertaking projects over a 90 day period. The Trust will celebrate its first cohort of yellow belt trainees on 6 March at an event where members of the Trust Board will be present to recognise the trainee achievements.

System / sector working

The NHS Sussex Committee in Common (CiC) met on 12 February 2025 and remains focussed on its commitment to the delivery of the shared Improving Lives Together Strategy and on making progress in relation to waiting lists and finances across the system.

We are building on the success of the Provider Collaborative Executive (PCE) partnership and the relationship developments within the Community and Acute provider collaboratives. We are doing this by structuring ourselves in a way that supports collaboration for the benefit of our population, staff & services, for improved quality, care & sustainability. This is underpinned by:

- Developing a provider collaborative with commissioning responsibilities and delegated authority
- Focussing on strategic transformation of end-to-end pathways & across organisational boundaries

We will move to a single Provider Collaborative merging the current Community and Acute Provider Collaboratives, forming the Sussex Provider Collaborative.

Sharing success

VIP Awards

In January we launched our monthly Values in Practice (VIP) award to help us recognise and celebrate colleagues who embody our new organisational values. We were delighted with the number of nominations we received from across the organisation and presented our January VIP award to Jennifer Foster, one of our healthcare assistants. She was nominated for expressing our value “succeeding together (over achieving alone)” for her proactive and enthusiastic support of new healthcare assistants alongside completing an apprenticeship.

Recommendation

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

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/03/2025	Agenda reference:	128-25		
Report title:	Board work programme 2025/26				
Sponsor:	Leonora May, Company secretary				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one- Board work programme 2025/26				
Executive summary					
Purpose of report:	To present the Board work programme for 2025/26 for review and approval.				
Summary of key issues	The Board work programme for 2025/26 has been drafted in line with the Board's responsibilities and has been drafted in line its sub-committee work plans. The Quality and safety committee and Finance and performance committee have reviewed their work programmes at their February 2025 meetings. The Audit and risk committee will review its work programme at its meeting in March 2025. The Board work programme 2025/26 will be flexible as priorities emerge for next year.				
Recommendation:	The Board is asked to review and approve its work programme for 2025/26, noting that there may be further iterations.				
Action required	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	<i>Outstanding patient experience</i>	<i>World-class clinical services</i>	<i>Operational excellence</i>	<i>Financial sustainability</i>	<i>Organisational excellence</i>
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	Standing Orders Code of governance for NHS Provider Trusts				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive leadership team				
	Date:	Feb 2025	Decision:		
Next steps:	Work plan used to inform 2025/26 Board meeting agendas				

Agenda item	08 May 2025	24 June 2025 (ARA)	10 July 2025	11 September 2025	13 November 2025	22 January 2026	12 March 2026	Lead
Standing items								
Welcome, apologies and declarations of interest	✓	✓	✓	✓	✓	✓	✓	Trust Chair
Patient story	✓		✓		✓	✓		Chief nursing officer
Staff story				✓			✓	Chief people officer
Minutes of the previous meeting	✓		✓	✓	✓	✓	✓	Trust Chair
Matters arising and actions pending from previous meetings	✓		✓	✓	✓	✓	✓	Trust Chair
Chair's report: - Strategic development committee assurance	✓		✓	✓	✓	✓	✓	Trust Chair
Chief Executive Officer's report: - Risk - Key strategic priorities - Partnership working (CIC assurance)	✓		✓	✓	✓	✓	✓	Chief executive officer
Governance, Strategy & Risk								
Freedom to Speak Up guardian report			✓			✓		FTSU guardian
Guardian of Safe Working report	✓				✓			GoSW guardian (Jennifer O'Neill)
Board assurance framework and Organisational risk register	✓		✓	✓	✓	✓	✓	Company secretary
Company secretary's report: - Compliance with Code of governance for NHS provider trusts 2024/25 - Compliance with licence conditions 2024/25 - Compliance with governing documents - Compliance with FPPT requirements - Annual review of Sols, SFIs, and SoD RoP	✓							Company secretary
Audit committee annual report		✓						Committee Chair
Annual Board effectiveness review incl. Board self assessment	✓						✓	Trust Chair Company secretary
Annual review of committee ToR	✓						✓	Committee Chair's Company secretary
Annual review of register of sealings							✓	Company secretary
Finance and performance								
Integrated quality and performance report: key strategic projects, KSO1, KSO2, KSO3, KSO4 and KSO5	✓		✓	✓	✓	✓	✓	Chief operating officer
Annual plan 2025/26 (approval)	✓							Chief finance officer Chief operating officer
Annual planning 2026/27 (update)							✓	Chief finance officer Chief operating officer
Annual items								
Quality annual reports: - learning from deaths - safeguarding - Infection, prevention and control - patient experience - research & innovation - consultant revalidation			✓					Chief nursing officer & chief medical officer
Workforce annual reports: - EDI annual report 2024/25 - WRES and WDES annual reports 2024/25 - Gender pay gap as at 31 March 2025 - Ethnicity pay gap as at 31 March 2025 - Action plan				✓	✓			Chief people officer
Operational annual reports: - Emergency planning, response and resilience							✓	Chief operating officer
Annual review of learning from patient stories			✓					Chief nursing officer
6 monthly safe staffing review	✓				✓			Chief nursing officer
National inpatient survey results					✓			Chief nursing officer
National staff survey results	✓							Chief people officer
Premises assurance model				✓				Chief executive officer

						✓		Chief people officer Chief nursing officer Company secretary
Annual review of raising concerns				✓				Chief operating officer
Annual assessment of addressing health inequalities				✓				Chief people officer
Annual assessment of organisational culture								
Committee assurance								
Quality & safety committee assurance	✓		✓	✓	✓	✓	✓	Committee chair
Finance & performance committee assurance	✓		✓	✓	✓	✓	✓	Committee chair
Audit & risk committee assurance	✓		✓	✓	✓	✓	✓	Committee chair
Strategic development committee assurance (incl. in Chair's report)	✓		✓	✓	✓	✓	✓	Committee chair
People committee assurance	✓		✓	✓	✓	✓	✓	Committee chair
Annual report & accounts								
Annual report 2025/25		✓						Company secretary
Audited annual accounts 2024/25 incl. external audit opinion		✓						Chief finance officer
Quality account 2024/25		✓						Chief nursing officer
Ad-hoc items								
Trust Constitution updates								Company secretary
Strategy implementation updates								Chief strategy officer
Private business								

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/03/2025	Agenda reference:		129-25	
Report title:	Establishment of People committee				
Sponsor:	Helen Edmunds, Chief people officer Leonora May, Company secretary				
Author:	Helen Edmunds, Chief people officer Leonora May, Company secretary				
Appendices:	Appendix one- draft terms of reference for People committee Appendix two- Scheme of delegation Appendix three- Standing orders				
Executive summary					
Purpose of report:	To seek approval for the establishment of a People committee.				
Summary of key issues	- It is standard practice for NHS Trusts to have a People Committee in place as a sub-committee of the Board, to create and maintain the trust as an organisation operating at the highest levels of workforce engagement, performance and efficiency delivery high quality care to our patients - People and culture issues are some of the biggest risks in the NHS, with people costs being the highest single area of expenditure. High quality staff are key to the quality of care and to patient experience. It is essential to have appropriate controls and assurances in place to manage these risks, and robust governance arrangements to ensure accountability - The committee will be an assurance committee; it will provide assurance to the Board on all areas within the committee's remit, specifically the People strategy and culture. The committee will create Board bandwidth to increase Non-executive oversight of key risk areas and allow sufficient depth of assurance				
Recommendation:	The Board is asked to approve the establishment of the People committee including the terms of reference and the changes to the Scheme of delegation and reservation of powers and Standing orders (as appended).				
Action required	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: <i>Outstanding patient experience</i>	KSO2: <i>World-class clinical services</i>	KSO3: <i>Operational excellence</i>	KSO4: <i>Financial sustainability</i>	KSO5: <i>Organisational excellence</i>
Implications					
Board assurance framework:	BAF2				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:	As set out within report				

Report to: Board of Directors
Agenda item: 129-25
Date of meeting: 06 March 2025
Report from: Helen Edmunds, Chief people officer
Leonora May, Company secretary
Report author: Helen Edmunds, Chief people officer
Leonora May, Company secretary
Date of report: 18 February 2025
Appendices: Appendix one- draft terms of reference for People committee
Appendix two- Scheme of delegation
Appendix three- Standing orders

People committee

Introduction

At the current time, people related areas of work, people metrics and associated reporting and assurance is undertaken via the Finance and Performance Committee. In order to have the skills, expertise and focus on workforce and culture that is required given the cultural challenges, it is proposed for there to be a People Committee established as a sub-committee of the Board.

A Workforce sub-committee has been established as a sub-committee of the Executive Leadership Team, with the first meeting taking place in January 2025.

Case for committee

It is standard practice for NHS Trusts to have a People Committee in place as a sub-committee of the Board, to create and maintain the trust as an organisation operating at the highest levels of workforce engagement, performance and efficiency delivery high quality care to our patients. A People committee is specifically focussed on workforce-related issues to oversee the development and implementation of the Trust's people strategy and ensure the Trust has robust plans in place to support the on-going development of the workforce.

People and culture issues are some of the biggest risks in the NHS, with people costs being the highest single area of expenditure. High quality staff are key to the quality of care and to patient experience. It is essential to have appropriate controls and assurances in place to manage these risks, and robust governance arrangements to ensure accountability.

A People Committee is responsible for the oversight and monitoring of people-related strategies and plans. There is opportunity for innovative thinking around issues such as how staff are deployed, trained and engaged as well as looking externally to relationships with local partners. A committee with the relevant skills and experience, focussed on these issues can provide a constructive space for challenge and imaginative provocation

Strategy and culture are part of the Board's unique remit, and these should be an area of focus of the People Committee. Being assured people issues are being well managed and the well-being of staff taken care of is important and should be evident from the people section of any performance report. A committee needs to understand where the areas of concern and issue lie and to be invited to advise where helpful and appropriate.

Proposed committee remit

The remit of the committee will include:

- Oversight of strategies and plans relating to the workforce, organisational development and culture
- Consideration of strategic workforce issues
- Monitoring key performance indicators relating to workforce issues
- Oversight of areas such as equality, diversity and inclusion, recruitment and retention, learning and development, staff health, safety and wellbeing, and workforce culture and satisfaction

Governance

The committee will be an assurance committee; it will provide assurance to the Board on all areas within the committee's remit, specifically the People strategy and culture. The committee will create Board bandwidth to increase Non-executive oversight of key risk areas and allow sufficient depth of assurance.

It is proposed that the committee will meet quarterly and the core membership of the committee will comprise of:

- Non-executive director Chair (Russell Hobby)
- Two Non-executive directors
- Chief People officer
- Chief Nursing officer
- Chief Operating officer
- Associate Non-executive director

Next steps

If there is agreement for the committee to be established, the next steps will be as follows:

- Other Board sub-committee terms of reference will be reviewed to ensure clarity regarding responsibilities between them
- Work plan to be drafted based on the committee's terms of reference
- First meeting of the committee to be held at the end of April 2025

Recommendation

The Board is asked to approve the establishment of the People committee including the terms of reference and the changes to the Scheme of delegation and reservation of powers and Standing orders (as appended).

Terms of reference	
Name of governance body	People Committee
Constitution	The People Committee (“the Committee”) is a standing committee of the Board of Directors, established in accordance with the Trust’s standing orders, standing financial instructions and constitution.
Accountability	The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.
Authority	The Committee is authorised by the Board of Directors to seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary, subject to approval of spend in line with scheme of delegation and reservation of power.
Purpose	The purpose of the Committee is to assure the Board of Directors of the: • Delivery of people, culture and organisational development strategies, plans and targets. To provide this assurance the Committee will maintain a detailed overview of: • Strategies, plans and targets relating to people, culture and organisational development • Strategic workforce issues • Key performance indicators related to workforce issues • Equality, diversity and inclusion • Recruitment and retention • Learning and development • Staff health, safety and wellbeing • Workforce culture and satisfaction • The management of organisational risks appropriate to the Committee’s remit To fulfil its purpose, the Committee will also: • Identify the key issues and risks requiring discussion or decision by the Board of Directors. • Advise on appropriate mitigating actions.
Duties and responsibilities	Duties To provide assurance to the Board that the Trust statutory and legal requirements related to workforce are being met and that the Trust has the necessary strategies, policies, procedures and capabilities in place to ensure a high performing and motivated workforce. Liaise where necessary with other Board sub-committees on cross-committee issues

relevant to the purpose of the People Committee.

Culture

- Support the Board with its annual assessment of organisational culture
- Oversight of cultural development within the Trust and the alignment of behaviours with the Trust's values and behaviour framework
- Oversight of working environment, including development, career progression and managerial culture and behaviour
- Oversight of equality, diversity and inclusion
- Oversight of speaking up as it relates to culture

Strategy

- Oversight of implementation and delivery of all strategies related to People, culture and organisational development

Workforce performance

- Review, interpret and challenge in-year workforce performance
- Oversee the development and delivery of any corrective action plans and advise the Board of Directors accordingly
- Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the Board of Directors
- Oversight of recruitment and retention, appraisals, education, development, reward and recognition, wellbeing

Employee relations

- Oversight of employee relations trends including discipline, grievances, bullying/harassment sickness and disputes

Organisational risks

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

Charing

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

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

Meetings

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

The Committee will meet formally quarterly.

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

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

Secretariat

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

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

Membership

Members

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

- Three Non-Executive Directors (including Committee chair)
- Chief People Officer
- Chief Nursing Officer
- Chief Operating Officer
- Associate Non-executive director

In attendance

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

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

Quorum

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

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

Attendance

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

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

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

Papers
Papers to be distributed to members and those in attendance at least three clear days in advance of the meeting.
Reporting
The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance. Draft minutes will be submitted for formal agreement at the next committee meeting. The Chair shall prepare a report of the latest Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues which require disclosure to the Board of Directors including where executive action is continually failing to address significant weaknesses. Issues of concern and/or urgency will be reported to the Board of Directors in between its formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the Trust chair. Instances of this nature will be reported to the Board of Directors at its next formal business meeting. The Committee Chair shall report at quarterly meetings of the Council of Governors.
Review
These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency. The next scheduled review of these terms of reference will be undertaken by the Committee in February 2026 in anticipation of approval by the Board of Directors at its meeting in March 2026.
*Definitions
In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Queen Victoria Hospital NHS Foundation Trust

Reservation of powers and scheme of delegation

Effective from ~~2-May-2024~~ 6 March 2025

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

1. Introduction

- 1.1. The *Code of governance for NHS provider trusts 2022* requires the board of directors of NHS foundation trusts to have a "schedule of matters specifically reserved for its decisions" (B.2.17) ensuring that management arrangements are in place to enable the clear delegation of its other responsibilities.
- 1.2. The purpose of this document is to provide details of the powers reserved to the Board of Directors, and those delegated to the appropriate level for the detailed application of trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.
- 1.3. All powers of the trust which have not been retained as reserved by the Board of Directors or delegated to a committee or sub-committee of the Board of Directors shall be exercised on behalf of the Board of Directors by the chief executive. The scheme of delegation identifies those functions, which the chief executive shall perform personally and those which are delegated to other Directors and Officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.
- 1.4. Where the Trust Board or one of its committees has reached a decision under its terms of reference, the subsequent documentation committing the Trust to that decision will be signed by the Chair of the committee or the Chief Executive.
- 1.5. It should be emphasised that the financial delegations in themselves give no power to act. The power to act up to the limits prescribed, derives from approved annual plans and budgets and, where applicable, authorised capital and revenue business cases.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

- 1.6. Each corporate function is constrained by its agreed annual plan, which governs staffing, facilities and financial resources. Corporate functions may not exceed agreed budgets or deviate from approved plans without prior agreement of the Chief Executive.
- 1.7. All projects are bound by these schemes of delegation even where funded partly or wholly from charitable or third party funds. Approval for business cases, and subsequent approval to commit expenditure must be in strict accordance with the detailed scheme of delegation, in addition to the requirement for approval to release funds which are set out in the Trust's charitable fund procedures.
- 1.8. This document covers only matters delegated by the Trust to its senior Officers. Each Director is responsible for delegations within their function and should produce their own scheme of delegation, which should be distributed to all relevant staff, including the finance department.
- 1.9. Director schemes of delegation may not exceed the limits set out in this framework but they may restrict delegation further. All such schemes of delegation should include the requirement that all officers with delegated authority must make formally documented arrangements to cover their delegations in circumstances where they are absent for more than 48 hours.

Caution over the use of delegated powers

- 1.10. Powers are delegated to Directors and Officers on the understanding they will not exercise delegated powers in a manner which in their judgement is likely to be a cause for public concern.

Directors' ability to delegate their own delegated powers

- 1.11. The Scheme of Delegation shows only the 'top level' of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other established procedures within the Trust. A Director's delegated power may be delegated to designated deputies.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~6 March 2025

Absence of Directors (or deputy) or Officer to whom powers have been delegated

- 1.12. In the absence of a Director or deputy/Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officer's superior unless alternative arrangements have been identified in the Scheme of Delegation or approved by the Director/Officer's superior.
- 1.13. In circumstances where the Chief Executive has not nominated an Officer to act in his/her absence, the Board of Directors shall nominate an Officer to exercise the powers delegated to the Chief Executive in his/her absence.

Definition and interpretations

- 1.14. Words importing the singular shall import the plural and vice-versa in each case.
- 1.15. In this document:

Budget manager means an Officer with clear delegated authority from a Director or level 2 manager to manage income and/or expenditure budgets. Delegated authority only applies to a budget manager's specific area of the Trust for which they are responsible for the budget.

Chief Executive means that, as Accounting Officer, the Chief Executive is accountable for the funds entrusted to the Trust. The Chief Executive has overall responsibility for the Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control. The Chief Executive should also ensure that he/she complies with the NHS foundation trust accounting officer memorandum.

Director means a Director of the Trust who is a voting member of the Trust Board (Chief Executive, Chief Finance Officer and, Medical Director and Chief Nurse).

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

Executive management team means the executive directors of the Board of Directors, the director of operations, the director of workforce and organisational development and the director of communications and corporate affairs

Hospital Management Team means the Clinical Directors and the decision making senior team of the Trust including all directors

Level 2 manager means Officers in the following posts, in relation to their own area of the Trust only:

- General managers
- Deputies to Directors (when not formally deputising in the Director's absence)
- Heads of functions directly reporting to a Director (e.g. head of commerce, medical workforce manager).

1.16. Unless specified otherwise, all amounts set out in this document exclude Value Added Tax (VAT).

2. Reservation of powers to the Board of Directors

2.1	General enabling provision	2.1.1 The Board of Directors may determine any matter it wishes within its statutory powers at a meeting of the Board of Directors convened and held in accordance with the Standing Orders for the Board of Directors. The Board of Directors also has the right to determine that it is appropriate to resume its delegated powers.
2.2	Regulation and control	2.2.1 Approve Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business and other arrangements relating to standards of business conduct. 2.2.2 Approve a Scheme of Delegation of powers from the Board of Directors to Officers which has been prepared by the Chief Executive under SO 6.5 (Delegation to Officers) of the SOs. 2.2.3 Delegate executive powers to be exercised by committees or sub-committees, or joint committees of the Board of Directors, and the approval of the terms of reference and specific executive powers of such committees under SO 6.3 (Delegation to committees) of the SOs.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

		2.2.4 Require and receive the declarations of interest of members of the Board of Directors which may conflict with those of the Trust and determine the extent to which a member of the Board of Directors may remain involved with the matter under discussion. 2.2.5 Approve arrangements for dealing with complaints. 2.2.6 Approve disciplinary procedure for Officers of the Trust. 2.2.7 Adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and agree modifications thereto. For clarity, this will comprise of details of the structure of the Board of Directors and its committees and sub-committees. Organisational structures below Executive Director are the responsibility of the Chief Executive who may delegate this function as appropriate. 2.2.8 Ratify any urgent or emergency decisions taken by the Chair and Chief Executive in accordance with SO 3.4 (Emergency Powers) of the SOs. 2.2.9 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 2.2.10 Approve arrangements relating to the discharge of the Trust's Responsibilities as a bailee for patients' property. 2.2.11 Approve proposals of the Nomination and Remuneration Committee regarding Board members and senior Officers and those of the Chief Executive for Officers not covered by the Nomination and Remuneration Committee. 2.2.12 Discipline Executive Directors who are in breach of statutory requirements or the SOs. 2.2.13 Subject to the provisions of paragraph 5 below, the authorisation of the use of the Seal.
--	--	---

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

		2.2.14 Suspension of the SOs. 2.2.15 Amendment of the Constitution, in accordance with the Constitution (amendments are subject to approval from the Council of Governors). 2.2.16 Approval and authorisation of institutions in which cash surpluses may be held.
	Committees	2.3.1 Appoint and dismiss committees of the Trust that are directly responsible to the Board of Directors. 2.3.2 Establish terms of reference and reporting arrangements for all committees of the Board. 2.3.3 Appoint and remove members of all committees or sub-committee of the Board of Directors or the appointment of Trust representative to third party organisations. 2.3.4 Receipt of reports from committees of the Trust including those which the Trust is required by its Constitution, or by the Regulator or by the Secretary of State, or by any other legislation, regulations, directions, or guidance to establish and to take appropriate action thereon. 2.3.5 Confirm the recommendations of the Trust's committees where the committees do have executive powers.
2.4	Strategy, business plans and budgets	2.4.1 Define the strategic aims and objectives of the Trust. 2.4.2 Approve the Trust's forward plan and budget in respect of each financial year setting out the application of available financial resources. 2.4.3 Approve and monitor the Trust's policies and procedures for the management of risk. Approve key strategic risks.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

	2.4.4 Subject to paragraph 54 (Significant Transactions) of the Constitution, ratify proposals for the acquisition, disposal or change of use of land and/or buildings or the creation of any mortgage charge or other security over any asset of the Trust. 2.4.5 Approve proposals for ensuring quality and developing clinical governance and risk management in services provided by the Trust, having regard to the guidance issued by the Regulator and/or the Secretary of State. 2.4.6 Approve proposals for ensuring equality and diversity in both employment and the delivery of services. 2.4.7 Approve the Trust's investment policy and authorise institutions with which cash surpluses may be held. 2.4.8 Approve the Trust's borrowing policy, which will include other long term financing arrangements such as leases. 2.4.9 Authorise any necessary variations to total budget spend of capital schemes of more than 10% or £25,000, whichever is the greater. Authorise any increase in the total capital programme. 2.4.10 Approve the Trust's banking arrangements. 2.4.11 Approve the Trust's Annual Business Plan. 2.4.12 Consider a merger, acquisition, separation or dissolution of the Trust. An application for a merger, acquisition, separation or dissolution of the Trust may only be made with the approval of more than half the members of the Council of Governors. 2.4.13 Consider a significant transaction as defined in the Constitution. A significant transaction may only be entered into if approved by more than half of the members of the Council of Governors voting in person at a meeting of the Council of Governors.
--	--

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ March 2025

2.5	Monitoring	2.5.1 Continuously appraise the affairs of the Trust by means of the receipt of reports as it sees fit from members of the Board of Directors, committees, and Officers of the Trust. All monitoring returns required by the Regulator and the Charity Commission shall be reported, at least in summary, to the Board of Directors. 2.5.2 Consider and approve the Trust's Annual Report and Annual Accounts, prior to submission to the Council of Governors and the Regulator. 2.5.3 Receive and approve the Annual Report and Accounts for funds held on trust. 2.5.4 Receive reports from the Chief Finance Officer on financial performance against budget and the annual business plan. 2.5.5 All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board.
2.6	Audit arrangements	2.6.1 Receive reports of Audit and Risk Committee meetings and take appropriate action. 2.6.2 Receive the annual management letter from the external auditor and agree action on the recommendations where appropriate of the Audit and Risk Committee. 2.6.3 Receipt of a recommendation of the Audit and Risk Committee in respect of the appointment of Internal Auditors (note: the recommendation in respect of External Auditors is made by the Audit and Risk Committee to the Council of Governors),
2.7	Policy determination	2.7.1 Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of Officers.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

3. Committee delegation

The Board of Directors may determine that certain powers shall be exercised by committees of the Board of Directors. The composition and terms of reference of such committees shall be determined by the Board of Directors from time to time taking into account where necessary the requirements of the Regulator and/or the Charity Commission (including the need to appoint an Audit and Risk Committee and a Remuneration Committee). The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with the SOs committees of the Board of Directors may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors. The Board of Directors have delegated decisions/duties to the following committees:

- Audit and Risk Committee
- Nomination and Remuneration Committee
- Charity Committee
- Quality and Safety Committee
- Finance and Performance Committee
- Strategic development Committee
- People Committee

A list of committees, along with their terms of reference, shall be maintained by the Deputy Company Secretary.

	Committee	Delegated items	Related documents
3.1	Audit and Risk committee	3.1.1 The Committee is authorised by the Board of Directors to: 3.1.1.1 investigate any activity within its terms of reference;	SFIs 3.2, SO 5.6

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

		3.1.1.2 commission appropriate independent review and studies; 3.1.1.3 seek relevant information from within the Trust and from all Officers; 3.1.1.4 Obtain relevant legal or other independent advice and to invite professional with relevant experience and expertise to attend meetings of the Audit and Risk Committee. 3.1.1.5 Approve specific policies and procedures relevant to the committee's remit; 3.1.2 The purpose of the Committee is the scrutiny of the organisation and maintenance of an Effective system of governance, risk management and internal control. This should include Financial, clinical, operational and compliance controls and risk management systems. 3.1.3 The Committee is responsible for maintaining an appropriate relationship with the Trust's internal and external auditors.	
3.2	Nomination and remuneration committee	3.2.1 The Committee is authorised by the Board of Directors to: 3.2.1.1 Appoint or remove the chief executive, and set the remuneration and allowances and other terms and conditions of office of the chief executive 3.2.1.2 Appoint or remove the other executive directors and set the remuneration and allowances and other terms and conditions of office of the executive directors, in collaboration with the chief executive. 3.2.1.3 consider any activity within its terms of reference;	SFI 10.1, SO 5.6

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

		3.2.1.4 seek relevant information from within the Trust; 3.2.1.5 instruct independent consultants in respect of Executive Director remuneration; 3.2.1.6 Request the services and attendance of any other individuals and authorities within relevant experience and expertise if it considers this necessary to exercise its functions. 3.2.2 On behalf of the Board of Directors, the Committee has the following responsibilities: 3.2.2.1 to identify and appoint candidates to fill posts within its remit as and when they arise; 3.2.2.2 to be sensitive to other pay and employment conditions in the Trust; 3.2.2.3 to keep leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy; 3.2.2.4 to give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors; 3.2.2.5 to sponsor the Trust's leadership development and talent management programmes;	
3.3	Charity committee	3.3.1 The Committee will: 3.3.2 Ensure Funds Held on Trust (charitable funds) are managed in accordance with the Trust's SOs and SFIs, as approved by the Board of Directors.	

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2 May 2024~~ 6 March 2025

		3.3.3 Receive regular reports from the Chief Finance Officer covering: 3.3.3.1 Number and value of funds 3.3.3.2 Purpose of funds 3.3.3.3 Income and expenditure analysis 3.3.4 Approve specific policies and procedures relevant to the committee's remit, and review the Annual Accounts prior to submission to the Corporate Trustee for formal approval 3.3.5 Ensure that the requirements of the Charities Acts and the Charities Commission are met and approve submissions required by regulators and auditors	
3.4	Quality and Safety committee	3.4.1 The Board of Directors has delegated authority to the Committee to take the following actions on its behalf: 3.4.1.1 approve specific policies and procedures relevant to the Committee's purpose, responsibilities and duties; 3.4.1.2 engage with the Trust's auditors in cooperation with the Audit and Risk Committee; 3.4.1.3 Seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary. 3.4.2 On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of : 3.4.2.1 the Trust's performance against the three domains of quality, safety, effectiveness and patient experience;	

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

		3.4.2.2 compliance with essential regulatory and professional standards, established good practice and mandatory guidance; 3.4.2.3 Delivery of national, regional, local and specialist care quality (CQUIN) targets.	
3.5	Finance and performance committee	3.5.1 The Board of Directors has delegated authority to the Committee to take the following actions on its behalf: 3.5.1.1 Approve specific policies and procedures relevant to the committee's remit; 3.5.1.2 Review, by way of the finance report, the submission of monthly monitoring reports to the regulator; 3.5.1.3 Approve other exception or ad-hoc reports required by the regulator; 3.5.1.4 Recommend to the Board the submission of the Trust's annual plan to the regulator; and 3.5.1.5 Seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary. 3.5.2 On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust's: 3.5.2.1 monthly financial and operational performance; 3.5.3 The Committee will make recommendations to the Board of Directors in relation to:	

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

		3.5.3.1 capital and other investment programmes; 3.5.3.2 cost improvement plans; and 3.5.3.3 Business development opportunities and business cases except for digital business cases.	
3.6	Strategic Development Committee	3.6.1 On behalf of the Board of directors, the committee will be responsible for providing strategic oversight and direction regarding the planning and development of the Trust wide organisational strategy including work related to clinical and enabling strategies and strategic projects and programmes. The committee will: • 3.6.1.1 Provide oversight and support to ensure appropriate resourcing and alignment of the strategy development • 3.6.1.2 Provide detailed oversight of the development of enabling strategies which might include but are not limited to digital, estates and facilities and the green plan, making recommendations related to these to the Board • 3.6.1.3 Provide oversight of the implementation and delivery of the Trust strategy and enabling strategies once approved by the Board • 3.6.1.4 Ensure and provide assurance to the Board that the Trust's strategy and enabling strategies align with the strategic ambitions of the NHS locally and nationally • 3.6.1.5 Identify and make recommendations to the Board in relation to strategic communications and engagement • 3.6.1.6 Ensure appropriate consideration of OD and culture requirements in regard to the development and implementation of the strategy • 3.6.1.7 Identify and monitor key strategic risks, issues and mitigations and escalate to the Board • 3.6.1.8 Identify, review and recommend strategic opportunities to the Board 3.6.2 The committee will make recommendations to the Board in relation to strategy, business development opportunities and business cases that are within the scope of its remit	

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

		The Board will retain its responsibility for defining the strategic aims and objectives of the Trust and the Board will continue to contribute to the development of a strategy.	
3.7	People Committee	<u>3.7.1 The committee will assure the Board of Directors of the delivery of people, culture and organisational development strategies, plans and targets. To provide this assurance the committee will maintain a detailed overview of:</u> • <u>Strategies, plans and targets relating to people, culture and organisational development</u> • <u>Strategic workforce issues</u> • <u>Key performance indicators related to workforce issues</u> • <u>Equality, diversity and inclusion</u> • <u>Recruitment and retention</u> • <u>Learning and development</u> • <u>Staff health, safety and wellbeing</u> • <u>Workforce culture and satisfaction</u> • <u>The management of organisational risks appropriate to the Committee's remit</u> <u>To fulfil its purpose, the Committee will also:</u> • <u>Identify the key issues and risks requiring discussion or decision by the Board of Directors</u> • <u>Advise on appropriate mitigating actions</u> • <u>Provide assurance to the Board that the Trust statutory and legal requirements related to workforce are being met and that the Trust has the necessary strategies, policies, procedures and capabilities in place to ensure a high performing and motivated workforce.</u> • <u>Liaise where necessary with other Board sub-committees on cross-committee issues relevant to the purpose of the People Committee</u>	

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2 May 2024~~ 6 March 2025

4. Board member delegation

	Board member	Duties delegated
4.1	Chief executive Officer	4.1.1 Accounting Officer to Parliament for stewardship of Trust resources. 4.1.2 Sign the accounts on behalf of the Board of Directors. 4.1.3 Ensure effective management systems that safeguard public funds and assist the Chair to implement requirements of corporate governance including ensuring managers: 4.1.3.1 Have a clear view of their objectives and the means to assess achievements in relation to those objectives 4.1.3.2 Be assigned well defined responsibilities for making best use of resources 4.1.3.3 Have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
4.2	Chief executive Officer and Chief Finance Officer	4.2.1 Ensure the accounts of the Trust are prepared under principles and in a format directed by the regulator. 4.2.2 Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs.
4.3	Chair	4.3.1 Leadership of the Board of Directors, ensuring its effectiveness on all aspects of its role and setting its agenda for meetings of the Board of Directors. 4.3.2 Ensuring the provision of accurate, timely and clear information to the Directors and the Council of Governors. 4.3.3 Ensuring effective communication with Officers, patients and the public.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

	Board member	Duties delegated
		4.3.4 Arranging the regular evaluation of the performance of the Board of Directors, its Committees and individual Directors. 4.3.5 Facilitating the effective contribution of Non-Executive Directors and ensuring constructive relations between Executive and Non-Executive Directors.
4.4	Board of directors	4.4.1 Meet regularly and to retain full and effective control over the Trust 4.4.2 Collective responsibility for adding value to the Trust, for promoting the success of the Trust by directing and supervising the Trust's affairs 4.4.3 Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed 4.4.4 Set the Trust's strategic aims, ensure that the necessary financial and human resources are in place for the Trust to meet its objectives, and review management performance 4.4.5 Set the Trust's values and standards and ensure that its obligations to patients, the local community and the Regulator are understood and met.
4.5	All members of the board of directors	4.5.1 Share corporate responsibility for all decisions of the voting members of the Board of Directors.
4.6	Non-executive directors	4.6.1 To bring independent judgement to bear on issues of strategy, performance, key appointments and accountability by: 4.6.1.1 Constructively challenge and contribute to the development of strategy 4.6.1.2 Scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

	Board member	Duties delegated
		4.6.1.3 Satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible 4.6.1.4 Determine appropriate levels of remuneration of executive directors and have prime role in appointing and where necessary , removing senior management and in succession planning 4.6.1.5 Ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses. 4.6.2 Sitting on Committees of the Board of Directors.

5. Scheme of delegation of powers from standing orders

SO ref	Delegated to	Duties delegated
1.2	Chair	Final authority on the interpretation of the SOs.
1.2	Chief executive Officer	Advise the Chair on the interpretation of the SOs.
2.9	Board of directors	Appointment of a Senior Independent Director.
3.2	Board of directors	To act as the Corporate Trustee of the Queen Victoria Hospital Trust Charitable Fund.
3.6	Chief executive Officer	Responsible for the overall performance of the executive functions of the Trust. Responsible for ensuring the discharge of obligations under applicable financial directions, the Regulator guidance and in line with the requirements of the NHS foundation trust accounting officer memorandum.
3.7	Chief finance officer	Responsible for the provision of financial advice to the Trust and to members of the Board of Directors and for the supervision of financial control and accounting systems.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SO ref	Delegated to	Duties delegated
3.8	Chief nurse	Responsible for effective professional leadership and management of nursing Officers of the Trust and is the Caldicott guardian.
3.11	Chair	Responsible for the operation of the Board of Directors.
3.11	Chair	Chair all meetings of the Board of Directors and associated responsibilities.
4.2	Chair	Call meetings of the Board of Directors.
4.4	Chair	Sign notices of meetings of the Board of Directors.
4.11	Chair	Give final ruling to permit late requests for items to be included on the agenda for meetings of the Board of Directors.
4.13	Secretary	Include any petition received by the Trust on the agenda for the next meeting of the Board of Directors.
4.25	Chair	Chair all meetings of the Board of Directors.
4.28	Chair	Give final ruling in questions of order, relevancy and regularity of meetings.
4.33	Chair	Have a second or casting vote.
4.39	Board of directors	Suspension of SOs.
4.43	Board of directors	Variation or amendment of SOs.
4.45	Secretary	Prepare minutes of the proceedings of the meetings of the Board of Directors and submit minutes for agreement at the next meeting of the Board of Directors.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SO ref	Delegated to	Duties delegated
4.45	Chair	Sign minutes of the proceedings of meetings of the Board of Directors.
4.48	Chair	Issue directions regarding arrangements for meetings of the Board of Directors and accommodation of the public and press.
5.1	Board	Subject to such directions as may be given by the Secretary of State, the Board may appoint Committees of the Board. The Board shall approve the membership and terms of reference of Committees and shall if it requires to, receive and consider reports of such Committees.
5.17	All	Duty of confidentiality regarding all matters reported to the Board of Directors, or otherwise dealt with by the committee, sub-committee or joint committee if the Board of Directors, or committee or sub-committee has resolved that it is confidential.
6.2	Chair and Chief Executive Officer	The powers which the Board of Directors has reserved to itself with the SOs may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board of Directors in public session for formal ratification.
6.6	Chief Executive Officer	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board of Directors
6.9	All	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.4	Secretary / Chair	Where a Director has any doubt about the relevance of an interest, this should be discussed with them.
7.6	Secretary	A register of interests shall be established and maintained.
7.15	Directors	Duty not to solicit for any person any appointment under the Trust or recommend any person for such appointment, and disclose informal discussions outside appointment panels or committees to the panel

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SO ref	Delegated to	Duties delegated
		or committee.
7.18	All	Disclose relationship between self and candidate for Officer appointment. (Chief Executive to report the disclosure to the Board of Directors).
7.19	Executive directors	Prior to acceptance of any appointment, disclose to the Chief Executive whether you are related to any other Director or holder of any officer under the Trust.
7.20	Directors	On appointment, disclose to the Board of Directors whether you are related to any other Director or holder of any officer under the Trust.
8.1	Directors and Officers	Comply with the Trust's standards of business conduct policy and relevant codes of conduct.
10.1	Secretary	Keep the Trust's Seal in a secure place.
10.2	Chair and one executive director	Sign to authenticate the seal.
10.3	Chief finance officer and Chief Executive Officer	Approve and sign any building, engineering, property or capital document.
11.1	Chief executive Officer/nominated executive director	Approve and sign all documents which will be necessary in legal proceedings.
11.2	Chief Executive Officer/ nominated officer	Authority to sign any agreement or document (save for deeds) the subject matter of which has been approved by the Board of Directors or a committee thereof.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~^{6 March 2025}

SO ref	Delegated to	Duties delegated
12.1	Chief Executive Officer	Ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within the SOs and SFIs.

6. Scheme of delegation of powers from standing financial instructions

SFI ref	Delegated to	Duties delegated
1 Introduction		
1.2.1	Chair	Final authority on interpretation of the SFIs.
1.2.1	Chief Executive Officer/ Chief Finance Officer	Advise the Chair on the interpretation of the SFIs.
1.4.1	All	All officers of the trust must comply with the SFIs.
2 Responsibilities and delegation		
2.1.2	Board of directors	Accountable for all of trust functions, even those delegated to the Chair, individual directors or officers.
2.4.1	Chief executive Officer	The chief executive is the trust's accounting officer.
2.4.4	Chief executive Officer	To ensure all existing officers and new appointees are notified of their responsibilities within the SFIs.
2.4.5	Chief Executive Officer & Chair	To ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
2.4.6	Chief Executive Officer	To ensure that financial performance measures with reasonable targets have been defined and are monitored, with robust systems and reporting lines in place to ensure overall performance is managed and arrangements are in place to respond to adverse performance.
2.4.7	Chief Executive Officer	Determine whether powers devolved under the SFIs and the scheme of delegation be taken back to a more senior level.
2.4.8	Chief Executive Officer	To ensure that the trust provides an annual forward plan to the regulator each year.
2.5.1	Chief Finance Officer	Responsible for: • Advising on and implementing the trust's financial policies; • Design, implementation and supervision of systems of internal financial control; • Ensuring that sufficient records are maintained to show and explain the trust's transactions, in order to report; • Provision of financial advice to other directors of the board and employees; and • Preparation and maintenance of records the trust may require for the purpose of carrying out its statutory duties.
2.6.1	All	All members of the board of directors and officers of the trust are severally and collectively responsible for security of the trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to the SOs, SFIs and all trusts policies and procedures.
3 Audit		
3.2.1	Audit and Risk committee	Provide an independent and objective view of internal control by: • Overseeing internal and external audit services (including agreeing both audit plans and monitoring progress against them);receiving reports from the internal and external auditors (including the external auditor's management letter) and considering the management response; • Monitoring compliance with SOs and SFIs;

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~6 March 2025

SFI ref	Delegated to	Duties delegated
		- Reviewing schedules of losses and compensations and making recommendations to the board of directors; - Reviewing the information prepared to support the annual governance declaration statement.
3.2.3	Chair of the Audit and Risk committee	Where audit and risk committee considers there is evidence of ultra vires transactions or improper acts or important matters that the audit and risk committee wishes to raise, the matter shall be raised at a full meeting of the board of directors.
3.3.1	Chief Finance Officer	In relation to audit, the Chief Finance Officer is responsible for: - Ensuring there are arrangements to review, evaluate and report on effectiveness of internal financial control by establishment of internal audit function; - Ensuring the internal audit is adequate and meets the NHS mandatory audit standards; - Ensuring the production of annual governance statement for inclusion in trust's annual report; - Provision of annual reports; - Ensuring effective liaison with relevant counter fraud services regional team or NHS protect; and - Deciding at what stage to involve police in cases of misappropriation or other irregularities.
3.3.2	Chief Finance Officer/ designated auditors	Entitled to require and receiver without prior notice: - Access to all records, documents, correspondence relating to any financial or other relevant transactions; - Access at all reasonable times to any land, premises or members of the board of directors or officers of the trust; - Production of any cash, stores or other property of the trust under the control of a member of the board of directors or officers; and - Explanations concerning any matter under investigation.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
3.4.2	Internal audit	To review, appraise and report on compliance with policies, plans and procedures; adequacy of control, suitability of financial and management data and the extent to which the trust's assets and interests are accounted for.
3.4.3	Internal audit	To assess the process in place to ensure the assurance frameworks are in accordance with current guidance from the regulator.
3.4.4	Internal audit	To notify the Chief Finance Officer should any matter arise which involves, or is thought to involve, irregularities concerning cash, stores or other property.
3.4.5	Lead internal auditor	Accountable to the Chief Finance Officer. Attend meetings of the audit and risk committee and have right of access to all members of the audit and risk committee, the Chair and the chief executive of the trust.
3.5.1	Council of Governors	Appoint external auditor to the trust.
3.5.1	Audit and risk committee	To ensure that external audit is providing a cost effective service that meets the prevailing requirements of the regulator and other regulatory bodies.
3.6.1	Chief Executive Officer and Chief Finance Officer	Monitor and ensure compliance with guidance issued by the regulator or NHS protect on fraud and corruption in the NHS.
3.6.2	Chief Finance Officer	Responsible for the promotion of counter fraud measure within the trust and ensure that the trust co-operate with NHS protect in relation to the prevention, detection and investigation of fraud in the NHS.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
3.6.4	Chief Finance Officer	Ensure the trust's local counter fraud specialist receives appropriate training in connection with counter fraud measures.
3.6.5	Chief Finance Officer	Be satisfied that the terms on which the services of a local counter fraud specialist from an outside organisation are provided are such to enable the local counter fraud specialist to carry out his functions effectively and efficiently.
3.6.7	Chief Finance Officer and local counter fraud specialist	At the beginning of each financial year, prepare a written work plan outlining the local counter fraud specialist's projected work for that financial year.
3.6.11	Chief Finance Officer	Prepare a 'fraud response plan' that sets out the action to be taken in connection with suspected fraud.
3.6.12 3.6.13	Chief Finance Officer	Inform police if theft or arson is involved. For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness (except if trivial and where fraud is not suspected), immediately notify the board of directors and the auditor.
3.7.1	Chief Finance Officer	To establish procedures for the management of expense claims submitted by officers.
3.7.2	Chief Finance Officer	Approval of any expense claims receive older than 3 months.
3.8.1	Secretary	Ensure that all officers are made aware of the trust's standards of business conduct and additional rules in respect of preventing corruption and complying with the bribery act 2010.
3.8.2	All	To notify the secretary of any gift, hospitality or sponsorship accepted (or refused) by any officer on behalf of the trust.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
3.8.2	Secretary	To record in writing, notification of any gift, hospitality or sponsorship accepted (or refused) by officers on behalf of the trust.
3.9.1	Chief Finance Officer	Report non-compliance with SFIs to the audit and risk committee.
3.9.2	All	To disclose any non-compliance with the SFIs to the Chief Finance Officer as soon as possible
4 Annual planning, budgets, budgetary control and monitoring		
4.1.1	Chief Executive Officer	Compile and submit to the board of directors and the regulator, strategic and operational plans.
4.1.2	Chief Finance Officer	Prepare and submit the operational plan to the financial and performance committee, the Board of Directors and the regulator
4.1.3	Chief Finance Officer	Compile and submit financial estimates and forecasts for both revenue and capital to the Board of Directors.
4.1.4	All	To provide the Chief Finance Officer with all financial, statistical and other relevant information as necessary for the compilation of such business planning, estimates and forecasts.
4.2.4	Chief Finance Officer	Ensure adequate training is delivered on an ongoing basis to enable the Chief Executive and other Officers to carry out their budgetary responsibilities.
4.4.1	Finance and performance committee	Submit budgets to the board of directors for approval.
4.2.4	All directors	To meet their financial targets as agreed in the annual plan approved by the board of directors.
4.3	All	Ensure income and expenditure is contained within budgets. Ensure workforce is maintained within budgeted establishment unless expressly authorised.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
		Ensure non-recurring budgets are not used to finance recurring expenditure. Ensure no agreements are entered into without the proper authority.
4.4.7	Board of Directors/ Chief Executive Officer	Approval of expenditure for which no provision has been made in an approved budget.
5 Annual accounts and reports		
5.1	Chief Finance Officer	Prepare financial returns in accordance with the guidance given by the regulator and the secretary of state for health, the treasury, the trust's accounting policies and generally accepted accounting principles
5.2	Chief Executive Officer	Certify annual accounts.
5.2	Chief Finance Officer	Prepare annual account. Submit annual accounts and any report of auditor on them to the regulator.
6 Bank accounts		
6.1–6.6	Chief Finance Officer	Manage the trust's banking arrangements including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.
6.1	Board of Directors	Approve banking arrangements.
7 Financial systems and transaction processing		
7.1-7.8	Chief Finance Officer	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
7.9	All	Duty to inform designated finance representatives of money due from transactions which they initiate/deal with.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
7.12	Chief Finance Officer	Approve arrangements for making disbursements from cash received.
7.14	All	Notify the Chief Finance Officer if an individual attempts to effect payment in cash over the value of £1,000.
8 Contracts for provision of services to customers		
8.1	Chief Finance Officer	Negotiating contracts with commissioners for the provision of services to patients in accordance with the annual plan.
8.4	Chief Finance Officer	Setting the framework and overseeing the process by which provider to provider contracts, or other contracts for the provision of services by the trust, are designed and agreed.
9 Contracts, tenders and healthcare service agreements		
9.1.2	Chief Executive Officer	Ensure that best value for money can be demonstrated for all services provided under contract or in-house.
9.1.2	All	Ensure contracts are best value for money at all times and to review all contracts prior to signing.
9.1.3	Chief Finance Officer	Advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained, establish procedures to ensure that competitive quotations and tenders are invited for the supply of goods and services and ensure that a register is maintained of all formal tenders.
9.4.1	Chief Finance Officer	Establish procedures to carry out financial appraisals and shall instruct the appropriate requisitioning officer to provide evidence of technical competence.
9.5.6	Chief Finance Officer	Establish procedures to ensure that tenders are opened and documented appropriately and within an agreed timescale.
9.5.7	Chief Executive Officer/ Chief	Approval of awarding of contracts for which tendering is deemed not strictly competitive.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
	Finance Officer	
9.5.8	Chief Executive Officer/ Chief Finance Officer	Where one tender is received will assess for value for money and fair price.
9.5.9	Chief Finance Officer	Decision to accept tenders after the deadline but before opening of the other tenders.
9.6.1	Chief Finance Officer	Enquiries concerning the financial standing and financial suitability of approved contractors.
9.10.4	Chief Finance Officer	Ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.
9.11.2	Chief Executive Officer	Nominate officers to commission service agreements with providers of healthcare.
9.12.3	Chief Executive Officer	Nominate an officer who shall oversee and manage each contract on behalf of the trust.
9.14.1	Chief Executive Officer	Ensure that best value for money can be demonstrated for all services provided on an in-house basis.
10 Terms of service, officer appointments and payments		
10.1.1	Board of Directors	Establish a nomination and remuneration committee.
10.2.3	Chief Executive Officer	Present to the board of directors procedures for determination of commencing pay rates, conditions of service etc. for Officers.
10.3.1	Board of Directors	Delegate responsibility to the director of human resources for: - Ensuring that all officers and executive directors are issued with a contract of employment in a form approved by the board of directors and which complies with employment legislation; and - Dealing with variations to, or termination of, contracts of employment.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
10.4.1	Chief Finance Officer	Make arrangement for the provision of payroll services to the trust to ensure the accurate determination for any entitlement and to enable prompt and accurate payment to officers.
10.4.2	Chief Finance Officer and Chief People Officer	Responsible for establishing procedures covering advice to managers on the prompt and accurate submissions of payroll data to support the determination of pay.
10.4.3	Chief Finance Officer	Issue detailed procedures covering payments to officers.
10.5.1	Chief Finance Officer and Chief People Officer	Approve advances of pay.
11 Non-pay expenditure		
11.1.1	Board of Directors	Approve the level of non-pay expenditure on an annual basis.
11.1.1	Chief Executive Officer	Determine the level of delegation to budget managers.
11.1.2	Chief Executive Officer	Set out the list of managers who are authorised to place requisitions for the supply of goods and services, and , the financial limits for requisitions and the system for authorisation above that level.
11.1.3	Budget managers	To appoint nominees who must be approved by the Chief Finance Officer, and to remain responsible for the actions of nominees when they act in place of the budget manager.
11.1.4	Chief Executive Officer	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
11.2.1	All	In choosing the item to be supplied or the service to be performed, shall always obtain best value for money for the trust.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
11.2.3	Chief Finance Officer	Responsible for the prompt payment of accounts and claims.
11.3.1	Chief Finance Officer	- Advise the board of directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. - Prepare detailed procedures for requisitioning, ordering, receipt and payment of goods, works and services. - Be responsible for the prompt payment of all properly authorised accounts and claims. - Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. - Ensure a system for submission to the Chief Finance Officer of accounts for payment. - Maintain a list of officers, including specimens of their signatures, authorised to certify any type of payment. - Delegate responsibility for ensuring that payment for goods and services is only made once goods/services are received. - Prepare and issue procedures regarding vat.
11.4.1	All	Fully comply with the procedures and limits specified by the Chief Finance Officer.
11.5.1	Chief Finance Officer	Approve proposed prepayment arrangements.
11.2.9	Chief Executive Officer / Chief Finance Officer	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within health building note 00-08.
11.3.1	All	Ensure that contracts with individuals or with individuals working through a limited company are appropriately authorised, provide value for money and do not expose the trust or the individual to tax and HMRC compliance risks.
12 Equity investments, external borrowing, public dividend capital and mergers and acquisitions		
12.1.1	Chief Finance Officer	Produce an investment policy in accordance with any guidance received from the regulator.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
12.1.3	Chief Finance Officer	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
12.2.1	Chief Finance Officer	Advise the board of directors concerning the trust's ability to pay interest on, and repay the public dividend capital (PDC) and any proposed commercial borrowing.
12.2.2	Chief Finance Officer	Applications for a loan or overdraft.
12.2.3	Chief Finance Officer	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
12.2.4	Chief Finance Officer	Approval of short terms borrowing requirements.
12.3.1	Board of Directors	Review and approval of special purpose vehicles, joint ventures with other entities and mergers and acquisitions.
12.3.2	Board of Directors	Approve any mergers or acquisitions in accordance with the constitution.
13 Capital investment and assets		
13.1.1	Chief Executive Officer	• Ensure adequate appraisal and approval processes are in place for determining capital expenditure priorities. • Management of all stages of capital schemes and for ensuring that schemes are delivered on time and to planned cost. • Ensure investment is not undertaken without confirmation, where appropriate, of responsible director's support and the availability of resources to finance all revenue consequences.
13.2.1	Chief Finance Officer	Prepare detailed procedural guides for the financial management and control of expenditure on capital assets, including the maintenance of an asset register.
13.2.2	Chief Finance Officer	Implement procedures to comply with guidance on valuation contained within the treasury's guidance.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
13.2.3	Chief Finance Officer	Establish procedures covering the identification and recording of capital additions.
13.2.4	Chief Finance Officer	Develop procedures covering the physical verification of assets on a periodic basis.
13.2.5	Chief Finance Officer	Develop policies and procedures for the management and documentation of asset disposals.
13.3.1	Chief Executive Officer	Responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer regarding the form of any register.
14 Stores and receipts of goods		
14.1.1	Chief Executive Officer	Delegate overall responsibility for the control of stores.
14.1.1	Chief Finance Officer	Responsible for systems of control.
14.1.3	Pharmaceutical officer	Responsible for the control of any pharmaceutical stocks.
14.1.5	Chief Finance Officer	Set out procedures and systems to regulate the stores including records for receipt of goods, issues and returned to stores and losses.
14.1.6	Chief Finance Officer	Agreed stocktaking arrangements.
14.1.7	Chief Finance Officer	Approval of alternative arrangements where a complete system of stores control is not justified.
14.2.1	Chief Executive Officer	Identify those officers authorised to requisition and accept goods from the NHS supply chain.
15 Disposals and condemnations, losses and special payments		
15.1.1	Chief Finance Officer	Prepare detailed procedures for the disposal of assets including condemnations, and ensure members of the board of directors and relevant officers are notified of this.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
15.1.2	Head of department	Advise the Chief Finance Officer of the estimated market value of the item to be disposed of.
15.2.1	Chief Finance Officer	Approve form to in which to record the condemning of unserviceable assets and provide a list of officers to countersign entries.
15.2.3	Condemning officers	Report evidence of negligence in use of assets to the Chief Finance Officer.
15.3.1	Chief Finance Officer	Prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.
15.3.2	All	Report discovered or suspected losses of any kind to their manager.
15.3.2	Managers	Report discovered or suspected losses of any kind to the chief executive and Chief Finance Officer
15.3.3	Chief Finance Officer	Immediately inform the police if theft or arson is involved in a suspected criminal offence.
15.3.4	Chief Finance Officer	Inform the trust's local counter fraud specialist (LCFS) and NHS Protect in cases of fraud or corruption.
15.3.5	Chief Finance Officer	Notify the audit and risk committee, LCFS and the external auditors of all frauds.
15.3.6	Chief Finance Officer	Notify the board of directors, external auditor and the audit and risk committee, at the earliest opportunity of losses apparently caused by theft, arson, or neglect of duty, except if trivial, or gross carelessness.
15.3.8	Chief Finance Officer	Take steps to safeguard the trust's interest in bankruptcies and company liquidators. Consider whether any insurance claim can be made for any losses incurred by the trust.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
15.2.8	Chief Finance Officer	Maintain a losses and special payments register in which write-off action is recorded and regularly report losses and special payments to the audit and risk committee on a regular basis.
16 Information technology		
16.1	Chief Finance Officer	Responsible for the accuracy and security of the computerised financial data of the trust and shall: • Devise and implement any necessary procedures to ensure adequate and reasonable protection of the trust's data, programmes and computer hardware; • Ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission and output; • Ensure that adequate controls exist such that computer operation is separated from development, maintenance and amendment; • Ensure that an adequate audit trail exists through the computerised system; • Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation; and • Publish and maintain a freedom of information (FOI) publication scheme.
16.2.1	Chief Finance Officer	Ensure that contracts for computer services for financial applications clearly define the responsibility of all parties and ensure rights of access for audit purposes.
16.2.2	Chief Finance Officer	Periodically seek assurances that adequate controls are in operation.
16.3.1	Chief Finance Officer	Ensure that risks to the trust arising from the use of information technology are effectively identified, considered and appropriate action taken to mitigate or control risk.
16.4.1	Chief Finance Officer	• Ensure that systems acquisition, development and maintenance are in line with corporate policies such as the trust's information technology strategy. • Ensure that data produced is complete and timely and accessible to the trust's finance officers. • Ensure computer audit reviews are carried out as necessary.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
17 Patients' property		
17.3	Chief Executive Officer	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.4	Chief Finance Officer	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all officers whose duty is to administer, in any way, the property of patients.
17.5	Senior officers	Inform officers, on appointment, their responsibilities and duties for the administration of the property of patients.
18 Retention of records		
18.1	Chief Executive Officer	Maintain archives for all documents required to be retained in accordance with the regulator and/or secretary of state guidelines.
18.2	Chief Executive Officer	Produce a records lifecycle policy, detailing the secure storage, retention periods and destruction of records to be retained.
19 Risk management and insurance		
19.1	Chief Executive Officer	Ensure that the trust has a programme of risk management which shall be approved and monitored by the board of directors.
19.3	Chief Executive Officer	Responsible for ensuring that the existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal financial control within the annual report and annual accounts.
19.4	Chief Finance Officer	Ensure that insurance arrangements exist in accordance with the trust's risk management policy.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

SFI ref	Delegated to	Duties delegated
20 Funds held on trust (charitable funds)		
20.5	Chief Finance Officer	Ensure that funds held on trust (charitable funds) are administered in line with statutory provisions, the trust's governance documents and charity commission guidance. Prepare procedural guidance in relation to the management and administration, disposition, investment, banking, reporting, accounting and audit of the funds held on trust (charitable funds) for the discharge of the board of directors responsibilities as the corporate trustee.

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2 May 2024~~ 6 March 2025

7 Financial limit delegation

REF	Duties delegated	Delegated to
1	Virements (reallocation of budgets) Within a Business Unit/Directorate Between Business Units/Directorates All other virements (e.g. Between revenue and capital)	Level 2 Officers responsible for cost centres Responsible Directors Responsible Directors AND Chief Finance Officer
2 approval of business cases and service developments (Does not include setting of pay and non-pay budgets as part of annual planning process) Note: Applies to all business cases and service developments and those within budgetary limits only.		
2.1	Revenue expenditure (5 year value) Up to £250,000 £250,001 to £1,000,000	Chief Finance Officer Chief Finance Officer AND Chief Executive Officer

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2 May 2024~~ 6 March 2025

	Over £1,000,000	Board of Directors
2.2	Capital expenditure and disposals	
	Up to £250,000	Chief Finance Officer
	£250,000 to £1,000,000	Chief Finance Officer AND Chief Executive Officer
	Over £1,000,000	Board of Directors
3 Quotations, tenders and selection of suppliers Also refer to the Procurement Department for further guidance: in many cases goods and services will already have been subject to a competitive exercise and there may be no requirement for further quotations or competition.		

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2 May 2024~~ 6 March 2025

3.1	Capital/revenue expenditure Up to £10,000 £10,001 to £50,000 £50,001 to WTO GPA Threshold (contact procurement department for current value) Over WTO GPA threshold (see note below – threshold is different for works and non-works)	Minimum requirements 1 Written quote (Authorised by Budget Manager) 3 Written quotes (Authorised by Budget Manager) Competitive Tender Exercise (Level 2 Manager AND Chief Finance Officer) WTO GPA Directive Requirements (Relevant Director AND Chief Finance Officer)
	All thresholds apply to the aggregate value of orders, which may be across different areas of the Trust. All Officers must consult the Procurement Department for guidance if they are unsure, who are jointly responsible with the approver for ensuring that thresholds are not breached trust-wide. The WTO GPA threshold refers to the World Trade Organisation Government Procurement Agreement Directive threshold for a procurement exercise to include publication on Find a Tender. As these thresholds regularly change and the Public Procurement Regulations are periodically updated, all Officers must consult the Procurement department for guidance. Where a public contract is awarded above £10,000 (including framework call-offs) it must be published as an awarded opportunity notice on Contracts Finder to comply with transparency requirements.	

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

3.2	Quotation and tenders process waivers Waiving of tender and quotation for items where estimates expenditure is less than £50,000 but greater than £10,000 (less than £10,000 requires only 1 quote) Waiving of tender and quotation procedures for items where estimated expenditure is greater than £25,000 not expected to exceed WTO GPA procurement thresholds. Waiver above the WTO GPA level will require final approval and authorisation by the Chief Executive Officer clearly stating the circumstances under which the Procurement Regulations are to be waived, following review at EMT and Audit and risk Committee.	Chief Finance Officer, (when Chief Finance Officer is unavailable, Chief Executive Officer), or Chief Executive (when Chief Finance Officer has commissioned the item or where there is a conflict) Chief Finance Officer, (when Chief Finance Officer is unavailable, Chief Executive Officer) or Chief Executive (when Chief Finance Officer has commissioned the item)
3.3	Opening tenders Electronic tenders received through on line e-Tendering tool.	Head of Procurement or Chief Finance Officer (in absence of Head of Procurement)
4 committing expenditure		

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

4.1	Revenue and non-capital works expenditure within approved financial plans or business plans Up to £5,000 Up to £10,000 Up to £100,000 Up to £250,000 Up to £1,000,000 Over £1,000,000	Budget Manager Level 2 Manager (Officer) Responsible Director Chief Finance Officer Chief Finance Officer AND Chief Executive Officer Board of Directors
4.2	Approval of purchase invoices for revenue and capital Up to £5,000 Up to £10,000 Up to £100,000 Up to £250,000 Up to £1,000,000 Over £1,000,000	Budget Manager Level 2 Manager (Officer) Responsible Director Chief Finance Officer Chief Finance Officer AND Chief Executive Officer Chief Executive on behalf of Board of Directors

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2 May 2024~~ 6 March 2025

4.3	Granting and termination of equipment leases and credit finance Trust's employee lease car scheme Leases/arrangements up to £250,000 Leases/ arrangements £250,000 to £1,000,000 Leases/ arrangements over £1,000,000	 Chief Finance Officer Chief Finance Officer AND Chief Executive Officer Board of Directors
4.4	Agreements and licences Letting or licencing of premises to or from other organisations (see also section 5 below for guidance on who can sign these agreements) Up to £250,000 £250,000 to £1,000,000 and signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases Over £1,000,000	 Chief Finance Officer Chief Finance Officer AND Chief Executive Officer Board of Directors

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

4.5

Condemning and disposal

Items obsolete, obsolescent, redundant, irreparable or unable to be repaired cost effectively

Up to £5,000 (carrying value)

Over £5,000 (carrying value)

Transfer or sale of assets to another organisation

Responsible Director

Chief Finance Officer (may be delegated in specific cases in writing, but no lower than to a level 2 manager)

Chief Finance Officer

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2 May 2024~~ March 2025

4.6	Losses, write-offs and compensation Note: 'novel, contentious or repercussive cases' should be deferred to the Department of Health for approval	
4.6.1	Losses of cash, Damage or loss of buildings, fittings, furniture, equipment or property in stores, Compensation payments made under legal obligation (excluding clinical negligence), Write off of Debtors (including Salary Overpayments) Up to £10,000 Up to £50,000 Over £50,001	Deputy Director of Finance Chief Finance Officer Board of Directors
4.6.2	Fruitless Payments (including abandoned capital schemes) Up to £10,000 Up to £50,000 Over £50,001	Deputy Director of Finance Chief Finance Officer Board of Directors
4.6.3	Ex-Gratia payments to patients and Officers for loss of personal effects. Police report required for losses over £100. Up to £10,000 Up to £50,000 Over £50,001	Deputy Director of Finance Chief Finance Officer Board of Directors

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

4.6.4	Ex-Gratia payments for clinical negligence or personal injury claims involving negligence or any other ex-gratia payments (where legal advice obtained and followed)	
	up to £50,000	Chief Finance Officer
	£50,001 to £100,000	Chief Executive Officer and Chief Finance Officer
	over £100,000	Board of Directors
4.6.5	Reimbursement of patients monies	Financial Services Manager
4.6.6	Removal expenses, excess rent and house purchase expenses	Chief People Officer
4.6.7	Contractual and non-contractual severance payments and all non-contractual payments, excluding Directors.	
	Up to £20,000	Chief People Officer
	Over £20,000	Chief Executive Officer
4.7	Expenditure from charitable funds	
	Up to £2,000	Executive director
	Up to £30,000	QVH Charity Committee
	Over £30,000	Corporate Trustee

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2 May 2024~~ 6 March 2025

5 signature of legally binding documents (All individuals signing contracts have a responsibility to review and assure themselves that they provide value for money and that due care has been exercised in their preparation, with formal legal advice provided if necessary. This applies to contracts that appear to have no financial value, as these might have financial or non-financial implications from termination)		
5.1	Signature to approve invoices or otherwise commit expenditure (e.g. engagement letter), without any further legally binding obligations.	See Section 4 (Committing Expenditure)
5.2	Signature of any document that will be a necessary step in legal proceedings involving the Trust(excluding valuation tribunal appeals and similar day-to-day property-related matters).	Chief Executive Officer (unless the Board has specifically given the necessary authority to another individual for the purposes of such proceedings)
5.3	Signature of the following property documents when part of day to day business and within approved business plans and financial envelopes: • Notices to activate rent reviews and lease expiries • Notices requiring signature on the granting of leases and licences • Licences permitting alterations or minor works by us in third party property or by others in our properties.	Associate Director of Estates

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

5.4	Signature of other contracts or other legally binding documents not required to be executed as a deed (see Standing Orders for guidance on documents to be executed as a deed), the subject matter and nature of which has been approved by the Board or committee to which the Board has delegated appropriate authority.	
	Up to £10,000	Budget Manager
	Up to £50,000	Level 2 Manager (Officer)
	Up to £100,000	Responsible Director
	Up to £250,000	Chief Finance Officer
	Up to £1,000,000	Chief Finance Officer AND Chief Executive Officer
	Over £1,000,000	Board of Directors

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2 May 2024~~ 6 March 2025

6 setting of fees, charges and income		
6.1	Private patient, overseas visitors, income generation and other patient related services	Associate Director Business Development
6.2	Price of NHS contracts	
	Setting fees and charges for contracts up to £50,000 per annum	Relevant director
	Setting fees and charges for contracts over £50,000 per annum	Chief Finance Officer
6.3	Authorisation of income credit notes	
	Up to £10,000	Budget managers
	Up to £50,000	Level 2 managers, Financial Services Manager and Associate Director Business Development
	Up to £100,000	Responsible Director
	Up to £250,000	Chief Finance Officer
	Up to £1,000,000	Chief Finance Officer AND Chief Executive Officer
	Over £1000,000	Board of Directors

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2 May 2024~~ 6 March 2025

7	Department of Health Interim Revenue Support Where the Trust is trading at a deficit there will be a cash support requirement from the Department of Health and Social Care (DHSC) to maintain operations. The total cash support requirement will be approved by the Board as part of the annual planning process. The cash support will be provided via an interim revenue support loan from the DHSC. The approval of the loan for the drawdown of the cash will be authorised per the limits below. Details of all loan agreements are reported to and overseen by the Finance and Performance Committee with prior approval by the Board through the agreement of the Operating Plan submission.	
7.1	£0- £1,000,000 £1000,001 - £2,000,000 Above £2,000,000	Chief Finance Officer Chief Finance Officer and Chief Executive Officer Board of Directors

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

8. Roles and responsibilities of the Council of Governors

- Appoint and, if appropriate, remove the Trust Chair
- Appoint and, if appropriate, remove the non-executive directors
- Decide the remuneration and allowances and other terms and conditions of office of the Chair and non-executive directors
- Approve any appointment of a chief executive officer
- Appoint and, if appropriate remove the Trust's external auditor
- Receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council of Governors
- Hold the non-executive directors, individually and collectively, to account for the performance of the Board
- Represent the interests of the members of the Trust as a whole and the interests of the public
- Approve 'significant transactions'
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and service for the health service in England
- Approve amendments to the Trust's constitution

In the event of a dispute between the Council of Governors and Board of Directors:

- 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
- 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
- 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

Reservation of powers and scheme of delegation

APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~2-May-2024~~ 6 March 2025

Queen Victoria Hospital NHS Foundation Trust

Standing orders for the Board of Directors

Approved by the Board of Directors at its meeting on ~~7-September-2023~~6 March 2025

Contents

Item	Page
INTRODUCTION	3
1 INTERPRETATIONS AND DEFINITIONS	4
2 THE FOUNDATION TRUST BOARD OF DIRECTORS	7
3 ROLE OF MEMBERS OF THE BOARD OF DIRECTORS.....	8
4 MEETINGS OF THE BOARD OF DIRECTORS	10
5 COMMITTEES.....	17
6 ARRANGEMENTS FOR THE EXERCISE OF BOARD FUNCTIONS BY DELEGATION	19
7 DECLARATION OF INTERESTS	20
8 STANDARDS OF BUSINESS CONDUCT POLICY	23
9 OVERLAP WITH OTHER POLICY STATEMENTS, PROCEDURES, REGULATIONS AND STANDING FINANCIAL INSTRUCTIONS.....	23
10 CUSTODY OF SEAL AND SEALING OF DOCUMENTS	24
11 SIGNATURE OF DOCUMENTS	24
12 MISCELLANEOUS	25

Introduction

Statutory framework

Queen Victoria Hospital NHS Foundation Trust ("**the Foundation Trust**"), became a Public Benefit Corporation on 1 July 2004 following the approval by the Regulator. The Foundation Trust is governed by the National Health Service Act 2006 ("**the 2006 Act**"), the Constitution and the Licence granted by the Regulator ("**the Regulatory Framework**"). The functions of the Foundation Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Board of Directors to adopt Standing Orders for the Board of Directors for the regulation of its proceedings and business. The Foundation Trust must also adopt Standing Financial Instructions which set out various responsibilities of individuals.

The Foundation Trust's principal place of business is the Queen Victoria Hospital, Holtye Road, East Grinstead, West Sussex RH19 3DZ.

As a Public Benefit Corporation, the Foundation Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Foundation Trust also has a common law duty as a bailee for patient's property held by the Foundation Trust on behalf of patients.

These Standing Orders ("SOs"), together with the Reservation of Powers and Scheme of Delegation and the Standing Financial Instructions, provide a comprehensive framework for the functions of the Trust. All Executive Directors, Non-Executive Directors and Officers should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

1 Interpretations and definitions

- 1.1 Any expression to which a meaning is given in the 2006 Act or any regulations or orders made under the 2006 Act shall have the same meaning in these SOs and in addition, defined terms used in these SOs have the same meaning as in the Constitution unless the context requires otherwise, or a contrary intention is evident.
- 1.2 Save as otherwise permitted by law, at any meeting of the Board of Directors, the Chair of the Foundation Trust shall be the final authority on the interpretation of these SOs (on which he/she should be advised by the Secretary).
- 1.3 Words importing the singular shall import the plural and vice-versa in each case.
- 1.4 In these SOs:

The 2006 Act is the National Health Service Act 2006 (as amended);

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;

Audit and Risk Committee means a committee of the Board of Directors established in accordance with paragraph 47 of the Constitution;

Board of Directors means the Board of Directors of the Foundation Trust, constituted in accordance with the Constitution;

Chair means the person appointed in accordance with the 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;

Committee means a committee appointed by the Board of Directors;

Conflict shall have the meaning ascribed to “Conflict” in paragraph 40.11.1 of the Constitution;

Constitution means the Queen Victoria Hospital NHS Foundation Trust Constitution and all annexes to it;

Council of Governors means the Council of Governors as constituted in accordance with the 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 the Constitution;

Director means a member of the Board of Directors;

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;

Foundation Trust means the Queen Victoria Hospital NHS Foundation Trust;

Funds held on Trust means those funds which the Trust holds at the date of Licence, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Section 47(2)(c) of the 2006 Act. Such funds may or may not be charitable;

Licence means the licence granted to the Foundation Trust under Section 88 of the 2012 Act;

Meeting Chair means the person presiding over a meeting, committee or event;

Nomination and Remuneration Committee means a committee constituted in accordance with paragraph 37.4 of the Constitution;

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;

Principal Purpose means the purpose set out in Section 43(1) of the 2006 Act;

Regulatory Framework means the 2006 Act, the Constitution and the Licence;

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 the Constitution;

Pecuniary Interest means an indirect interest in a contract if the Director:

- Or a nominee of the Director, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same; or,
- is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

The interest of a Director's spouse, civil partner (as defined in the Civil Partnerships Act 2004) or co-habitee shall, if known to the person, be deemed for the purposes of these SOs to be also an interest of the person.

A director shall not be regarded as having a pecuniary interest in any contract if: neither the Director or any person connected with the Director has any beneficial interest in the securities of a company of which the Director or such person appears as a member; or,

- any interest that the Director or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence them in relation to considering or voting on that contract; or
- those securities of any company in which the Director (or any person connected with them) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Any remuneration, compensation or allowance payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of these SOs.

Standing Financial Instructions (SFIs) means the Queen Victoria Hospital NHS Foundation Trust's Standing Financial Instructions;

Standing Orders (SOs) means the basic rules and procedures for the Queen Victoria Hospital NHS Foundation Trust's Board of Directors.

2 The Foundation Trust Board of Directors

Composition of the Board of Directors

- 2.1 The composition of the Board of Directors is set out at paragraph 31 of the Constitution.

Appointment of the Chair and other members of the Board of Directors

- 2.2 The Chair and other members of the Board of Directors shall be appointed in accordance with paragraphs 34 and 37 of the Constitution.

Terms of office of the Chair and other members of the Board of Directors

- 2.3 The period of tenure, suspension and removal of the Chair and other members of the Board of Directors shall be in accordance with paragraphs 34, 35, 37 and 38 of the Constitution.

Appointment and powers of the Deputy Chair

- 2.4 The Deputy Chair shall be appointed in accordance with paragraph 36 of the Constitution.
- 2.5 Any appointment as Deputy Chair shall be for a period not exceeding the remainder of their existing term of office as a Non-Executive Director or as specified by the Council of Governors on appointment.
- 2.6 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. Thereupon, the Council of Governors may appoint another Non-Executive Director as Deputy Chair in accordance with paragraph 36 of the Constitution.
- 2.7 The Deputy Chair may act as Chair in accordance with paragraph 36.6 of the Constitution or if the Chair of the Foundation Trust has died or has ceased to hold office.
- 2.8 In the event of circumstances provided by paragraph 36.6 of the Constitution and/or 1.4 of the Standing Orders, references to the Chair in these Standing Orders shall be taken to include references to the Deputy Chair.

Appointment of a Senior Independent Director

- 2.9 The Board of Directors may appoint a Non-Executive Director to be the Senior Independent Director, for such period, not exceeding the remainder of their term as a member of the Board of Directors, as they may specify on appointment. The appointment for the Senior Independent Directors shall be made in accordance with paragraph 36 of the Constitution.
- 2.10 If a Non-Executive Director resigns from the office of Senior Independent Director (in accordance with paragraph 36.3 of the Constitution), the Board of Directors may appoint another Non-Executive Director as Senior Independent Director in accordance with the provisions of Standing Order 2.9.

3 Role of members of the Board of Directors

Corporate role of the Board of Directors

- 3.1 All business shall be conducted in the name of the Foundation Trust.
- 3.2 All funds received in trust shall be held in the name of the Foundation Trust as corporate trustee.
- 3.3 The powers of the Foundation Trust established under statute shall be exercised by the Board of Directors meeting in public session except as otherwise provided by paragraph 39 and Annex 6 (Conduct of meetings of the Council of Governors and the Board of Directors) of the Constitution.
- 3.4 The Board of Directors will function as a corporate decision-making body. Executive and Non-Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Foundation Trust in carrying out its statutory and other functions.
- 3.5 The Foundation Trust has the functions conferred on it by the Regulatory Framework. Directors acting on behalf of the Trust as corporate trustees are acting as quasi trustees. Accountability for Charitable Funds held on Trust is to the Charity Commission and to the Regulator. Accountability for non-charitable Funds held on Trust is only to the Regulator.

Chief Executive

- 3.6 The Chief Executive shall be responsible for the overall performance of the executive functions of the Foundation Trust. The 2006 Act designates the Chief Executive of an NHS foundation trust as the accounting officer. The Chief Executive shall be responsible for ensuring the discharge of obligations under applicable financial directions, the Regulator's guidance and in line with the requirements of the NHS foundation trust accounting officer memorandum.

Chief Finance Officer

- 3.7 The Chief Finance Officer shall be responsible for the provision of financial advice to the Foundation Trust and to members of the Board of Directors and for the supervision of financial control and accounting systems. The Chief Finance Officer shall be responsible along with the Chief Executive for ensuring the discharge of obligations under applicable financial directions and the regulator's guidance.

Medical director

- 3.8 The medical director shall be responsible for effective professional leadership and management of medical staff of the Foundation Trust and shall be the responsible officer for NHS medical revalidation. The medical director shall provide advice to the Chief Executive and the Board of Directors on key strategic medical efficacy issues and matters relating to the medical workforce of the Foundation Trust.

Chief Nurse

- 3.9 The Chief Nurse shall be responsible for effective professional leadership and management of nursing staff of the Foundation Trust and is the Caldicott guardian. The Chief Nurse shall

provide advice to the Chief Executive and the Board of Directors on key strategic care quality issues and matters relating to the nursing workforce of the Foundation Trust.

Non-Executive Directors

- 3.10 The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Foundation Trust. They may, however, exercise collective authority when acting as the Board of Directors or when chairing a Committee of the Board of Directors which has delegated authority to act on behalf of the Board of Directors.

Chair

- 3.11 The Chair shall be responsible for the operation of the Board of Directors and shall chair all meetings of the Board of Directors when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.
- 3.12 The Chair shall liaise with the Council of Governors and its appointments committee over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for the Non-Executive Directors' induction, portfolio of interests, assignments and performance.
- 3.13 The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors.
- 3.14 The Chair shall ensure that the designation of lead roles or appointments of members of the Board of Directors as required by the Regulator or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement.

Corporate role of the Council of Governors

- 3.15 The Council of Governors shall fulfil its statutory duties in accordance with the Regulatory Framework.

Schedule of matters reserved to the Board of Directors and the Scheme of Delegation

- 3.16 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors meeting in formal session. These powers are set out in the Reservation of Powers and Scheme of Delegation and shall have effect as if incorporated into these Standing Orders.
- 3.17 Subject to the Regulatory Framework and such guidance or best practice as may be issued by the Regulator, the Board of Directors may make arrangements for the exercise of any of its functions by a Committee or sub-committee of the Board of Directors or by a Director or an officer in each case subject to such restrictions and conditions as the Board of Directors considered appropriate. The powers and decisions which the Board of Directors has delegated to Committees, sub-committees, Directors or Officers are set out in the Reservation of Powers and Scheme of Delegation.

4 Meetings of the Board of Directors

Calling meetings

- 4.1 Subject to Standing Orders 4.2 and 4.3 below, meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.
- 4.2 The Chair may call a meeting of the Board of Directors at any time.
- 4.3 One third or more of the whole number of members of the Board of Directors may requisition a meeting in writing to the Chair. If the Chair refuses or fails to call a meeting within seven Clear Days of a requisition being presented, the members of the Board of Directors who signed the requisition may forthwith call a meeting of the Board of Directors.

Notice of meetings and the business to be transacted

- 4.4 Before each meeting of the Board of Directors, a written notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an Officer authorised by the Chair to sign on their behalf shall be delivered to every Director (this includes email), or sent by post to the usual place of residence of such Director, so as to be available to every Director at least four Clear Days before the meeting
- 4.5 Want of service of the notice on any Director shall not affect the validity of a meeting.
- 4.6 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.
- 4.7 Before each meeting of the Board of Directors a public notice of the time and place of the meeting, and the public part of the agenda and associated papers shall be published on the Foundation Trust's website at least three (3) Clear Days before the meeting, save in the case of emergencies.
- 4.8 In the event of an emergency giving rise to the need for an immediate meeting, failure to comply with the notice periods referred to in SO 4.4 and (where relevant SO 4.7 above) shall not prevent the calling of, or invalidate, such a meeting without the requisite notice provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

Setting the agenda

- 4.9 The Board of Directors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted ("standing Items").
- 4.10 A member of the Board of Directors who desires a matter to be included on an agenda, other than a Standing Item or a motion, should make their request in writing to the Chair at least ten (10) Clear Days before the meeting. Requests made less than ten (10) Clear Days before a meeting may be included on the agenda at the discretion of the Chair.
- 4.11 No business shall be transacted at any meeting of the Board of Directors which is not specified in the notice of that meeting unless the Chair, in their absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered by the

Board of Directors as a matter of urgency. A decision by the Chair to permit consideration of the item in question and (where relevant) the supporting papers shall be recorded in the minutes of that meeting.

Agenda and supporting papers

- 4.12 Before each meeting of the Board of Directors, an agenda of the meeting and any supporting papers will be provided electronically to each member of the Board of Directors at least three (3) Clear Days before the meeting, save in an emergency. Failure to serve such a notice on more than three (3) Directors will invalidate the meeting.

Petitions

- 4.13 Where a petition has been received by the Foundation Trust, the Secretary shall include the petition as an item for the agenda of the next meeting of the Board of Directors.

Notice of motion

- 4.14 A Director desiring to move or amend a Motion shall send a written notice thereof at least ten (10) Clear Days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under these SOs. This paragraph shall not prevent any Motion being moved during the meeting, without notice on any business mentioned on the agenda. A Motion may be proposed by the Chair of the meeting or any member of the Board of Directors present. It must also be seconded by another member of the Board of Directors.

Withdrawal of motion or amendments

- 4.15 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

Motion to rescind a resolution

- 4.16 Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of four (4) other members of the Board of Directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any member of the Board of Directors other than the Chair to propose a motion to the same effect within six (6) months; however the Chair may do so if they consider it appropriate.

Emergency motions

- 4.17 Subject to the agreement of the Chair, a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared by the Chair to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

Motions: procedure at and during a meeting

- 4.18 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.
- 4.19 When a motion is under discussion or immediately prior to discussion it shall be open to a member of the Board of Directors to move:
- 4.19.1 an amendment to the motion; or
 - 4.19.2 the adjournment of the discussion or the meeting; or
 - 4.19.3 that the meeting proceed to the next item of business; (*) or
 - 4.19.4 the appointment of an ad hoc committee to deal with a specific item of business; or
 - 4.19.5 that the motion be now put (*); or
 - 4.19.6 a motion resolving to exclude the public (including the press).

In the case of Standing Orders denoted by () above to ensure objectivity motions may only be put by a member of the Board of Directors who has not previously taken part in the debate and who is eligible to vote.

- 4.20 No amendment to the motion shall be admitted if, in the opinion of the Chair, the amendment negates the substance of the motion.

Written motions

- 4.21 In urgent situations and with the consent of the Chair, business may be effected by a member of the Board of Directors written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.
- 4.22 If all members of the Board of Directors have been notified of the proposal and a simple majority of the member of the Board of Directors entitled to attend and vote at a meeting of the Board of Directors confirms acceptance of the written motion either in writing or electronically to the Secretary within five (5) Clear Days of dispatch then the motion will be deemed to have been resolved notwithstanding that the Directors have not gathered in one place.
- 4.23 The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date a member of the Board of Directors who has previously indicated acceptance can withdraw and the motion shall fail.
- 4.24 Once the resolution is passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

Chair of meeting

- 4.25 At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair (if the board has appointed one), if present, shall preside. If the Chair and any Deputy Chair are absent, such Non-Executive Director as the Chair has previously designated or, in the absence of such designation or the designated Non-Executive Director being absent, as the Directors present choose, will preside.
- 4.26 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair of the Board of Directors, if present, shall preside. If the Chair and Deputy

Chair of the Board of Directors are absent, or are disqualified from participating, such Non-Executive Director as the Chair has previously designated or, in the absence of such designation or the designated Non-Executive Director being absent (on the grounds of declared conflict of interest or otherwise), as the Directors present shall choose, shall preside.

- 4.27 If any matter for consideration at a meeting of the Board of Directors relates to the interests of the Chair or the Non-Executive Directors as a class, neither the Chair nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under discussion. The Directors (excluding the Chair and the Non-Executive Directors) shall elect one of the number to preside during that period and that person shall exercise all the rights and obligations of the Chair, including (for the avoidance of doubt) the right to exercise a second or casting vote where the numbers of votes for and against a motion is equal. The Directors shall consider whether in fact the matter for consideration requires referral to the Council of Governors.

Chair's ruling

- 4.28 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of these Standing Orders and Standing Financial Instructions will be final.

Quorum

- 4.29 No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the voting members of the Board of Directors are present, including at least one voting Executive Director and one Non-Executive Director.
- 4.30 In accordance with Annex 7 (Meetings of the Council of Governors and the Board of Directors – Electronic Communication) of the Constitution, members of the Board of Directors participating in meetings of the Board of Directors by telephone, video or computer link or other such agreed means shall count towards the quorum for so long as the members have the ability to communicate interactively and simultaneously with all members of the Board of Directors in attendance at the meeting, including all member attending by way of electronic communication.
- 4.31 An officer in attendance for an Executive Director member but without formal acting up status may not count towards the quorum.
- 4.32 If the Chair or another member of the Board of Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that individual will 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 voted upon at that meeting. Such a position will be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting of the Board of Directors (for example when the Board of Directors considers the recommendations of the Remuneration Committee). The requirement for at least one Non-Executive Director to form part of the quorum shall not apply where the Non-Executive Directors are excluded from a meeting of the Board of Directors.

Voting

- 4.33 Subject to Standing Orders 4.38 to 4.41 or as otherwise provided by the Standing Orders, every question put to vote at a meeting shall be determined by a majority of the votes of the members of the Board of Directors present and voting on the question and in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.
- 4.34 At the discretion of the Chair, all questions put to the vote will be determined by oral expression or by a show of hands. Any voting member of the Board of Directors attending by telephone, video or computer link shall cast their vote verbally and such action shall be recorded in the minutes of the meeting.
- 4.35 If at least one-third of the voting members of the Board of Director so request, the voting (other than by paper ballot) on any question may be recorded to show how each members present voted or abstained.
- 4.36 A paper ballot may be used if a majority of the voting members of the Board of Directors present so request, in which case any person attending by telephone, video or computer link shall cast their vote verbally and such action shall be recorded in the minutes of the meeting. If a Director so requests, their vote shall be recorded by name.
- 4.37 An officer, who has been appointed formally by the Board of Directors to act up for a voting Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, will be entitled to exercise the voting rights of the Executive Director. An officer attending the meeting of the Board of Directors to represent a voting Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Member. An officer's status when attending a meeting will be recorded in the minutes of the meeting.
- 4.38 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

Suspension of Standing Orders

- 4.39 Except where this would contravene any statutory provision of the Regulatory Framework or any guidance or best practice issued by the Regulator, any one or more of these Standing Orders may be suspended at any meeting of the Board of Directors, provided that at least two-thirds of the whole number of the voting members of the Board of Directors are present (including at least one voting Executive Director and one Non-Executive Director) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension will be recorded in the minutes of the meeting.
- 4.40 A separate record of matters discussed during the suspension of Standing Orders will be made and will be available to the Chair and members of the Board of Directors. This record of matters is separate from the minutes of the meeting of the Board of Directors.
- 4.41 No formal business may be transacted while Standing Orders are suspended.
- 4.42 The audit and risk committee shall review every decision to suspend Standing Orders.

Variation and amendment of Standing Orders

- 4.43 These Standing Orders may be amended only if:
1. a notice of motion under Standing Orders 4.14 has been given;

2. upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting of the Board of Directors;
3. at least two-thirds of the member of the Board of Directors are present at the meeting where the variation is being discussed;
4. at least half of the Non-Executive Directors vote in favour of the amendment; and
5. the variation proposed does not contravene a statutory provision, direction or guidance or best practice advice issued by the Regulator, or the terms of the Foundation Trust's Constitution.

Minutes

- 4.44 The names of the Chair and members of the Board of Directors present shall be recorded in the minutes of the meeting.
- 4.45 The minutes of the proceedings of a meeting of the Board of Directors will be drawn up by the Secretary and submitted for agreement at the next ensuing meeting of the Board of Directors, to be signed by the person presiding at it.
- 4.46 No discussion will take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

Admission of the public and the press

- 4.47 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board of Directors but shall be required to withdraw upon the board resolving as follows:

"That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".

- 4.48 The Chair or person presiding over the meeting of the Board of Directors will give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors' business can be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and representatives of the press will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board of Directors to complete its business without the presence of the public or press".

- 4.49 Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, shall be confidential to the members of the Board of Directors, nominated officers, 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.

Use of equipment for recording or transmission of meetings

- 4.50 Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board of Directors.

Observers

- 4.51 The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any meetings of the Board of Directors and may change, alter or vary these terms and conditions as it deems fit.

5 Committees

- 5.1 Subject to the Regulatory Framework and such guidance issued by the Regulator, the Board of Directors may and, if directed by the Regulator shall, appoint Committees of the Trust, consisting wholly or partly of members of the Board of Directors of the Trust. The Board of Directors may only delegate its powers to such a Committee if that Committee consists entirely of Directors of the Trust.
- 5.2 A committee or joint committee appointed under this Standing Order 5 may, subject to the Regulatory Framework and such guidance and/or best practice advice as may be issued by the Regulator or the Board of Directors or other Health Service Bodies in question, appoint sub-committees consisting wholly or partly of members of the Committee (whether or not they are members of the Board of Directors); or wholly of persons who are not members of the Board of Directors subject to the same proviso as in this Standing Order 6.3 to 6.5 relating to membership of the Committee and delegation of powers.
- 5.3 The Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees or sub-committees established by the Board of Directors. In such a case the term "Chair" is to be read as a reference to the Chair of the Committee or sub-committee as the context permits, and the term "Director" is to be read as a reference to a member of the Committee also as the context permits. (There is no requirement to hold meetings of Committees or sub-committees established by the Foundation Trust in public.)
- 5.4 The Board of Directors shall approve the appointments to each of the Committees, which it has formally constituted. Where the Board of Directors determines and regulations permit that persons, who are neither Directors nor officers, shall be appointed to a Committee the terms of such appointment shall be determined by the Board of Directors as defined by the Regulatory Framework. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with its Constitution. The Board of Directors may elect to change the committees, sub-committees and joint-committees of the Board of Directors, as necessary, without requirement to amend these Standing Orders.
- 5.5 The Board of Directors shall also determine the terms of reference of Committees and sub-committees and shall, if it requires to, receive and consider reports of such Committees
- 5.6 The Committees established by the Board of Directors are:
 1. Audit and Risk Committee (also in accordance with paragraph 47 of the Constitution)
 2. Nomination and Remuneration Committee (also in accordance with paragraphs 37.3 and 37.4 of the Constitution)
- 5.7 In addition, the Board of Directors shall establish and maintain the following Committees:
 1. Finance and Performance Committee
 2. Quality and Safety Committee
 3. Strategic Development Committee
 4. People Committee

- 5.8 The Board of Directors may also establish such Committees as it requires to discharge the Foundation Trust's responsibilities.
- 5.9 Terms of reference for Committees established by the Board of Directors will be reviewed annually, approved by the Board of Directors and published on the Foundation Trust's website.

Appointments for statutory functions

- 5.10 Where the Board of Directors is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Regulator, and where such appointments are to operate independently of the Board of Directors, such appointment shall be made in accordance with the regulations and directions issued by the Regulator.

Joint committees¹

- 5.11 Joint committees may be appointed by the Board of Directors, by joining together with one or more bodies consisting of, wholly or partly of the Chair and Directors of the Foundation Trust or other bodies, or wholly of persons who are not Directors of the Trust or other bodies in question.
- 5.12 Any Committee or joint committee appointed under this Standing Order may, subject to such directions or guidance as may be issued by the Regulator or the Foundation Trust, appoint sub-committees consisting wholly or partly of members of the Committee(s) or joint committee(s) or wholly of other persons provided that the Foundation Trust is always represented by an Executive Director on such Committees, joint committees or sub-committees.

Terms of reference

- 5.13 Each such Committee and sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting to the Board of Directors) as the Board of Directors shall decide and shall be in accordance with any legislation and/or guidance and/or best practice issued by the Regulator. Such terms of reference shall have effect as if incorporated in the Standing Orders. Where Committees are authorised to establish sub-committees they may not delegate executive powers to sub-committee unless expressly authorised by the Board of Directors.

Delegation of powers

- 5.14 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.
- 5.15 In the event of an urgent decision required by the Board of Directors or a sub-committee, such a decision can be considered by a Committee by email or other electronic correspondence. This is subject to the quorum of the Board of Directors or sub-committee endorsing the required decision.

Confidentiality

- 5.16 A member of a committee, sub-committee or joint committee shall not disclose a matter dealt with, by, or brought before, the committee without its permission until the Committee,

¹ Please note that all decisions of the joint committee will need to be ratified by the Board of Directors

sub-committee or joint committee (as appropriate) shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

- 5.17 A Director or a member of a committee, sub-committee or joint committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, sub-committee or joint committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee, sub-committee or joint committee shall resolve that it is confidential.

6 Arrangements for the exercise of board functions by delegation

- 6.1 Subject to the Regulatory Framework and such guidance or best practice as may be issued by the Regulator, the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee or by a Director or an officer of the Foundation Trust in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

Emergency powers

- 6.2 The powers which the Board of Directors has reserved to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board of Directors in public session for formal ratification (unless for reasons of the nature of the information for example it is privileged, not disclosable or of commercial sensitivity when it will need to go to the confidential session). The Board of Directors may also instruct the Chair to take certain actions and report back to a subsequent meeting.

Delegation to Committees

- 6.3 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by Committees, or sub-committees, or joint committees, which it has formally constituted in accordance with the Constitution. The Constitution and the terms of reference of these Committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board of Directors.
- 6.4 When the Board of Directors is not meeting as the Foundation Trust in public session it shall operate as a Committee and may only exercise such powers as may have been delegated to it by the Foundation Trust in public session.

Delegation to Officers

- 6.5 Those functions of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to a Committee or sub-committee or joint committee shall be exercised on behalf of the Foundation Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Foundation Trust.
- 6.6 The Chief Executive shall prepare the Scheme of Delegation and Reservation of Powers identifying their proposals, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation and Reservation of Powers which shall be considered and approved by the Board of Directors.

- 6.7 Nothing in the Scheme of Delegation and Reservation of Powers shall impair the discharge of the direct accountability to the Board of Directors of the Chief Finance Officer to provide information to and advise the Board of Directors in accordance with statutory requirements. Outside these statutory requirements, the Chief Finance Officer shall be accountable to the Chief Executive for operational matters.
- 6.8 The arrangements made by the Board of Directors as set out in the Scheme of Delegation and Reservation of Powers shall have effect as if incorporated in these SOs, but for the avoidance of doubt, neither these SOs nor the Scheme of Delegation and Reservation of Powers form part of the Constitution.

Duty to report non-compliance with Standing Order

- 6.9 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or approval. All members of the Board of Directors and officers have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

7 Declaration of interests

- 7.1 These Standing Orders and Standing Financial Instructions must be read in conjunction with paragraph 40 and Annex 8 (Conflicts of Interest of Governors and Directors) of the Constitution which shall have effect as if incorporated in this Standing Order.
- 7.2 Notwithstanding the application of paragraph 40 of the Constitution, all members of the Board of Directors should declare the nature and extent of all relevant and material interests on appointment to the Foundation Trust and thereafter at the beginning of each financial year and when a declaration becomes inaccurate, incomplete or obsolete. Directors' interests should be recorded in the Board of Directors' minutes. Any changes of interests should be declared at the next meeting of the Board of Directors following the change occurring, recorded in the minutes of that meeting and added to the register of interests.
- 7.3 It is the obligation of the Director to inform the Secretary of the Trust in writing within seven (7) days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the register of interest of Directors.
- 7.4 If members of the Board of Directors have any doubt about the relevance of an interest, this should be discussed with the Secretary or Chair.
- 7.5 During the course of a Board of Directors meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chair having the casting vote.

Disability of Chair and Directors in proceedings on account of pecuniary interest

- 7.6 Subject to the provisions of this Standing Order, if the Chair or a member of the Board of Directors has any Pecuniary Interest, direct or indirect, in any contract, proposed contract or other matter is present a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable

after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

- 7.7 Subject to applicable legislation, the Regulator may, subject to such conditions as it may think fit to impose, remove any disability imposed by this standing order in any case in which it appears to it in the interests of the National Health Service that the disability should be removed
- 7.8 The Board of Directors may exclude the Chair or a member of the Board of Directors from a meeting of the Board of Directors while any contract, proposed contract or other matter in which they have a Pecuniary Interest is under consideration.
- 7.9 This standing order applies to a Committee or a sub-committee and a joint committee as it does to the Board of Directors and applies to a member of any such Committee (whether or not they are also a Director) as it applies to a member of the Board of Directors.

Interests of officers in contracts

- 7.10 Any Director or Officer of the Foundation Trust who comes to know that the Foundation Trust has entered into or proposes to enter into a contract in which they or their spouse, civil partner or co-habitee has any Pecuniary Interest, direct or indirect, the Director or officer shall declare their interest by giving notice in writing of such fact to the Secretary as soon as practicable.
- 7.11 A Director or Officer should also declare to the Secretary any other employment or business of other relationship of theirs, or of their spouse, civil partner or co-habitee that conflicts, or might reasonably be predicted could conflict with the interests of the Foundation Trust.
- 7.12 The Foundation Trust will require interests, employment or relationships so declared to be entered in a register of interests of members of staff.

Fit and proper person test

- 7.13 As established by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("**the Regulations**"), the Trust has a duty not to appoint a person or to allow a person to continue to be an Executive Director or equivalent or a Non-Executive Director of the Trust under given circumstances known as the "fit and proper persons test".
- 7.14 In accordance with its fit and proper person requirements policy, the Trust requires Executive and Non-Executive Directors of the Board of Directors to declare on appointment and thereafter annually that they remain a fit and proper person to be employed as a Director.
- 7.15 If members of the Board of Directors have any doubt about the Regulations or declarations, this should be discussed with the Secretary or Chair.
- 7.16 The consequences of false, inaccurate, or incomplete information by individuals subject to the Regulations may be their removal from office pending the outcome of an investigation.

Duty of candour

- 7.17 As established by Regulation 20 of the Regulations, the Trust has a duty to act in an open and transparent way with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.
- 7.18 In accordance with its being open / duty of candour policy, the Trust requires that all relevant Officers apply the following key principles of candour when communicating with patients, their families and carers following a patient safety incident, complaint or claim where a patient was harmed:
1. acknowledge, apologise and explain when things go wrong;
 2. conduct a thorough investigation into the patient safety incident and reassuring patients, their families and carers that lessons learned will help prevent the patient safety incident recurring;
 3. provide support for those involved to cope with the physical and psychological consequences of what happened.

Canvassing of and recommendations by Directors in relation to appointments

- 7.19 Directors or members of any Committee of the Board of Directors may be approached by candidates wishing to increase their understanding of the organisation during the appointment process. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the appointing panel or committee.
- 7.20 Directors shall not solicit for any person any appointment under the Foundation Trust or recommend any person for such appointment; but this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Foundation Trust.

Relatives of Directors or Officers

- 7.21 Candidates for any staff appointment under the Foundation Trust shall, when making an application, disclose in writing to the Chief Executive whether they are related to any Director or the holder of any office under the Foundation Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.
- 7.22 The Chair and every Director and officer of the Foundation Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors on any such disclosure made.
- 7.23 Prior to acceptance of any appointment, Executive Directors should disclose to the Chief Executive whether they are related to any other Director or holder of any office under the Foundation Trust.
- 7.24 On appointment, Directors should disclose to the Board of Directors whether they are related to any other Director or holder of any office under the Foundation Trust.
- 7.25 Where the relationship to a Director of the Foundation Trust is disclosed, Standing Orders in respect to the 'Disability of Chair and Directors in proceedings on account of pecuniary interest' shall apply.

8 Standards of business conduct policy

- 8.1 Directors and officers should comply with the Foundation Trust's standards of business conduct policy and relevant codes of conduct.
- 8.2 Members of the Board of Directors must also comply with the Foundation Trust's annual declarations by Directors process.

9 Overlap with other policy statements, procedures, regulations and standing financial instructions

Policy statements: general principles

- 9.1 The Board of Director, Committees, sub-committees and joint committees will from time to time agree and approve policy statements and procedures which will apply to all or specific groups of officers of the Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate meeting minutes and will be deemed where appropriate to be an integral part of the Foundation Trust's Standing Orders and Standing Financial Instructions.

Specific policy statements

- 9.2 These Standing Orders and the Standing Financial Instructions should be read in conjunction with the following policy statements:
 - 1. Standards of business conduct policy
 - 2. Disciplinary policy and procedure
 - 3. Appeals policy and procedure
 - 4. Raising concerns (whistleblowing) policy

all of which shall have effect as if incorporated in these Standing Orders.

Specific guidance

- 9.3 These Standing Orders and the Standing Financial Instructions must be read in conjunction with current legislation and guidance and any other relevant guidance issued by the Regulator.

10 Custody of seal and sealing of documents

Custody of seal

- 10.1 The Secretary shall keep the seal of the Foundation Trust in a secure place.

Sealing of Documents

- 10.2 Documents can only be sealed once they have been authorised by a resolution of the Board of Directors or of a committee thereof, or where the Board of Directors has delegated its powers.
- 10.3 Building, engineering, property or capital documents do not require authorisation by Board of Directors or a committee thereof, but before presenting for seal these documents do require the approval and signature of the Chief Finance Officer (or an officer nominated by them) and the authorisation and countersignature of the Chief Executive (or an officer nominated by them who shall not be within the originating directorate).
- 10.4 The fixing of the seal shall be authenticated by the signature of the Chair (or the Deputy Chair in the absence of the Chair) and one Executive Director.

Register of sealing

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

11 Signature of documents

- 11.1 Where any document will be a necessary step in legal proceedings on behalf of the Foundation Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or nominated Executive Director.
- 11.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Foundation Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board of Directors or any Committee, sub-committee or joint committee with delegated authority.

12 Miscellaneous

Standing Orders to be given to Directors and Officers

- 12.1 It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies where appropriate of SOs.

Documents having the standing of Standing Orders

- 12.2 SFIs and the Scheme of Delegation shall have effect as if incorporated into these Standing Orders.

Review of Standing Orders

- 12.3 Standing Orders shall be reviewed annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in the Standing Orders.

Joint finance arrangements

- 12.4 The Board of Directors may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 75 of the 2006 Act. The Board of Directors may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 75 of the 2006 Act.

Report cover-page

References

Meeting title:	Board of Directors		
Meeting date:	06/03/2025	Agenda reference:	130-25
Report title:	Annual report on the use of the Trust seal 2024/25		
Sponsor:	Leonora May, Company secretary		
Author:	Leonora May, Company secretary		
Appendices:	Appendix one: entry to register of sealing 2024/25 2/24		

Executive summary

Purpose of report:	To provide the board with an update on the use of the Trust seal, in line with the requirement within section 10 of the Trust's Standing orders				
Summary of key issues	There has been one use of the Trust seal since the last annual report: 1. Completion documents for the sale of land at Queen Victoria Hospital: Deed of Overage for the land at the Queen Victoria Hospital, East Grinstead, West Sussex RH19 3DZ between (1) Queen Victoria Hospital NHS Foundation Trust and (2) Brookworth (East Grinstead) Limited TP1 for the transfer of land at the Queen Victoria Hospital, East Grinstead, West Sussex RH19 3DZ				
Recommendation:	The Board is asked to note the contents of this report.				
Action required	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	<i>Outstanding patient experience</i>	<i>World-class clinical services</i>	<i>Operational excellence</i>	<i>Financial sustainability</i>	<i>Organisational excellence</i>

Implications

Board assurance framework:	BAF5- compliance- ensures compliance with the Trust's Standing orders
Corporate risk register:	None
Regulation:	Ensures compliance with the Trust's Standing orders
Legal:	None
Resources:	None

Assurance route

Previously considered by:	NA			
	Date:		Decision:	
Next steps:	NA			

Report to: Board of Directors
Agenda item: 130-25
Date of meeting: 06 March 2025
Report from: Leonora May, Company secretary
Report author: Leonora May, Company secretary
Date of report: 20 February 2025
Appendices: Appendix one: entry to register of sealing 2024/25 2/24

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

Introduction

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

Background

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

Sealing of Documents

- 10.2 *Documents can only be sealed once they have been authorised by a resolution of the Board of Directors or of a committee thereof, or where the Board of Directors has delegated its powers.*
- 10.3 *Building, engineering, property or capital documents do not require authorisation by Board of Directors or a committee thereof, but before presenting for seal these documents do require the approval and signature of the Chief Finance Officer (or an officer nominated by them) and the authorisation and countersignature of the Chief Executive (or an officer nominated by them who shall not be within the originating directorate).*
- 10.4 *The fixing of the seal shall be authenticated by the signature of the Chair (or the Deputy Chair in the absence of the Chair) and one Executive Director.*

Register of sealing

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

Annual report

Since 1 April 2024, the Trust seal has been affixed to one document on 22 May 2024 as authorised by the Chief executive officer and Chief finance officer. The seal was attested by the Trust Chair and Chief executive officer. The entry to the register of sealing is appended to this report and was related to the land sale:

2/24:

Deed of Overage for the land at the Queen Victoria Hospital, East Grinstead, West Sussex RH19 3DZ between (1) Queen Victoria Hospital NHS Foundation Trust and (2) Brookworth (East Grinstead) Limited

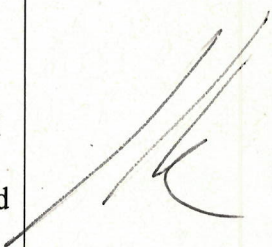
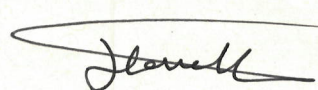
TP1 for the transfer of land at the Queen Victoria Hospital, East Grinstead, West Sussex RH19 3DZ

Recommendation

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

REGISTER FORM

To be completed for each use of the Trust's seal electronically, except for signature

Date	Description	Authorised Signatory CEO and DoF or nominee
22/05/2024	Completion documents for the sale of land at Queen Victoria Hospital: 2/24 Deed of Overage for the land at the Queen Victoria Hospital, East Grinstead, West Sussex RH19 3DZ between (1) Queen Victoria Hospital NHS Foundation Trust and (2) Brookworth (East Grinstead) Limited 3/24 TP1 for the transfer of land at the Queen Victoria Hospital, East Grinstead, West Sussex RH19 3DZ	 MARIO DINEEN CHIEF FINANCE OFFICER James Lowell 

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/03/2025	Agenda reference:	131-25		
Report title:	Organisational risk register				
Sponsor:	Executive risk owners				
Author:	Leonora May, Company secretary				
Appendices:	Appendix one- Organisational risk register				
Executive summary					
Purpose of report:	The Organisational risk register as at 17 February 2025 is presented to the Board for review.				
Summary of key issues	- There are currently 16 open risks on the organisational risk register (15 at last review) (all have been reviewed and approved by the Executive committee for quality and risk (ECQR)) - The highest scoring risks are related to the non-compliance with the Trust's governing documents; mental capacity assessments and the Trust breaking even in 2025/26 (risk 137 see new risks below). All of these risks currently score 16 - The relevant organisational risks have been reviewed by the Finance and performance committee and Quality and safety committee at recent meetings				
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:
	<i>Outstanding patient experience</i>	<i>World-class clinical services</i>	<i>Operational excellence</i>	<i>Financial sustainability</i>	<i>Organisational excellence</i>
Implications					
Board assurance framework:	Organisational risks to be linked to the BAF BAF risks being updated				
Organisational risk register:	Appendix one				
Regulation:	CQC well led Risk management framework				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	ECQR, ELT, Quality and safety and Finance and performance committees				
	Date:	February 2025	Decision:		

Report to: Board of Directors
Agenda item: 131-25
Date of meeting: 06 March 2025
Report from: Executive risk owners
Report author: Leonora May, Company secretary
Date of report: 20 February 2025
Appendices: Appendix one- Organisational risk register

Organisational risk register

Introduction and background

The organisational risk register as at 17 February 2025 is presented for information. The full register is included with this report as appendix one.

Organisational risks are either risks which score more than 15 or those that require organisational wide oversight due to organisation wide action required, significant spend on controls or where there is requirement to aggregate multiple local risks.

The Executive committee for quality and risk (ECQR) is now reviewing the Organisational risk register monthly and approving risks for inclusion or removal from the Organisational risk register.

The relevant organisational risks have been reviewed by the Audit and risk committee, Finance and performance committee and Quality and safety committee at recent meetings.

The organisational risks should inform BAF risks and the organisational risk register will be appended to future BAF reports for information. Following the publication of the organisational strategy 2025-2030, the Board recognised that the risks which make up the Board assurance framework are due a refresh to provide a realistic view of the most fundamental strategic risks and key controls to support mitigation. The Board had an initial discussion about this in its seminar in December 2024 and work has started on developing a new Board assurance framework.

Risks

- There are currently 16 open risks on the organisational risk register (15 at last review) (all have been reviewed and approved by the Executive committee for quality and risk (ECQR))
- The highest scoring risks are related to the non-compliance with the Trust's governing documents; mental capacity assessments and the Trust breaking even in 2025/26 (risk 137 see new risks below). All of these risks currently score 16
- Risk 117 (medical devices may fail to the point where we cannot repair due to age and unavailability of the parts of the device) has been added to the organisational risk register during the period.
- Risk 121 (failing of paging system) has been added to the organisational risk register during the period

Changes to risk scores during the period

- Risk 47 (failure of electrical infrastructure)- The score of this risk has been reduced during the period from a rating of 16 to a rating of 12 due to the upgrade of the power availability
- Risk 48 (fire alarm system not alerting the areas appropriately)- The score of this risk has been reduced during the period from a rating of 20 to a rating of 9 due to completion of works on the network cabling and the planned upgrade to an L1 fire system
- Risk 54 (There is a risk that the boiler system might fail and require full boiler replacement)- The score of this risk has been reduced during the period from a rating of 25 to a rating of 15 due to the hire boiler now being on site. The consequence of this risk has not changed as the failure of the hire boiler would still mean that the hospital has to close

Heat map

<i>Likelihood</i>	<i>Consequence</i>				
	Negligible	Minor	Moderate	Major	Catastrophic
Almost certain					
Likely			88 125*	14 16 137*	
Possible			48	11 47 115 121 17 38 117	49 53 54 132*
Unlikely			77	73	
Rare					

*new risk to be added to the organisational risk register

Risks closed and removed from the organisational risk register

- Risk 21 (provider/ commissioner arrangements may change which may result in adverse impact to the operational and financial sustainability and/ or resilience of the Trust) - this risk was closed on 3 February 2025 with the following rationale 'strategy development completed. Trusts strategy approved at Board in November 2024, implementation plan in progress to ensure continued internal and external collaboration and engagement as the Trust aligns to the agreed priorities and deliverables. Risk closed'

New risks to be added to the organisational risk register

The following risks have been approved to go onto the organisational risk register by the Executive committee for quality and risk and will be included in the register submitted to the next meeting:

Risk ID	Risk Description - Cause	Risk Description - Risk	Risk Description - Effect	Initial Rating
Risk 00000125	Due to lack of an SLA with a mental health provider	There is a risk that patients suffering a mental health crisis or requiring mental health support whilst undergoing an inpatient stay may not get the help they need	Which may result in inappropriate transfers of care or inability to provide targeted interventions that improve the patient's recovery and rehabilitation	12
Risk 00000132	Due to competing internal and external priorities, such as internal organisational priorities, financial resources, adherence to planning guidance priorities	There is a risk that the implementation of the QVH strategy is delayed or unable to progress	Which may result in failure to deliver the QVH strategy, reputational impact, uncertainty for the future direction or financial impact	15
Risk 00000137	Due to the trusts underlying financial position and changes to financial regime (particularly elective care)	There is a risk that the trust will not be able to submit a breakeven plan for 2025/2026	Which may result in financial limitations, loss of financial autonomy, challenges to deliver strategy	16

Recommendation

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

Risk ID	Risk Description - Cause	Risk Description - Risk	Risk Description - Effect	Initial Rating	Current Rating	Target Rating	Target Date	Owner	Handler	Child Controls	Actions	Actions completed	Actions Outstanding	Comments
Risk 00000011	Due to ineffective communication or a breakdown in trust	There is a risk that there may be a breakdown in the effective working relationship between the Board and the Council of Governors	Which may result in further formal regulatory action impacting on the reputation and sustainability of the Trust	15	12	8	31/03/2025	Leonora May	Leonora May	Code of conduct for governors Code of governance for NHS provider trusts Development of Trust strategy People Relationship building between Board and Council of Governors	None identified			
Risk 00000014	Due to a culture of non-compliance with processes and procedures	There is a risk of a non-compliant event involving SFIs or scheme of delegation and reservation of powers	Which may result in regulatory action including fines, adverse publicity or impact to reputation	12	16	8	31/03/2025	Leonora May	Leonora May	Audit and risk committee Scheme of delegation and reservation of powers Standing financial instructions	Board level review of Scheme of delegation and reservation of powers Longer term actions to address wider cultural issues	0	2	
Risk 00000016	Due to the structure and timeframes of the patient pathway	There is a risk that mental capacity assessments are not being routinely undertaken when required	This may result in either absence of valid consent for procedures that are undertaken or procedures being declined without patient having capacity to do so, which may result in patients being unable to continue with treatment or procedure being completed without full compliance with the MCA	20	16	3	28/06/2025	Edmund Tabay	Ian Cruickshank	Awareness training MCA compliance audit MCA lead MCA training for consultants	Repeat the Audit of compliance Set up task and finish group to review processes and patient pathways to identify opportunities MCA training	0	3	Reviewed Risk and residual score after mitigations. Reduced to 16. Policy updated and changes to training. Audit data presented to clinical teams. MCA policy approved, awaiting new MCA document sign off.
Risk 00000017	Due to the potential for individuals not feeling safe to speak up	There is a risk that staff may not speak up with concerns	Which may result in concerns not being addressed leading to patient safety issues, staff safety issues, reputational damage	16	12	4	18/12/2025	Edmund Tabay	Edmund Tabay	Cultural transformation steering group External FTSU Guardian FTSU engagement FTSU policy Monitoring of FTSU referrals	Implement FTSU engagement plan Board engagement plan Organisational culture assessment	0	3	
Risk 00000038	Due to insufficient and inadequate space on Peanut ward to meet the individual care needs of both children who are inpatients and those who need to be seen in an outpatient setting for surgical assessment.	There is a risk that the environment on Peanut ward is not appropriate for children or their families, particularly those with additional needs. There is a further risk that due to limitations in Peanut space that children are alternatively cared for in areas which are not adequately set up for paediatric care and do not have sufficient staff clinically skilled to support the holistic care of children.	Which may result in children's care being compromised by limitations in the physical estate available to support them. This may lead to limitations in access to appropriately trained paediatric staff in an outpatient setting which may compromise individualised care and privacy for children and their families and, potentially impact on safeguarding processes.	16	12	6	16/05/2025	Tamara Everington	Rosie Lindley	Monitoring throughput within ward Process for paediatric admission, stay and discharge Risks to paediatric	Review provision for Paediatrics across QVH (strategic priority for year one)	0	1	Reviewed by Jane Dickson and Tamara Everington. Included risks from Peanut Ward care for inpatients as well as the outpatient risk. Owner changed to TE. Discussed risk and is a cross-directorate risk, therefore more appropriate to add to Organisational Risk Register for organisational oversight. Scheduled for approval at next ECQR on 18/11/24
Risk 00000047	Due to the age and construction of existing electrical cabling and infrastructure on site	There is a risk of multiple failures of the site electrical systems	Which may result in loss of electrics, increased costs for repairs, potential injury to staff due to wiring faults	16	12	6	31/03/2025	Claire Lowe	Claire Lowe	47 Fixed wire	Specification for works to be written	0	1	The estates team have engaged with specialist contractors and consultants and have inspected the electrical infrastructure in more detail, this has enabled the Estates team to upgrade the power availability from the utility company UKPN to 700kva from 400kva at DSS1. Further works are required to upgrade the sub mains switch rooms and cupboards across the site to lower the risk further. Electrical inspections and replacement infrastructure electrical equipment currently being tendered.
Risk 00000048	Due to the lack of a L1 fire alarm system across all areas of the site, faults with existing fire alarm cabling and fire alarm panels	There is a risk that a fire could occur and the fire alarm system may not alert the area(s) appropriately	Which may result in risks to those on site, switchboard not being notified of a fire activation, fire enforcement action, damage to the estate	9	9	4	31/03/2025	Claire Lowe	Claire Lowe	48 Fire alarm system	Fire alarm panels and communication system to be replaced	0	1	Chubb have undertaken significant works on the network cabling that have removed the faults on the fire alarm system, with the sounder circuits working correctly across site at this time of writing Chubb Fire are currently undertaking the installation of a new network cabling system and panel replacement project, this will reduce the risk of fire alarm system failure. The Trust are also undertaking the remaining areas across site to be upgraded to an L1 fire alarm system, with Rowntree being started in January 2025. Upgraded to Organisational Register due to risk score increase Issues with fire alarm system identified on 22/11/24. Current risk score therefore increased and risk slightly re-worded to add in issues with cabling and panels. Fire alarm works underway, estimated completion Feb 25.
Risk 00000049	Due to the incorrect installation of the fire damper system, areas without current coverage, lack of previous maintenance	There is a risk that fire dampers may fail to operate in the event of a fire	Which may result in fire spreading, harm to individuals, loss of services and resulting impacts	15	15	6	31/03/2025	Claire Lowe	Claire Lowe	49 Dampers	Replace and repair dampers	0	1	Surveys complete. Awaiting programme of works
Risk 00000053	Due to the heating and hot water systems running on gas only (no dual fuel capability)	There is a risk that the site suffers a loss of heating and hot water systems in the event of a gas outage	Which may result in the inability to continue to delivery services, financial and reputational impact	15	15	5	31/03/2026	Claire Lowe	Claire Lowe	53 Energy centre	Establish funding for energy centre	0	1	Energy centre required to remove risk
Risk 00000054	Due to the age and condition of some boilers on site, and inability to obtain replacement parts	There is a risk that a boiler might fail and require full boiler replacement	Which may result in financial impact, impact to services and resulting impacts	25	15	4	31/03/2026	Claire Lowe	Claire Lowe	54 Energy Centre 54 Temporary boilers	Seek funding for new energy centre (£4.5m)	0	1	We have installed a 2MW temporary boiler and pipe work system to reduce the risk of failure. Temporary boilers being installed in areas where boilers have failed completely.

Risk 00000073	Due to limited dedicated EPRR resources and skills and experience of trust staff	There is a risk that the trust is unprepared to manage a major incident or business continuity event	Which may result in sustained loss of services, inability to recover from an incident, reputational impact, financial loss, regulatory action	12	8	6	31/03/2026	Kirsten Timmins	Ashley Hunt	EPRR exercising schedule EPRR policy and procedures in place EPRR resources On call rota TNA	Recruitment of substantive EPRR officer	0	1	Risk approved for escalation to the Organisational Risk Register at the ECQR 16/12/24. No changes to current risk score, although JD is currently with HR for evaluation.
Risk 00000077	Due to a larger overall patient waiting list following the pandemic and the increased complexity of patient treatments, fluctuating demand and capacity	There is a risk that patients may come to harm whilst waiting for treatment	Which may result in delayed patient treatment, potential patient harm, reputational impact	15	6	4	31/03/2026	Kirsten Timmins	Victoria Worrell	Waiting list management action plan Weekly access meeting Weekly RTT PTL meeting	Weekly update to COO and CMO	0	1	Risk approved for escalation to the Organisational Risk Register at the ECQR 16/12/24
Risk 00000088	Due to challenges in performance resulting from internal and external factors	There is a risk we fail to deliver compliance with operational and NHS constitutional standards in relation to performance	Which may result in a negative impact in patient outcomes/experience, reputational impact, financial impact	16	12	9	31/03/2026	Kirsten Timmins	Victoria Worrell	88 Policy and training 88 Referral to Treatment monitoring 88 Reporting of data to Sussex ICB 88 Reporting to clinical governance meetings (Plastics) 88 Reporting to weekly system DMO1 and sleep planning meeting Improved operational governance Internal Audit	Cancer Action Plan Waiting List Action Plan	0	2	Risk approved for escalation to the Organisational Risk Register at the ECQR 16/12/24
Risk 00000115	Due to the additional unexpected costs, NHS financial/activity pressures or inability to deliver the activity plan.	There is a risk that the Trust will fail to deliver a breakeven or better position	Which may result in additional financial restrictions and controls being implemented by the ICB or NHSE.	12	12	8	31/03/2025	Jon Bell	Jonathan Wharton	Nationally allocated funding Q4 Cost improvement programme	Complete national funding evaluation Evaluation of cost improvement plans	0	2	
Risk 00000117	Due to the lack of a strategic overview of medical devices across the trust (age, condition etc.) and the lack of a capital replacement plan for Medical Device replacement	There is a risk that our Medical devices may fail to the point where we cannot repair due to age and unavailability of the parts of the device	Which may result in service delivery disruption to our patients	16	12	6	30/07/2025	Edmund Tabay	Jan Somera	117 Finance capital replacement plan 117 Finance planning 117 Medical Devices register	Reinstigated the medical devices under the leadership of the Interim CNO Pull together a tender specification for the medical devices contract Engaging with the current contract supplier Working with contract supplier to ensure that asset register is up to date	1	3	Due to the capital spending for clinical and medical devices this year, the risk score is reduced
Risk 00000121	Due to end of life contract for supplier of Paging system infrastructure and no availability of parts, if the system fails there is no guarantee of repair	There is a risk that the paging system fails, Business continuity response will be instigated but there is no alternative supplier so BC would continue until new supplier is sourced and new system is implemented	Emergency page not received by Resuscitation team	12	12	8	31/03/2025	Kirsten Timmins	Bill Gordon	Ashley Hunt	Scope to understand number of pagers required for emergency response teams Identify alternative supplier for pager solution and place order Scope and agree alternative solution for those not on Resuscitation team Replacement bleep system	1	3	Replacement of bleep system on priority one for purchase by the financial year end

Report cover-page			
References			
Meeting title:	Board of Directors		
Meeting date:	06/03/2025	Agenda reference:	132-25
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 9 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 9 (December 2024) 2024/25.		
Summary of key issues	KSO 1 Outstanding Patient Care There were no concerns noted in the quality metrics for M9 with no never events or serious patient safety investigations reported since the last Board meeting. Data demonstrates deployment of safe staffing in inpatient areas. To support the recording of ethnicity status from patients, A3 methodology has been used to better understand the difficulties in collecting this data and actions are being taken forward. KSO 2 World Class Clinical Services FFT overall positive recommendation rates are high. VTE risk assessment compliance remains above target. Unplanned readmissions to CCU are being evaluated as a part of the national ICNARC data collection process and remain low at 0.9% for 2024/25 with no recurring themes to inform a change in practice. An audit of Mental Capacity Act compliance has illustrated suboptimal practice. Work on policy, process and culture around this is underway. KSO 3 Operational Excellence RTT 18-week performance remains in line with the national benchmark yet deteriorated slightly to 56.1% given the focus on treating the long waiting patients. The trust reported an anticipated increase in the number of patients waiting over 52 weeks; this is due to prioritisation of cancer patients, challenges within breast and skin services, and supporting the wider Sussex system with the treatment of long waiting patients. The number of patients waiting over 65 weeks is forecast to increase further over the next two months, before improvement in March 2025 as patients progress through their treatment pathway. The trust is predicting 50 patients >65 weeks at 31 March 2025 which predominantly sit within breast and skin, and the trust year end position has been communicated to the ICS and Region. Continued efforts are underway to try to reduce the year end long waiting position further. Cancer performance for the Faster Diagnosis Standard achieved the constitutional standard and 62-day cancer performance remained above the 70% planning guidance target. There was an increase in the number of patients waiting over both 62 days and 104 days although late tertiary referrals continues to impact these numbers. Additional capacity is being scheduled to reduce the backlog.		

Diagnostics (DMO1) performance was below 95% target for 2024/25 in M9 primarily due to capacity constraints in the sleep service although still significantly above the national average of 78%.

The trust continued to meet the urgent care 4-hour standard in M9.

The trust reported 104.1% weighted activity against plan in M9 due to lower activity within the December plan compared to previous months.

KSO 4 Financial Sustainability

The trust continues to meet its break-even plan at M9, but this has required the release of £2.1m of non-recurrent benefits. The forecast continues to meet the break-even plan for the year, however there are a number of risks being managed that could impact the position.

Achievement of efficiencies is on plan although this has partly been delivered through non-recurrent savings. The forecast assumes £2m of savings are non-recurrent.

Agency spend reduced in M9 for the third month but remains above the cap year to date.

Capital spend is behind plan partly due to timing related to payments for the Electronic Patient Record and the revised schedule of the development of the Community Diagnostic Centre that will now take place in 2025/26. Agreement has been reached for the funding for the CDC to be moved from this year to 2025/26.

A proposal for utilising the underspend to address high priority digital and medical equipment requirements has been prepared for Board approval.

The system position for M9 is behind plan impacted by deficit positions for East Sussex Healthcare and University of Sussex Hospitals.

KSO 5 Organisational Excellence

Recognising there has been an increase in employee relations cases resulting from people speaking up about poor behaviours, the Wellbeing and Inclusion team, Organisational Development team and People Promise Manager are focussing on culture development across the Trust.

Listening work has been undertaken and continues to take place across directorates, these include team sessions, 1:1s, with learning being shared and specific development interventions put in place.

The Cultural Transformation Steering Group starts in February 2025.

Development work will commence with the Board (Diversity MOT) in February 2025 led by Absolute Diversity.

The Wellbeing and Inclusion team are liaising with community providers to offer Wellbeing MOTs and are commencing menopause cafes.

Major Projects 2024/25

KSO 2 World Class Clinical Services

To implement and optimise an on-site Local Anaesthetic Unit – LAU continues to function and deliver procedures as planned. Phase 2 workstream continues to progress at the pace agreed deliberately at Executive level due to competing priorities for internal resource in BI and Finance to support other major projects. Options for the way forward are being considered and will be aligned to the new planning guidance.

	KSO 3 Operational Excellence <i>To deliver the Community Diagnostic Centre programme</i> – The East Grinstead CDC pre-application has been submitted to the local council and the Planning Pre-application meeting has taken place. The external design will also be reviewed to reduce the visual impact of the facility. Continued engagement meetings with the planning authority have taken place for Bognor. Planning permission will then be submitted in January 2025 for East Grinstead with planning permission expected to be agreed in mid-February 2025. <i>To deliver the Sussex Pathology Network Programme</i> – progress is being made across a number of the work streams although the overall project is running behind schedule at system level. Some work on hold while a reprioritisation process is undertaken <i>To deliver Year 1 of the Electronic Patient Record</i> – following the decision to delay the first phase go-live in November 2024, further work has been carried out regarding finances and benefits realisation and mitigations are being worked through. External factors are also impacting delivery timescales. KSO 5 Organisational Excellence <i>To design and implement a systematic continuous improvement approach across the organisation</i> – yellow belt training sessions are progressing well. Executive training sessions scheduled for January 2025. Benefits realisation framework being developed for the improvements being undertaken.				
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:	KSO2:	KSO3:	KSO4:	KSO5:
	<i>Outstanding patient experience</i>	<i>World-class clinical services</i>	<i>Operational excellence</i>	<i>Financial sustainability</i>	<i>Organisational excellence</i>
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:	03/02/2025, 24/02/2025, 25/02/2025		Decision: N/A
Next steps:		Continue to embed the monthly reporting processes			



Integrated Quality and Performance Report

Month 9 – December 2024



Integrated Quality and Performance Report - Scorecard

Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	LCL	UCL	Summary
Breakeven YTD	Dec 24	£0.0m			£0.0m	£0.0m				
RTT >65 Weeks	Dec 24	0			73	47	61.54	13.66	109.42	Common cause - no significant change
% Overall FFT Recommendation Rate	Dec 24	90%			95.8%	96.2%	95.64	94.00	97.28	Common cause - no significant change
Ethnicity recording	Dec 24	95%			81.4%	81.7%	78.70	75.36	82.04	Special cause improving
Smoking Status	Dec 24	95%			99.2%	99.6%	98.88	97.63	100.14	Common cause - no significant change

Major Projects

Major Project	This Month	Overall Status	Last Month	Summary
To implement and optimise an on-site Local Anaesthetic Unit		Off track but mitigations in place		Phase 2 workstream progressing. Draft options paper in development
To deliver the Community Diagnostic Centre programme		QVH on track Bognor behind plan		Planning permission to be submitted Jan '25 for EG and Feb '25 for Bognor
To deliver the Sussex Pathology Network programme		Off track but mitigations in place		Part of wider system project for multiple projects
To implement year one of the Electronic Patient Record		Risk to delivery of plan		First phase go-live delayed. Finance and external factors impacting timelines
To design and Implement a systematic continuous improvement approach across the organisation		On track		Implementation going well



Integrated Quality and Performance Report - Summary

December 2024

KSO 1 Outstanding Patient Experience

No concerns noted in the Quality metrics.

No improvement noted in ethnicity recording compliance. A3 methodology has been used to better understand the causes of non completion of data, actions are being taken forward.

1 inpatient fall, low harm. Investigation completed.

Zero reportable pressure ulcers.

Data demonstrates deployment of safe staffing in inpatient areas.

12 medical emergency calls resulting in 3 transfers out, and one admission to CCU. 10 no/low harm, 2 unknown harm as awaiting investigation.

2 reportable hospital acquired infections.

KSO 2 World Class Clinical Services

FFT overall positive recommendation rates are high.

VTE risk assessment compliance remains above target

Unplanned readmissions to CCU are being evaluated as a part of the national ICNARC data collection process and remain low at 0.9% for 24/25 with no recurring themes to inform a change in practice

An audit of Mental Capacity Act compliance has illustrated suboptimal practice. Work on policy, process and culture around this is underway.

KSO 3 Operational Excellence

RTT 18-week performance remains in line with the national benchmark yet deteriorated slightly to 56.1% given the focus on treating the long waiting patients. The trust reported an anticipated increase in the number of patients waiting over 52 weeks; this is due to prioritisation of cancer patients and supporting the wider Sussex system with the treatment of long waiting patients. The number of patients waiting over 65 weeks is forecast to increase further over the next two months, before improvement in March 2025 as patients progress through their treatment pathway.

Cancer performance for Faster Diagnosis Standard performance achieved the constitutional standard and 62-day cancer performance remained above the 70% planning guidance target. There was an increase in the number of patients waiting over both 62 days and 104 days although late tertiary referrals continues to impact these numbers. Additional capacity is being scheduled to reduce the backlog.

Diagnostics (DM01) performance was below 95% target for 2024/25 in M9 primarily due to capacity constraints in the sleep service, although significantly above the national average of 78%.

The trust continued to meet the urgent care 4-hour standard in M9.

The trust reported 104.1% weighted activity against plan in M9.

Theatre productivity was 2.4% in M9 which was impacted by staff sickness and annual leave over the festive period.

KSO 4 Financial Sustainability

The trust continues to meet its break-even plan and is forecasting to achieve break-even at the year end using non-recurrent measures, although a number of risks identified could impact the position. Achievement against the Elective Recovery Fund target is slightly behind plan and to deliver the plan will require overperformance against plan for the remaining months. Agency spend reduced in Month 9 but remains above the cap year to date. Efficiency plans are on target although £1.2m is being delivered non-recurrently.

Capital spend continues to be behind plan mainly due to timing of payments for the EPR and the revised schedule for delivery of the Community Diagnostic Centre. A proposal for using the underspend to accelerate medical equipment and digital priorities will be presented to the Board.

KSO 5 Organisational Excellence

The Wellbeing and Inclusion team is working with EDI Champions to advocate for inclusion and to co-design culture and inclusion work going forward, with a resource pack shared to help champions develop in their roles. In addition to the new Employee Assistance programme 'Vivup' the team are liaising with community providers to offer Wellbeing MOTs and will commence Menopause Cafes to broaden QVH's wellbeing offer in 2025.

The Employee Relations team is currently advising on 32 cases, in line with trust policy.

Appraisal rates continue to be an area of focus, targeting those whose appraisal is more than three months overdue.

December 2024

KSO 2 World Class Clinical Services

To implement and optimise an on-site Local Anaesthetic Unit – LAU continues to function and deliver procedures as planned. Phase 2 workstream continues to progress at the pace agreed deliberately at Executive level due to competing priorities for internal resource in BI and Finance to support other major projects. A paper is being drafted for ELT setting out the options for the way forward and will be aligned to new planning guidance.

KSO 3 Operational Excellence

To deliver the Community Diagnostic Centre programme – The East Grinstead CDC pre-application has been submitted to the local council and the Planning Pre-application meeting has taken place. The external design will also be reviewed to reduce the visual impact of the facility. Continued engagement meetings with the planning authority have taken place for Bognor. Planning permission will then be submitted in January 2025 for East Grinstead with planning permission expected to be agreed in mid-February 2025.

To deliver the Sussex Pathology Network Programme – progress is being made across a number of the work streams although the overall project is running behind schedule at system level. Some work on hold while a reprioritisation process is undertaken

To deliver Year 1 of the Electronic Patient Record – following the decision to delay the first phase go-live in November 2024, further work has been carried out regarding finances and benefits realisation and mitigations are being worked through. External factors are also impacting delivery timescales.

KSO 5 Organisational Excellence

To design and implement a systematic continuous improvement approach across the organisation – yellow belt training sessions are progressing well. Executive training sessions scheduled for January 2025. Benefits realisation framework being developed for the improvements being undertaken.

KSO1 Outstanding Patient Care 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

- 1.95% ethnicity recording
- 2.95% smoking status recording

 CareQuality
Commission

The Queen Victoria Hospital (East Grinstead)

CQC overall rating

Good ●

23 May 2019



Overview

No improvement noted with Ethnicity recording, A3 has been completed and a work plan agreed. Further data has highlighted areas for improvement.

1 fall reported, patient reported a fall in the carpark prior to admission, no harm noted.

Smoking status compliance remains stable.

100% complaints responded to on time, work continues to improve response times and involvement from the directorate teams. The response target is currently 45 days and discussions are underway to reduce this.

Deployment of safe staffing in all inpatient areas noted.

2 reportable hospital acquired infections – One C.Diff infection attributable to QVH although deemed unavoidable, due to bowel management system in place and high antibiotic usage. One MSSA positive infection, root cause analysis completed and cause of bacteraemia from wound swabs.

Zero never events or formal patient safety investigations commenced.

One open CAS alert – not relevant for this Trust, awaiting executive sign off.

Positive Assurance/Improvements

Patient complaint responses within planned response time.

Challenges

Delay to the start of ethnicity recording improvements.

2 reportable hospital acquired infections.

Mitigations and Actions

Further deep dive into the monthly data for recording ethnicity has been completed . Action plan compiled. Aim to achieve target by end March 2025

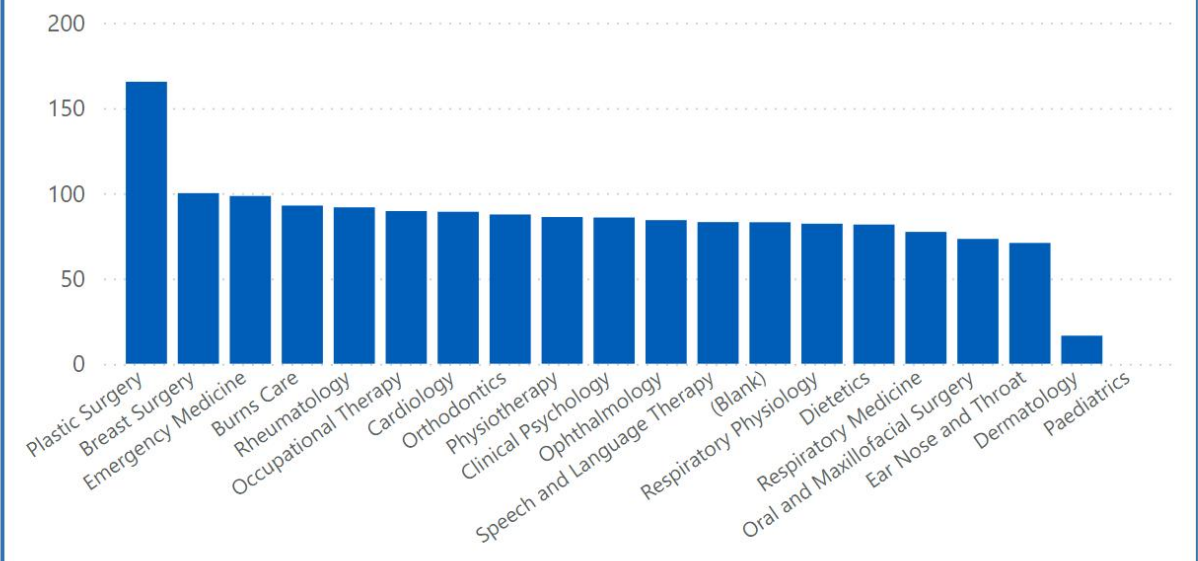
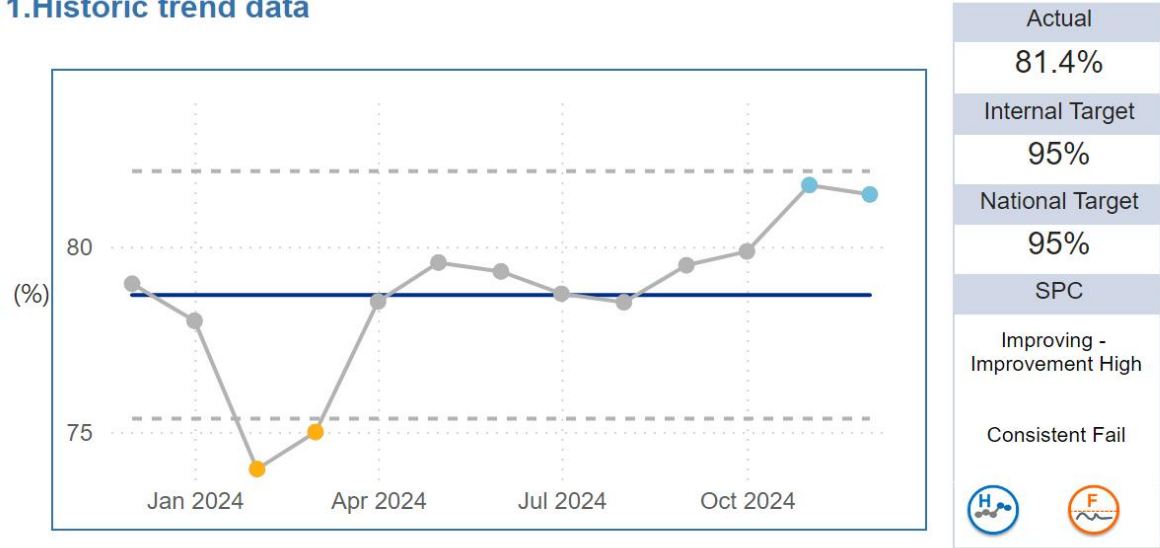
All testing and actions as per policy.

KSO1 Outstanding Patient Care - Scorecard

Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	UCL	LCL	Summary
Ethnicity recording	Dec 24	95%			81.4%	81.7%	78.70	82.04	75.36	Special cause improving
Smoking Status	Dec 24	95%			99.2%	99.6%	98.88	100.14	97.63	Common cause - no significant change
Falls per 1,000 Occupied Bed Days	Dec 24	7			1.3	1.1	3.34	10.69	-4.00	Common cause - no significant change
Hospital Aquired PU Per 1,000 Occupied Bed Days	Dec 24	0			0.0	2.1	0.44	2.45	-1.58	Common cause - no significant change
% Complaints Responded On Time	Dec 24	70%			100.0%	100.0%	95.35	117.70	73.01	Common cause - no significant change
Safer Staffing Compliance	Dec 24	90%			99.6%	99.4%	99.56	100.29	98.83	Common cause - no significant change

Metric	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Number of Complaints	4	7	1	2	12	6	3	9	3	5	7	4	5
Number of Open CAS Alerts	2	2	2	1	2	2	2	3	2	2	1	0	1
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient safety incident investigations (Internal)	0	0	0	0	1	0	1	1	0	0	0	0	0
Patient safety incident investigations (External)	0	0	0	0	0	0	0	0	0	0	0	0	0
Mortalities	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital Acquired CDI, MRSA, E.Coli, MSSA	0	0	0	0	0	1	0	0	0	0	1	1	2
Oliver McGowan Training Compliance	67.6%	75.4%	80.5%	83.0%	87.5%	89.4%	90.5%	91.9%	92.5%	92.8%	92.2%	92.1%	92.2%

1.Historic trend data



3.Top Contributors

1. There is low opportunity to improve MIU recording, about 70 patients per month
2. Medium impact opportunity with inpatients about 500 per month
3. The highest impact opportunities sit within outpatients, as there are 3277 unrecorded ethnicity activities in October 2024, where the total target is an improvement of 2850 per month, the majority of this improvement is likely to come from outpatients.

In outpatient, the highest recording gaps were as follows:

Specialty	Oct-24
PS - Plastic Surgery	1,331
MF - Maxillo Facial	484
Corneo, Occulo, Glaucoma	382
Therapies - OT, PT, SALT, Dietetics	369
OD - Orthodontics	256
SS - Sleep Medicine	144

Root causes of collection gaps have initially been identified as follows;

- Training and understanding for staff on why we are asking, feeling comfortable to ask, and patients' comfort levels in understanding why they need to share
- Where data does not come through at referral, it is then either not captured at first appointment, or captured on paper and not transferred to digital record

4.Action Plan

Actions	Target Date
---------	-------------

- Standardised patient check-in process including ethnicity capture at all plastics, eyes, MaxFac and therapies receptions
- Create and deliver training for receptionists and cancer team on how and why to ask for patients' ethnicity
- Design a poster for patients explaining why we may ask for sensitive information
- Understand which teams capture ethnicity on paper without transferring to digital record at 1st appointment & address process steps. Orthodontics & Therapies.
- Add columns in Patient Centre which show the status of recording which can be added to different search results e.g. patient search, clinic lists, waiting lists

Smoking Status		Reporting Month: Dec 24	Executive Lead: CNO																										
1.Historic trend data Actual 99.2% Internal Target 95% National Target 95% SPC Common Cause Consistent Pass P <table><tr><th>Month</th><th>Actual (%)</th></tr><tr><td>Jan 2024</td><td>97.8</td></tr><tr><td>Feb 2024</td><td>96.5</td></tr><tr><td>Mar 2024</td><td>99.0</td></tr><tr><td>Apr 2024</td><td>99.2</td></tr><tr><td>May 2024</td><td>98.3</td></tr><tr><td>Jun 2024</td><td>98.2</td></tr><tr><td>Jul 2024</td><td>98.5</td></tr><tr><td>Aug 2024</td><td>100.0</td></tr><tr><td>Sep 2024</td><td>100.0</td></tr><tr><td>Oct 2024</td><td>100.0</td></tr><tr><td>Nov 2024</td><td>99.5</td></tr><tr><td>Dec 2024</td><td>99.2</td></tr></table> 100 50 0 Ear Nose and Throat Oral and Maxillofacial Surgery Plastic Surgery Ophthalmology Paediatric Surgery Physiotherapy		Month	Actual (%)	Jan 2024	97.8	Feb 2024	96.5	Mar 2024	99.0	Apr 2024	99.2	May 2024	98.3	Jun 2024	98.2	Jul 2024	98.5	Aug 2024	100.0	Sep 2024	100.0	Oct 2024	100.0	Nov 2024	99.5	Dec 2024	99.2	3.Top Contributors Nil to report, target achieved. Worthy of note this data relates to elective patients only	
Month	Actual (%)																												
Jan 2024	97.8																												
Feb 2024	96.5																												
Mar 2024	99.0																												
Apr 2024	99.2																												
May 2024	98.3																												
Jun 2024	98.2																												
Jul 2024	98.5																												
Aug 2024	100.0																												
Sep 2024	100.0																												
Oct 2024	100.0																												
Nov 2024	99.5																												
Dec 2024	99.2																												
4.Action Plan Actions Target Date																													

KSO1 Outstanding Patient Care - Watch Metric



Actual	SPC
99.6%	Common Cause
Internal Target	Consistent Pass
90%	 
National Target	
90%	

Day	Planned Staff			Actual Staff			Night
	RN	NA	HCA	RN	NA	HCA	
	5295.75	92	2300	5261.25	92	2300	
				99.30%	100.00%	100%	
	7687.75			7653.25			
				99.6%			
Total Hours							
% Planned Hrs Met							
Total Hrs Planned & Actual - Combined Reg & Support							
% Planned Hrs Met - Combined Reg & Support							

Planned Staff			Actual Staff			Night
RN	NA	HCA	RN	NA	HCA	
3634	115	1092.5	3622.5	115	1092.5	
			99.7%	100.0%	100.0%	
4841.5			4830			
			99.8%			

Current Position	Issues	Actions & Timelines
Safe staffing deployed throughout the inpatient areas.	None identified.	Temp staffing oversight group in place Revised policies and SOPs in pace for booking agency and bank in nursing.

KSO2 World Class Clinical Services Ambition

*We will deliver excellent clinical
and patient outcomes*

Board Assurance Framework

- 01 Patient services
- 02 Workforce strategy
- 03 Physical infrastructure
- 04 Long term sustainability
- 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*)



Overview

FFT recommendation rate remains above the internal target for paediatrics, inpatient areas, outpatient areas and MIU.

VTE risk assessment compliance remains above target.

A baseline audit of PROMS data collection across services is underway with evidence for work in all therapies, trauma, breast and facial palsy to date. Further evidence is being sought. The need for a reporting database such as RedCAP is clear.

Unplanned readmissions to CCU are being evaluated as a part of the national ICNARC data collection process and remain low at 0.9% for 24/25 with no recurring themes to inform a change in practice.

There are 2 inquests pending with the first due 5-7 February 2025. Evaluation of deaths following transfer out of 2 patients with complex conditions has been completed through an SJR (Summary Judgement Review) form completed by a senior clinician. Identified learning is being shared through governance channels. Ongoing review of patients who have died within 30 days of QVH and in relation to care through the sleep service. No significant concerns identified.

A new process to improve safeguarding around children who miss appointments (Was not brought – WNB) has been implemented and will be regularly monitored.

An audit of Mental Capacity Act compliance has illustrated suboptimal practice. Work on policy, process and culture around this is underway.

Positive Assurance/Improvements

The Better Together strategy is being revisited by the Engagement Team to include it within the Trust's engagement strategy.

The Datix system has an additional category of Patient Experience incidents - 'learning from' meetings triangulate data from incidents, informal and formal complaints, FFT, new claims, and activity within the management of violence and aggression.

Challenges

The RedCAP database is being locally installed in Q4 to support future PROMs data capture however this was an unfunded project and is competing with other demands on IT resource.

A CQC report has been submitted around equipment faults which have required repeat radiation exposure for a small number of patients. Work is underway with the equipment suppliers & other stakeholders to address this. The ongoing risk is on the risk register.

Mitigations and Actions

Work required to complete RedCAP installation & configuration in progress.

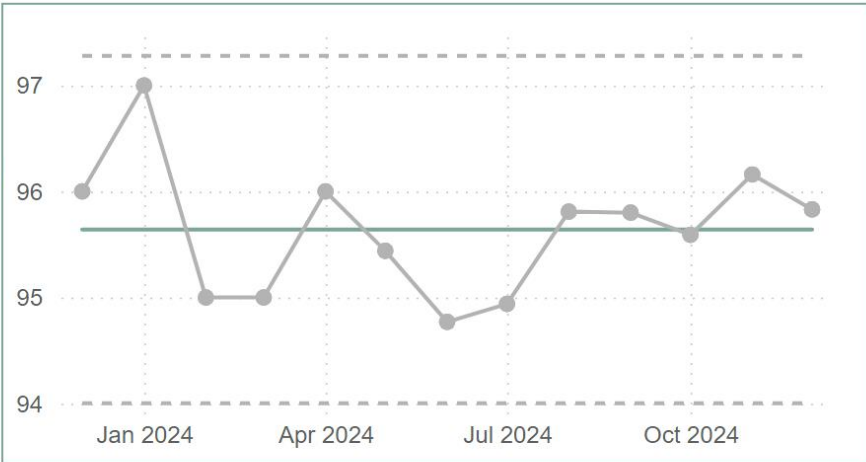
Baseline PROMS evaluation is underway.

Work to improve understanding and compliance with MCA is underway.

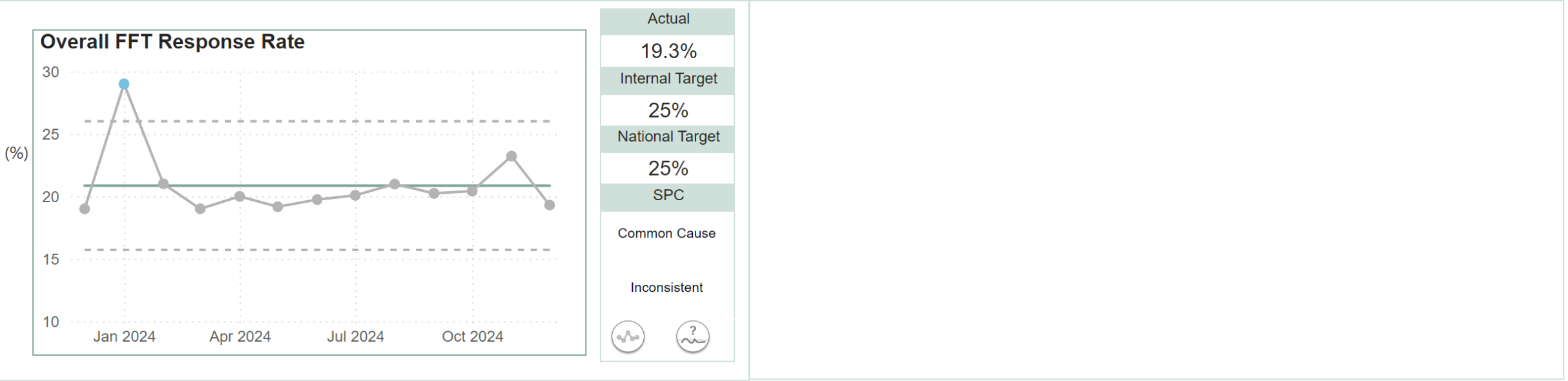
KSO2 World Class Clinical Services - Scorecard

Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	LCL	UCL	Summary
% Overall FFT Recommendation Rate	Dec 24	90%	🟡	🟢	95.8%	96.2%	95.64	94.00	97.28	Common cause - no significant change
Overall FFT Response Rate	Dec 24	25%	🟡	🟡	19.3%	23.2%	20.86	15.71	26.00	Common cause - no significant change
FFT Recommendation Rate - Inpatients	Dec 24	90%	🟡	🟢	99.3%	100.0%	99.68	98.22	101.14	Common cause - no significant change
FFT Response Rate - Inpatients	Dec 24	25%	🟡	🟡	43.4%	36.8%	43.10	22.86	63.34	Common cause - no significant change
FFT Recommendation Rate - Inpatients Children	Dec 24	90%	🟡	🟢	100.0%	100.0%	99.13	95.39	102.88	Common cause - no significant change
FFT Response Rate - Inpatients Children	Dec 24	25%	🟡	🟡	10.7%	24.7%	18.81	-2.47	40.09	Common cause - no significant change
FFT Recommendation Rate - MIU	Dec 24	90%	🟡	🟡	94.3%	94.6%	92.14	85.33	98.95	Common cause - no significant change
FFT Response Rate - MIU	Dec 24	25%	🟡	🟡	18.5%	21.5%	19.62	13.28	25.96	Common cause - no significant change
FFT Recommendation Rate - Outpatients	Dec 24	90%	🟡	🟢	95.2%	95.6%	95.41	94.47	96.35	Common cause - no significant change
FFT Response Rate - Outpatients	Dec 24	25%	🟡	🟡	17.2%	19.5%	17.37	14.35	20.39	Common cause - no significant change
Readmissions< 30 Days	Dec 24	2%	🟡	🟡	2.4%	1.5%	2.32	0.33	4.30	Common cause - no significant change
VTE Risk Assessment	Dec 24	95%	🟡	🟡	97.2%	97.9%	97.45	93.22	101.68	Common cause - no significant change
Medication Incidents (No and low harm)	Dec 24				7	18				
Medication Incidents (Moderate harm or above)	Dec 24				0	0				
Medication Incidents (Harm unknown at time of reporting)	Dec 24				3	3				

KSO2 World Class Clinical Services - Annual Goal

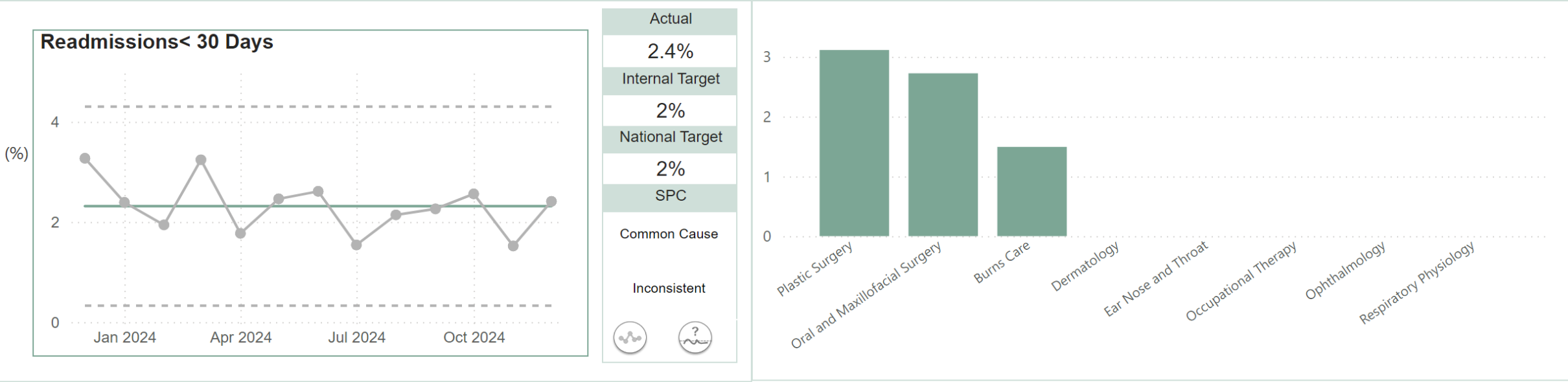
% Overall FFT Recommendation Rate		Reporting Month: Dec 24	Executive Lead: CMO												
1.Historic trend data <table><tr><td>Actual</td><td>95.8%</td></tr><tr><td>Internal Target</td><td>97%</td></tr><tr><td>National Target</td><td>90%</td></tr><tr><td>SPC</td><td>90%</td></tr><tr><td>Common Cause</td><td></td></tr><tr><td>Consistent Pass</td><td></td></tr></table>		Actual	95.8%	Internal Target	97%	National Target	90%	SPC	90%	Common Cause		Consistent Pass		2.Stratified data Our FFT recommendation rate remains above both the internal and external target of 90%.	
Actual	95.8%														
Internal Target	97%														
National Target	90%														
SPC	90%														
Common Cause															
Consistent Pass															
3.Top Contributors Ongoing encouragement to increase responses in all areas. Content themes shared with directorates and at patients experience meeting to inform improvements.		4.Action Plan <table><tr><th>Actions</th><th>Target Date</th></tr><tr><td>A detailed review of incidents relating to patient transport has been requested and actions identified will be taken forward</td><td>End Feb 2025</td></tr></table>		Actions	Target Date	A detailed review of incidents relating to patient transport has been requested and actions identified will be taken forward	End Feb 2025								
Actions	Target Date														
A detailed review of incidents relating to patient transport has been requested and actions identified will be taken forward	End Feb 2025														

KSO2 World Class Clinical Services - Watch Metric



Current Position	Issues	Actions & Timelines
No significant change.		

KSO2 World Class Clinical Services - Watch Metric



Current Position	Issues	Actions & Timelines

KSO2 World Class Clinical Services – 2024/25 Major Projects

Local Anaesthetic Unit	Executive Lead: CNO Lead:	Reporting Month: Dec 24	Overall Status: 
The LAU project is split into three Phases. 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. Given significant project risks and the need for an experienced project manager to lead in the development of the business case, the Trust agreed to pause Phase 2 of the project in mid-June. LAU activities from Phase 1 continue to be delivered. Progress to date • Identify the type of procedures to move to the future LAU – completed with MaxFac & Plastics GMS • Identify the number of procedures to be moved to the future LAU; completed • Model activity and income, main theatres session release, model staffing requirements – in progress • Equipment and infrastructure that would be needed – in progress nearing completion			

Milestones	Planned Date	Actual/Forecast Date	Commentary
Identification of appropriate data	30/09/24	30/11/24	Complete
Phase 1 evaluation report	04/10/24	04/10/24	Complete.
Development of Phase 2 project plan	04/10/24	04/10/24	Draft project plan with timelines to deliver paper on way forward.
Est of workstreams to support Phase 2 needs assessment	04/10/24	04/10/24	Work streams established.
Paper on way forward	30/11/24	17/02/25	Pending ongoing modelling activity.

Risks / Issues	Description	Mitigating Action
Availability of data	Adequate data to make appropriate decisions about Phase 2 and 3	Engagement with Business Intelligence, Operations and Finance to get robust demand capacity modelling.
Delivery expectations	Varying expectations as to outcomes from the project	Discussions with teams across the trust to understand views and communicate project scope, objectives and deliverables.

KSO3 Operational Excellence

Ambition

We will deliver timely and efficient care for our patients

Board Assurance Framework

- 01 Patient services
- 02 Workforce strategy
- 03 Physical infrastructure
- 04 Long term sustainability
- 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*)



Overview

RTT performance: The trust’s 18-week performance remains in line with the national benchmark yet deteriorated slightly to 56.1% given the focus on treating the long waiting patients passed 18 weeks. The trust reported an anticipated increase in the number of patients waiting over 52 weeks; this is due to prioritisation of cancer patients and supporting the wider Sussex system with the treatment of long waiting patients. The number of patients waiting over 65 weeks is forecast to increase further over the next two months, before improvement in March 2025 as patients progress through their treatment pathway.

Cancer performance: The trust has experienced a 12.9% increase in the number of Urgent Suspected Cancer referrals when compared to the prior year. Faster Diagnosis Standard performance achieved the constitutional standard of 75% in M9 and the 62-day cancer performance remained above the 70% planning guidance target. The trust reported an increase in the number of patients waiting over both 62 days and 104 days, with an anticipation that these positions will continue to deteriorate until M10, given patient choice over the festive period and complex surgical pathways. 31-day performance deteriorated in month and actions are being worked through to address this.

Diagnostics (DM01): The trust’s DM01 position was 89.1% in M9, which was below the 95% target outlined in 2024/25 planning guidance, yet significantly higher than the national benchmark. The deterioration in M9 was primarily driven by capacity constraints in Sleep services given staff sickness, maternity leave and vacancy factors.

Outpatient productivity: M9 performance of 42.4% remains consistent with the past 12 months; however, additional work will be required to meet the 46% planning target. Utilisation of the Patient Initiated Follow Ups (PIFU) service continued to exceed the 2% target set locally. Missed appointment rate remains steady, including spoke site data.

Theatre productivity: QVH achieved 82.4% capped elective theatre utilisation in M9 which was an anticipated decrease on the prior month due to staff sickness and annual leave over the festive period.

Income: The trust reported 104.1% against plan in M9.

Positive Assurance/Improvements

RTT performance: The proportion of trust patients waiting over 65 weeks is 0.24%, which is similar to the national position (0.22%), and compares favourably to the overall Sussex position (1.17%). The trust continues to support the wider Sussex position to treat long waiting patients.

Cancer performance: M8 FDS performance achieved 81.3% overall (constitutional standard 75%), and 62-day performance achieved the cancer planning guidance target of 70%.

Diagnostics (DMO1): The trust’s performance continues to be significantly higher than regional and national averages.

Outpatient productivity: PIFU utilisation performance (2.54%) exceeded the 2% local target; identification of improvement opportunities to reduce missed appointment rates.

Theatre productivity: consistently met the target for elective early finishes since July 2023.

Challenges

RTT performance: the prioritisation of cancer performance and supporting the wider Sussex system is impacting RTT performance.

Cancer performance: constraints in theatre and clinic capacity; reduction in consultant workforce; administrative delays; complex diagnostic and treatment pathways.

Diagnostics (DMO1): underperformance in overnight Sleep procedures, exacerbated by the inability to outsource these diagnostic tests.

Outpatient productivity: not yet achieving the 46% national target; challenging utilisation of PIFU pathways due to complex conditions; work required to understand and reduce the rate of missed appointments.

Mitigations and Actions

RTT performance: Significant internal focus on long waiting position, with additional activity being scheduled to reduce the number of patients waiting over 65 weeks.

Cancer performance: demand and capacity analysis for each service; staff recruitment to cover workforce gaps; pathway re-design opportunities following Head and Neck analysis.

Diagnostics (DMO1): review of the Sleep waiting list; pathway transformation work.

Outpatient productivity: exploration into further productivity opportunities, particularly around PIFU.

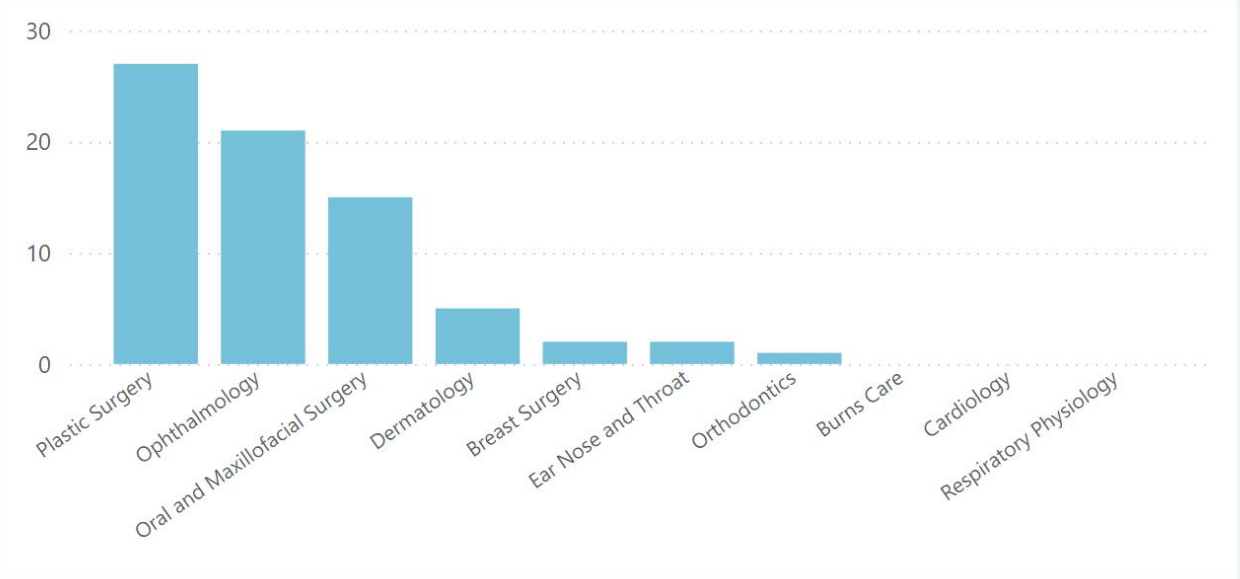
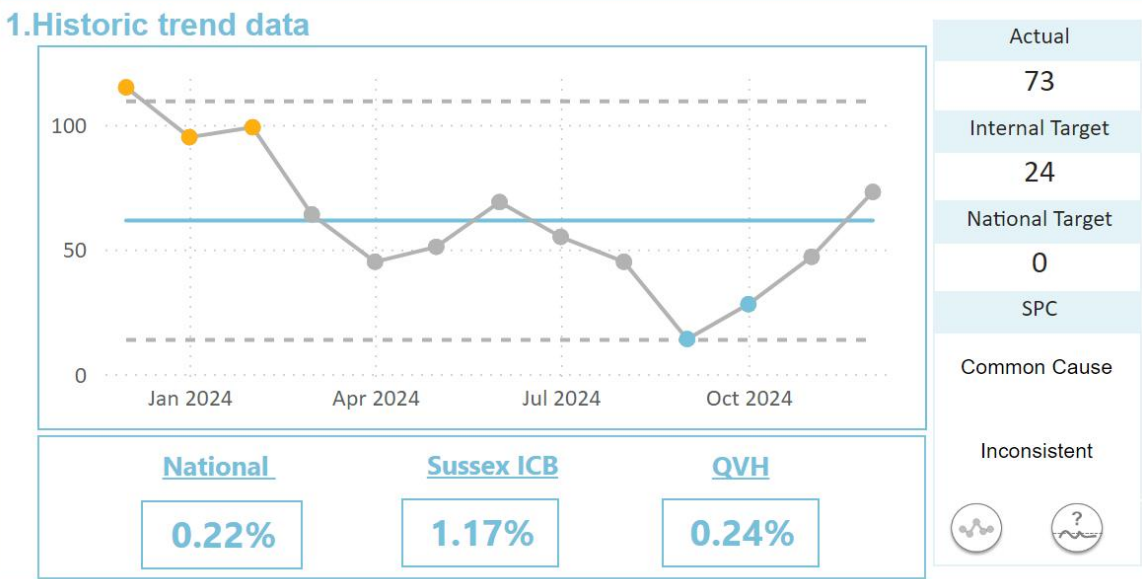
KSO3 Operational Excellence - Scorecard

Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	UCL	LCL	Summary
RTT >65 Weeks	Dec 24	0			73	47	61.54	109.42	13.66	Common cause - no significant change
RTT 18 Week Wait Performance	Dec 24	92%			56.1%	57.3%	58.83	61.50	56.16	Special cause worsening
RTT Waiting List	Dec 24				19592	19401	18,572.23	19,092.04	18,052.42	Special cause worsening
RTT >78 Weeks	Dec 24	0			12	7	7.92	17.68	-1.83	Common cause - no significant change
RTT >104 Weeks	Dec 24	0			0	0	0.00			Special cause worsening
% Income Vs Plan	Dec 24	100%			104.1%	93.6%	100.41	118.92	81.90	Common cause - no significant change
Cancer 28 Day FDS	Nov 24	75%			81.3%	83.6%	84.18	93.15	75.22	Common cause - no significant change
Cancer 31 Days	Nov 24	96%			83.2%	90.9%	88.07	96.49	79.64	Common cause - no significant change
Cancer 62 Days	Nov 24	85%			74.8%	79.5%	78.93	97.55	60.32	Common cause - no significant change
Cancer Waits > 62 Days	Dec 24	32			105	86	60.31	84.91	35.70	Special cause worsening
Cancer Waits > 104 Days	Dec 24	3			32	29	16.31	25.17	7.44	Special cause worsening
Diagnostics 6 Week Wait Performance	Dec 24	99%			89.1%	92.3%	93.43	98.41	88.45	Common cause - no significant change
MIU 4 Hour Performance	Dec 24	95%			99.6%	99.1%	99.25	100.70	97.80	Common cause - no significant change
% of 1st & Outpatient Procedure Appointments	Dec 24	46%			42.4%	42.0%	42.93	44.88	40.98	Common cause - no significant change
Theatre Elective Utilisation - QVH Site (Capped)	Dec 24	85%			82.4%	86.4%	82.77	88.21	77.33	Common cause - no significant change

RTT >65 Weeks

Reporting Month: Dec 24

Executive Lead: COO



3.Top Contributors

The trust reported an increase in the number of patients waiting over 65 weeks in M9, with 26 of the 73 patients being transfers from within the wider Sussex system. The trust continued to perform in line with the national average for the proportion of patients on the overall waiting list that have been waiting longer than 65 weeks (0.24%).

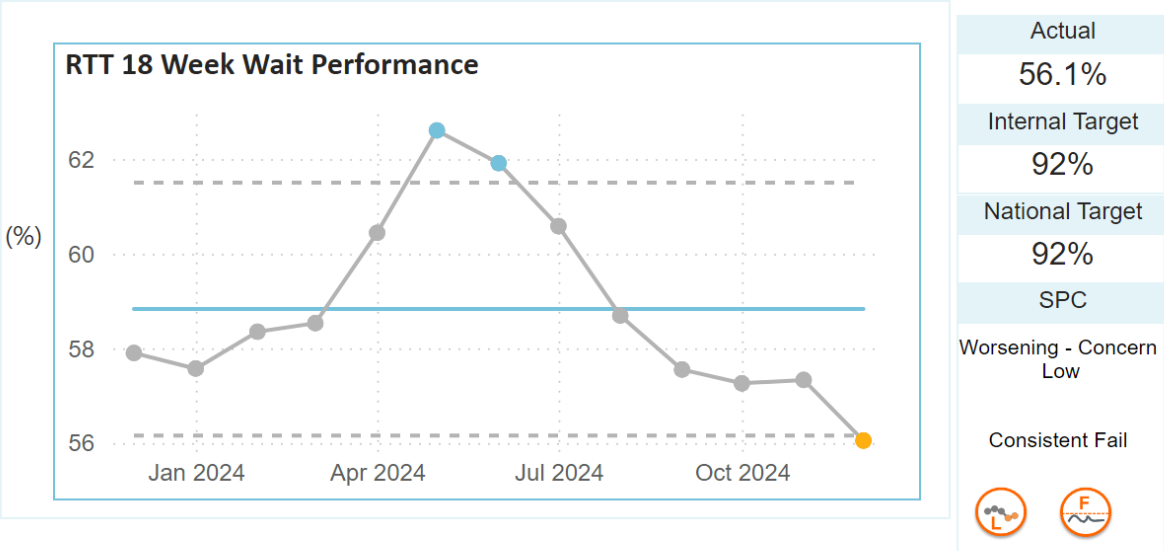
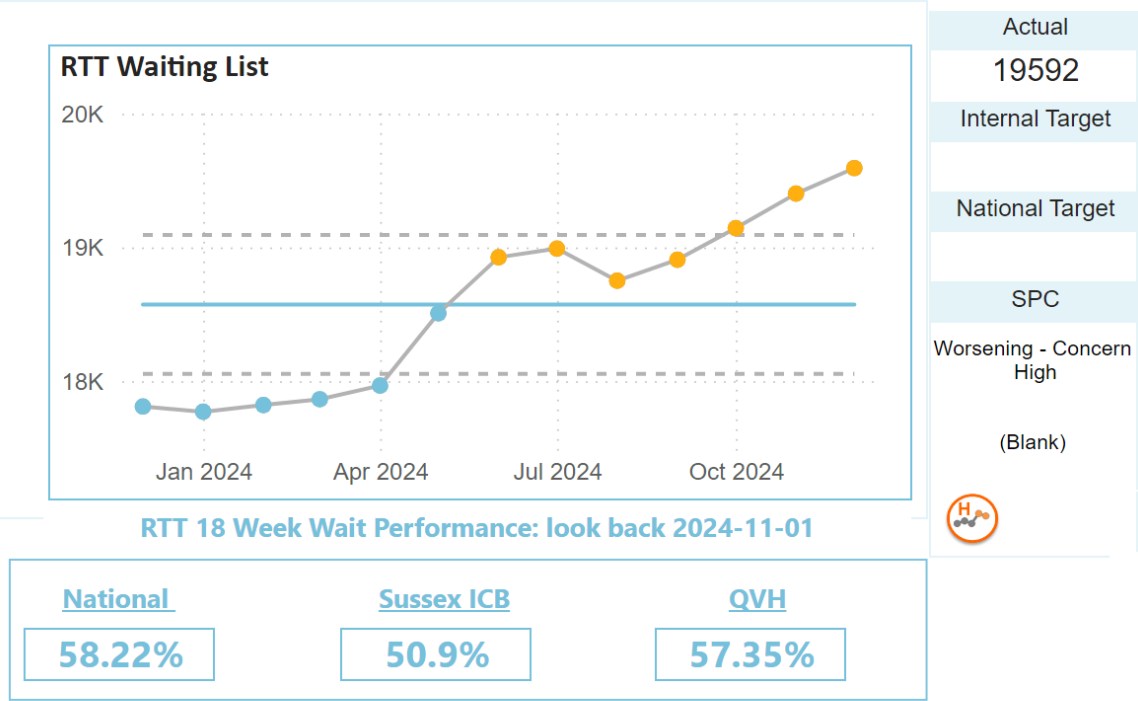
The trust’s M9 position was impacted by a number of ongoing challenges:

1. Increased Urgent Suspected Cancer (USC) referrals
2. Increased demand for immediate breast surgery (on a cancer pathway), which has reduced the theatre and staffing capacity to treat long waiters in Breast
3. Complexities in the treatment of Corneo transfers, with the need for some patients to attend additional clinic appointments before scheduling
4. Late tertiary sleep referrals that are received as diagnostic only but can require conversion to treatment. Following decision to treat, QVH are responsible for subsequent reporting.

4.Action Plan

Actions	Target Date
Twice weekly executive oversight of patients at risk of >65 weeks to track progress and unblock issues.	
Successful recruitment into the B5 system co-ordinator vacancy (6-month fixed term post to support Sussex transfers) who has now commenced employment in the position.	
Super Saturday list booked in January 2025 to support the treatment of patients requiring skin procedures.	
To address workforce gaps and increase capacity, recruitment has occurred in: Plastics – locum Breast consultant (commencing M11), and locum Skin consultant (commencing M10); Head and Neck – consultant (commencing M10), and ongoing recruitment to OMFS registrar / fellow posts.	

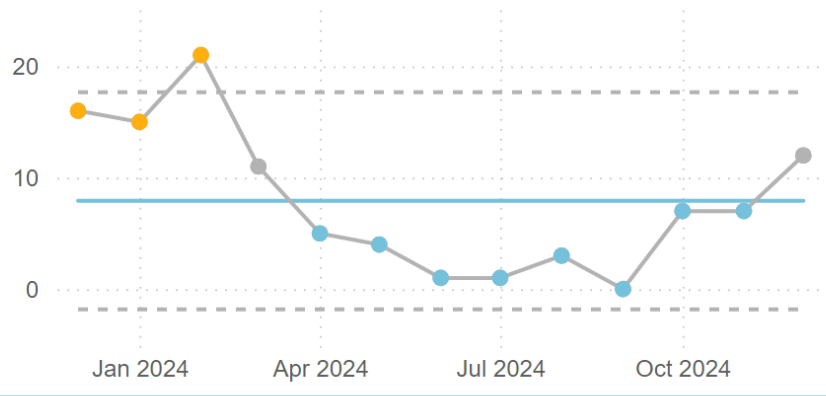
KSO3 Operational Excellence - Watch Metric



Current Position	Issues	Actions & Timelines
RTT waiting list: The trust reported an increase in the total number of incomplete pathways; M9 saw an increase of 191 patients with a total RTT backlog of 19,592. The increased number of incomplete pathways was primarily driven by Sleep. 18 week wait: The trust's 18 week performance has remained in line with the national average. However, the prioritisation to treat those waiting over 52 weeks has meant fewer patients are treated within 18 weeks, leading to a gradual deterioration in performance.	Improved clock stop data related to spoke sites would support full waiting list analysis. M9 12 week validation performance was 35.4% due to limited resources and RTT staff sickness over the festive period. Increased validation is an area of opportunity and is being reviewed as part of Business Planning.	Business Intelligence Unit to collect comprehensive clock start / stop data, broken down by site and specialty level. Ongoing actions to improve the trust's 12 week validation position include: 12 week 'flag' that highlights patients requiring validation - Development of a PowerBI dashboard to monitor validation performance regularly - Recruitment to senior RTT validator vacancy in progress The trust will be focussing on outpatient productivity from Q4 onwards; this will help to identify opportunity areas where GIRFT recommendations can be applied to reduce RTT time and improve patient experience.

KSO3 Operational Excellence - Watch Metric

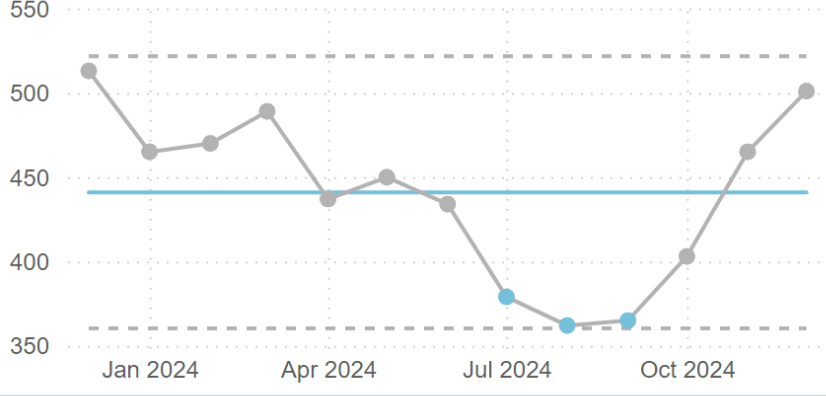
RTT >78 Weeks



RTT >78 Weeks: look back 2024-11-01

Actual	12
Internal Target	0
National Target	0
SPC	8
Common Cause	Inconsistent

RTT >52 Weeks



Actual	501
Internal Target	734
National Target	734
SPC	440
Common Cause	Consistent Pass

National

0.02%

Sussex ICB

0.3%

QVH

0.04%

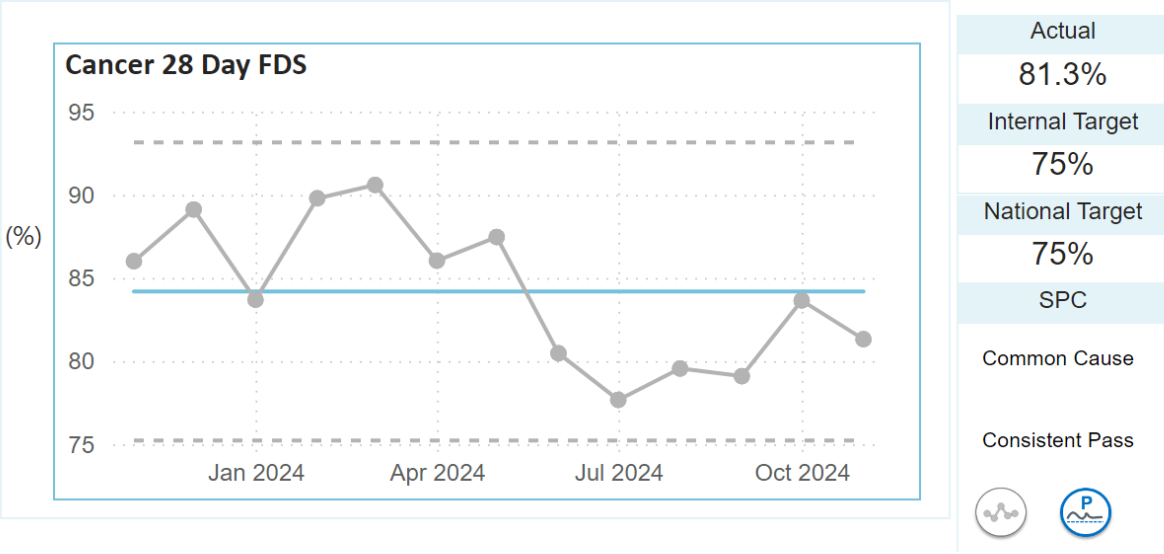
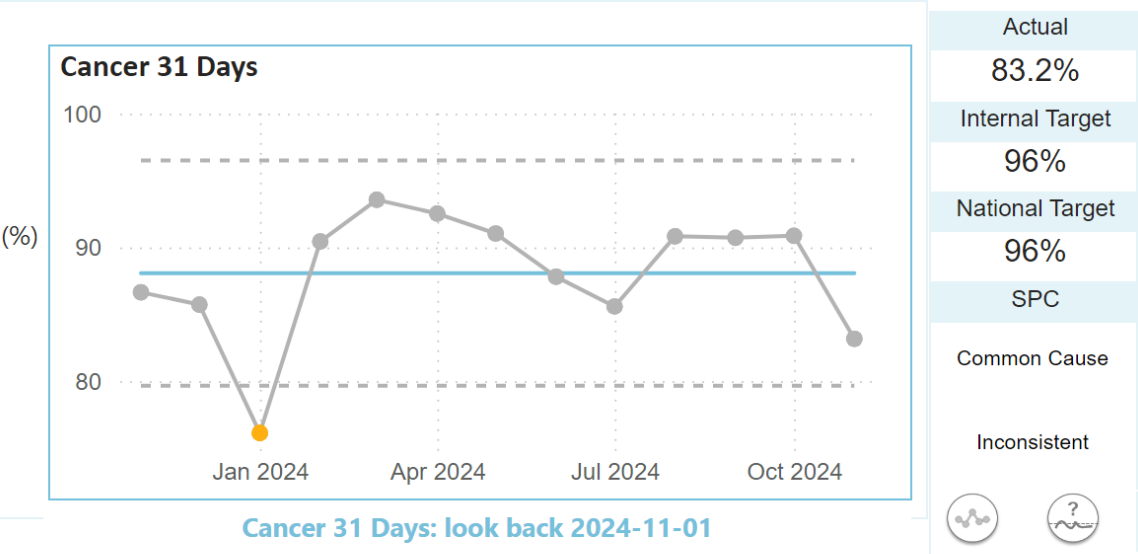
Current Position	Issues	Actions & Timelines
78 week wait: The trust reported 12 breaches of patients waiting over 78 weeks in M9, 10 of which were transfers or late referrals from Sussex trusts. 52 week wait: The trust reported an increase from 465 to 501 patients waiting over 52 weeks in M9, which included an increase of 31 in Plastics, 17 in Corneo and 1 in Sleep. The declining position in M9 was driven by the transfer of Sussex patients waiting longer than 65 weeks, who then took priority over 52 week wait patients. Clinically urgent patients – such as those on a cancer pathway – were also prioritised.	78 week wait: ongoing transfer of patients past 70 weeks, primarily consisting of MOHS and Skin referrals; theatre cancellations due to short-term patient illness. 52 week wait: patient choice to delay treatment over the festive period; continued prioritisation of theatre capacity for cancer and longer waiting patients.	78 week wait: CMO review of all patients waiting over 78 weeks, as per NHSE guidance. 52 week wait: management of patient choice delays in line with the Elective Access policy; ongoing demand and capacity planning for 2025/26 to anticipate the potential challenges in service delivery.



POD	Activity Plan	Activity Actual	Activity Variance	Activity %	Price Plan	Price Actual	Price Variance	Price %
Day Cases	889	1011	122	114%	£1,249,938	£1,381,029	£131,091	110%
Elective	216	205	-11	95%	£754,379	£763,026	£8,647	101%
First Outpatients	3308	3458	150	105%	£547,205	£563,369	£16,164	103%
Outpatient Procedures	2787	2937	150	105%	£594,236	£566,861	-£27,376	95%
Grand Total	7200	7611	411	106%	£3,145,758	£3,274,285	£128,527	104.1%

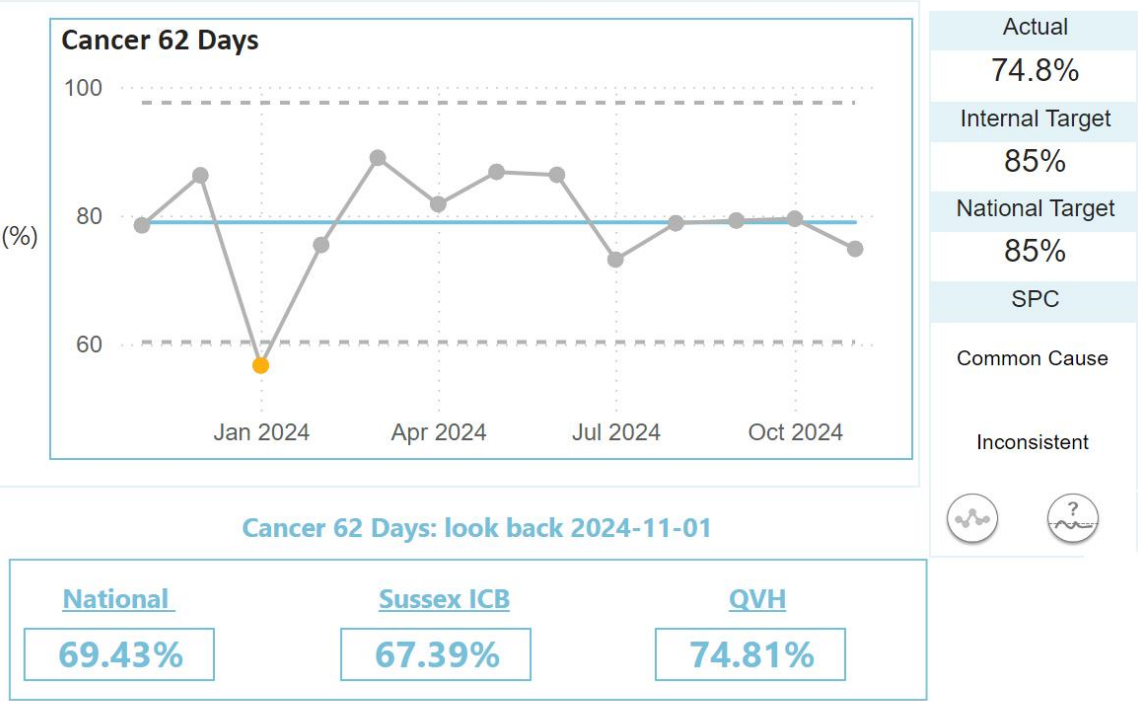
Current Position	Issues	Actions & Timelines
The trust reported 104.1% against plan in M9. Activity levels decreased from the previous month but given the festive period, this was expected and accounted for. - Day cases exceeded the plan, delivering 114% of expected activity and 110% of expected income - First outpatient appointments also exceeded plan for both expected activity (105%) and expected income (103%) - Elective work delivered on expected income (101%), despite not delivering expected activity levels (95%) - Outpatient procedures delivered on activity plan (105%) yet delivered 95% of the income plan.	Underperformance in Sleep outpatient procedures, partly due to a reduction in the level of outsourcing. Deterioration in M10 position is anticipated due to workforce gaps: - OMFS – registrar and fellow vacancies, alongside the temporary reduction in Head and Neck workforce due to a consultant's sabbatical period - Plastics – reduction of 1.0 WTE in consultant workforce until mid-M10 - Sleep – workforce impacted by long-term sickness and maternity leave, with temporary recruitment to the post unsuccessful	Outsourcing of Sleep outpatient procedures has re-commenced, supported by a comprehensive demand and capacity analysis of the service, and pathway transformation work. Planned recruitment to address workforce gaps: - Head and Neck consultant predicted to commence employment in M10; ongoing recruitment to OMFS registrar / fellow posts - Recruitment in Plastics includes a locum Breast consultant (commencing M11) and locum Skin consultant (commencing M10). Plastics consultant who is on leave will begin phased return in M10.

KSO3 Operational Excellence - Watch Metric



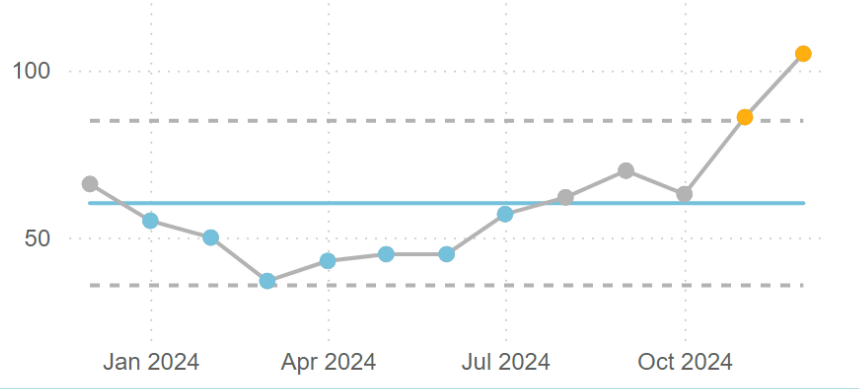
<u>National</u>	<u>Sussex ICB</u>	<u>QVH</u>
91%	85.51%	83.15%

Current Position	Issues	Actions & Timelines
31 Days (31d): The trust did not achieve the constitutional standard of 96%. Speciality performance; Skin 83.4%, Head and Neck 92.3%; Breast 50.0%. FDS: Performance remained above the constitutional standard of 75%. The trust also exceeded the regional (75.3%) and national (77.4%) averages.	The trust's 31d Skin position continues to be affected by theatre capacity. Breast 31d position challenged due to increased demand for immediate Breast reconstruction, coupled with a reduction in capacity due to the loss of one locum consultant.	Demand and capacity analysis is ongoing, with appropriate actions being proposed: <i>Super Saturday</i> Skin lists are booked in January. An additional locum Breast consultant will commence employment in M10, while recruitment for a substantive post is underway.



Current Position	Issues	Actions & Timelines
The trust reported performance of 74.8% in M8. QVH continues to perform in the top 40% nationally, and above the 70% target outlined in 2024/25 planning guidance; however, the constitutional standard of 85% is not consistently met. Compared to 2023/24, the number of urgent suspected cancer referrals received year-to-date has increased by 12.9%. The trust anticipates a decline in performance in M9 due to ongoing capacity constraints and pathway complexities. The position may not be recovered until M10 given patient choice to delay treatment over the festive period. Latest Data Refresh: 1/21/2025 11:04:16 AM	Ongoing insufficient capacity for outpatient Skin BBN (breaking bad news) appointments. Pathway delays secondary to pending MDT outcomes Complex Head and Neck 62 day pathway requiring multiple diagnostic investigations. Latest Commentary Refresh: 9/3/2024 10:00:49 PM	Consideration into how to increase BBN outpatient capacity, with options including: 1. Creation of a dedicated oncology clinic in the locum Skin consultant's job plan 2. Requiring most outpatient Skin clinics to include a proportion of BBN appointments However, further discussions will be required with the Skin clinical lead. MDT clinical lead has agreed that for biopsy confirmed patients, MDT discussion is not required prior to the BBN outpatient appointment. However, registrars are likely to need additional support where patients are awaiting an MDT outcome. Head and Neck 62 day pathway analysis undertaken. The outcomes were reviewed and presented in the January Cancer Board; suggestions included development of CNS clinics, straight-to-test pathways, and expansion of the pathway navigator's responsibilities.

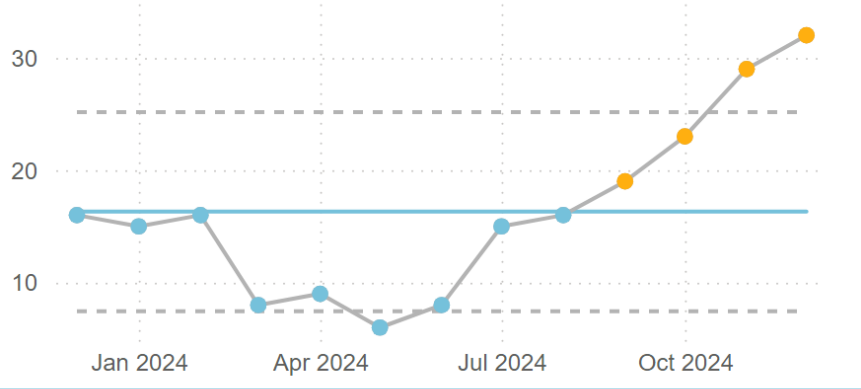
Cancer Waits > 62 Days



Actual
105
Internal Target
32
National Target
32
SPC
Worsening - Concern High
Consistent Fail



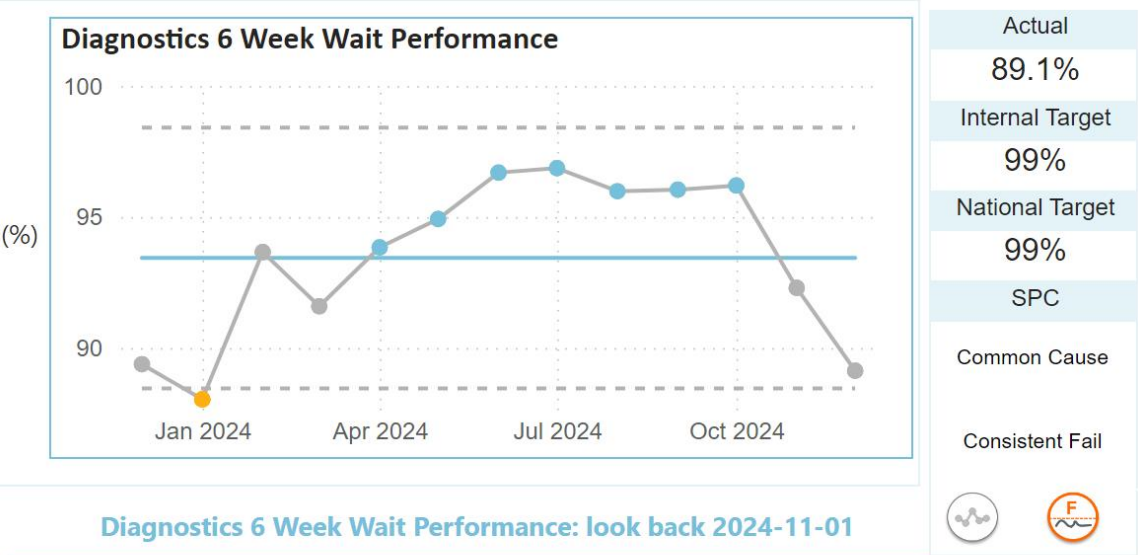
Cancer Waits > 104 Days



Actual
32
Internal Target
3
National Target
3
SPC
Worsening - Concern High
Consistent Fail



Current Position	Issues	Actions & Timelines
The trust reported an increase in M9 to 105 patients waiting over 62 days. This equates to 15.9% of the PTL, versus a target of 6% or less. Patients waiting over 104 days are included in the 62 day backlog; in M9, there were 32 patients exceeding 104 days. The number of patients within this cohort grew by 3 in M9, with 1 additional patient in each specialty. Late tertiary referrals (>38 days) represent 30% of the backlog.	Complex Breast intermediate pathway, which requires: genetic testing, sentinel lymph node biopsy, theatre capacity, and the availability of visiting breast surgeons. Complex medical and social patient factors, including: patient co-morbidities, safeguarding requirements, and incomplete input from support services. Complex Head and Neck pathway requiring significant consultant input.	Close monitoring of each patient through weekly pathway validation and discussion on the Cancer PTL meeting. Outstanding actions are discussed, with appropriate escalation to the Head of Performance and Access and management team. Liaising with support services and external organisations to progress patient pathways. Head and Neck pathway analysis has identified touchpoints where the pathway navigator or clinical nurse specialists can action outstanding tasks.



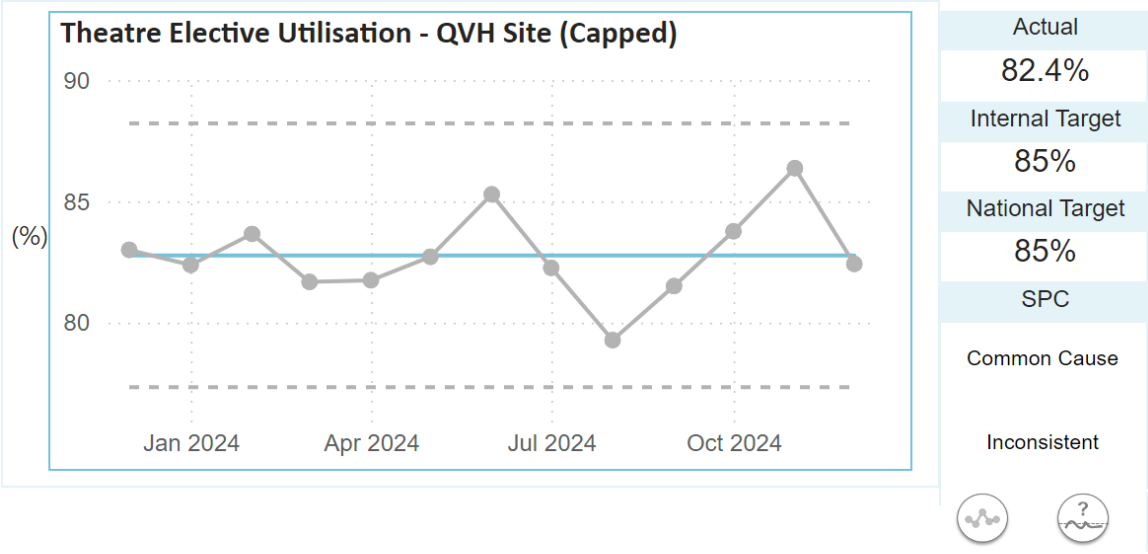
<u>Sleep Studies - National</u>	<u>Sleep Studies - Sussex ICB</u>	<u>Sleep Studies - QVH</u>
66.72%	78.82%	81.37%

Current Position	Issues	Actions & Timelines
The trust's DM01 position deteriorated from 92.3% in M8 to 89.1% in M9. This was primarily driven by capacity constraints in Sleep services Despite not achieving the 95% target outlined in 2024/25 planning guidance, retrospective insight highlighted that M8 performance significantly exceeded both the national and regional averages. Performance remains within normal variation, indicating no statistically significant change in M9.	Underperformance in overnight Sleep procedures due to: 1. Workforce reduction secondary to long-term staff sickness 2. Reduction in the number of procedure slots secondary to complex patient combinations 3. Patient choice The above is exacerbated by the trust's inability to outsource the challenged Sleep procedures. However, other diagnostic tests in Sleep have been successfully outsourced; this will improve the level of activity delivered but may consequentially worsen the trust's DM01 position.	Blocked capacity on overnight clinic templates to prioritise booking the longest waiting patients, irrespective of the complexity of patient combinations. Planned review of the Sleep waiting list, in line with the Trust's access policy to appropriately review or discharge patients. Regular validation of the Sleep PTL, with any pathway barriers escalated to the Head of Performance and Access and discussed in the fortnightly Access and Performance Board meetings. Plans to undertake pathway transformation work in Sleep, with the aim of maximising workforce efficiency through a reduction in the volume of tasks (e.g. utilisation of eRS to standardise and improve the referral process).



Measure	Month	Performance	Target	Variation	Assurance
Outpatient Productivity - % of Cancellations by Patient on the Day	December 24	1.34%	1%		
Outpatient Productivity - Patient Initiated Follow Ups (PIFU)	December 24	2.54%	2%		
Outpatient Productivity - Missed Appointment Rate	December 24	5.56%	4%		

Current Position	Issues	Actions & Timelines
The trust reported 42.4% in M9. Performance has remained consistent over the past 12 months; however, additional work will be required to meet the 46% national target. NHSE have outlined that Patient Initiated Follow Up (PIFU) should be the outcome for 5% of all outpatient appointments by March 2029. Improved utilisation of PIFU services (currently 2.54% performance) would reduce the volume of follow-up appointments with lower clinical value, thereby releasing additional capacity for first outpatient appointments. However, the potential for improvement is limited by the complexity of the conditions being managed by the trust's specialist services. Missed appointment rates remains steady, including spoke site data. Further analysis is planned for offsite activity where DNA rate currently exceeds 10%. Latest Data Refresh: 1/21/2025 11:04:16 AM	Challenged expansion of PIFU due to the management of complex conditions. Lack of clarity regarding the factors driving the high rate of missed appointments, particularly at spoke sites. Inability to maximise productivity due to clinic template variations. Latest Commentary Refresh: 9/3/2024 10:00:49 PM	Planned exploration into further PIFU opportunities during 2025 pathway transformation work. This will also identify pathways that can be re-designed with fewer clinical touchpoints. Ongoing monthly performance monitoring using SPC, with specific focus on offsite activity. Planned consideration into how to improve this, including the use of PKB and / or AI. Demand and capacity analysis is being conducted for each specialty, with an aim to maximise the number of appointments through standardised clinic templates. This will also identify discrepancies between clinic lists, which can be addressed as per GIRFT recommendations.



Measure	Month	Performance	Target	Variation	Assurance
Elective Late Starts (Mins)	December 24	12	15		
Elective Early Finishes(Mins)	December 24	19	30		
Theatre Productivity - % of Cancellations on the Day	December 24	6.25%	5%		
Daycase Rate	December 24	83.14%	85%		
Theatre Elective Utilisation- QVH Site (Uncapped)	December 24	85.91%	85%		

Current Position	Issues	Actions & Timelines
QVH achieved 82.4% capped elective theatre utilisation in M9. The elective early finishes metric has consistently met the target of under 30 minutes since July 2023. The number of same-day theatre cancellations was highlighted as an area requiring attention in M7; this subsequently improved in M8 from 5.36% to 3.89%. However, M9 performance deteriorated to 6.25% due to reduced workforce availability, short-term patient illness and patient choice to delay treatment over the festive period.	Lower theatre utilisation rate in OMFS continues to provide an opportunity to improve the trust's overall position. Ongoing Pre-Assessment Unit (PAU) capacity challenges, including workforce gaps.	Triumvirates previously engaged in a data-driven approach to improve theatre utilisation, with "deep-dive" data packs increasing ophthalmic list utilisation rate. OMFS remains the main contributor to underutilisation, and discussions are planned to help identify the causative factors and implement solutions. PowerBI dashboard for theatres has been created; this provides easily accessible updates on key performance indicators, comparing the trust's sub-specialty performance to local and / or national targets. This data will be used in service level meetings to independently address the present challenges. Successful recruitment process for Pre-Assessment Unit vacancy. Alongside this, demand and capacity analysis is being conducted, including a review of clinic templates to ensure standardisation in-line with national guidance.

KSO3 Operational Excellence – 2024/25 Major Projects

Deliver the Community Diagnostic Centre Programme	Executive Lead: CEO Lead:	Reporting Month: Dec 24	Overall Status: QVH Bognor
---	------------------------------	----------------------------	----------------------------

Programme for the delivery of CDCs within the QVH site and on the University of Chichester site (Bognor). The trust has commissioned Mott MacDonald to drive the delivery of this programme.

Progress has been made within the following areas at both sites:

1. Expressions of Interest for a Design and Build Contract at each site has been issued. Positive response received
2. Discussion continues around agreeing Heads of Terms for the land lease at the University of Chichester (Bognor). Legal teams are engaged.
3. Continued engagement on planning for Bognor.
4. Work on some elements of the East Grinstead CDC have been required to align the formal pre-application response received on the 24 December 2024.
5. 2 week delay on planning submission and a delay to RIBA 3 completion. RIBA 3 workshop is now planned for 11 February for East Grinstead.

Key areas for focus over the next period are continued engagement with key external stakeholders on planning issues, and approval processes of the Full Business Cases.

Milestones	Planned Date	Actual/Forecast Date	Commentary
Agreement on Heads of Terms	30/09/24	30/12/24	Discussions with University of Chichester continue and hope to be concluded asap
Full Business Case development	30/10/24	30/12/24	QVH CDC Business Case to Trust Board 16 January 2025, Bognor CDC Business Case to Trust Board 6 March 2025
QVH Town Planning Submission	16/01/24	16/01/24	Expected submission of planning permissions for East Grinstead in January 2025
Bognor Town Planning Submission	13/03/24	13/03/24	
Risks / Issues	Description		Mitigating Action
Bognor Environmental Agency (EA) feedback	EA feedback regarding ground levels and flood risk may lead to increase in cost and time		Engaging with EA – formal response is expected before Christmas
Agreement of Bognor land lease			Principles for heads of terms to inform lease at Bognor under discussion. Licence for access almost completed

KSO3 Operational Excellence – 2024/25 Major Projects

To deliver the Sussex Pathology Network Programme		Executive Lead: CMO Lead:	Reporting Month: Dec 24	Overall Status:
The Sussex Pathology Network (SPN) Programme has multiple projects progressing concurrently with QVH as a member organisation: LIMS - Contract negotiations completed with Clinisys to support the extended project timeframes as a result of the re-baselined plan agreed in June 2024. Contract negotiations ongoing with Cloud 21 – agreement in principle. LIMS LLD (Low Level Design), Data validation and UAT (User Acceptance Testing) preparation is ongoing Order Comms – An SBAR (Situation, Background, Assessment and Recommendation) has been raised to reflect the exception status of this project. The previous project plan was not deliverable due to delays with the suppliers technical third party. An exception plan has been received, impact assessed, and options presented to an emergency project board. QVH has approved 'Option 4' from the exception report as our preference which is in line with the preferred option of the other Trusts. Digital Histopathology (DHP) – Overall SPN are delivering to the accelerated roll out plan, with 40.1% of cases reported digitally in November across the network. QVH has made significant progress in December with orders placed for the digital slide scanner and Sectra image storage and network configuration being achieved with a target for go-live by financial year end. Managed Services Contract (MSC) – The MSC project is currently undertaking Round 2 of the procurement. The bidders are now creating their submissions due on 28th February 2025. The working group will be focusing on collating the Round 3 documentation pack to go through governance in advance of Round 3 beginning in May 2025. SPN (S7) Target Operating Model (TOM) – Work has continued throughout December on further development of the Outline Business Case. Efforts have focused on refreshing the financial baseline, collation & analysis of activity data. The project milestones have also been re-baselined. Information relating to the current lab space across SPN has been collated. Quality Workstream – The Steering Group has been cancelled awaiting the conclusion of the reprioritisation discussions Workforce – The project has been put on hold due to reprioritisation discussions across SPN				
Milestones		Planned Date	Actual/Forecast Date	Commentary
LIMS LLD sign off		01/09/24	06/02/25	Delayed due to dependencies on Clinisys functionality. Being reviewed for potential impact on critical path
Ordercomms: SPN access to platform - enable config phase		07/11/24	31/01/25	Delays with Telefonica. Ongoing conversations to confirm technical requirements have been positive. Anticipate successful connectivity by the end of January.
MSC – Bidder final submissions (Round 2)		Feb 25	Feb 25	Round 2 will now continue until May 2025 so evaluation and moderation will coincide with LIMS UAT.
Digital histopathology: QVH go live		Dec 24	Feb 25	Identification of compliant procurement approaches delayed raising of Purchase Orders. Efforts are being made to reach operational readiness as early in 2025 as possible. Delay in scanner delivery may impact go-live target
Risks/Issues		Description		Mitigating Action
Finance 2025/26		Financial pressure for FY 25/26 for LIMS/Order Comms due to re-baselined plan		Liaise with Imaging Network to understand how contribution could be identified/share costs with Radiology/liase with suppliers to ensure Value for Money
LIMS/Order Comms extension		Project extensions for LIMS and Ordercomms require contract negotiations with suppliers. This could result in additional costs.		Estimated additional costs included in the financial impact assessment. Negotiate with suppliers to ensure value for money
Ordercomms vacancies		Vacancies for PM and Project Support. Potential slippage if decisions not made in a timely manner. Risk to project delivery if risks and issues are not identified		SBAR to Steering Group. Recruitment ongoing, procure Project Management Services to mitigate delay in recruiting
Recruitment constraints		Trust policies on recruitment cause delays to onboarding staff, resulting in project delays and underspend of NHSE funding		Pathology to escalate challenges to DDOs and SPN Transformation Team

To deliver year one of the Electronic Patient Record	Executive Lead: COO Lead:	Reporting Month: Dec 24	Overall Status: 
--	-------------------------------------	-----------------------------------	---

The first phase go-live of November 2024 has been delayed, and as such the programme has moved from Amber to Red. Post go-live support would have been extremely challenging for the operational teams in the lead up to winter pressures, Christmas annual leave and change freezes. The time taken to recruit people to key roles has also impacted the delivery of the first phase, particularly the Testing and Training workstreams. Therefore, a safe November go live would have been difficult to achieve due to lack of workstream resources.

A programme re-phasing exercise has taken place, and a revised plan was taken to the EPR Programme Boards in December 2024. Assurance was required regarding finances and benefits realisation before the plan could be agreed. There are currently cost pressures regarding the programme budget, and mitigations to close this gap are being worked through. There are also external factors, outside of the EPR programme control, which impact delivery timescales.

A revised business case summary is being prepared for Board which outlines the changes to the original business case.

The EPR programme team continue to work at pace to prepare for the EPR programme go-live.

Milestones	Planned Date	Actual/Forecast Date	Commentary
Recruitment of team to deliver EPR	30/09/24	31/01/25	All workstream leads have now been appointed. There are a number of internal roles still outstanding including a clinical role, HR/OD lead and clinical safety officer
Clinical engagement	31/10/24	31/01/25	Clinical engagement and identifying internal resources to support the programme are still being worked through. Medical CAG has been established.

Risks/Issues	Description	Mitigating Action
Programme date revision	First phase go live of November is being revised	Revised plan has now been proposed. Decision has been deferred whilst Programme Board seek assurances on finances and benefits.
Benefits realisation	There is a risk that the benefits included in the Full Business Case may not be fully realised in the anticipated timelines	A benefits review is underway with support from the supplier, Altera along with benefits plans being provided by other Trusts who have implemented Sunrise.
Programme finances	There are currently cost pressures within the programme budget which are being worked through.	The programme team are exploring a number of mitigating actions to offset this risk.

KSO4 Financial Sustainability

Ambition

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

Board Assurance Framework

- 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



Overview

- At the close of December 2024, the trust continued to report break-even against plan and had a cash balance of £5.3m. The M9 position was supported by release of £0.7m non-recurrent benefits. The underlying position at Month 9 has increased to a deficit of £2.1m, mitigated through the release of non-recurrent benefits.
- The forecast is for the achievement of the trust's break-even plan, however, there are a number of risks that could impact on a breakeven position and achievement will require an improvement in the current run-rate and receipt of additional income expected in M12.
- ERF Income delivered to plan in M9, although there is still some underperformance in Sleep diagnostics activity. The Elective activity income to date has been calculated using the 2019/20 baseline as a 12-month average and is £1m (at flex) below the activity plan year to date. This has been partly offset by additional McIndoe activity (pass-through) and additional ERF income relating to 2023/24. However, having reconciled the estimated value to the recently published NHSE values for M1-5, there is a further shortfall identified against the original income plan of £0.5m due to baseline issues and higher levels of LVA activity than estimated. To deliver 125% by the end of the year will require over-performance against plan for the remaining months, although it remains unclear how ERF may be transacted in Q4 due to potential capping arrangements.
- Trust agency spend has reduced in M9 compared to trend and is £2.3m YTD which reflects 4.2% of the pay bill (national cap is 3.2%). The in-month agency position in month was partly driven by lower spend due to reduced activity over the Christmas period. The trust continues to work on ways to reduce the agency run rate further.
- Overall pay was lower than trend of the last 3 months derived by reduced agency spend and reduced worked WTE (21). However there has been an increase in non-pay against trend.
- Efficiency plans of £6.5m are included in the trust plan. The trust is delivering the plan although £1.2m is being delivered non-recurrently YTD with forecast non-recurrent efficiencies of £2m
- The trust's original capital plan for the year was £17.5m including capital spend associated with the receipts from the sale of land. The revised forecast is £11.8m before plans to accelerate spend on medical equipment and digital priorities. Capital spend YTD is £2.6m. This is mainly due to the Electronic Patient Record (EPR) scheme (£4m underspent) which is mainly due to timing of payments and the Community Diagnostic Centre where the trust has agreed with NHS England around brokerage of the capital allocation. The Trust has identified a number of schemes to bring forward from 25/26 to ensure the capital budget is spent in full in 2024/25.

Positive Assurance/Improvements

- The trust is delivering the break-even position YTD at Month 9 after the release of £2.1m of non-recurrent benefits.
- The trust ERF performance was 120% as at M9 YTD (following reconciliation to NHSE published actuals for M1-5) against original estimated value. Underperformance in M5-M8 and previous industrial action has had some impact on the income to date.
- The agency position has improved compared to the YTD trend in M9 through a combination of reduced nursing agency shifts, reduced activity over the Christmas period and the impact of the Trust initiative to convert agency spend to bank spend where possible.

Challenges

- The position includes a net £2.1m of non-recurrent benefits. In order to continue to break even the run-rate will need to improve over M9-12.
- To deliver the activity and increase productivity across the trust. In order to deliver the target, activity needs to over-perform against plan for the remainder of the year. National changes are planned to ERF funding in Q4 which may be a risk to the Trust.
- Agency spend remains high and at 4.2% of overall pay YTD is significantly above the national agency cap (3.2%). In-month position now below the cap.

Mitigations and Actions

- Additional cost improvement meetings were held with directorates in December to identify improvements to the year end position and delivery of these is being monitored through a weekly Q4 financial recovery meeting, chaired by the CFO.
- Monitor activity in the trust monthly review meetings and drive productivity in theatres.
- Recruitment to vacancies and conversion of agency staff to bank or fixed term contracts some of which has taken place in M7 and M8. A temporary spend review group has been in place since September to review the use of temporary spend.

KSO4 Financial Sustainability - Scorecard

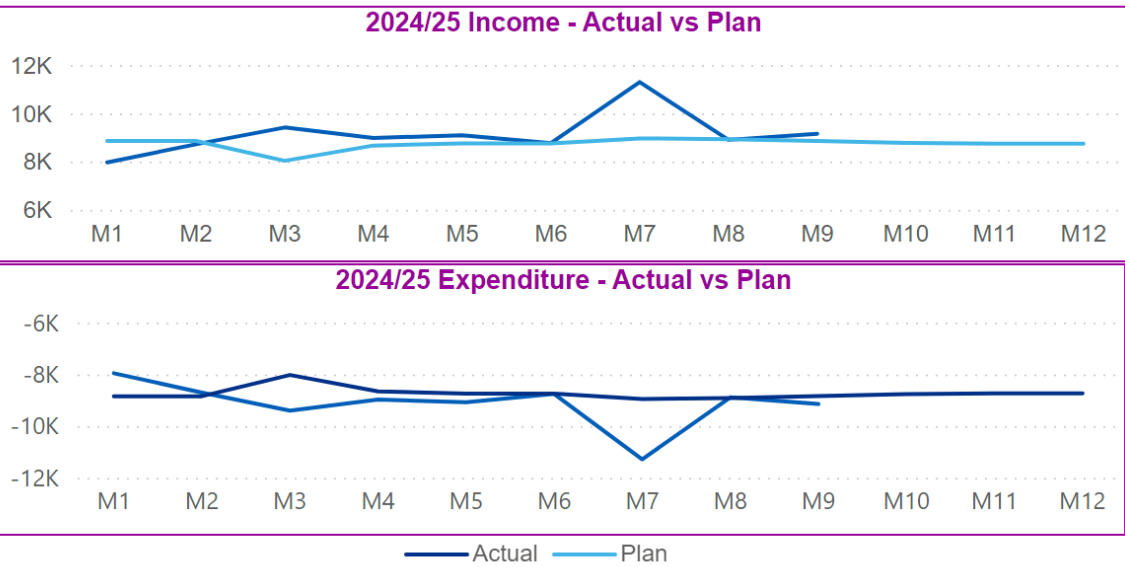
Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	LCL	UCL	Summary
Breakeven YTD	Dec 24	£0.0m			£0.0m	£0.0m				
Cash At Bank YTD	Dec 24				£5.3m	£4.9m				
Capital Spend YTD	Dec 24	£12.8m			£2.6m	£2.3m				
Efficiencies YTD	Dec 24	£4.6m			£4.6m	£4.0m				
BPPC (NHS & Non-NHS) Volumes	Dec 24	95%			89.7%	88.9%				
BPPC (NHS & Non-NHS) Values	Dec 24	95%			89.3%	88.7%				
Agency Spend Less than 3.2% of Total Pay Bill	Dec 24	£1.8m			£2.3m	£2.2m				

Sussex System Financial Summary

Surplus/(Deficit) by Organisation £m	YTD Plan	YTD Actual	YTD Variance Favourable(Adverse)		Full Year Plan
ESHT	(£14.3m)	(£24.6m)	(£10.3m)	(2.0%)	(£11.7m)
QVH	(£0.0m)	-	£0.0m	0.0%	-
SCFT	(£2.2m)	(£1.5m)	£0.7m	0.3%	-
SPFT	(£16.6m)	(£16.6m)	£0.0m	0.0%	(£18.6m)
UHSx	(£31.0m)	(£46.1m)	(£15.1m)	(1.3%)	(£19.5m)
Provider Total	(£64.1m)	(£88.8m)	(£24.7m)	(1.0%)	(£49.8m)
ICB	-	£0.1m	£0.1m	0.0%	-
System (ex DSF)	(£64.1m)	(£88.8m)	(£24.6m)	(0.8%)	(£49.8m)
Deficit Support Funding	£47.8m	£47.8m	-	-	£49.8m
System (inc DSF)	(£16.3m)	(£40.9m)	(£24.6m)	(0.8%)	-

Reporting Month: Dec 24

Executive Lead: CFO



2.Stratified data

Breakeven

Annual Target

Forecast Outturn

Income & Expenditure

£ - £ -

Cash at bank

£14.3m £9.9m

Capital Spend

£17.5m £11.8m

Efficiencies

£6.5m £6.5m

BPPC (NHS & Non-NHS)

Volume

95% 95%

Value

95% 95%

3.Top Contributors

- The trust is delivering the break-even position YTD at Month 9.
- The trust Elective Recovery Fund (ERF) performance was 120% at M9 YTD and will need over-performance in remaining months to deliver its revised activity plan of 125% by the end of the year.
- Under-performance in M5-M8 and previous industrial action has impacted the trust income although this has been partly offset by additional ERF benefit from 23/24 and pass-through activity in McIndoe in terms of ERF value.
- The trust agency spend is £2.3m YTD which reflects 4.2% of the pay spend.

4.Action Plan

Actions

Target Date

To identify improvements via directorate CIP meetings to the monthly run-rate to deliver a break-even position by year end

Jan-25

KSO4 Financial Sustainability - 24/25 - Watch Metric

Financial Performance											
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	8,550	8,857	8,551	(306)	79,665	78,740	79,666	926	105,030	106,201	1,171
Other Operating Income	598	223	598	375	3,226	1,992	3,225	1,233	2,654	3,631	977
Total Income	9,148	9,080	9,149	69	82,891	80,732	82,891	2,159	107,684	109,832	2,148
Pay											
Substantive	(5,409)	(5,905)	(5,410)	495	(49,338)	(51,284)	(49,277)	2,007	(68,614)	(67,114)	1,500
Bank	(423)	(335)	(432)	(97)	(3,071)	(3,000)	(3,230)	(230)	(4,002)	(4,791)	(789)
Agency	(91)	(92)	(90)	2	(2,303)	(1,004)	(2,303)	(1,299)	(1,278)	(2,370)	(1,092)
Total Pay	(5,923)	(6,332)	(5,932)	400	(54,712)	(55,288)	(54,810)	477	(73,894)	(74,275)	(381)
Total Non-Pay	(2,676)	(2,184)	(2,666)	(482)	(23,266)	(20,363)	(23,167)	(2,804)	(27,869)	(29,636)	(1,767)
Total Non Operational Expenditure	(574)	(587)	(574)	13	(5,118)	(5,289)	(5,120)	170	(6,198)	(6,198)	0
Total Expenditure	(9,173)	(9,103)	(9,172)	(69)	(83,096)	(80,940)	(83,097)	(2,157)	(107,961)	(110,109)	(2,148)
Surplus/(Deficit)	(25)	(23)	(23)	(0)	(205)	(207)	(206)	2	(277)	(277)	0
Technical Adjustments	23	23	23	0	206	207	206	(1)	277	277	0
Adjusted Surplus / (Deficit)	(2)	(0)	(0)	(0)	1	(0)	0	0	0	0	0

Current Position	Issues	Actions & Timelines
- The Trust position at Month 9 is a breakeven position. - The ERF position is c£1.5m behind plan which is partially offset by 23/24 ERF income (£0.5m) and additional McIndoe income (pass through - £0.25m) - Pay is favourable to plan YTD although this is partly driven by vacancies due to slippage in the CDC timetable. - Non-pay spend increased in M9 compared to trend mainly due to an increase in bad debt provision, increased spend on sleep equipment and increased utilities costs. - Agency spend is £0.1m in month and £2.3m YTD which is 4.2% of the overall pay bill.	- Whilst the position is breakeven, the YTD position is supported by a net c£2.1m of non-recurrent benefits - The plan contains an additional stretch target of £1.2m which sees activity grow in later months. In order to deliver the target, activity needs to increase from recent performance. - Agency spend remains high, above the annual agency cap of 3.2% though has been under the cap for the last 3 months	- Work to increase productivity and deliver additional efficiencies. Meetings with Directorates held and outputs to be costed - Monitor activity in the trust monthly review meetings and drive productivity in theatres. - Recruitment to vacancies and conversion of agency staff to bank or fixed term contracts

KSO4 Efficiencies - 24/25 - Watch Metric

Financial Performance Month 9 2024/25											
Efficiency											
	In Month £'000				Year to Date £'000				Forecast Outturn £'000s		
	24/25	Plan	Actual	Variance	24/25	Plan	Actual	Variance	Plan	Forecast	Variance
Non-Pay NHS Subcontracted		188	0	(188)		1,688	0	(1,688)	2,250	0	(2,250)
Non-Pay non-NHS Subcontracted		184	184	0		1,648	1,648	0	2,200	2,200	0
Pay - Agency		31	0	(31)		157	0	(157)	250	0	(250)
Non-Pay - Procurement (excl Drugs)		22	(8)	(30)		198	443	245	260	1,172	912
Pay - Establishment Reviews		29	288	259		263	359	96	350	482	132
Income - Additional Productivity		180	169	(11)		660	2,164	1,504	1,200	2,656	1,456
Total		634	634	0		4,614	4,614	(1)	6,510	6,510	0

Current Position	Issues	Actions & Timelines
- As at M9, the trust is delivering its efficiency plan. - Additional productivity schemes are offsetting underperformance in non-pay and reduction of agency schemes. Overperformance income relating to 23/24 is no longer offsetting the shortfall in productivity schemes. - The position includes a combined £1.2m of non-recurrent benefits relating to 23/24 ERF over performance and release of provisions.	- Of the £6.5m efficiencies programme, the revised plan has identified £3.7m to be delivered through productivity schemes including the £1.2m stretch target. As at M9 there is some slippage against productivity schemes currently, in part offset by 23/24 non-recurrent ERF income. The additional productivity scheme sees an increase in plan in the later months of the year. - Agency schemes will not deliver in 24/25 though improvement has been made in Q3 to reduce agency costs. Underperformance is expected to be mitigated by non-recurrent schemes.	- Implementation of new software to monitor the efficiency programme across the trust. This has been populated for M9. - ERF productivity continues to be reviewed in directorate meetings to identify areas of underperformance and develop recovery plans. - Efficiencies programme group has been created to monitor and track performance and identify actions to mitigate under delivery. Temporary spend group has been set up to review and challenge areas of temporary spend.

KSO4 Capital Spend - 24/25 - Watch Metric

Financial Performance Month 9 2024/25											
Capital Spend											
	In Month £'000				Year to Date £'000				Forecast Outturn £'000s		
	24/25	Plan	Actual	Variance	24/25	Plan	Actual	Variance	Plan	Forecast	Variance
IT		50	2	(48)		560	215	(345)	710	710	0
Medical Equipment		50	22	(28)		550	651	101	600	629	29
Estates Maintenance		100	0	(100)		1,190	414	(776)	1,437	1,408	(29)
Estates Other		85	0	(85)		844	0	(844)	994	994	0
EPR		80	203	123		4,547	592	(3,955)	4,787	4,787	0
CDC		850	0	(850)		4,018	678	(3,340)	6,706	1,426	(5,280)
Other Capital		375	0	(375)		1,125	0	(1,125)	2,250	1,895	(355)
Total		1,590	227	(1,363)		12,834	2,550	(10,284)	17,484	11,849	(5,635)

Current Position	Issues	Actions & Timelines
- YTD Spend as at Month 9 is £1.3m against CRL of £3.7m (which covers IT, Medical Equipment and Estates schemes) - EPR spend £0.6m against annual budget of £4.8m - CDC spend £0.7m against the updated forecast of £1.4m for this financial year	- Progress in the Estates department is steady but slow. A plan is now in place outlining the work needed to fully utilise the remaining budget. In the IT department, several purchase orders are being processed for procurement. The Medical Devices department has exhausted its annual budget, with £0.2 million allocated from Estates to ensure any urgent requests for medical devices are fulfilled. Overall, the trust is behind its target CRL for the year as of M9. - Significant element of EPR spend this year is phase 2 payment to Altera £2.3m this is expected to be paid before the year end 2024/25 with another £2m allocated to resources. - CDC - Significant construction will not be happening until next year, subject to planning permission. Brokerage has been agreed with the ICB where CDC budget for current year has been transferred to another trust. This will be refunded to QVH in 2025/26.	- Regular meetings are now in place with the Estates, IT and Medical devices teams to closely monitor the spend for the remaining four months. - The project is regularly reviewed monthly as part of the EPR project board. - Brokerage now agreed.

KSO5 Organisational Excellence

Ambition

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

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 continuous improvement approach across the organisation (QP) (SDP) (Exec Lead: CSO)



Overview

Wellbeing & Inclusion - The team are working with EDI Champions to advocate for inclusion and to co-design culture and inclusion work going forward, with a resource pack shared to help champions develop in their roles. The team have completed a listening exercise with a team in OMFS & Eyes. A listening exercise is commencing in Plastics & Burns to better understand team culture and wellbeing. Our new Employee Assistance programme 'Vivup' has launched, offering a broad range of benefits from a 24/7 support helpline to access to an online GP; more wellbeing benefits are expected to launch in January 2025. The team are liaising with community providers to offer Wellbeing MOTs and will commence Menopause Cafes to broaden QVH's wellbeing offer in 2025.

Sickness absence: the rolling 12-month sickness absence rate has not seen any movement since last month and remains below 4%, indicating a stable picture and is anticipated to improve as we move out of the winter months.

Employee Relations: currently advising on 32 cases, in line with Trust Policy. 21 open cases – some in monitoring and some being actively managed. 11 pending cases awaiting actions. The cases are broken down into investigation: 1 informal open, 2 formal open and 2 formal pending; conduct: 7 informal open and 2 informal pending; performance: 1 formal open; probation: 1 formal open; grievance: 2 formal open collective cases; dignity and respect: 1 informal pending, 3 formal open; consultation/engagement: 1 informal pending, 1 formal open and 2 formal pending; redeployment: 1 formal pending trial completion, 2 formal unsuccessful; facilitation/mediation: 1 informal open, 1 formal pending; Medical & Dental: 4 formal pending. The team are advising on several complex sickness management cases which will progress to hearings. Policies are under review and are being written in line with NHS England People Policy template which meet the accessibility standards required following outcomes from EDI research and results. The new re-design of the manager's training is in development, working towards a launch in Spring 2025 which will be accompanied by Managers and Employees support hub on the Intranet in Autumn/Winter 2025.

Mandatory and Statutory Training (MAST) Compliance for M9 is 91%, above the Trust KPI of 90%.

Appraisal compliance has increased by 0.23% to 84.98% from 84.75% in M8. Medical appraisals decreased by 2.65% to 78.16% in M9. Information is escalated to Head of Medical HR each month. Targeted actions continue with managers who have staff who are overdue their appraisal by 3 months or more.

Medical Education; December teaching activities: 2 Dec Plastics teaching, 3 Dec Regional Anaesthetics career day, planning is underway for February doctors' induction and mandatory training morning

Positive Assurance/Improvements

- All permanent staff MAST compliance remains above 90% target
- Bank and agency use continue to reduce
- TTH remains below KPI at 50.5 days
- Turnover remains stable at 11.9%
- Reduction in vacancy rate to below KPI

Challenges

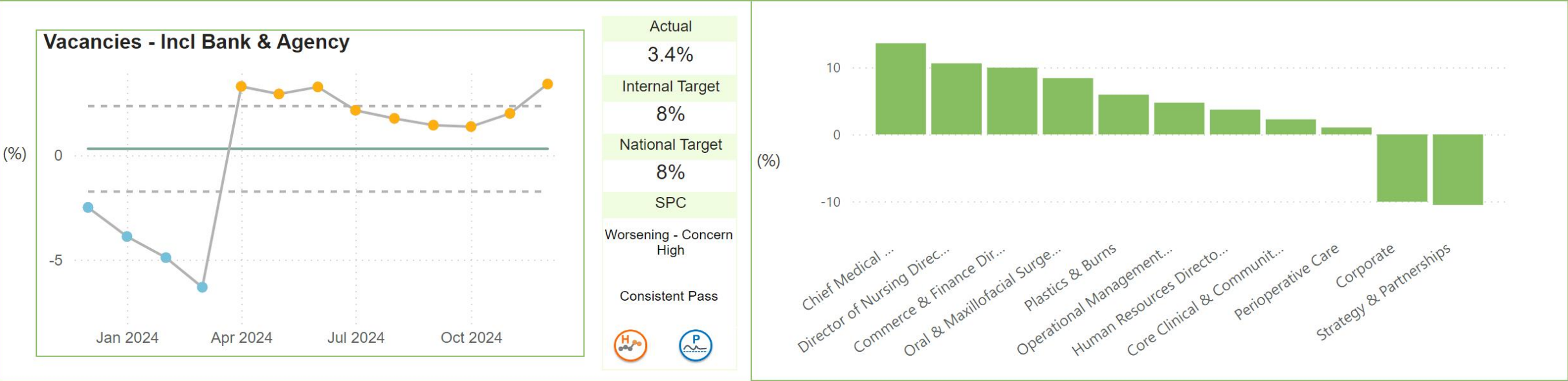
- MAST compliance slightly improved however, DNAs and late notice cancellations are being reviewed to maximise attendance
- Cultural concerns relating to poor behaviours have resulted in additional ER cases.
- Areas where previous high levels of tolerance to poor behaviours / informal ways of managing the behaviours are now speaking out – this is to be encouraged, with support in place being increased for teams / managers

Mitigations and Actions

- DNA & Cancellation report is produced and shared with directorates monthly. This report will be closely monitored to see if any themes or trends are appearing. This issue was highlighted in the monthly business unit reporting and will be further escalated if trend continues.
- Weekly ER case reviews in place
- Cultural transformation steering group commencing in Feb 2025
- Listening sessions in place in areas where poor behaviour has been reported / manager support increased
- Ongoing programme of work via workforce teams to promote the behaviour framework and coaching conversations

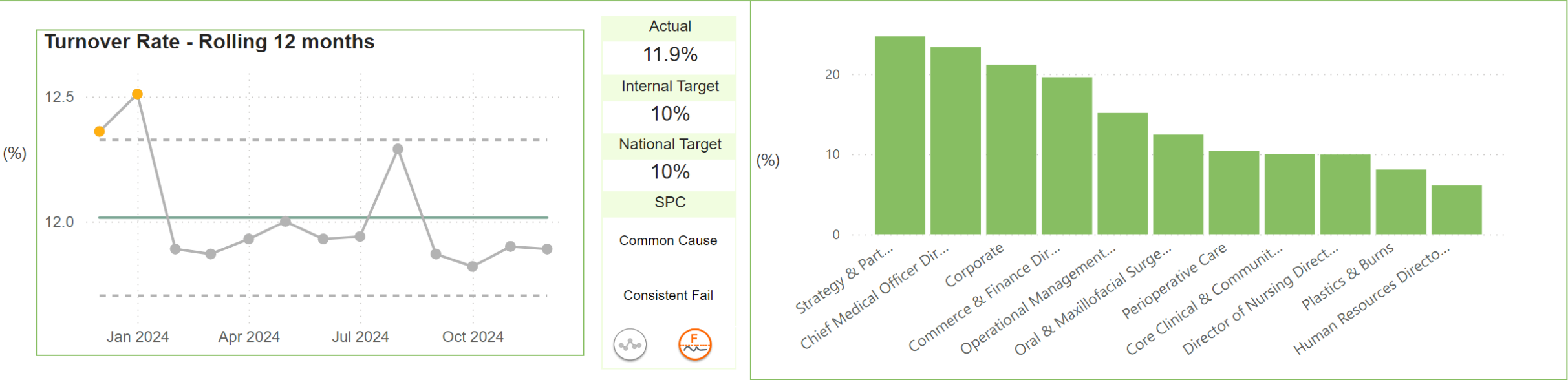
KSO5 Organisational Excellence - Scorecard

Metric	Latest Month	Target	Variation	Assurance	Actual	Previous Month	Mean	LCL	UCL	Summary
Vacancies - Staff In Post	Dec 24	8%			7.8%	8.0%	8.48	6.30	10.65	Common cause - no significant change
Vacancies - Incl Bank & Agency	Dec 24	8%			3.4%	2.0%	0.31	-1.74	2.35	Special cause worsening
Average Time To Hire - Days	Dec 24	53			50.5	42.9	54.38	28.61	80.14	Common cause - no significant change
Turnover Rate - Rolling 12 months	Dec 24	10%			11.9%	11.9%	12.02	11.70	12.33	Common cause - no significant change
Sickness absence rate - Rolling 12 months	Dec 24	3%			3.8%	3.8%	3.60	3.46	3.74	Special cause worsening
Appraisal Rate	Dec 24	90%			85.0%	84.8%	83.88	81.98	85.78	Common cause - no significant change
Statutory & Mandatory Training Compliance	Dec 24	90%			91.0%	90.4%	91.85	90.48	93.22	Common cause - no significant change
Agency Usage In Month (WTE)	Dec 24				14.0	19.1	24.45	16.37	32.52	Special cause improving
Bank Usage In Month (WTE)	Dec 24				73.3	87.1	85.22	65.02	105.42	Common cause - no significant change

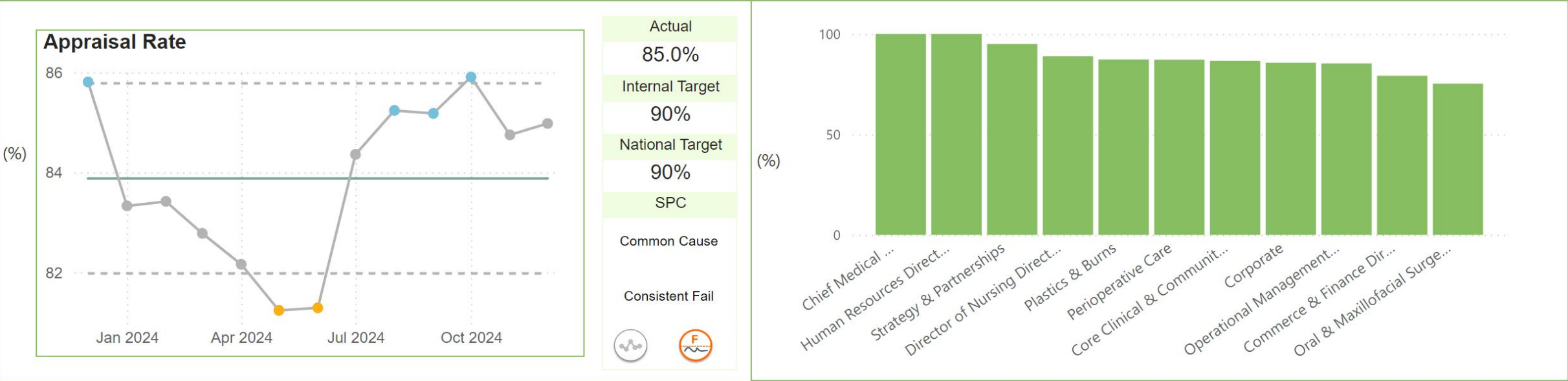


Current Position	Issues	Actions & Timelines
• Vacancy levels have seen increase of 1.4% in M9 to 3.4%, however remains below KPI of 8% • Bank usage has decreased in M9 from 82.4 WTE to 73.25WTE • Agency usage has decreased in M9 from 19.1 WTE to 14.0 WTE • Vacancies (SIP) has reduced to 7.8% in M9 (118.92 WTE) - A&C highest staff group and Domestic/Catering the highest department. • Trust Establishment in M9 was 1125.97 WTE against our plan of 1054.40 WTE at M9. This remains below our control total of 1165.73 WTE • Current Substantive staff in post is 1038.72 WTE	• Vacancy rate is at 3.4% with a 1.4% increase from M8 which can be seen with the reduction in Bank and Agency Usage. • Trust establishment is showing 127.01 WTE vacancies; with Admin and Clerical the highest staff group at 38.14 vacancies. The highest area is Commerce and Finance at 28.64 (mainly in building and engineering, finance, catering, domestics and procurement). • There is recruitment activity in these areas and a review of admin vacancies is underway with scrutiny around longer-term vacancies.	• Continuing to audit all bank workers and reduce booking length with instruction to recruit to vacancies • Recruitment is in place to cover vacancies in domestics/catering to reduce the vacancy number • Work continues within the South East Collaborative to align bank rates, • The Temporary Staffing Reduction Oversight group continues to meet with each directorate to review agency and bank use against activity / vacancies.

KSO5 Organisational Excellence - Watch Metric

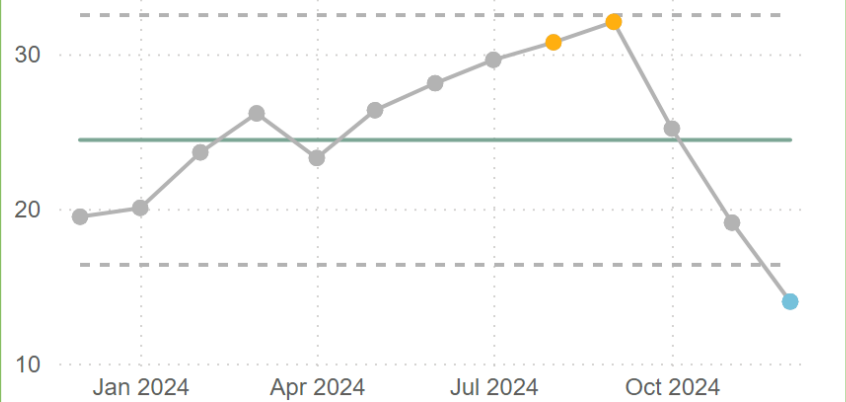


Current Position	Issues	Actions & Timelines
- No change to turnover in M9 and remains at 11.9% 12 WTE starters and leavers with leavers increasing by 3 from M8	- Highest number of leavers within Periop (5) and A&C staff group (4.59) - Highest reason for leaver was dismissal at 1.85 WTE	Work continuing with People Promise Manager carrying out leavers conversations to ascertain reasons and look at how to retain staff



Current Position	Issues	Actions & Timelines
- Appraisal compliance increased from 84.75% in M8 to 84.98% in M9 (0.23%) - Medical & Dental Appraisal decreased 2.65% in M9 to 78.16% from 80.81% - Clinical AfC appraisal increased 0.97% on M8 (86.98%) - Non-Clinical AfC appraisal increased 0.44% on M8 (85.07%) 15 staff (not on long-term sick) are more than 9 months overdue for their appraisal, an increase from 12 in M8 of which one is M&D staff - There are 9 staff off work long-term sick who are therefore not able to have their appraisal		- Email sent to triumvirate leads to highlight teams with less than 80% compliance - Email sent to all staff whose compliance is below 80% and line managers copied in - Funding Panel requires appraisal compliance before awarding any funding - Compliance is highlighted at monthly IQPR meetings - A monthly manager report highlights which staff are more than 3mnths out of date – this is escalated through to triumvirate leadership teams / ELT for discussions with managers and staff. - IM&T staff have appraisals booked for January 2025 (M10)

Agency Usage In Month (WTE)



Actual

14.0

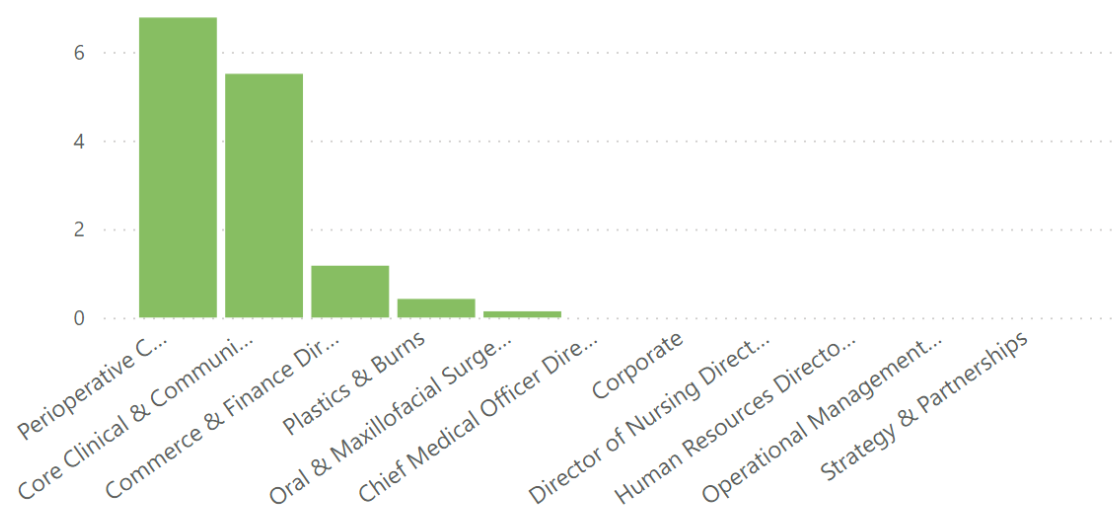
Internal Target

National Target

SPC

Improving - Improvement Low

(Blank)



Current Position	Issues	Actions & Timelines
- Agency use continues to reduce with 14 WTE used in M9 compared to 19.1 in M8 - Bank has also reduced to 73.3 WTE from 87.1 in M8	- Highest agency use continues in periop at 6.77 WTE and highest staff group N&M at 3.97 WTE - Highest bank usage was in Perioperative at 23.15 WTE.	- Agency approvals to go through Heads of Nursing once rosters and need have been reviewed, to continue to safely reduce agency and bank use across directorates. - Consultants are starting in anaesthetics team from Feb – May 2025 in substantive roles. - The Temporary Staffing Reduction Oversight Group meets bi-weekly with directorates to provide check and challenge and support reduction in agency and bank use - It is recognised there will be some agency use attributable to H2 additional activity / weekend working from M8 onwards.

Appraisal/Career conversations at QVH: The updated appraisal and career form is now available on QNet for staff to access.

Apprenticeship Levy: Preparation underway for apprenticeship week (10 – 17 Feb) and will be promoted at February Team Brief.

Coaching at QVH: Triumvirate and senior leaders coaching skills training workshop has been advertised and organised for January 25. Eight managers/leaders are currently being supported by qualified coaches and 2 mentoring relationships.

Culture work: OD&L team are working with Strategy and ELT teams around cultural work interventions. Cultural concerns relating to poor behaviours have resulted in additional ER cases. Areas where previous high levels of tolerance to poor behaviours / informal ways of managing the behaviours are now speaking out – this is to be encouraged, with support in place being increased for teams / managers. The wellbeing team are undertaking listening work across identified departments / directorates to support where poor behaviours have been identified / where investigations are underway. The Cultural Transformation Steering Group starts in February 2025. Development work will commence with the Board (Diversity MOT) in February 2025 led by Absolute Diversity.

Leadership / Management Development: work is being done in the SE region to develop a leadership framework and code of practice for all managers. Alongside this will be a range of tools and a leadership programme for use across the system. Management essentials programme is in development, with a leadership essentials programme to be scoped, working with OD leads across the Sussex system to share resources, skills and knowledge.

People Pulse - New: QVH is utilising the People Pulse platform to capture the NQPS data from 1 January 25.

Staff Survey 2024: Data has been received, and work is underway to analyse results for directorates and produce reports. Results are under embargo until early March 25 and cannot be shared until this date.

Succession Planning: Head of OD&L has been working with the region to develop and pilot succession planning at QVH which will be launched across the region. A draft sub-strategy has been developed along with supporting templates. Further work on templates will be needed to simplify documentation.

WEX at QVH: The WEX placement application period closes on 19 January and shortlisting will be conducted following this date.

Medical Education: Exception reporting; three reports have been submitted in December, all relating to hours and all from plastic surgery. All reports will be reviewed by the resident doctor's Educational Supervisor and the GOSW.

KSO5 Organisational Excellence – 2024/25 Major Projects

Continuous Improvement		Executive Lead: CSO Lead:	Reporting Month: Dec 24	Overall Status:
1. The QVH Way Continuous Improvement (CI) programme and milestones remain on track 2. Yellow belt – First cohort projects nearing completion with second cohort commencing projects linked to Trust's KSO's . Celebration and reflection event planned for March 2025 3. Working with Executive Leadership Team to ascertain projects in alignment with Trust's KSO's for the third Yellow belt cohort in February 2025 and Green belt in March 2025 4. Improvement huddle boards are operational in nine areas across the organisation, with a further seven areas planned for Q4 including Pharmacy and Strategy 5. Head of CI working with Interim Head of PMO to develop benefits realisation framework on improvements undertaken and planned across the organisation 7. Communication and engagement continues with regular articles in Connect. The CI team visits continue across implemented huddle board areas to support and embed the programme, with the development of a 'community of practice' for staff to share ideas and successes planned to commence in Q4 8. First executive and deputy CI masterclass scheduled for January 2025 9. Triumvirate training sessions completed, with huddle board development sessions planned for early January 2025 10. 2025/26 Year 2 of the CI programme final review in progress with CI partners, including alignment of new KSO's in conjunction with the Executive Leadership Team				
Milestones	Planned Date	Actual/Forecast Date	Commentary	
Continued CI training and huddle boards developed in areas across the organisation	Ongoing	Ongoing	Nine areas now in action, with a further seven areas planned for development in Q4	
Three Executive, Deputies and Triumvirate CI training sessions to be scheduled	30/09/2024	20/12/2024	Executive and Deputy CI executive masterclass scheduled for January 2025, two further sessions to be diarised	
Further support and training required for Triumvirate Leadership teams	16/12/2024	31/01/2025	Training completed, with productivity board training arranged for January 2025	
CI Awareness (Mandatory Training)	20/12/2024	28/02/2025	Video footage of December 2024 Yellow belt training required to brand the QVH Way approach. Plan to complete in Q4 with no impact to the overall programme delivery	
Risks / Issues	Description		Mitigating Action	
Organisational engagement	Risk of lack of engagement in the programme across the organisation		Engagement plans in place and associated milestones identified	

Interpretation of Summary Icons for Statistical Process Charts

		Assurance			
					
Variation/Performance		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
		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
		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 target	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
		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

Integrated Quality and Performance Report - Glossary

Abbreviation	Definition
AHP	Allied Health Professionals
BAF	Board Assurance Framework
BPPC	Better Practice Payment Code
BU	Business Unit
CD	Clinical Director
CDC	Community Diagnostic Centre
CDEL	Capital Departmental Expenditure Limit
CDI	Clostridium difficile infection
CEO	Chief Executive 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:	06/03/2025	Agenda reference:	132-25
Report title:	Capital Forecast 2024/25 update		
Sponsor:	Jon Bell, Interim Chief Finance Officer		
Author:	Jon Bell, Interim Chief Finance Officer		
Appendices:	None		

Executive summary

Purpose of report:	To provide an update on the capital spend position at the end of month 9 and the plans agreed by the Board to utilise the underspend.				
Summary of key issues	The Trust assessment of forecast spend on capital against the capital budget would leave a £2.8m underspend for 2024/25. The Trust has therefore drawn up plans to utilise this underspend on purchasing high priority medical equipment and digital assets that can be purchased and received prior to the year end. The Board was asked to approve this approach outside of the usual meeting cycle, due to the urgency and this was granted. The Board is now asked to ratify its approval of the revisions to capital allocations. All purchases have progressed using compliant procurement routes, using existing frameworks, and the capital budget is expected to be utilised in full.				
Recommendation:	The Board is asked to ratify it's out of meeting approval of the revisions to the capital allocation in Q4 2024/25 made in February 2025.				
Action required	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	<i>Outstanding patient experience</i>	<i>World-class clinical services</i>	<i>Operational excellence</i>	<i>Financial sustainability</i>	<i>Organisational excellence</i>

Implications

Board assurance framework:	KSO1, KSO2, KSO3, KSO4, KSO5
Corporate risk register:	None
Regulation:	None
Legal:	None
Resources:	none

Assurance route

Previously considered by:	Executive Leadership Team Board (out of meeting approval)			
	Date:	February 2025	Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 132-25
Date of meeting: 06 March 2025
Report from: Jon Bell, Interim Chief Finance Officer
Report author: Jon Bell, Interim Chief Finance Officer
Date of report: 27 February 2025
Appendices: None

Capital Forecast 2024/25 update

The Trust assessment of forecast spend on capital against the capital budget would leave a £2.8m underspend for 2024/25. The Trust has therefore drawn up plans to utilise this underspend on purchasing high priority medical equipment and digital assets that can be purchased and received prior to the year end.

The capital budget for 2024/25 is £13.3m with spend as at month 9 currently reported as £2.6m and a year-end forecast of £10.6m. This forecast assumes that the allocated estates capital is spent in full (£4.0m compared to a Month 9 spend of only £0.4m) and plans have been put in place to achieve this.

Brokerage of the capital underspend within the system has been explored but this is not an option.

The Digital Team and the Medical Equipment Group (chaired by the Chief Nursing Officer) have identified high priority capital purchases that equal £2.3m which can be delivered within this year and there is a further £0.5m allocated for capital programme costs. In addition, £0.87m of capital purchases have been identified that could be purchased in this year, albeit they are of a lower priority, if there are delays in any of the planned purchases.

In addition to the above, the Executive approved the purchase of £0.9m of medical equipment related to the Bognor CDC, funded through the CDC capital allocation.

The cash position of the Trust has been reviewed and as most of the capital programmes (e.g. CDC and EPR) are supported with cash, the Trust has sufficient cash to cover this spend within the original capital budget.

The Trust has significant capital pressures next year, particularly on the EPR programme, where the phasing of the national capital is not aligned to the programme phasing. The objective with how the capital underspend this year is utilised is to prioritise bringing forward spend that would otherwise need to be prioritised in 2025/26, freeing up that capital resource to support the capital pressures next year.

The Board was asked to approve this approach outside of the usual meeting cycle, due to the urgency and this was granted.

Following Board approval all purchases have progressed using compliant procurement routes, using existing frameworks, and the capital budget is expected to be utilised in full.

Recommendation

The Board is asked to ratify its out of meeting approval of the revisions to the capital allocation in Q4 2024/25 made in February 2025.

Report cover-page

References

Meeting title:	Board of Directors		
Meeting date:	06/03/2025	Agenda reference:	133-25
Report title:	Premises Assurance Model (PAM) Update		
Sponsor:	Abigail Jago, Acting Chief Executive Officer		
Author:	Claire Lowe, Interim Director of Estates and Facilities Melanie Tranmer, Compliance Manager Diane Talbot, Business Manager		
Appendices:	Appendix one - PAM submission 2024 Summary		

Executive summary

Purpose of report:	This is the annual PAM update to Board				
Summary of key issues	- PAM is a statutory requirement, which needs to be submitted in September each year. - An improved process is now in place to ensure correct sequencing ensuring board sign off prior to external submission for future years - Across the 491 assessment questions a rating is applied as either outstanding, good, moderate improvement, minimal improvement or inadequate and a number of areas were rated as inadequate. There were no new risks identified as part of this process and all estates risks and mitigations are on the risk register - PAM is managed and submitted by the Estates team but accountability rests with various teams for ensuring it is completed accurately and on time - The estates team is working with departments to produce a quarterly monitoring report to track progress which will be reported to Executive Leadership Team and Finance & Performance committee				
Recommendation:	For retrospective approval of PAM submission 2024 and noting improved process to ensure Board sign off prior to return in subsequent years				
Action required	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	<i>Outstanding patient experience</i>	<i>World-class clinical services</i>	<i>Operational excellence</i>	<i>Financial sustainability</i>	<i>Organisational excellence</i>

Implications

Board assurance framework:	KSO2 & KSO3
Corporate risk register:	A number of the areas which are investigated as part of the PAM process have already been identified within the Trust as risks and detailed on the department or corporate risk registers with appropriate mitigations in place.
Regulation:	NHSE / CQC
Legal:	None
Resources:	The resource required to complete PAM is significant and is currently led within the Estates compliance team.

Assurance route

Previously considered by:	Finance and Performance Committee (noting some subsequent update to paper)			
	Date:	24/02/25	Decision:	Approved
Next steps:	Trust Board review			

Report to: Board of Directors
Agenda item: 133-25
Date of meeting: 06 March 2025
Report from: Abigail Jago, Acting Chief Executive Officer
Report author: Claire Lowe, Interim Director Estates & Facilities
Melanie Tranmer Compliance Manager
Diane Talbot, Business Manager
Date of report: 27 February 2025
Appendices: Appendix one - PAM submission 2024 Summary

Premises Assurance Model (PAM) Update

Introduction

This report provides an update to the board on Premises Assurance Model (PAM) following its submission in October 2024.

Executive summary

PAM is a requirement from NHS England. It was first published in 2013 and was made mandatory for Trusts to complete in July 2022. The model supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services. It is one of a suite of documents that provides assurance that the estate is safe, efficient, and effective and of high quality.

PAM contains 491 self-assessment questions that cover 50 subject sections over 5 domains. The process is labour intensive and admin heavy and requires the co-operation and involvement of several different teams across the Trust. Subject matter experts in their fields from Estates & Facilities, Health & Safety, Chief Nurse, IPC and Staff & Patient Experience are all required to input into this return.

PAM is sent to Trusts in May to be submitted in September. NHS England granted an extension last year to several Trusts for the submission to be made in October due to internal resource and team changes. The PAM should be approved by the Board in advance of submission to NHSE.

The Board is being asked to retrospectively approve last year's PAM submission as due to team changes and deadlines for submission this return was submitted out of sync with that requirement. This has been scheduled into the board reporting schedule for future years and a strengthened governance framework that supports estates and facilities function is being implemented. A summary of QVH's submission can be found in appendix one – PAM Submission 2024

Situation

It is worth noting that the changes in scoring from previous years is not unexpected due to personnel changes within the estates team, the wider experience they bring and the significant focus on the estate and infrastructure requested and supported by the Board.

Responsibility for PAM

PAM is currently coordinated by the Estates Team, with input from subject matter experts across the Trust from Estates & Facilities, Health & Safety, Chief Nurse, IPC and Staff & Patient Experience. Progress with required actions is being monitored quarterly at ELT.

Risks and mitigation

The detail and breadth of the areas covered within this assessment are described in the appendix.

The areas which are investigated as part of the PAM process and have been rated as inadequate have already been identified within the Trust as risks and detailed on the department or corporate risk registers with appropriate mitigations in place.

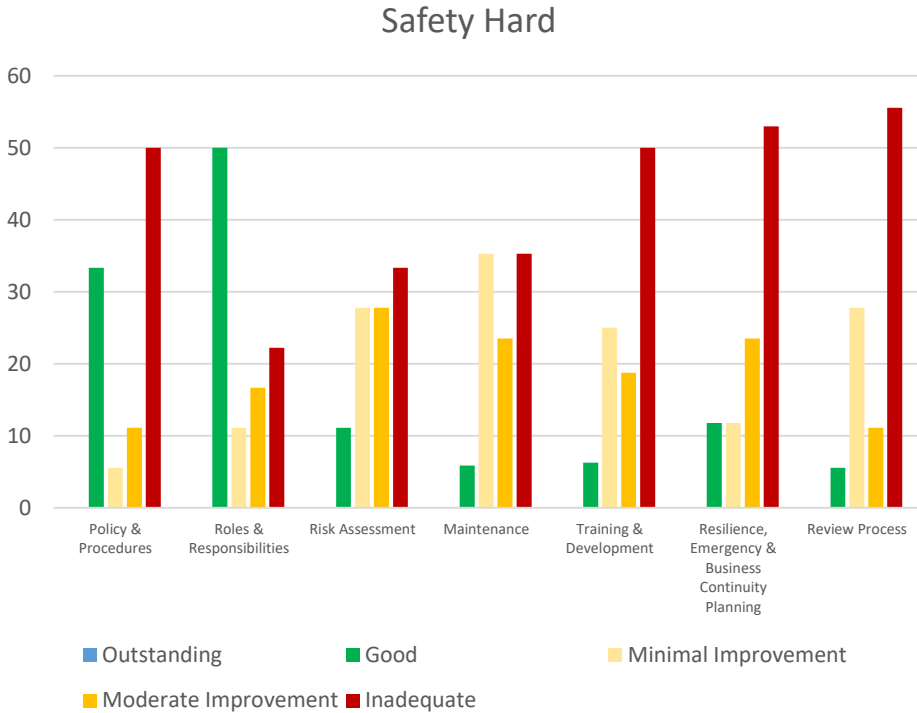
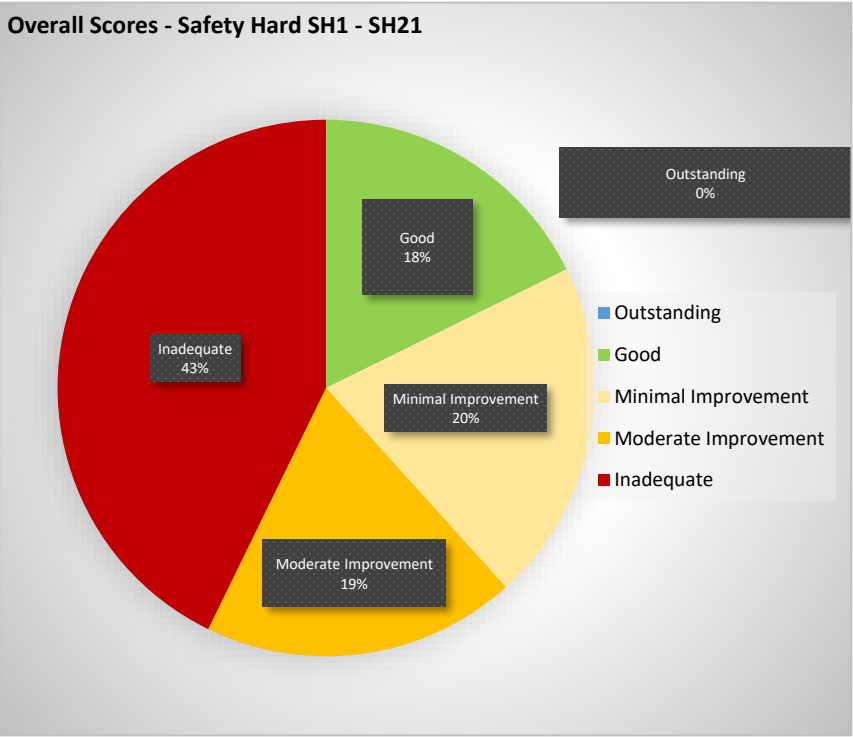
Recommendation

The Board is recommended to retrospectively **approve** the submission of the PAM 2024 and to note the improved process for oversight of future submissions.

Appendix 1 - PAM Submission 2024

Safety Hard – Section SH1 – SH21

1	Section	Areas - Safety Hard
	SH1	Estates & Facilities Operational Management
	SH2	Design, Layout and Use of Premises
	SH4	Health & Safety at Work
	SH5	Asbestos
	SH6	Medical Gas Systems
	SH7	Natural Gas and Specialist Piped Systems
	SH8	Water Safety Systems
	SH9	Electrical Systems
	SH10	Mechanical Systems
	SH11	Ventilation, Air Conditioning and Refrigeration Systems
	SH12	Lift, Hoists and Conveyance Systems
	SH13	Pressure Systems
	SH14	Fire Safety



Number	Questions
1	Policy & Procedures
2	Roles & Responsibilities
3	Risk Assessment
4	Maintenance
5	Training & Development
6	Resilience, Emergency & Business Continuity Planning
7	Review Process

Matrix Scores by %					
Number	Outstanding	Good	Minimal Improvement	Moderate Improvement	Inadequate
1	0	33.33	5.55	11.11	50
2	0	50	11.11	16.66	22.22
3	0	11.11	27.77	27.77	33.33
4	0	5.88	35.29	23.52	35.29
5	0	6.25	25	18.75	50
6	0	11.76	11.76	23.52	52.94
7	0	5.55	27.77	11.11	55.55
Overall Scores - Safety Hard SH1 - SH21	0	123.88	144.25	132.44	299.33

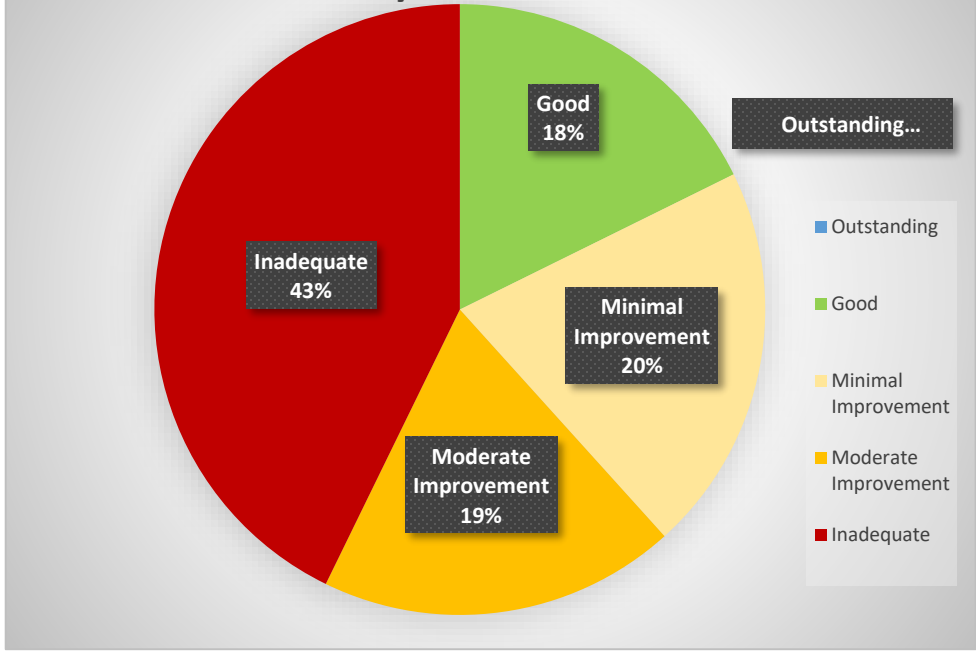
Safety Hard – Section SH1 – SH21

Section	Areas - Safety Hard
SH1	Estates & Facilities Operational Management
SH2	Design, Layout and Use of Premises
SH4	Health & Safety at Work
SH5	Asbestos
SH6	Medical Gas Systems
SH7	Natural Gas and Specialist Piped Systems
SH8	Water Safety Systems
SH9	Electrical Systems
SH10	Mechanical Systems
SH11	Ventilation, Air Conditioning and Refrigeration Systems
SH12	Lift, Hoists and Conveyance Systems
SH13	Pressure Systems
SH14	Fire Safety
SH16	Resilience, Emergency and Business Continuity Planning
SH17	Safety Related Issues
SH18	Services - Safe & Suitable
SH19	Contract Management for Soft and Hard FM Services
SH21	Self-Harm - Risks

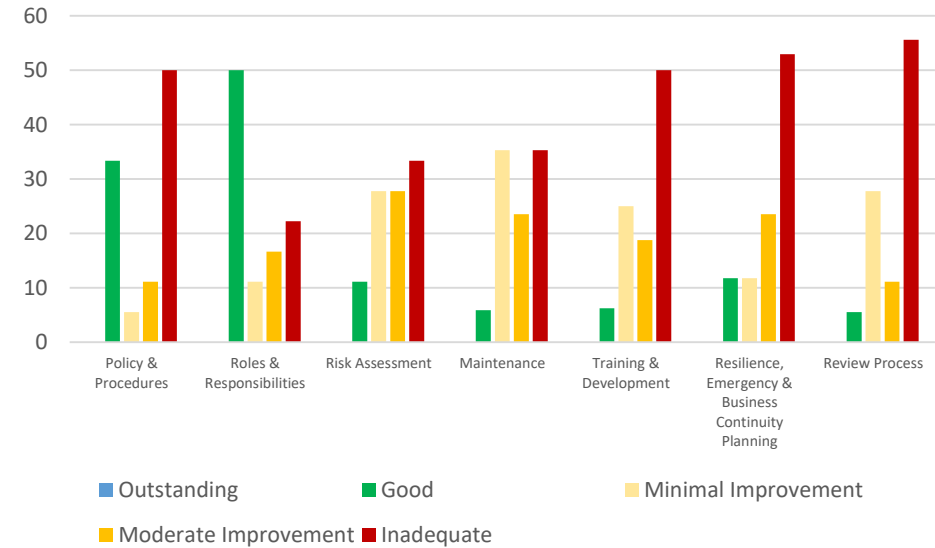
Number	Questions
1	Policy & Procedures
2	Roles & Responsibilities
3	Risk Assessment
4	Maintenance
5	Training & Development
6	Resilience, Emergency & Business Continuity Planning
7	Review Process

Notes	
SH3	Estates and Facilities Documentation Management (not Included)
SH15	Medical Devices -N/A
SH20	This Section Has Been Taken Out

Overall Scores - Safety Hard SH1 - SH21



Safety Hard

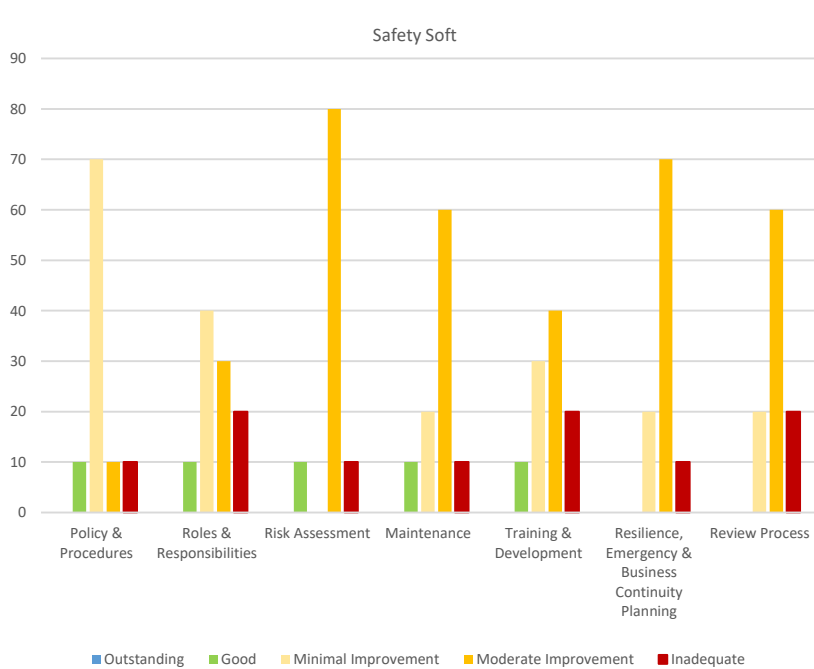
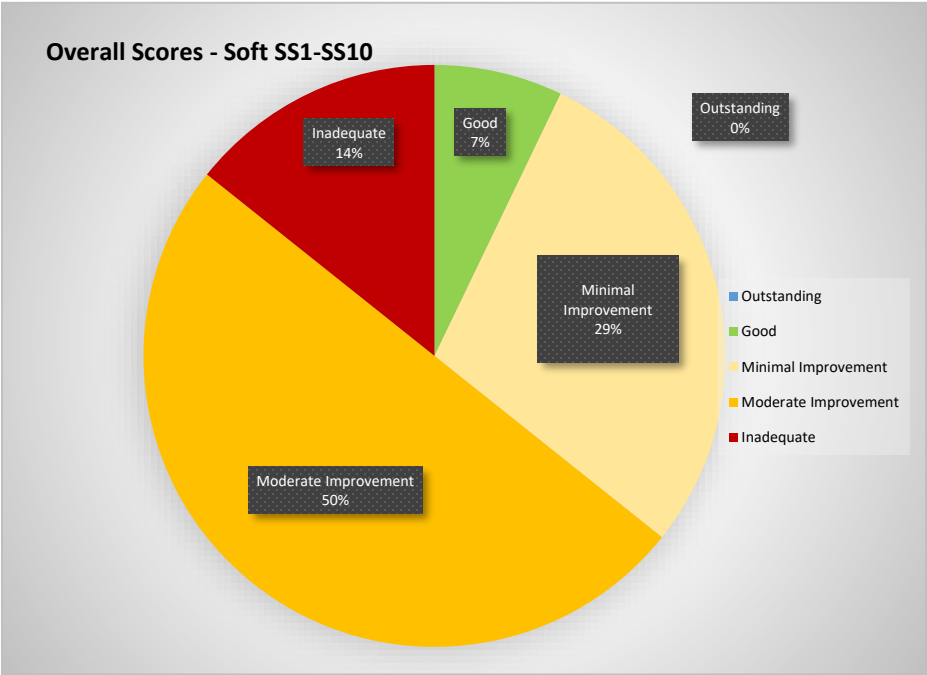


Safety Soft

Section	Areas - Safety Soft
SS1	Catering Services
SS2	Decontamination Process
SS3	Waste & Recycling
SS4	Cleanliness & Infection Control
SS5	Laundry and Linen Services
SS6	Security Management
SS7	Transport Services
SS8	Pest Control
SS9	Portering Services
SS10	Estates IT and Building Information Management Systems

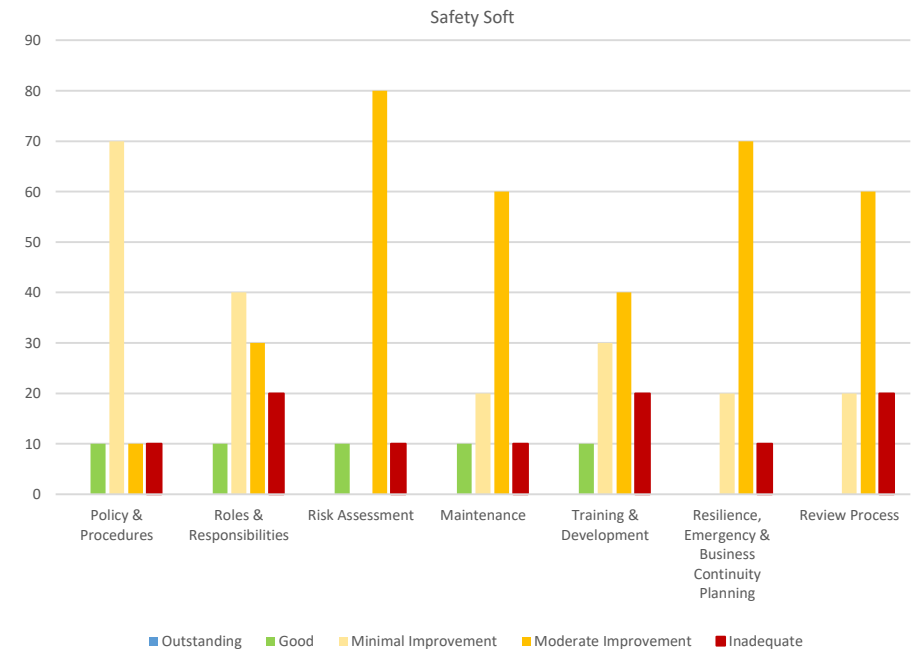
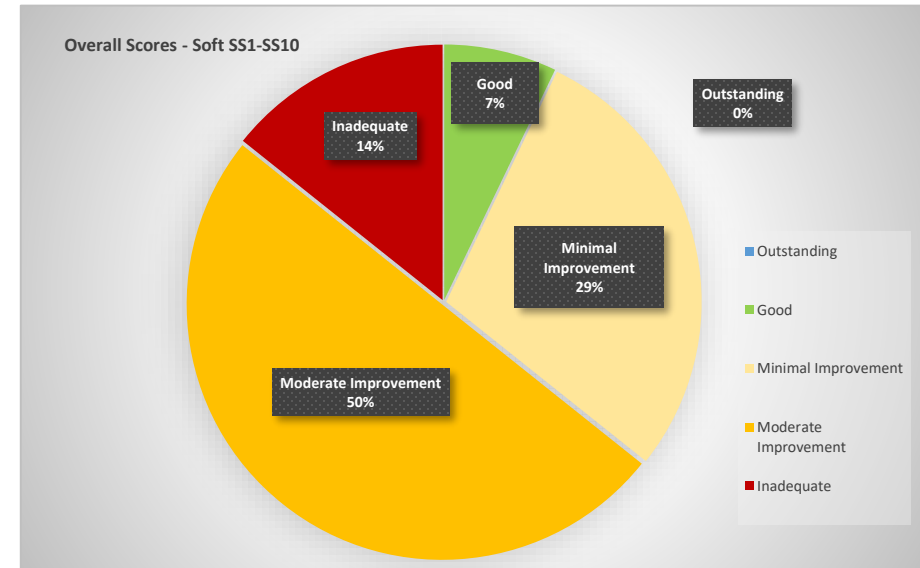
Number	Questions
1	Policy & Procedures
2	Roles & Responsibilities
3	Risk Assessment
4	Maintenance
5	Training & Development
6	Resilience, Emergency & Business Continuity Planning
7	Review Process

Matrix Scores by %					
Outstanding	Good	Minimal Improvement	Moderate Improvement	Inadequate	
0	10	70	10	10	
0	10	40	30	20	
0	10	0	80	10	
0	10	20	60	10	
0	10	30	40	20	
0	0	20	70	10	
0	0	20	60	20	



Section	Areas - Safety Soft
SS1	Catering Services
SS2	Decontamination Process
SS3	Waste & Recycling
SS4	Cleanliness & Infection Control
SS5	Laundry and Linen Services
SS6	Security Management
SS7	Transport Services
SS8	Pest Control
SS9	Portering Services
SS10	Estates IT and Building Information Management Systems

Number	Questions
1	Policy & Procedures
2	Roles & Responsibilities
3	Risk Assessment
4	Maintenance
5	Training & Development
6	Resilience, Emergency & Business Continuity Planning
7	Review Process

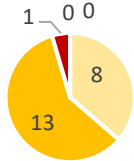


1	Section	Areas - Patient Experience
	P1	Engagement and Involvement
	P2	Condition Appearance Maintenance Privacy and Dignity
	P3	Cleanliness of the Estates & Facilities
	P4	Access and Car Parking arrangement
	P5	Providing High Quality and Supportive Environment
	P6	Catering Standards

Matrix Scores - Out of 22 Questions				
Outstanding	Good	Minimal Improvement	Moderate Improvement	Inadequate
0	0	8	13	1

Patient Experience 22 Questions

- Outstanding
- Good
- Minimal Improvement
- Moderate Improvement
- Inadequate

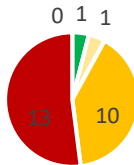


2	Section	Area - Efficiency
	F1	Performance Management of the Estates and Facilities Operations
	F2	Approach to Improved Efficiency in Running Estates & Facilities
	F3	Efficiencies in Capital Procurement Refurbishments and Land Management
	F4	Robust Financial Controls Procedures and Reporting
	F5	Estates & Facilities Services are Continuously Improved and Sustainability

Matrix Scores - Out of 25 Questions				
Outstanding	Good	Minimal Improvement	Moderate Improvement	Inadequate
0	1	1	10	13

Efficiency 25 Question

- Outstanding
- Good
- Minimal Improvement
- Moderate Improvement
- Inadequate

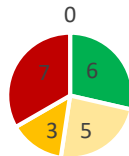


3	Section	Area - Effectiveness
	E1	Vision and Strategy to Deliver good quality Services to Estates & Facilities
	E2	Town Planning
	E3	Management of Land and Property
	E4	Sustainability

Matrix Scores - Out of 21 Questions				
Outstanding	Good	Minimal Improvement	Moderate Improvement	Inadequate
0	6	5	3	7

Effectiveness 21 Questions

- Outstanding
- Good
- Minimal Improvement
- Moderate Improvement
- Inadequate

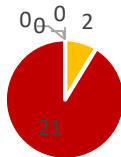


4	Section	Area -Governance
	G1	Governance Framework
	G2	Vision and Values
	G3	Access to Professional Advice

Matrix Scores - Out of 21 Questions				
Outstanding	Good	Minimal Improvement	Moderate Improvement	Inadequate
0	0	0	2	21

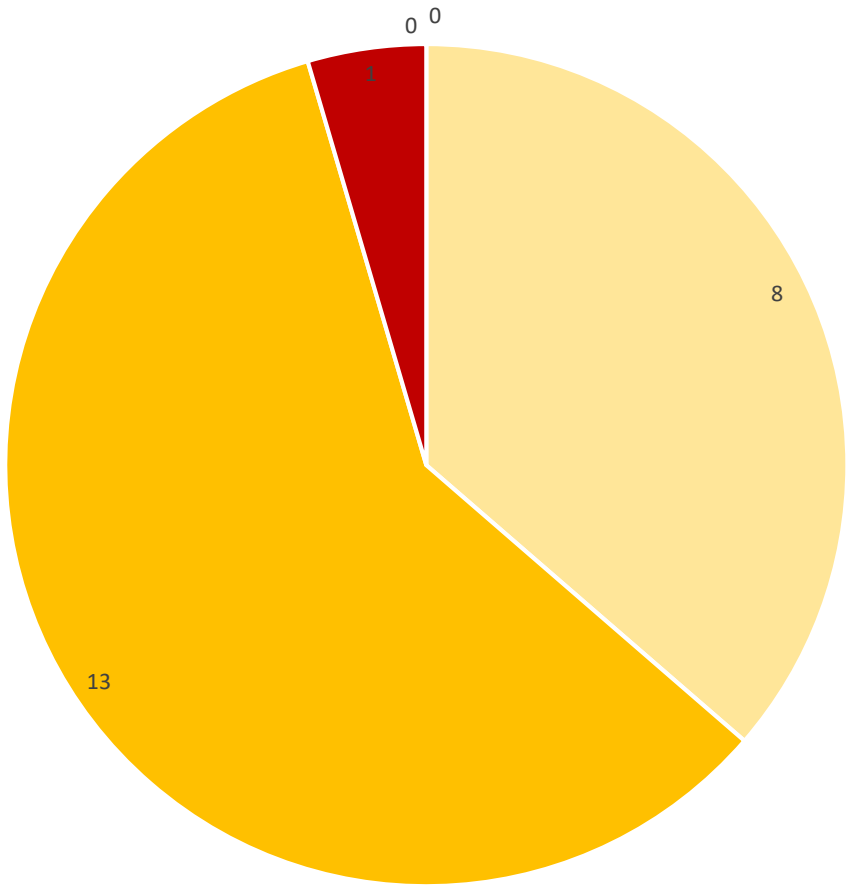
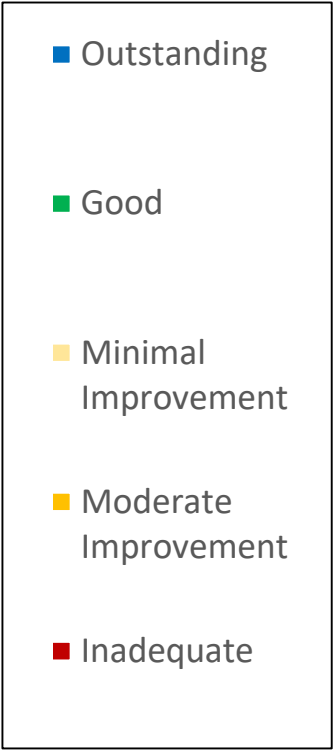
Governance 21 Questions

- Outstanding
- Good
- Minimal Improvement
- Moderate Improvement
- Inadequate



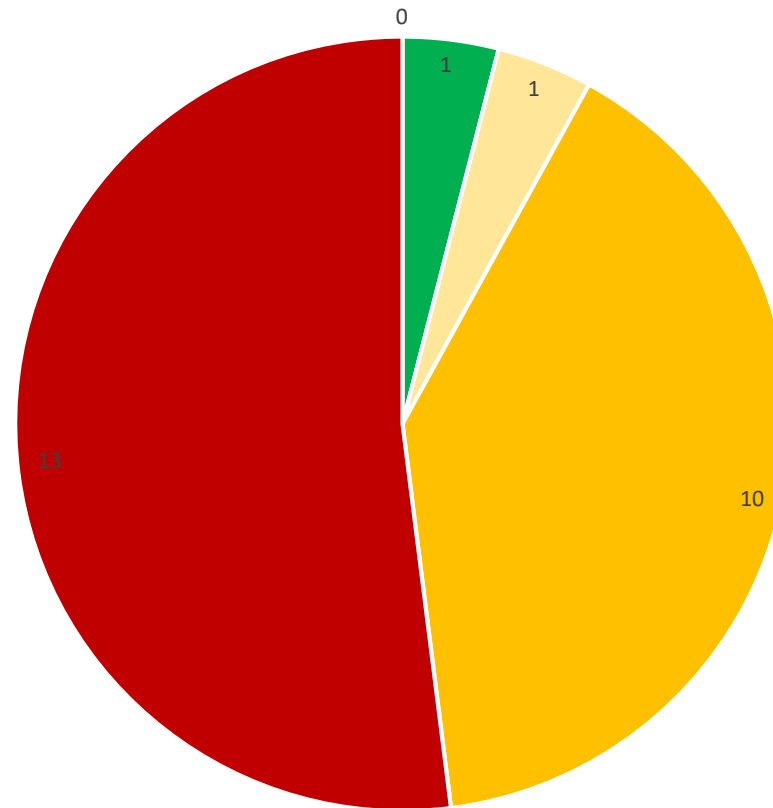
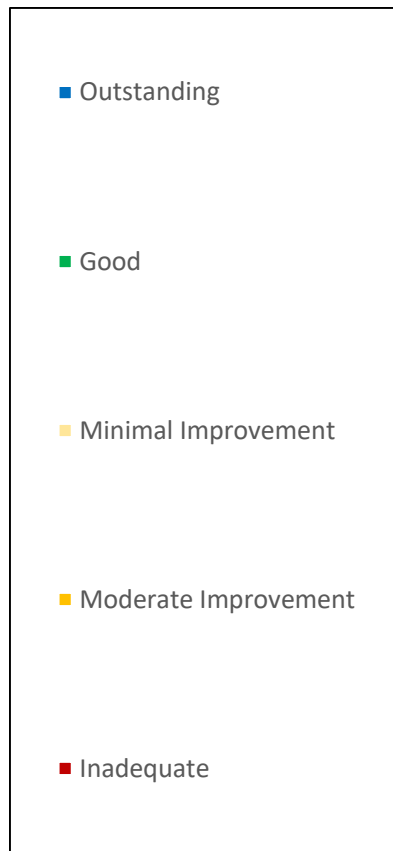
Within each of the above areas the questions were non-identical and therefore were scored within each section.

Patient Experience
22 Questions

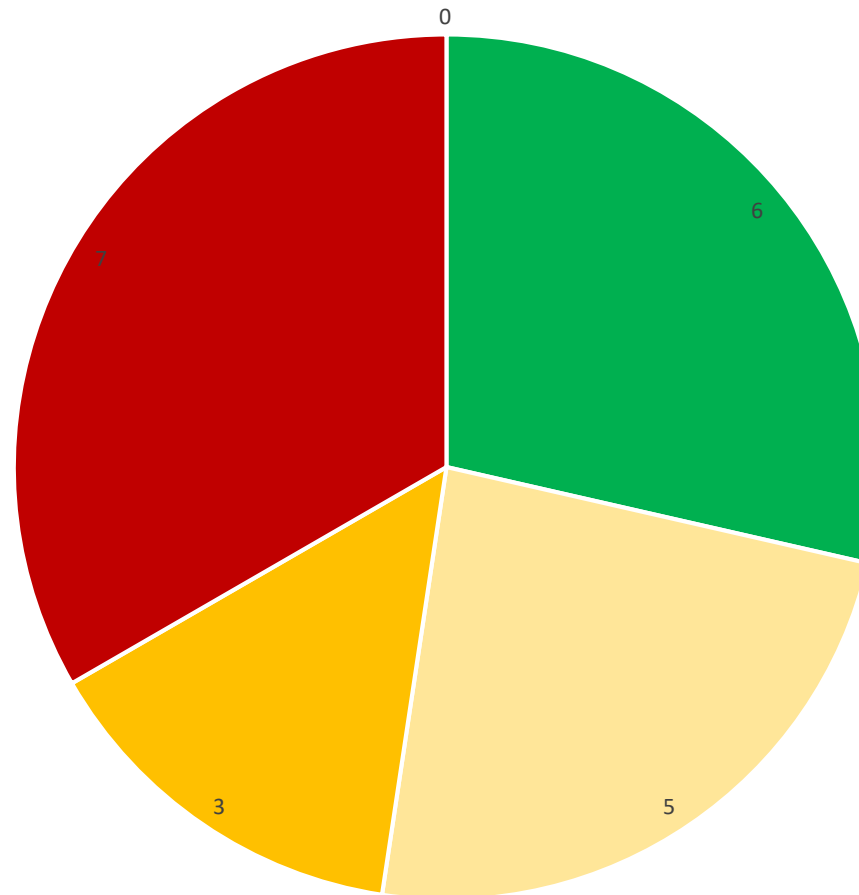


Efficiency

25 Questions

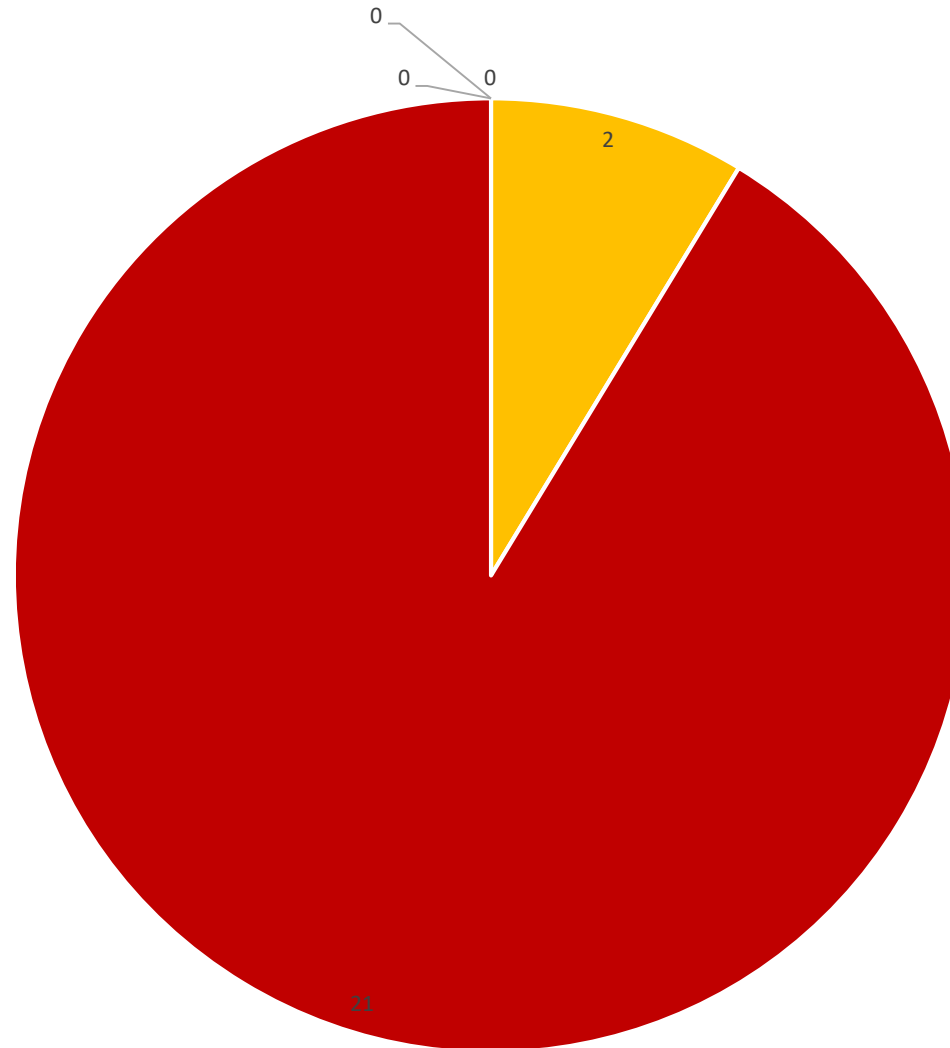


Effectiveness 21 Questions



Governance

21 Questions



Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/03/2025		Agenda reference:	134-25	
Report title:	Annual Equalities Report 2023-2024				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Sacha Campbell, Wellbeing and Inclusion Manager Lawrence Anderson, Deputy Chief People Officer				
Appendices:	Annual Equalities Report: 2023 - 2024				
Executive summary					
Purpose of report:	To provide an annual update on the Trust’s Equality, Diversity and Inclusion (EDI) metrics and challenges, providing context in our local area. The report provides an overview of the EDI metrics in 2023-24 and compares with population data for Mid Sussex, which is more representative of our workforce than just the local East Grinstead area. This report summarises our WRES, WDES and additional EDI data and is in a revised format to provide a concise display of information. The report also provides an update on our performance against the NHS EDI 6 High Impact Actions. This is a retrospective report based on data already presented at board from 31 March 2024.				
Summary of key issues	This report expands on the previously reported and considered WRES, WDES and Pay reports for the Trust. • The Trust has a higher representation of those with protected characteristics than those in Mid Sussex, apart from the age of our youngest workforce and those with a declared disability. • The trust has seen improvements in the last 3 years in declaration of disability, the number of staff from a Black and Ethnic Minority background, those declaring their sexuality, and an increase in staff declaring their faith or belief away from Christianity. • Our workforce between the ages of 21-25 has increased the most, however remains below the age profile of Mid Sussex with our most represented age group between the ages of 46-50. • White candidates account for the highest number of appointments into roles, despite there being fewer white applicants than those from an Asian or black background. • Staff from outside the UK / from a BME background report as having a worse work experience compared to their white colleagues				
Recommendation:	To note the report ahead of publication on the public facing website.				
Action required	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	To deliver outstanding care	To innovate and improve	To be an excellent employer	To deliver sustainable services	To collaborate with others
Implications					
Board assurance framework:	BAF 2				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Leadership Team				

	Finance and Performance Committee			
	Date:	10/02/2025 24/02/2025	Decision	Report approved for Public Board
Next steps:	Once approved report will be published on the public facing website.			

Report to: Board of Directors
Agenda item: 134-25
Date of meeting: 06 March 2025
Report from: Helen Edmunds, Chief People Officer
Report author: Lawrence Anderson, Deputy Chief People Officer
 Sacha Campbell, Wellbeing and Inclusion Manager
Date of report: 5 February 2025
Appendices: Annual Equalities Report 2023-24

Annual Equalities Report 2023-24

Introduction

The Annual Equalities Report provides information on our key Equality, Diversity and Inclusion (EDI) data and metrics as at 31 March 2024. During this time QVH have reported and presented its Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and national pay gap reports for Gender and Ethnicity. This paper provides a summary to the accompanying report along with insights to what our data is telling us.

Equality and Diversity summary

As a Trust, the diversity of our workforce increased in the year 23/24. QVH has seen a 1.63% increase in BME representation to 21.20% across the organisation, and our disabled staff representation increased by 0.9% to 6.67% across the organisation.

Staff reported race discrimination had decreased and this was echoed amongst an increase in disabled colleagues who reported they believed the trust provided equal opportunities for career progression or promotion. However, BME staff reported they were over 4 times more likely to experience discrimination than their white colleagues.

Bullying and Harassment amongst those from a BME background or who have a disability remains a concern. Staff from these groups continued to report higher proportions of these behaviours than their white and non-disabled colleagues. 27% of BME staff and 28% of disabled staff reported they experienced bullying and harassment from patients.

The likelihood of candidates from a BME background being appointed into roles in the Trust also represented a challenge in 23/24, and saw an increase of 0.41 in the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants. For disabled staff the likelihood was much better. The likelihood of disabled candidates being appointed into roles went from 2.05 in 22/23 to 1.11 in 23/24.

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.

The overall Trust gender pay gap for 2024 is 33.1% (Mean) and 32.2% (Median).

There is a significant ethnicity pay gap in favour of BME colleagues (mean gap - 20.79%, median gap -29.67%).

For 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.

Insights

1. Staff from outside the UK or a BME background and those with disabilities report as having a worse experience in the workplace than their white and non-disabled colleagues. Evidence in the 2023 staff survey and the analysis undertaken in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports highlight this an issue for QVH. However, reporting of bullying and harassment incidents and cases are low amongst staff from these staff groups.

In summary, to address this the Trust are:

- a. Undertaking listening work with our staff to understand where and why there are barriers to reporting inappropriate behaviours and how these barriers can be removed.
 - b. QVH will be undertaking a series of cultural reviews with teams and departments to understand where poor cultures exist, alongside increasing staff confidence to report concerns.
 - c. The Trust have established an EDI Group to help foster a compassionate and inclusive culture alongside introducing a People Promise Manager utilising national funding to implement the areas of the national people promise, including being compassionate and inclusive alongside improving employee engagement.
 - d. Increasing the amount of EDI Champions across the organisation to improve trust and confidence across the workforce, and provide an additional platform to raise concerns
2. Evidence shows candidates from a white background are twice as likely to be appointed from shortlisting as BME candidates. This gap has narrowed for those candidates with a disability. Asian and black applicants are most likely to

apply, but less likely to progress to shortlisting, interview and appointment than white applicants. In order to address this the Trust are:

- a. Seeking to provide ongoing training to recruiting managers to highlight the importance in equality and diversity in recruiting staff
 - b. Review of additional data to understand numbers from application to shortlisting as there are often applications for roles from unqualified people from outside of the UK
 - c. Embedding diverse interview panels across the organisation to ensure broader perspectives are accounted for, to reduce bias and provide improved decision making to promote fairness and inclusivity.
 - d. Undertake a thorough review of the current recruitment process and practice and identify opportunities to increase diversity of applicants and candidates.
3. QVH has a large gender pay gap, which is higher than the benchmark of other Trusts nationally. Our gender pay gap is 33.1% mean and 32.2% median, and largely driven by our consultant body and men in senior agenda for change positions. As a trust we have a higher proportion of women undertaking lower banded roles at the Trust alongside a significant proportion of our workforce at the top of their bands both in Agenda for Change roles and Medical & Dental roles provides stagnation year on year in bringing the gap down.
- a. Analysis has been undertaken for the last 4 years and shows a significant improvement in the gender pay gap, particularly amongst Medical and Dental staff and in the last 2 years the gap of newly recruited staff is 1.11% mean and 2.18% median.
 - b. The trust have introduced stricter workforce controls led by members from the Executive leadership team to provide scrutiny to all additional pay requests and uplifts.
 - c. The trust continues to work with our Deaneries and higher education providers to support flexible programmes and working patterns to attract a more diverse workforce.

Recommendation

The Board is asked to note the contents of the report prior to publication of the report on the Trust's public facing website.

Annual Equalities Report

1 April 2023 – 31 March 2024



Slide	Content
3	Executive summary
4	Introduction
5	Data, limitations & language
6	2024 National report summaries
8	QVH and our local community
17	3-year diversity progress
24	Attraction and recruitment
29	Staff experience
34	NHS England High Impact Actions update 2023/24

Executive Summary

Background

This report runs from 1 April 2023 - 31 March 2024

As of 31 March 2024, we had 1,221 staff members

Among our staff:

- 75.8% are female, and 24.2% are male
- 21.2% are from ethnic minority backgrounds
- 26.6% were born outside of the UK
- 6.7% have declared a disability
- 3.1% identify as LGB+

This report tells us:

- Both BME and disabled staff have a poorer experience of equality and inclusion at QVH and are less likely to report this internally
- The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants has increased by 0.41 since 2022/23
- Female staff are less likely than male staff to be in higher paid roles
- BME staff are more likely than white staff to be in higher paid AfC roles (-20.79% mean gap), but less in M&D roles (8.89% mean gap)
- Applicants with a disability are less likely to apply for roles, or less likely to declare their disability (2.1% of applications in 2023/24)
- Colleagues from marginalised groups may be reluctant to disclose their diversity data

In 2023/24, we have:

- Improved our representation of BME, disabled and LGB+ staff
- Established an EDI group as the focus for all of our EDI work
- Developed the Progress Pride Pledge
- Revised the appraisal process to incorporate wellbeing and career development
- Held work experience events and offered work experience placements
- Established a Workforce Controls group to review all requests for pay rises and additional payments

Going forward, we will:

- Review individual and collective Executive and Board objectives
- Develop a programme of support for managers to extend the range of apprenticeships available
- Develop initiatives to attract apprentices from diverse backgrounds
- Develop targeted career pathways for all staff groups
- Collaborate to develop a restorative, just learning culture approach to incidents, where appropriate



Introduction

Who we are

Queen Victoria Hospital NHS Foundation Trust (“QVH”) is an organisation, with 1,221 people in full and part time posts as at 31 March 2024.

QVH is based in East Grinstead, with some colleagues based in spoke sites in Kent, Surrey and other locations in Sussex.

We are proud to support a multicultural workforce, represented by **55** nationalities. QVH also benefits from a range of diverse ethnicities, ages, abilities, beliefs and sexual orientations.

Our approach

We recognise the people that work at QVH are our greatest asset and the heart of the services we provide.

We are guided by our values of **‘quality, pride and humanity for continuous improvement’** to attract, recruit and retain a skilled and diverse workforce.

In this report, we provide an overview of our equality and diversity monitoring data as of 31 March 2024, identifying areas of improvement, progress to date and setting goals for the future.

Our responsibilities

At QVH, we are legally required to promote equality in all that we do as an employer and service provider.

The Public Sector Equality Duty of the Equality Act 2010 requires us to actively:

1. Eliminate discrimination
2. Advance equality of opportunity
3. Foster good relations between people with protected characteristics and those without.

Protected characteristics include age, disability, ethnicity or race, sex, gender reassignment, marital status, pregnancy and maternity status, religion/belief and sexual orientation.

Data, limitations and language

Data

The data in this report relates only to staff directly and substantively employed or appointed by QVH, including those on secondment, hosted by QVH. This does not include those on honorary contracts who are directly employed by other healthcare providers.

Internal data has been gathered from the Trust's Electronic Staff Record system ("ESR") and applicant tracking system, Trac. Local community data has been sourced from the Office for National Statistics' 2021 Census.

Limitations

Data categories from the 2021 Census do not align exactly to ESR and Trac data; where this occurs, data has been categorised on a best-fit basis.

Data for transgender and non-binary staff cannot be captured as ESR does not offer options to declare a gender identity outside of the binary (female and male).

Language

It is important to note the terminology and language used within equality legislation do not always reflect the identities, preferences and lived experiences of individuals.

Within this report, we use the term "disability" as it is defined in the Equality Act 2010 and reflected in NHS Workforce Disability Equality Standard ("WDES") terminology. However, we recognise that some who fall under the legislative definition may not consider themselves to have a disability.

When referring to ethnicity, this report uses the term "Black and minority ethnic" to refer to groups of people whose ethnicity or race is a key factor in their experience at work. This is to ensure consistency with NHS Workforce Race Equality Standard terminology. However, we recognise that some prefer other terms, such as "global majority" or "racialised groups".

2024 National report summaries

WRES

- 2023/24 saw an increase of **1.63%** in BME staff, growing from **19.57%** in 2023 to **21.20%** in 2024
- Rates of harassment, bullying or abuse from staff towards BME colleagues have significantly decreased by **8.26%**, though remains high at **21.7%**
- **4.24%** fewer BME staff report discrimination at work from their manager, team leader or other colleagues
- BME staff are over **4** times as likely to experience discrimination compared to white staff
- The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants has increased by **0.41** since 2022/23

WDES

- 2023/24 saw an increase of **0.9%** in staff who have declared a disability, growing from **5.77%** in 2023 to **6.67%** in 2024
- 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 2023 to **61.1%** in 2024
- Bullying and harassment towards disabled staff from managers has increased by **1.4%**, from **14.6%** in 2023 to **16.0%** in 2024

Gender Pay

- The Trust's gender pay gap for 2024 is **33.1%** (mean) and **32.2%** (median)
- The AfC gender pay gap for is **7.83%** (mean) and **5.83%** (median)
- The Medical and Dental gender pay gap is **16.9%** (mean) and **11.31%** (median). This is a significant median improvement from 2023 (**31.3%**)
- Staff in Admin & Clerical have seen the pay gap reduce from 2023 by **7.87%**, however it remains significant at **27.07%** (reduced from 34.94%)
- This is due in part to a disproportionate number of men in more senior admin roles and senior male clinicians earning top of grade and bonus payments relative to our total workforce

Ethnicity Pay

- Colleagues from a multicultural background represent **21.25%** of the workforce, with year-on-year increases seen
- For the workforce overall there is a significant ethnicity pay gap in favour of BME colleagues (**-20.79%** mean and **-29.67%** median)
- The AfC ethnicity pay gap is **-3.32%** (mean) and **-27.46%** (median), both in favour of BME staff
- The Medical and Dental pay gap is **8.89%** (mean) and **22.14%** (median), both 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.



QVH and our local community

In summary:

QVH has a **higher representation of female, BME, and international colleagues** compared to the Mid Sussex community.

The **majority of QVH colleagues are aged 56-60**, with lower representation in the highest and lowest age bands.

QVH has a **lower representation of colleagues with declared disabilities** compared to the Mid Sussex community.

QVH has **higher representation in terms of ethnicity, birth region, and sex** compared to the local community.

QVH colleagues are **more likely to be married or in a civil partnership** and have a higher representation of various faiths and beliefs.

QVH has a **higher representation of LGB+ colleagues**, though many opt not to disclose their sexual orientation.

Pages:

9 10 11 12 13 14 15 16 17



3-year diversity progress

In summary:

There has been an **increase** in the number of colleagues declaring a **disability, female colleagues, and BME colleagues** since 2022.

The number of colleagues **not disclosing** their sexual orientation has **decreased**, while those declaring as **Gay/Lesbian or Bisexual** have **increased**.

The number of colleagues declaring various **faiths and beliefs** has **increased**, with a minor increase in non-disclosure.

The number of colleagues in **civil partnerships** has **increased**, while **married** colleagues have **decreased**.

Age representation has seen **increases** in the **youngest and oldest** age bands.

18 19 20 21 22 23 24



Attraction and recruitment

In summary:

Female applicants are **more likely** to apply, be shortlisted, interviewed, and appointed compared to male applicants.

Applicants aged **25-29** are **most likely** to apply, while ages **40-44** are **most likely** to be appointed.

White applicants are **more likely** to be shortlisted, interviewed, and appointed compared to other ethnicities.

Applicants **without** a declared disability are **more likely** to be appointed.

Heterosexual applicants are **more likely** to be appointed, with representation **increasing** for **Gay/Lesbian** applicants at shortlisting and appointment stages.

25 26 27 28 29



Staff experience

In summary:

White staff scored QVH higher for **Diversity & Equality**, while **BME staff** scored higher for **Inclusion**.

Female staff scored higher for **Diversity & Equality**, while **male** staff scored marginally higher for **Inclusion**.

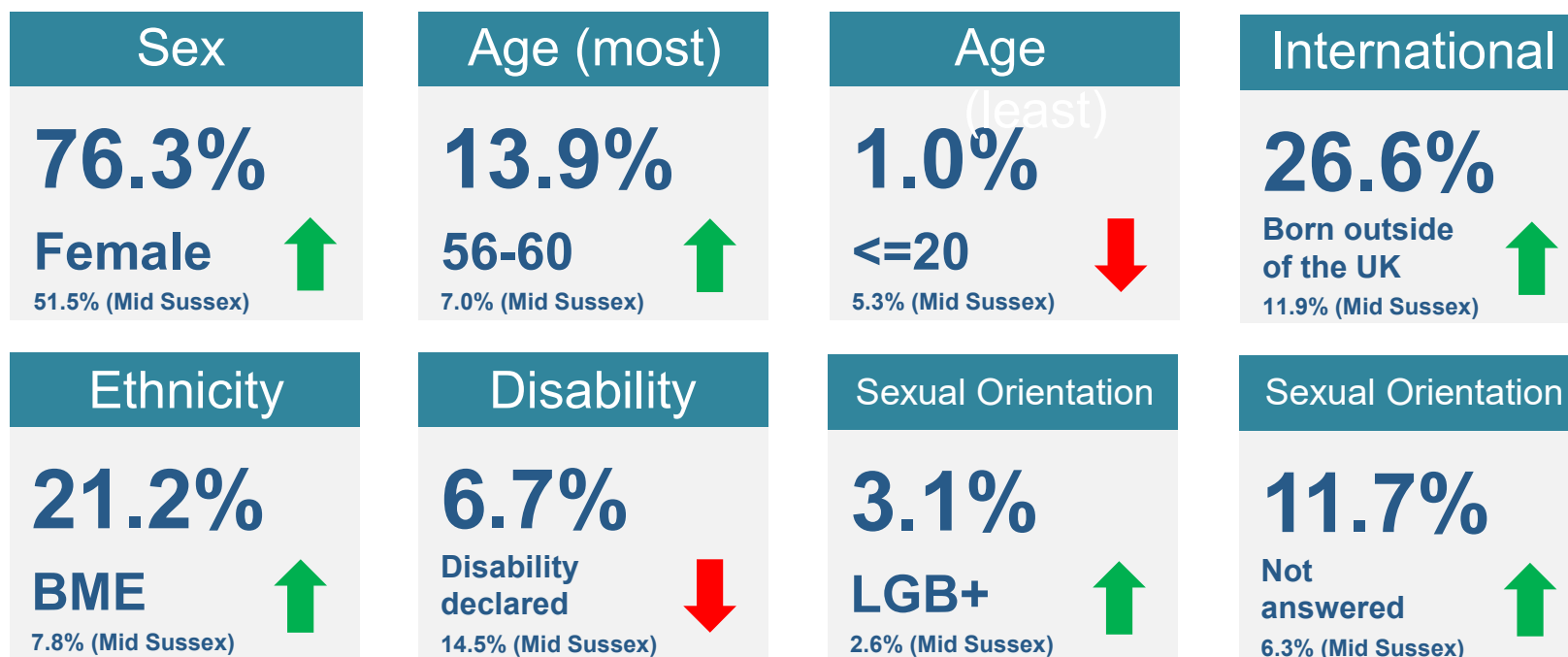
Disabled colleagues scored **lower** for both **Diversity & Equality** and **Inclusion** compared to colleagues without a disability.

Bisexual colleagues scored lower for both **Diversity & Equality** and **Inclusion** compared to heterosexual colleagues.

30 31 32 33 34

At a glance

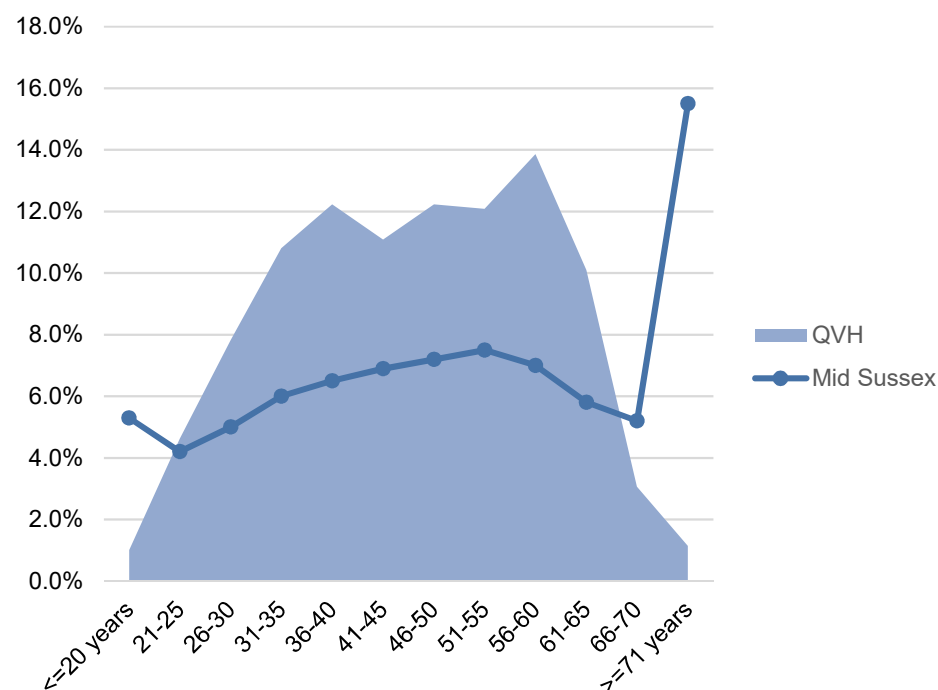
QVH representation is **lower** than Mid Sussex
 QVH representation is **higher** than Mid Sussex



Age

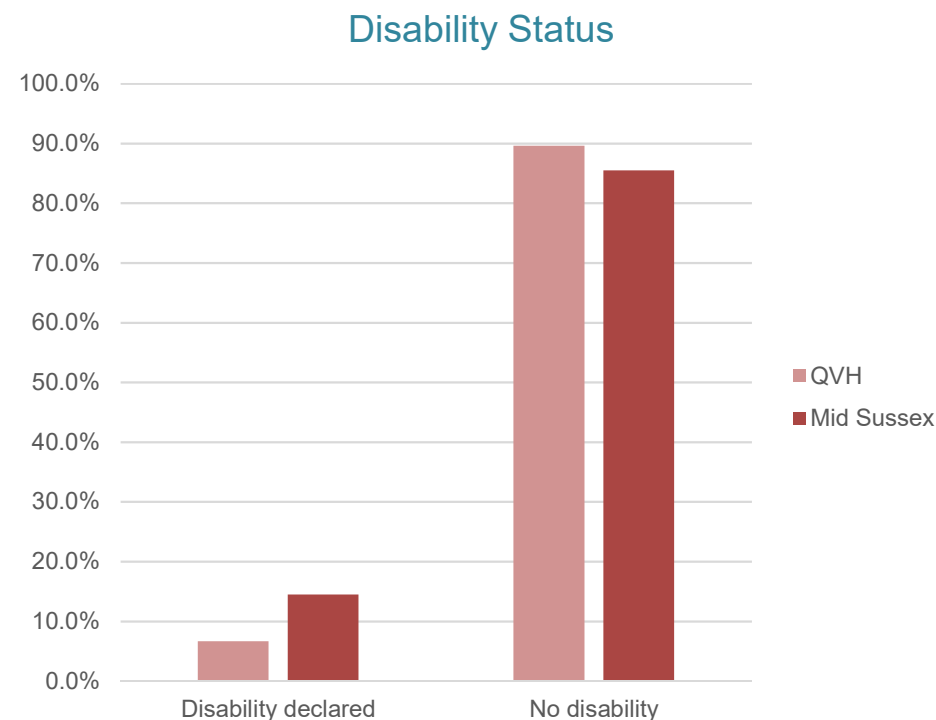
- QVH has a higher representation of ages **26-60** than Mid Sussex
- The majority of QVH colleagues are aged **56-60**, after which representation reduces compared to the Mid Sussex community
- QVH is least represented within the highest and lowest age bands at **1.1%** and **1%** respectively
- Mid Sussex overall has a much larger population of those at **71** years of age or older; however, it is important to note that **23.9%** of Mid Sussex residents report that they are retired, which may account for this difference.

Age Banding



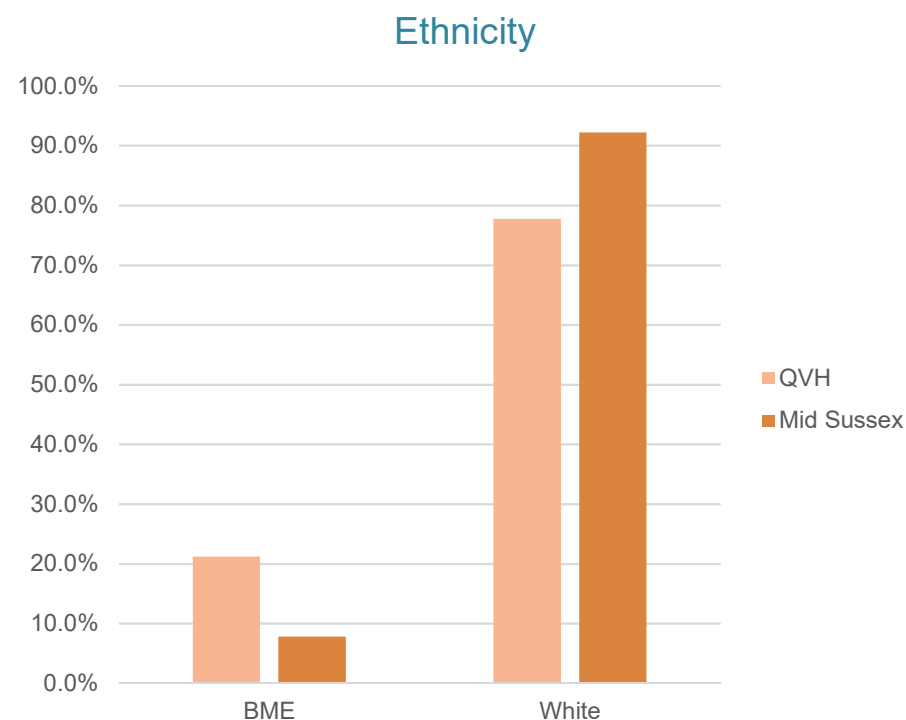
Disability

- QVH has a lower representation of colleagues who have declared a disability than the Mid Sussex community by approximately half (**6.7%** vs. **14.5%**)
- However, **35.5%** of Mid Sussex residents describe themselves as economically inactive, including those seeking work, retirees, those undertaking full-time education, those looking after the home or family and those who are too unwell to work.
- Of this **35.5%**, **2.2%** of Mid Sussex residents describe themselves as too unwell to work due to long-term sickness or disability.



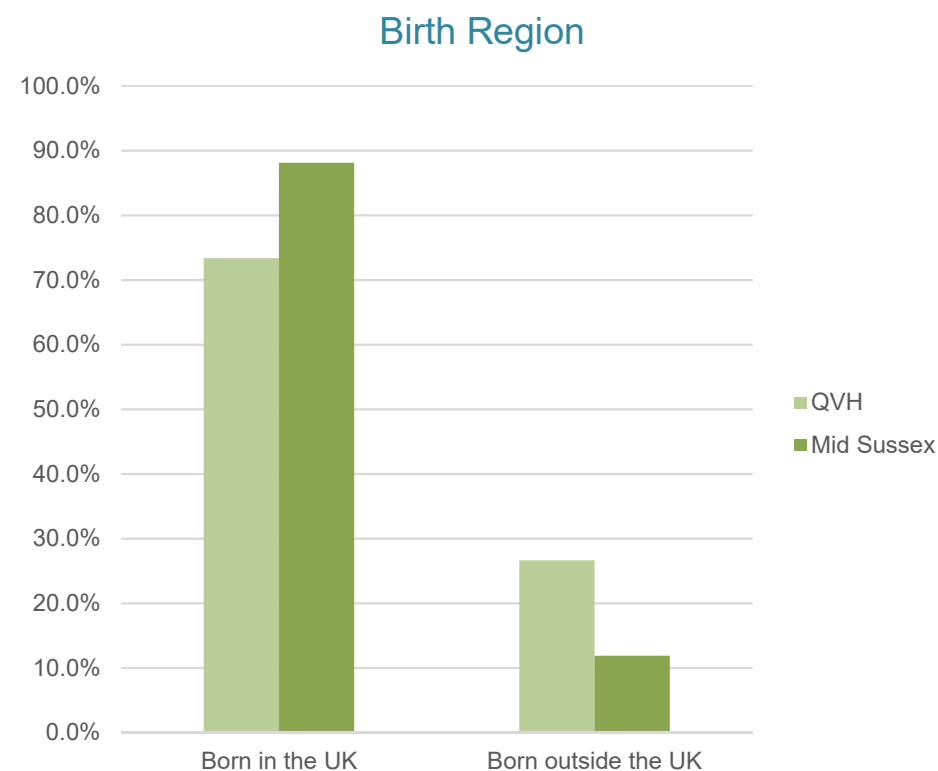
Ethnicity

- QVH has a **higher** representation of BME colleagues than the Mid Sussex community (**21.2%** vs. **7.8%**)



Birth Region

- QVH has a **higher** representation of colleagues born outside the UK than the Mid Sussex community (**26.6%** vs. **11.9%**)



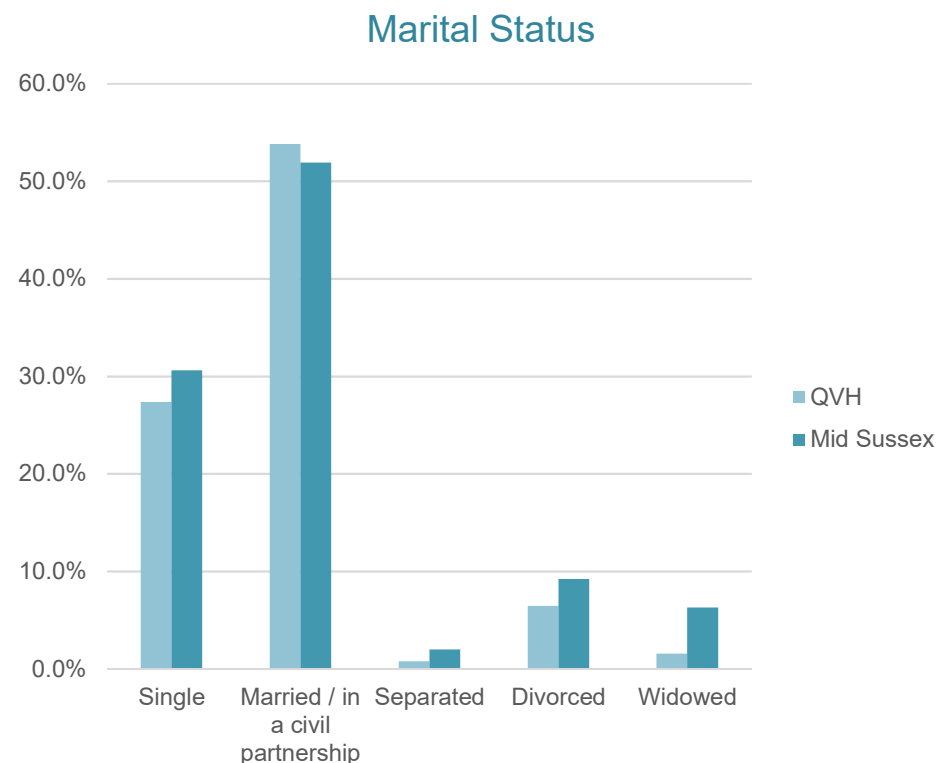
Sex

- QVH has a **higher** representation of female colleagues than the Mid Sussex community (**76.3%** vs. **51.5%**)
- However, it is important to note that other genders that may be present at QVH, such as intersex, transgender and non-binary, cannot be recorded on ESR.



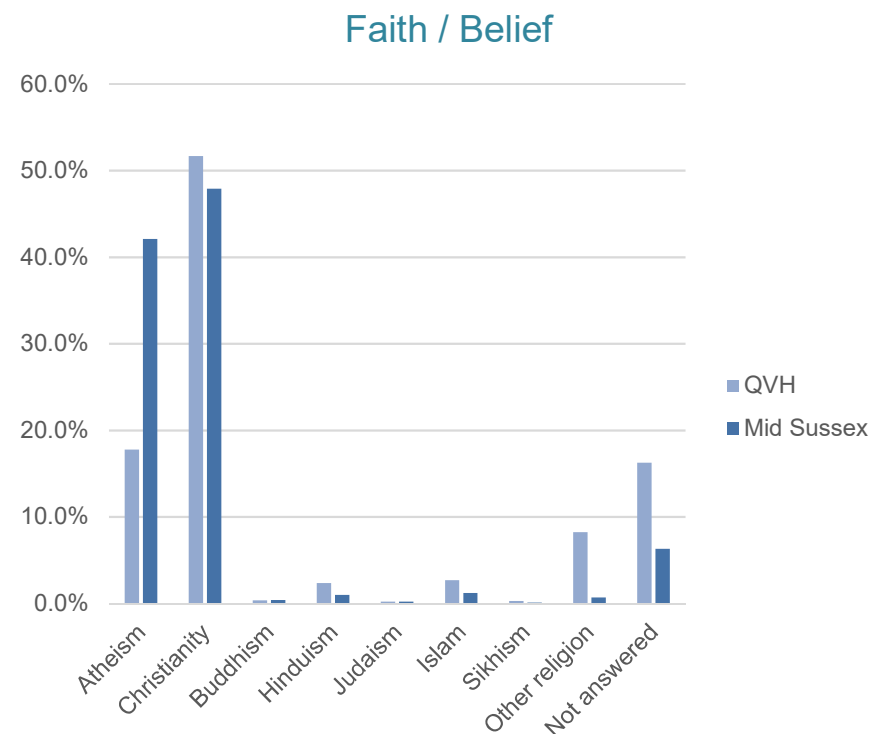
Marital Status

- QVH has a **higher** representation of colleagues who are married or in a civil partnership than the Mid Sussex community. These colleagues represent the majority at QVH
- **Fewer** colleagues are single, separated or divorced than in the local area
- Significantly **fewer** QVH colleagues are widowed than within Mid Sussex; however, this may be explained by the higher population of residents aged 71 and over in the area.



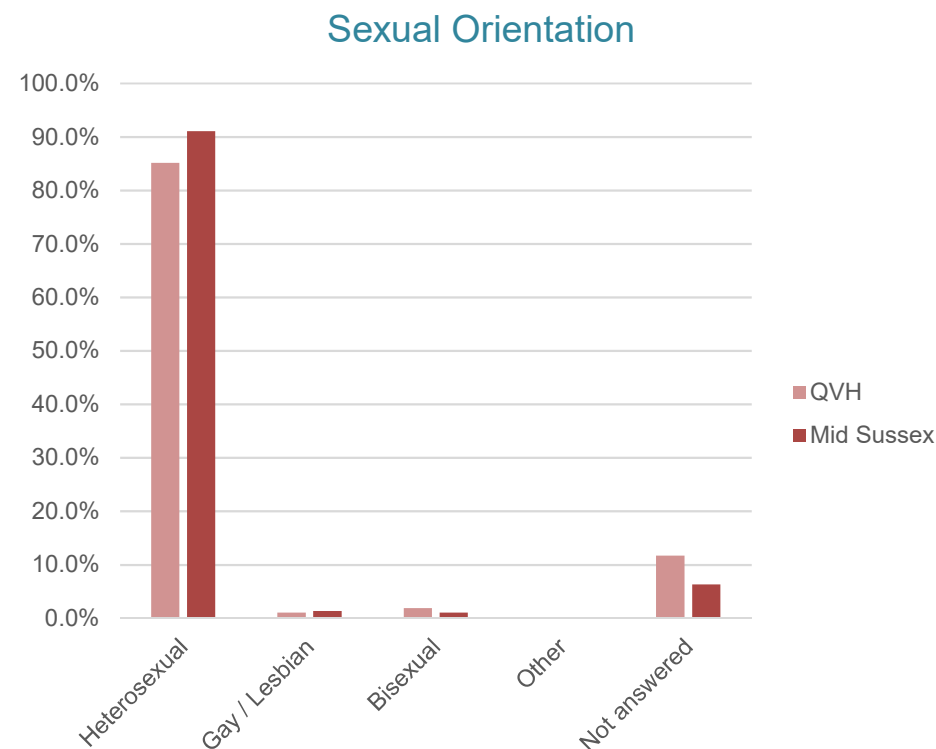
Faith / Belief

- QVH has a **higher** representation of Christian, Hindu, Islamic and Sikh colleagues than the Mid Sussex community
- **Fewer** colleagues declare their belief as Atheism
- Significantly **more** QVH colleagues opt not to respond to this question than Mid Sussex residents. This may suggest hesitance among QVH colleagues to disclose their faith or belief to the Trust.



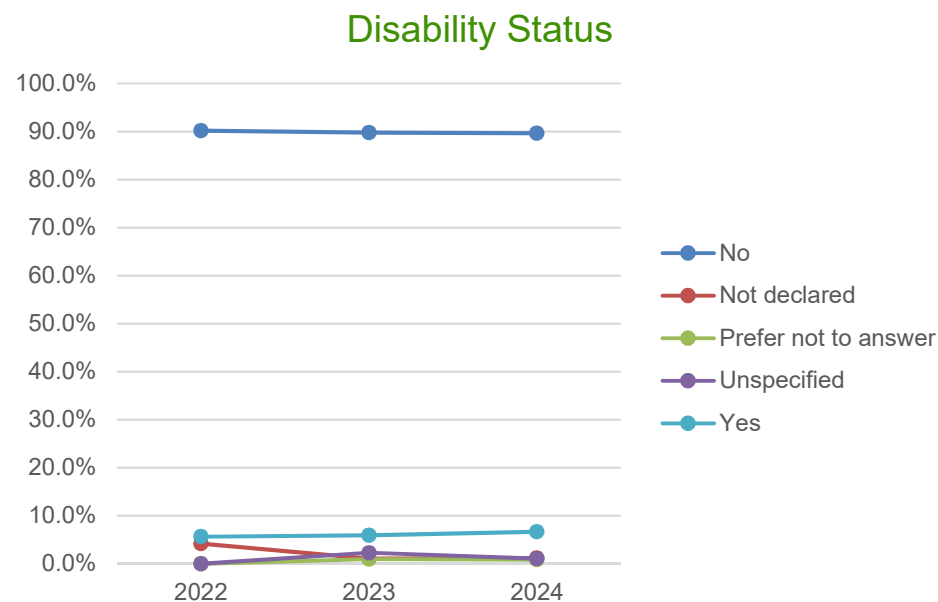
Sexual Orientation

- QVH has a **higher** representation of LGB+ colleagues than the Mid Sussex community
- Significantly **more** QVH colleagues opt not to respond to this question than Mid Sussex residents. This may suggest hesitance among QVH colleagues to disclose their sexual orientation to the Trust
- It is important to note that some sexual orientations, such as pansexual, asexual and more cannot be identified within ESR; these are captured under “Other”.



Disability

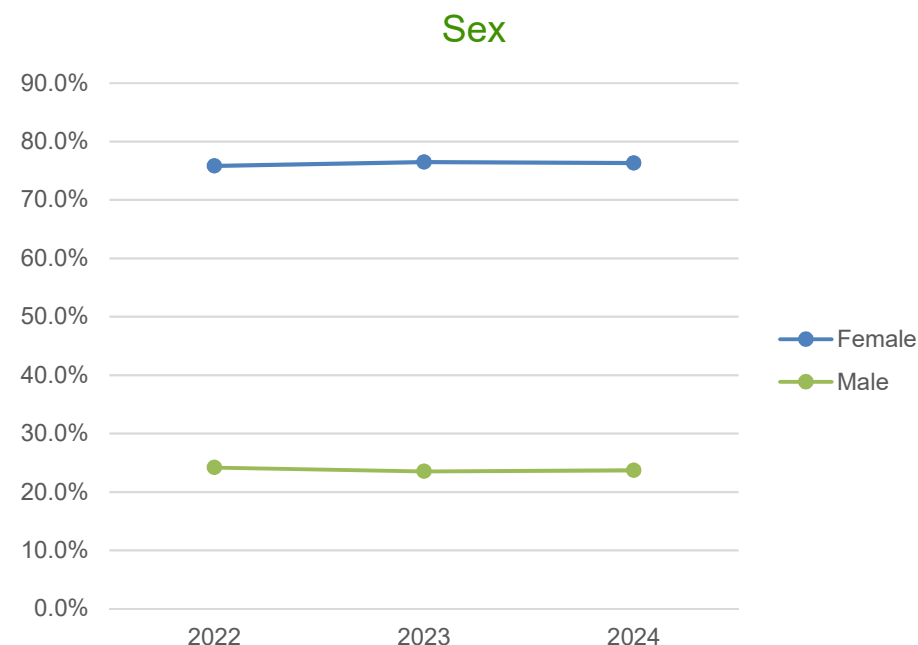
- Since 2022, the number of colleagues declaring a disability has increased each year, from **5.6%** to **6.7%**
- The number of colleagues who have selected “Prefer not to answer” has decreased from **1.0%** to **0.9%** since 2023
- The number of colleagues who have declared they do not have a disability has decreased from **90.2%** to **89.6%**



3-year diversity progress

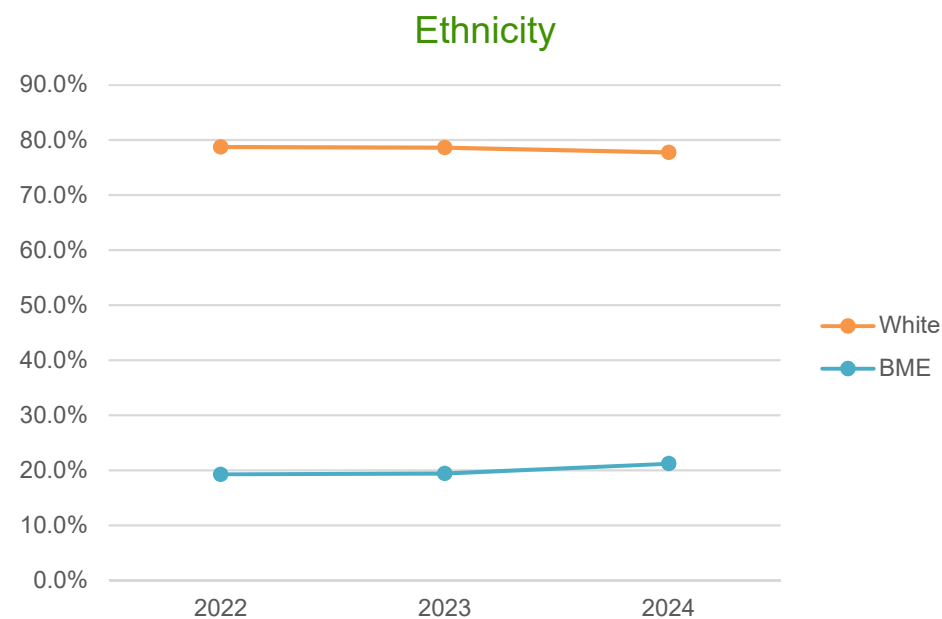
Sex

- Since 2022, the number of female colleagues has increased from **75.8%** to **76.3%**
- Following a small decrease in 2023, the number of male colleagues slightly increased in 2024 (**23.5%** to **23.7%**)
- However, it is important to note that other genders that may be present at QVH, such as intersex, transgender and non-binary, cannot be recorded on ESR.



Ethnicity

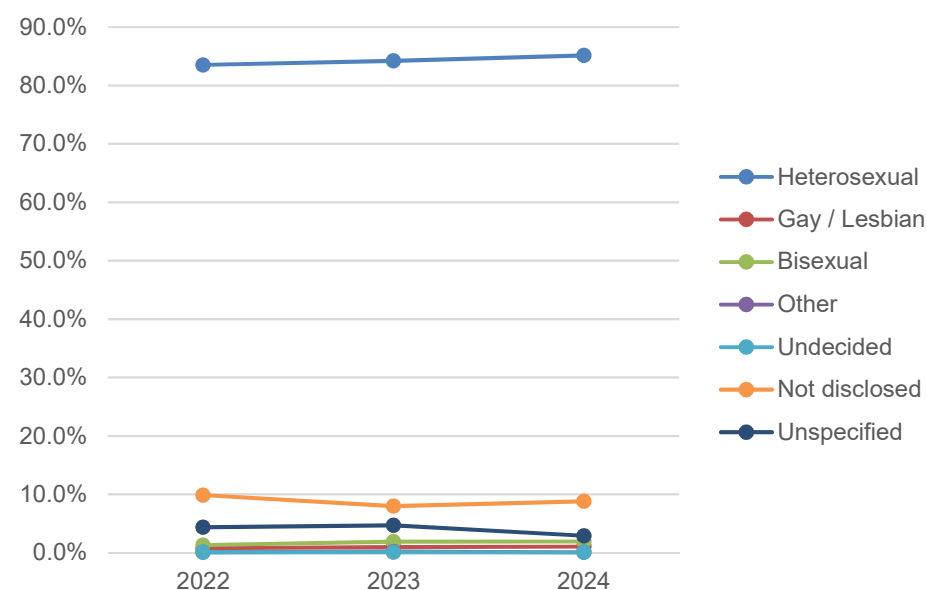
- Since 2022, the number of colleagues declaring their ethnicity as black and Minority Ethnic (BME) has increased each year, from **19.3%** to **21.2%**



Sexual Orientation

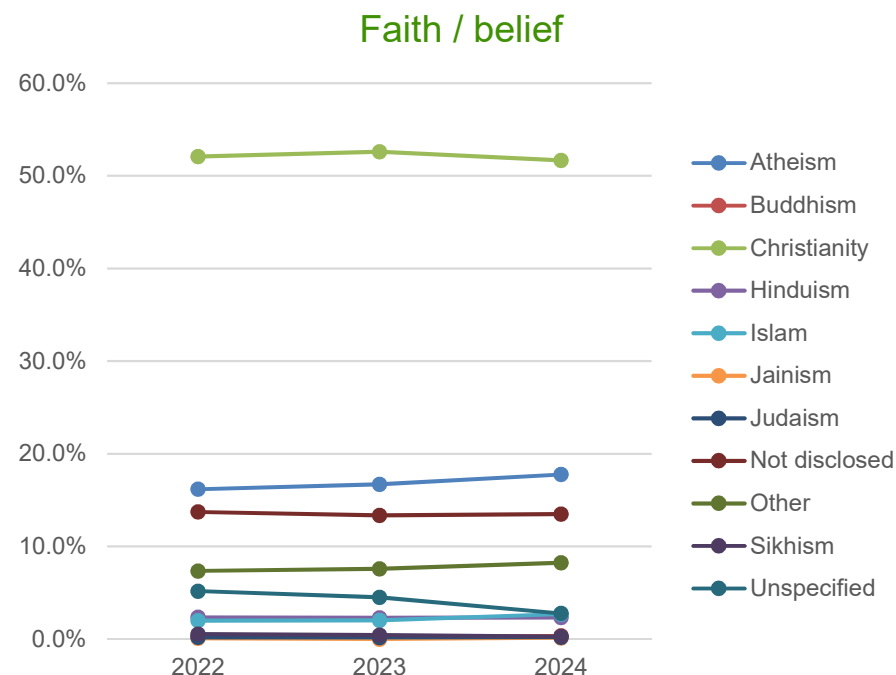
- Since 2022, the number of colleagues who have selected “Not disclosed” has decreased from **9.9%** to **8.8%**
- However, this represents an increase in non disclosure compared to 2023 (**8.0%**)
- The number of colleagues that have declared their orientation as Gay / Lesbian has increased each year since 2022, from **0.8%** to **1.1%**
- The number of colleagues that have declared their orientation as Bisexual has also increased since 2022, from **1.3%** to **1.9%**.

Sexual orientation



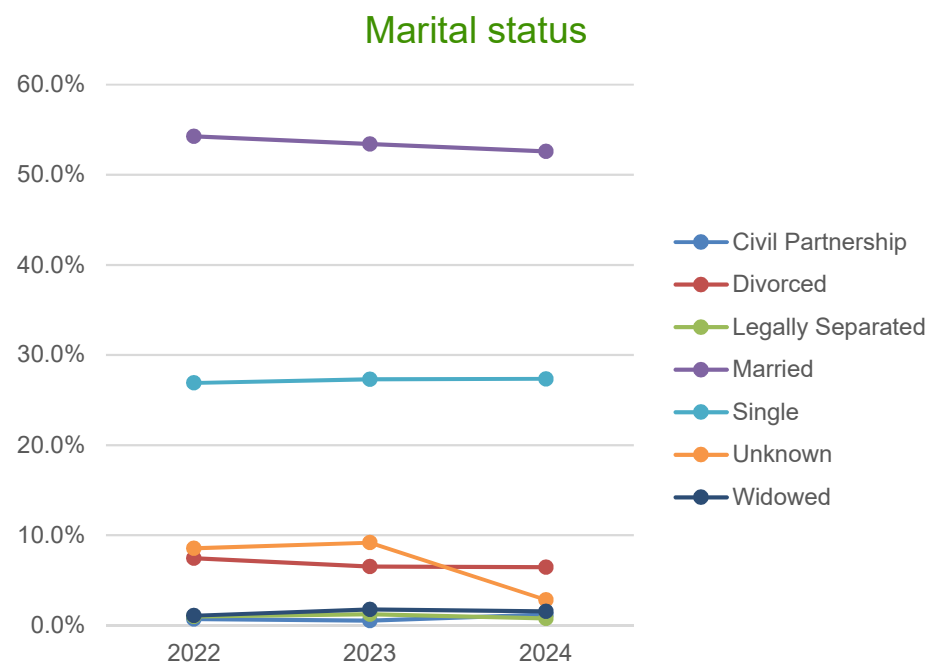
Sexual Orientation

- Since 2023, the number of colleagues who have declared their faith or belief as Christianity has decreased from **52.6%** to **51.7%**
- Since 2022, the number of colleagues declaring their faith or belief as Atheism, Other, Islam and Hinduism have increased
- Since 2023, the number of colleagues who have chosen not to disclose their faith or belief has had a minor increase of **0.1%** (from **13.4%** to **13.5%**)



Marital Status

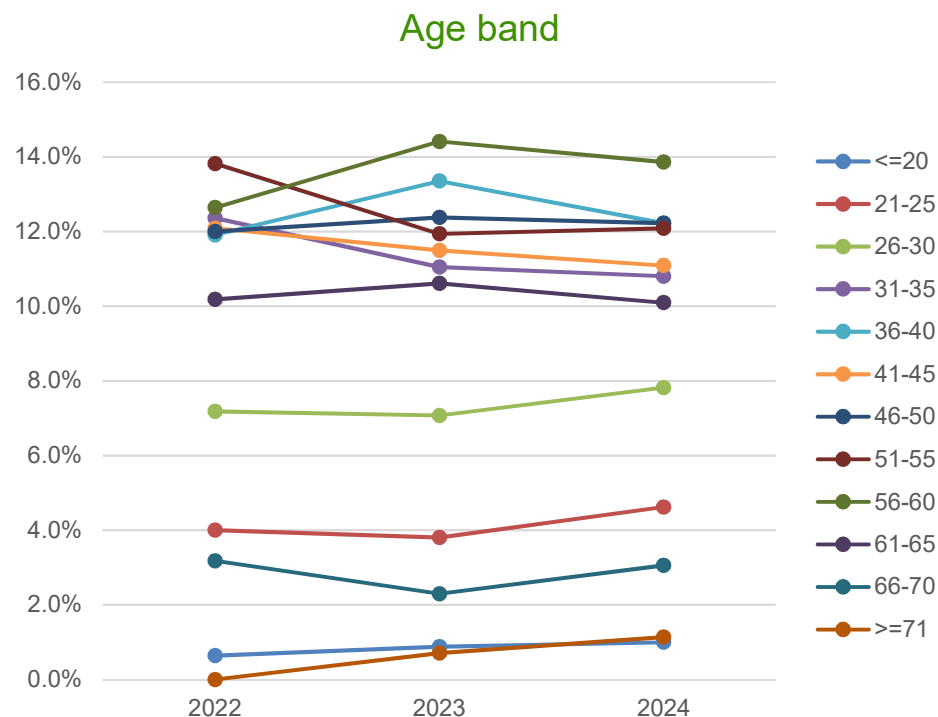
- Since 2022, the number of colleagues in a civil partnership has increased from **0.7%** to **1.2%**
- Since 2022, the number of married colleagues has decreased each year, from **54.3%** to **52.6%**
- While there was a small increase in the number of colleagues who had not declared their marital status between 2022-23, significantly more opted to declare in 2024 (a decrease from **9.2%** to **2.8% unknown**)



3-year diversity progress

Age

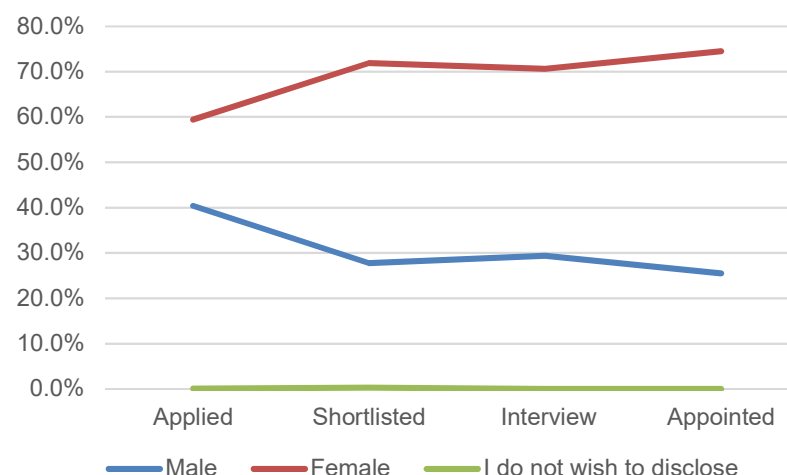
- Since 2022, ages **>=71**, **<=20** and **21-25** have increased the most
- Since 2022, ages **31-35**, **51-55** and **41-45** have decreased the most
- Ages **56-60** remain the most represented at QVH from 2023 to 2024
- Ages **<=20** are the least represented at QVH



Sex

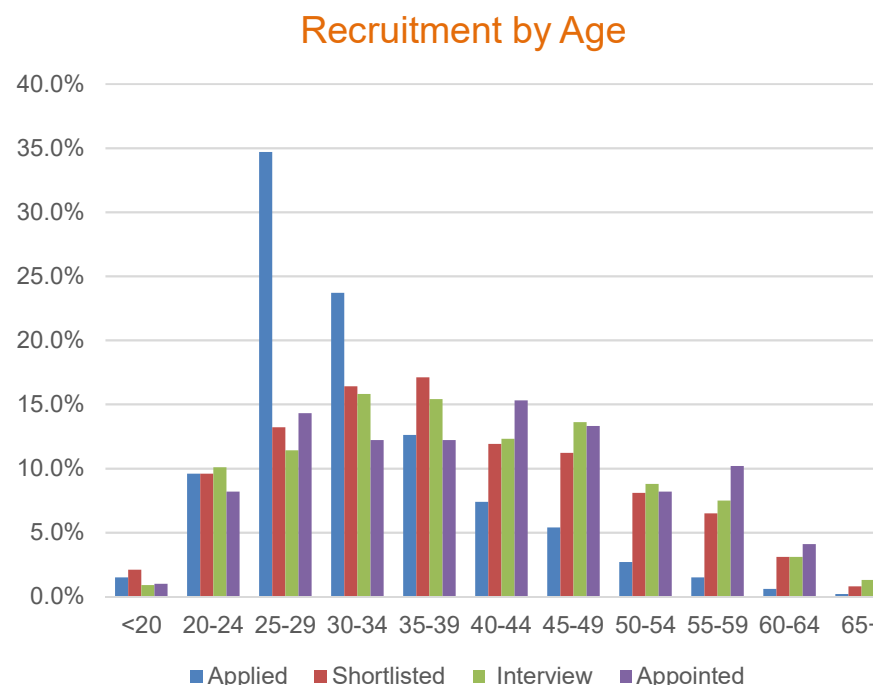
- **Female** applicants were most likely to apply, be shortlisted, be interviewed and be appointed to vacancies in 2023-24.
- **Male** applicants were significantly more likely to be rejected at shortlisting and interview than females
- The difference in male shortlisted candidates to appointments in 2023-24 was **-2.30%**
- The difference in female shortlisted candidates to appointments in 2023-24 was **2.50%**.

Recruitment by Sex



Age

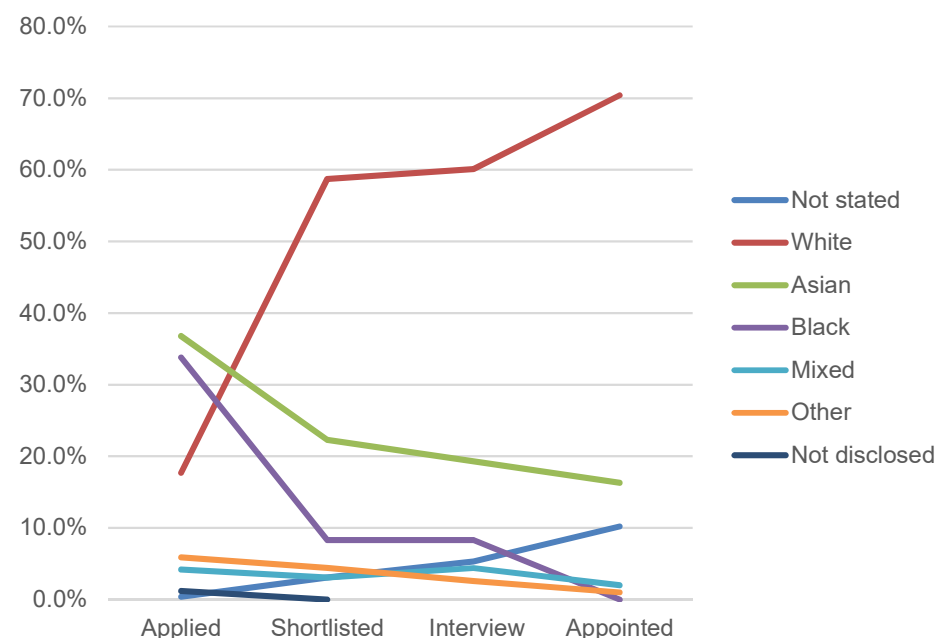
- Applicants aged **25-29** were most likely to apply for roles at QVH (**34.7%** of applications), while ages **65+** were least likely (**0.2%**)
- Ages **35-39** were most likely to be shortlisted (**17.1%** of shortlisted candidates), while ages **65+** were least likely (**0.8%**).
- Ages **30-34** were most likely to be interviewed (**15.8%** of interviewed candidates), while ages **<20** were least likely (**0.9%**)
- Ages **40-44** were most likely to be appointed (**15.3%** of appointments), while ages **<20** were least likely (**1.0%**).



Ethnicity

- **White** applicants are not the most likely to apply for roles at QVH, but are more likely than any other ethnicity to be shortlisted, interviewed and appointed
- **Asian** and **black** applicants are most likely to apply, but less likely to progress to shortlisting, interview and appointment than white applicants
- Applicants who **do not state** their ethnicity and those who declare their ethnicity as **mixed** are least likely to be shortlisted
- Applicants who declare their ethnicity as **other** (including any that are not white, Asian, black or mixed) are least likely to be selected for interview

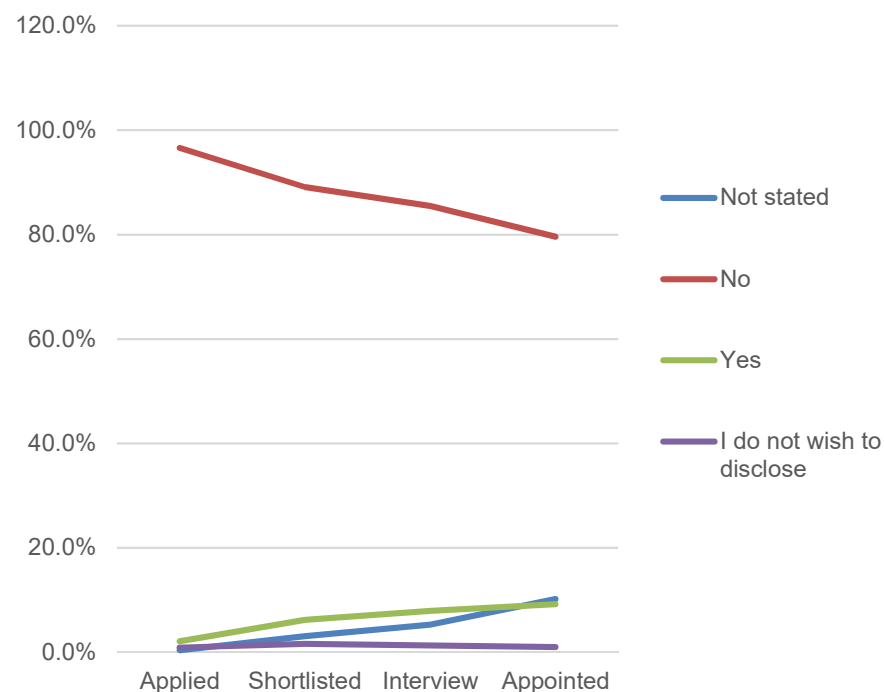
Recruitment by Ethnicity



Disability Status

- Applicants who state they do not have a disability are more likely to apply for roles at QVH, be shortlisted, interviewed and appointed
- **2.1%** of applicants declared that they consider themselves to have a disability
- Applicants who declared that they consider themselves to have a disability represented **9.2%** of all appointments in 2023-24.

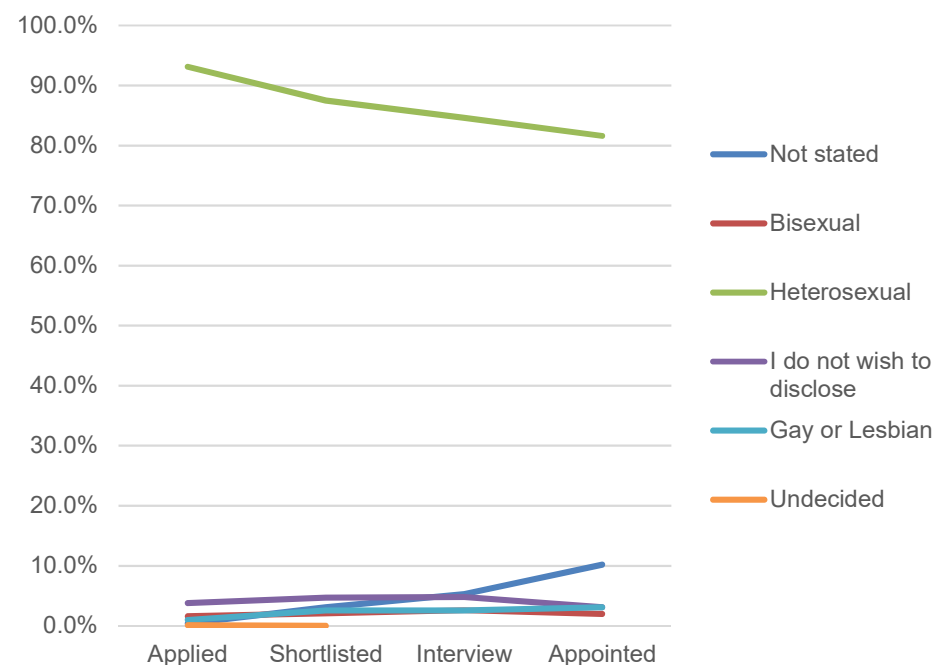
Recruitment by Disability Status



Sexual Orientation

- Applicants who declare their sexual orientation as **heterosexual** are more likely to apply for roles at QVH, be shortlisted, interviewed and appointed
- While the number of applicants who declare their sexual orientation as **gay** or **lesbian** is low, representation increases at shortlisting and appointment
- The representation of **bisexual** applicants steadily increases through application, shortlisting and interview but reduces at the appointment stage

Recruitment by Sexual Orientation



Staff experience

In this section, **2023 NHS Staff Survey** data is used to establish the differences in staff experience for those with protected characteristics and those without.

To achieve this, the Diversity and Equality and Inclusion sub-scores under the Compassionate and Inclusive survey questions are utilised. This includes questions around respect for individual differences, experiences of discrimination and reasonable adjustments.

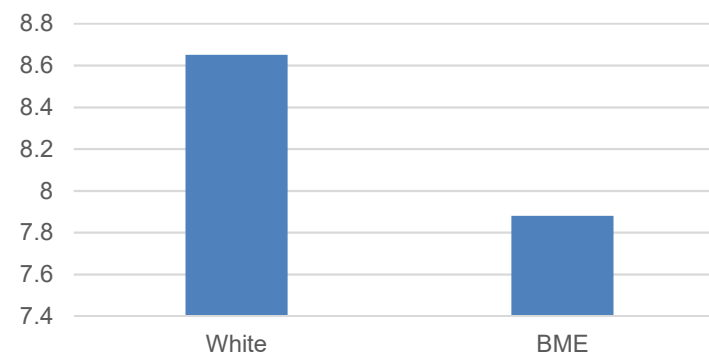
This data is compared to Employee Relations casework data around capability, conduct and bullying and harassment to understand where those with protected characteristics may be over or underrepresented.



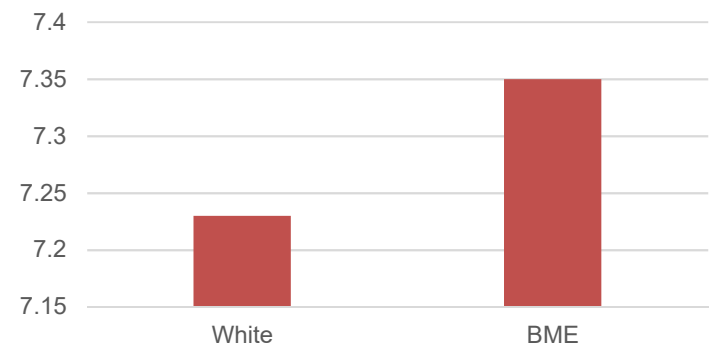
Ethnicity

- **White** staff scored QVH higher for Diversity & Equality (**8.65**) than BME colleagues (**7.88**)
- However, **BME** staff were more likely to score QVH highly for Inclusion (**7.35**) than white colleagues (**7.23**)
- White staff were also more likely to undergo performance management and disciplinary processes
- White staff were more likely to raise bullying and harassment concerns to the Employee Relations team.

Diversity & Equality



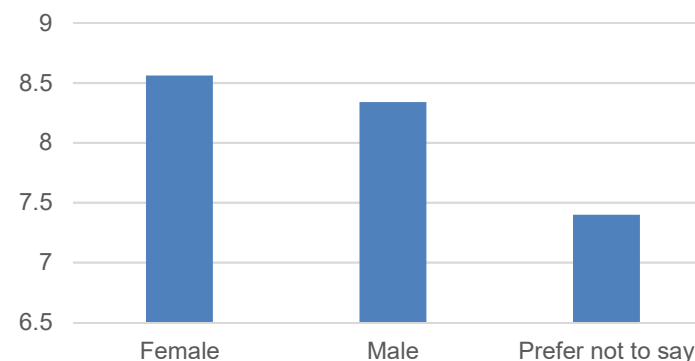
Inclusion



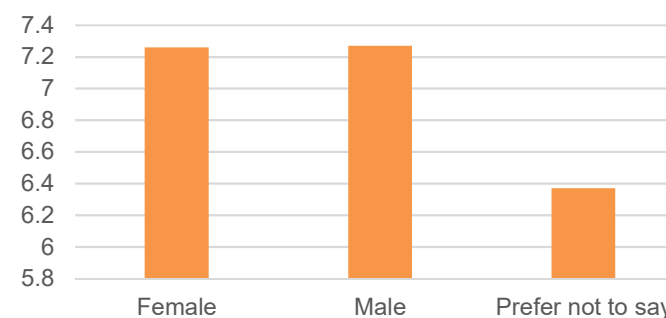
Gender

- **Female** staff scored QVH higher for Diversity & Equality (8.56) than male colleagues (8.34)
- However, **male** staff were marginally more likely to score QVH highly for Inclusion (7.27) than female colleagues (7.26)
- In both cases, staff who opted **not to disclose** their gender scored QVH lower than female and male colleagues.
- **Female** colleagues are more likely to undergo performance management and to raise bullying and harassment concerns to Employee Relations
- **Male** colleagues are more likely to undergo disciplinary processes.

Diversity & Equality



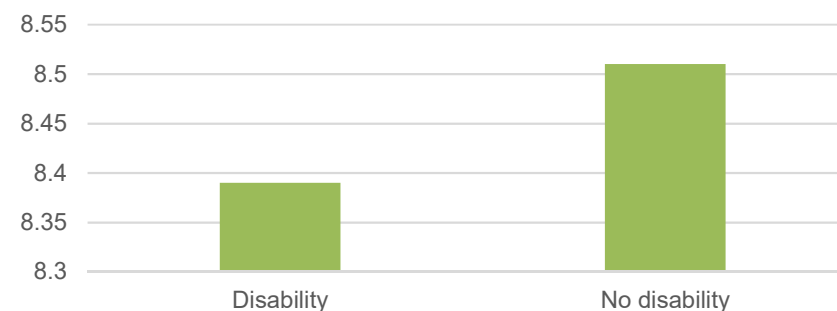
Inclusion



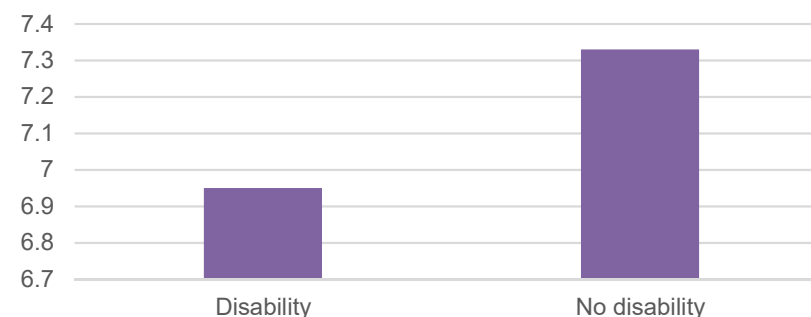
Disability Status

- **Disabled** colleagues scored QVH lower for both Diversity & Equality (**8.39**) and Inclusion (**6.95**) than colleagues without a disability (**8.51** and **7.33** respectively)
- In both cases, staff who opted **not to disclose** their gender scored QVH lower than female and male colleagues.
- Colleagues who declare they have a disability are significantly **less** likely to undergo performance management or disciplinary processes, and are less likely to raise bullying and harassment concerns to Employee Relations
- This may suggest that **disabled** staff feel less empowered to raise concerns around equality, diversity and inclusion.

Diversity & Equality



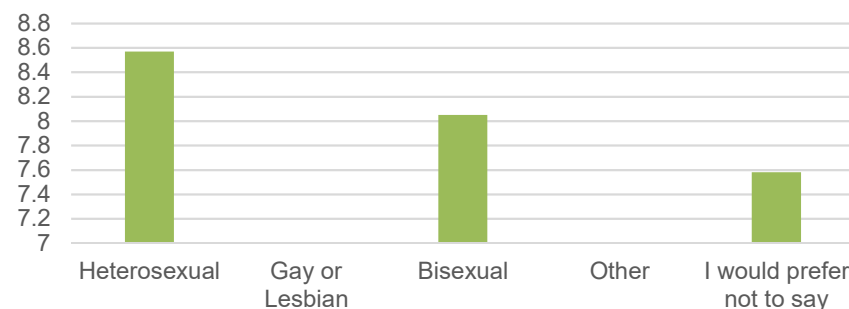
Inclusion



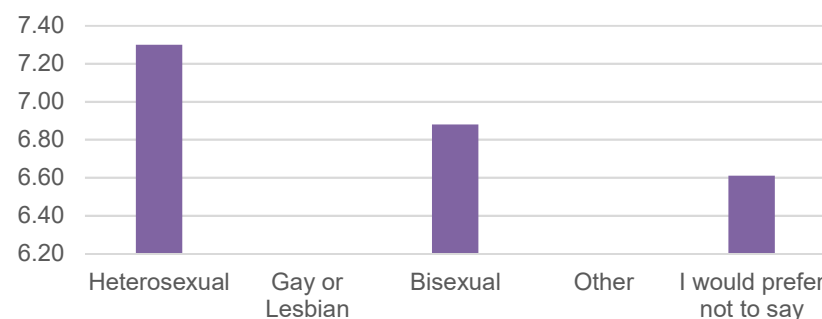
Sexual Orientation

- **Bisexual** colleagues scored QVH lower for both Diversity & Equality (**8.05**) and Inclusion (**6.88**) than heterosexual colleagues (**8.57** and **7.30** respectively)
- In both cases, staff who opted **not to disclose** their sexual orientation scored QVH lower than all others.
- It is important to note that no score is available for staff who identify as gay or lesbian, suggesting that these colleagues opted not to respond or not to disclose their sexual orientation
- While heterosexual staff are more likely to undergo performance management processes, it is important to note that **20%** of individuals who underwent these identified as **gay or lesbian**.

Diversity & Equality



Inclusion



NHS England High Impact Actions update 2023/24

High Impact Action	QVH Actions
1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	We have: • Included a draft EDI commitment in the Executive portfolio review • Established an EDI group as the focus for all of our EDI work We will: • Review individual and collective Executive and Board objectives • Communicate these objectives at our monthly Team Brief • Establish a template for Board reporting and agree metrics
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	We have: • Held school work experience events • Offered work experience placements • Developed a Step Into Health platform for Armed Forces service members who wish to access healthcare jobs We will: • Develop a programme of support for managers to extend the range of apprenticeships available • Develop initiatives to attract apprentices from diverse backgrounds internally and externally • Develop a guide on Right to Work status to educate recruiting managers
3. Develop and implement an improvement plan to eliminate pay gaps.	We have: • Published our 2023-24 Gender Pay Gap and Ethnicity Pay Gap reports with action plans for each • Established a Workforce Controls group to review all requests for pay rises and additional payments We will: • Update our Recruitment & Selection Policy to ensure that flexible working is actively promoted
4. Develop and implement an improvement plan to address health inequalities within the workforce.	We have: • Started to develop our Health Inequalities Strategy for 2025-2030 We will: • Continue working towards the publication of the Health Inequalities Strategy and identify priorities
5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.	We have: • Offered coaching skills to all staff and launched a course on Coaching Skills for Managers • Provided an induction programme for all medical trainees, with additional support provided where needed We will: • Develop targeted career pathways for all staff groups
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	We have: • Committed to the Trust anti-racism statement • Published our Domestic Abuse policy and are developing our VPR policy • Developed the Progress Pride Pledge We will: • Collaborate to develop a restorative, just learning culture approach to incidents where appropriate

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/03/2025	Agenda reference:		135-25	
Report title:	Annual report on Emergency Preparedness Resilience and Response (EPRR)				
Sponsor:	Kirsten Timmins, Chief Operating Officer				
Author:	Ashley Hunt, Deputy Chief Operating Officer				
Appendices:	Appendix one -Outcome of Emergency Planning Core Standards Assessment in 2024				
Executive summary					
Purpose of report:	To provide an update on the Trust's preparedness to respond to an emergency incident.				
Summary of key issues	- The Trust achieved a full compliance rating in relation to NHSE's Emergency Planning Core Standards Assessment in 2024. - This is the highest level of compliance and an improvement on the substantial compliance rating received in the previous year. - The Trust carried out training and exercising during 2024, including Cyber Security, and responded to a number of incidents including adverse weather and failure of the outsourced decontamination service. - The trust has gone out for recruitment of a dedicated EPRR Lead who will support the planning and delivery of training for the year ahead. Should recruitment not be successful, the trust will look to upskill a staff member to take on this responsibility.				
Recommendation:	The Board is asked to approve the report.				
Action required	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	<i>Outstanding patient experience</i>	<i>World-class clinical services</i>	Operational excellence	<i>Financial sustainability</i>	<i>Organisational excellence</i>
Implications					
Board assurance framework:	Impact on BAF 1 (patient services) and BAF 5 (compliance breach)				
Corporate risk register:	Ability to meet duties on the Trust in relation to emergency planning and response under the Civil Contingencies Act 2004.				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality and Safety Committee				
	Date	26/02/25	Decision	Approved to go to Trust Board	
Next steps:					

Report to: Board of Directors
Agenda item: 135-25
Date of meeting: 06 March 2025
Report from: Kirsten Timmins, Chief Operating Officer
Report author: Ashley Hunt, Deputy Chief Operating Officer
Date of report: 26 March 2025
Appendices: Appendix one -Outcome of Emergency Planning Core Standards Assessment in 2024

Annual Report on Emergency Preparedness, Resilience and Response (EPRR)

Background

Under the Civil Contingencies Act 2004, Queen Victoria NHS Foundation Trust is categorised as a Category 1 Responder. This places specific duties on the Trust in relation to emergency planning and response. Additionally, the Trust has other obligations as required by contracts and assurance standards set by NHS England.

The Chief Operating Officer has oversight of the Trust's Emergency Planning, Response and Recovery (EPRR) functions, providing senior leadership for mitigating the impact of adverse incidents and undertaking horizon scanning to ensure services have robust business continuity plans in place to ensure the continued delivery of services.

Training and Exercising

The Trust continues to train internal staff on a variety of incident scenarios and participate in the Sussex Local Health Resilience Partnership training opportunities. Training has been undertaken on how to manage hazardous material incidents such as chemical or radiation emergencies as part of the annual training programme, specifically directed towards our Minor Injuries Unit service.

QVH is in the process of recruiting a dedicated EPRR Lead who will support the planning and delivery of training for the year ahead. Should recruitment not be successful, the trust will look to upskill a staff member to take on this responsibility.

During 2024 the Trust took part in ICB led incident escalations to check the communication protocols, an IT table top exercise to test our business continuity based on a cyber-attack, and a live exercise run by Ashford and St Peter's Hospital which was based on a burns patient needing to access specialist care and how we would triage and manage our resources.

Incident Response

The Trust has activated procedures to respond to a number of incidents during 2024, including;

- industrial action
- adverse weather including flash flooding
- general boiler failures and estates issues
- failure of our outsourced decontamination service provider.

Debriefing sessions were undertaken following incidents to identify the lessons learnt and opportunities for improvement.

Business Continuity

All on-call managers were asked to complete a training needs analysis to ensure they had the relevant competencies and experience, supported by the completion of Principles in Health Command (PHIC) training.

The Trusts has robust Business Continuity Plans in place, which are updated each year.

The future aspiration of the EPRR function is to utilise the NHSE Business Continuity Management Toolkit to support the validation of local level Business Continuity Plans and to develop a KPI framework for the Trust focussing on;

- Number of EPRR exercises,
- maintaining the PIHC training target,
- attendance by key personnel at debriefing sessions, identifying the tolerance levels of Business Continuity Plans that are up to date and compliant.

These KPIs would be developed through exploration and learning from system partners and internal benchmarking.

Core Standard Annual Assurance Process Outcome

All NHS Trusts who are category 1 and 2 responders (Civil Contingencies Act 2004) are required to complete a self-assessment and submit a statement of readiness to NHS England stating compliance against the national requirements of EPRR. The annual assurance process was formally completed with assessments by the ICS EPRR team.

The Trust submitted their EPRR Core Standards Assurance Process in November 2024 and received confirmation on 28th November 2024 that the Trust was 100% compliant with all 59 core standards assessed. Full compliance is the highest level of compliance, and demonstrates an improvement from the previous year.

In relation to the 11 deep dive standards, the Trust was non-compliant with one standard and fully compliant with the other ten standards, identifying a requirements to update the training slides to include Cyber training. The training slides are in the process of being updated to reflect this.

Continuous Improvement

Through the recruitment of the EPRR Lead the ambition of the service is to embed a KPI framework that meets the needs of the Trust and delivers assurance regarding the continued compliance of the EPRR Framework.

Continued attendance at the EPRR conferences, Sussex Health responders Group and the Local Health Responders Group will continue to support the ongoing learning and shared best practice across all parts of the Sussex Health system.

Recommendation

The Board is asked to approve the annual report on EPRR.

Liz Blackburn
Deputy Chief Nurse
Queen Victoria Hospital
Holtye Road
East Grinstead
West Sussex
RH19 3DZ

NHS Sussex Integrated Care Board
Sackville House
Brooks Close
Lewes
BN7 2FZ
sxicb.epr@nhs.net
<https://www.sussex.ics.nhs.uk/>

28 November 2024

Dear Liz

Re: NHS England EPRR Core Standards Assurance Process 2024 - Queen Victoria Hospital NHS Trust

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

Following the review of Queen Victoria Hospitals (QVH's) self-assessment against the NHS England (NHSE) Core Standards for EPRR at the Local Health Resilience Partnership (LHRP) Executive Group on 20 November 2024, as part of the annual assurance process, we are writing now to formally confirm the outcome.

Please note that whilst NHSE have yet to formally approve the overall submission for Sussex Integrated Care System (ICS) following their own internal review process, they were present at the LHRP Exec meeting and agreed with our statement of assurance. It is therefore unlikely that the overall position or individual ratings for Sussex will change.

Outcome of the assessment process

As discussed at the final meeting in October 2024 QVH have been assessed as **fully compliant** against the NHSE EPRR Core Standards.

QVH were fully compliant with all the 59 core standards assessed. Of the 11 deep dive standards, QVH were not compliant with one standard and fully compliant with the other ten standards.

NHS England define fully compliant as:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.

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

Advisories

Ref	Core Standard	2024 rating	Rationale	Advisory
10	Duty to maintain plans: IRP		Plan requires amendments – as advisory - but not due for review until December 2024.	a) 003 Plan due for review December 2024; please review the incident level definitions against the EPRR framework 2022 as out of date terminology is used.
22	Training and Exercising - EPRR training		TNA and training records now in place, with 15/28 on-call staff PHIC trained. Exercising schedule also available.	b) Monitor plan to increase PHIC training November (aim to achieve 90% by November) c) Ensure the incident levels in IRP (003) and staff training literature reflects the EPRR framework (as 10 above)
65	Hazmat/CBRN – PPE Access		Fit test numbers appeared low due to staff turnover. The plan has been articulated as: • 11 new fit testers have been trained • additional 10 FIT testing kits have been purchased to enable the new FIT testers to complete the FIT testing • reminders in infection control updates to get FIT tested • part of their annual appraisal • Communications in our weekly newsletter about fit testing	d) Monitor plan for fit test training compliance, with aim to increase numbers of staff completed by November.

Deep dive partially or non-compliant standards

Deep Dive

DD8	Deep Dive – Cyber included in EPRR training		EPRR training slides to be updated to include Cyber	
-----	---	--	---	--

Next steps

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

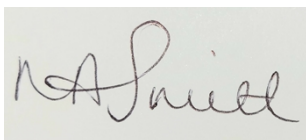
It would also be helpful if you could confirm to us when you will be taking the outcome of the core standards assurance process to your Board for review.

The ICB EPRR team will be working with your EPRR team to agree a SMART action plan to address the comments noted in the table above by the end of February 2025 for discussion at the Core Standards 2025 launch meeting in March. This will allow us to identify areas where collaborative working would be beneficial, and for those actions to be included in the ICS EPRR Workplan.

The action plan will then be reviewed on a monthly basis to help facilitate significant improvements throughout the year to support the core standards assurance process for 2025.

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

Yours faithfully,



Nicki Smith
Director of EPRR and System Resilience



Claudia Griffith
Chief Delivery and Strategy Officer
Accountable Emergency Officer

On behalf of Sussex NHS ICB

Cc: EPRR team

Enc:

1. Final Core Standards Assessment Spreadsheet
2. Board report writing aide memoire

Report cover-page

References

Meeting title:	Board of Directors		
Meeting date:	06/03/2025	Agenda reference:	136-25
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	- The Trust's external auditor, Azets, has provided its plan for the audit of the Trust's Annual Report and Accounts for 2024/25 and assessment of Value for Money (VfM) arrangements. - Given the issues identified with the Trust's internal control framework, it is likely that the Trust's Annual Governance Statement (AGS) 2024/25 will conclude that there have been significant issues with the internal control framework, but are being addressed. This year, an assurance survey is being introduced for completion by all executive directors to further inform the AGS. - Work is being undertaken to strengthen the assurances relating to compliance of finance, procurement and workforce controls. The key areas of focus of financial grip and control have been identified, based on an assessment of the risk posed by weaknesses in these areas.				
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:
	<i>To deliver outstanding care</i>	<i>To innovate and improve</i>	<i>To be an excellent employer</i>	<i>To deliver sustainable services</i>	<i>To collaborate with others</i>

Implications

Board assurance framework:	None
Corporate risk register:	None
Regulation:	None
Legal:	None
Resources:	None

Assurance route

Previously considered by:				
	Date:		Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 136-25
Date of meeting: 06 March 2025
Report from: Paul Dillon-Robinson, committee Chair
Report author: Paul Dillon-Robinson, committee Chair
Ellie Simpkin, Governance manager
Date of report: 19 February 2025
Appendices: None

Sub-committee assurance report
Audit & risk committee – 19 February 2025 – extraordinary meeting

Key agenda items

- **External audit plan and progress update**
- **Outline annual governance statement 2024/25**
- **Controls and assurance**

Alert

- The Trust's external auditor, Azets, has provided the committee with its plan for the audit of the Trust's Annual Report and Accounts for 2024/25 and assessment of Value for Money (VfM) arrangements. The significant risks to financial statement have been identified (particularly around year-end balances, including valuation of land and buildings) and an initial risk assessment of the potential significant weaknesses in respect of VfM arrangements has also been undertaken by the auditor, which they will work on.
- As discussed by the committee at its meeting in November 2024, it has become apparent that there have been issues with the Trust's internal control framework and it is likely that the Trust's Annual Governance Statement (AGS) 2024/25 will conclude that there have been significant internal control weaknesses. This year, an assurance survey is being introduced, for completion by all executive directors, to ensure transparency for any currently unknown issues and will further inform the AGS. The committee has stressed the importance of the Trust being open and transparent in its AGS, while presenting a clear picture of the actions being taken to address matters. The committee will review a draft of the AGS 2024/25 at its next meeting on 26 March 2025.

Assure

- The committee received an update on the work being undertaken to strengthen the controls in place, and thereby provide assurance relating to the effective operation of controls within finance, procurement and workforce. The committee noted the progress which has been made to date; including weekly meetings of the Workforce Control Panel, budget holder training and the establishment of a Financial Controls Review group, chaired by the Chief Finance Officer. Further actions, including a review of the Trust's Standing Financial Instructions and Scheme of Delegations, are due to be completed in the forthcoming months. The key areas of focus of financial grip and control have been identified, based on an assessment of the risk posed by weaknesses in these areas. The committee highlighted the importance of accountability and noted the cultural shift which is needed to ensure that good governance practices are embedded across the organisation.

Advise

None to raise

Risks discussed and new risks identified

None to raise

Recommendation

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

Report cover-page

References

Meeting title:	Board of Directors		
Meeting date:	06/03/2025	Agenda reference:	137-25
Report title:	Quality & Safety Committee Assurance Report		
Sponsor:	Shaun O’Leary, Committee chair		
Author:	Shaun O’Leary, Committee chair Riya Jose, Governance officer		
Appendices:	None		

Executive summary

Purpose of report:	To alert, assure and advise the Board regarding matters considered at the committee meeting held on 25 February 2025.				
Summary of key issues	- Mental Capacity Act (MCA) compliance remains a high-risk issue (score: 16), with low training uptake and inconsistent application. A Task & Finish Group is addressing this. - A new risk (risk 125) highlights the lack of a mental health provider agreement, risking delays in patient support and inappropriate transfers. - The Health & Safety scoping exercise identified compliance gaps, including the absence of a formal strategy and KPIs. A governance framework and training programme are in development. - Quarter 3 Quality Priorities show mixed progress. Patient Safety (Green) is on track, but Clinical Effectiveness and Patient Experience (Amber/Red) face challenges, including infrastructure delays and unmet equality data targets. - Electronic Patient Record (EPR) implementation is progressing, but medical staff engagement remains a challenge. Further engagement plans are being developed. - The Emergency Preparedness Resilience and Response (EPRR) Annual Report confirms NHS compliance, but business continuity planning and emergency response training require improvement. - The 2025/26 committee work programme and Terms of Reference were approved. - Significant improvement of compliance with National Safety Standards for Invasive Procedures (NATSSIPs)				
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:
	<i>To deliver outstanding care</i>	<i>To innovate and improve</i>	<i>To be an excellent employer</i>	<i>To deliver sustainable services</i>	<i>To collaborate with others</i>

Implications

Board assurance framework:	None
Corporate risk register:	None
Regulation:	None
Legal:	None
Resources:	None

Assurance route

Previously considered by:				
	Date:		Decision:	
Next steps:				

Report to: Board of Directors
Agenda item: 137-25
Date of meeting: 06 March 2025
Report from: Shaun O'Leary, Committee chair
Report author: Shaun O'Leary, Committee chair
Riya Jose, Governance officer
Date of report: 25 February 2025
Appendices: None

**Sub-committee assurance report
Quality & safety committee – 25 February 2025**

Key agenda items

- **Executive Committee for Quality & Risk –report for the Quality & Safety Committee**
- **Committee work programme 2025/26**
- **Annual review of committee Terms of reference**
- **Annual assurance report to Audit & risk committee**
- **Organisational risk register**
- **Quality Priorities 2024/25 (quarter 3) and draft Quality Priorities 2025/26**
- **Integrated Quality & Performance Report**
- **Mental Capacity Act training/compliance**
- **Emergency Preparedness Resilience & Response annual report**
- **Health & safety - outcome of scoping exercise**
- **National Safety Standards for Invasive Procedures report**

Alert

- The Committee acknowledged continued risk of non-compliance with MCA training across key clinical areas. The Task & Finish group, established to address this, is reviewing training delivery, compliance tracking, and process integration. Despite policy updates, this remains an active risk with a risk score of 16 on the Organisational Risk Register.
- A new risk (risk 125) has been added to the Organisational Risk Register, highlighting the lack of a strategic agreement with a mental health provider. This may result in patients experiencing a mental health crisis not receiving timely support, leading to potentially inappropriate transfers and delays in intervention. The Executive Team is exploring options, including the development of a Service Level Agreement (SLA) with external providers. The risk has been classified as High (score: 12).
- The Health & Safety scoping exercise identified gaps in policy implementation and compliance monitoring. The Committee noted that there is currently no formal Health & Safety strategy and a lack of Key Performance Indicators (KPIs) to measure progress. Work is underway to develop a structured approach to governance, staff training, and reporting mechanisms.

Assure

- The Committee reviewed progress on Quality Priorities 2024/25 (quarter 3). Patient Safety (Continuous Improvement) is rated Green, with progress in Yellow Belt training rollout and development of the A3 Key Strategic Objectives framework. Clinical Effectiveness is rated Amber/Red, as ethnicity data capture targets have not been met, though smoking cessation compliance remains high. Patient Experience is rated Amber/Red, with delays in infrastructure improvements, such as handrails, and ongoing work to

improve patient feedback mechanisms. The 2025/26 Draft Quality Priorities are in final draft and will be agreed in the next reporting period.

- The Month nine Integrated Quality & Performance Report (IQPR) confirmed that the Trust remains compliant with core quality and safety standards. The Electronic Patient Record (EPR) implementation is progressing, but medical engagement remains a challenge, with further engagement strategies being developed. Concerns persist regarding patient waiting times and delays in diagnostic services, which require ongoing scrutiny.
- The Emergency Preparedness, Resilience & Response (EPRR) Annual Report confirmed compliance with NHS England's core standards. However, further development is needed in business continuity planning and staff training on emergency response protocols.
- The Committee received assurance on National Safety Standards for Invasive Procedures (NATSSIPS) implementation, confirming progress in standardising safety measures for invasive procedures. Training uptake has improved, and compliance monitoring continues to be strengthened.

Advise

- The 2025/26 Committee work programme and revised Terms of Reference were approved, subject to amendments discussed in the meeting, including phasing annual reports to balance workload, strengthening governance oversight of health inequalities, clarifying the distinction between oversight and assurance, refining policy classification and approval processes, updating responsibilities for external regulatory submissions, and ensuring Health & Safety governance gaps are addressed within the assurance framework.
- The Annual Assurance Report to the Audit & risk committee was endorsed, highlighting improvements in governance, key risks requiring ongoing oversight (such as MCA compliance), and the need for continued focus on clinical effectiveness.
- The Committee was informed of staffing challenges in the Sleep Service, where workforce shortages continue to impact service delivery. Interim staffing solutions, including cross-team support, are being explored while permanent recruitment progresses.

Risks discussed and new risks identified

- The Mental Capacity Act compliance (ongoing risk - moderate, score: 16)
- Lack of strategic agreement with a mental health provider (new risk - moderate, score: 12)
- Health & Safety compliance gaps (action plan in development)
- Medical engagement in EPR implementation (ongoing risk - medium)
- Workforce challenges in Sleep Service (mitigation plan in progress)

Recommendation

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

Report cover-page

References

Meeting title:	Board of Directors		
Meeting date:	06/03/2024	Agenda reference:	138-24
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	- There is support for the East Grinstead Community Diagnostic Centre (CDC). Further work is needed in order for the Board to be fully assured as to the quality and robustness of the finances and plan. - The committee is supportive in principle of a move to a consolidated implementation of the Electronic Patient Record (EPR), however, further work is needed on the presentation of the revised business case, project plan and risks. There was a discussion on the changes to the original business case and project governance and the process of quality assurance by the NHS Frontline Digitisation Team. - There continues to be a number of risks to achieving a yearend breakeven position and capital spending continues to be materially behind plan. - Cancer performance is meeting the Faster Diagnostic Standard and the 62 day target for 2024/25. There has been increase in the number of patients waiting over 62 days and 104 days with late referrals from tertiary providers continuing to impact. - There has been an anticipated increase in the number of patients waiting over 52 weeks and 65 weeks. The Trust is predicting that it will not achieve the year-end target of zero 65 week waits. - The Fire Enforcement Notice which the Trust received in February 2024 has been lifted which is a significant achievement for the Trust. - The committee received details on the risk to patients, staff and assets arising from the Local Security Management Services action plan and the mitigating actions. - The committee noted an update on business planning and the significant challenges QVH faces both next year and beyond given the change in financial guidelines and non-recurring support to this year's outcome. - The committee agreed to recommend to Board the retrospective approval of the Trust's Premises Assurance Model (PAM) for 2024.				
Recommendation:	The Board is asked to note the contents of the report				
Action required	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: <i>To deliver outstanding care</i>	KSO2: <i>To innovate and improve</i>	KSO3: <i>To be an excellent employer</i>	KSO4: <i>To deliver sustainable services</i>	KSO5: <i>To collaborate with others</i>

Implications

Board assurance framework:	None
Corporate risk register:	None
Regulation:	None
Legal:	None
Resources:	None

Assurance route

Previously considered by:				
	Date:		Decision:	

Report to: Board of Directors
Agenda item: 138-25
Date of meeting: 06 March 2025
Report from: Peter O'Donnell, committee Chair
Report author: Peter O'Donnell, committee Chair
Ellie Simpkin, Governance manager
Date of report: 24 February 2025
Appendices: None

**Sub-committee assurance report
Finance & performance committee – 24 February 2025**

Key agenda items

- **East Grinstead Community Diagnostic Centre (CDC) full business case**
- **Electronic Patient Record (EPR) revised business case summary**
- **Integrated Quality and Performance Report – month nine**
- **Major project update – milestone & resource plan**
- **Business planning 2025/26**
- **Outpatient continuous improvement programme**
- **Equality and diversity annual report 2023/24**
- **Premises Assurance Model**
- **Critical infrastructure update**
- **Organisational Risk Register**
- **Annual assurance report to Audit & risk committee**
- **Committee's terms of reference 2025/26**

Alert

- The committee considered the full business case for the East Grinstead Community Diagnostic Centre (CDC). The committee is supportive of the business case, however, it suggested that further work is needed in order for the Board to be fully assured as to the quality and robustness of the plan and ensure transparency on the risks. Queries were raised over activity planning and how any slippage will be managed. There also needs to be further articulation of the value for money considerations.
- There has been detailed consideration of the proposed revised approach to the Electronic Patient Record (EPR) programme which would see the Trust move from a phased to a consolidated implementation. The committee is supportive in principle of the move to a consolidated approach, however, it believes that further work is needed on the presentation of the financial case and benefits. Questions were asked on the staff training plan, engagement with clinical teams and the business continuity plans for 'go live'. The committee also asked for 'lessons learned' to be conducted, given the changes to the original business case. It was suggested that the revised business case outlines the quality assurance process undertaken by the NHS Frontline Digitisation Team.
- There has been an anticipated increase in the number of patients waiting over 52 weeks with the prioritisation of cancer patients, challenges within breast and skin services, and the transfers from other Trusts across Sussex impacting performance. The Trust is predicting that it will not achieve the target of zero patients waiting over 65 weeks for treatment by 31 March 2025.
- Cancer performance is meeting the Faster Diagnosis Standard and the 62 day target for 2024/25, however, there has been increase in the number of patients waiting over 62 days and 104 days with late referrals from tertiary providers continuing to impact.

- Diagnostics (DMO1) performance in month nine was 89.1% against target of 95% due to staffing challenges in sleep services.
- The Trust continues to meet its break-even plan but this has required the release of £2.1m of non-recurrent benefits. There continues to be a number of risk to achieving a yearend breakeven position which are being managed.
- The capital budget is underspend. The team believe they will utilise the capital funding budget in full but there is a lot to do to achieve this.
- Work continues to deliver the improvements to the estates critical infrastructure, however, there remains a number of risks including the electrical infrastructure, boilers and fire safety. The team is seeking additional funding opportunities, where available.

Assure

- As requested at its meeting in January 2025, the committee received details on the risk to patients, staff and assets arising from the Local Security Management Services action plan and the mitigating actions. The committee was reassured that a new door access system and CCTV system is being procured which is planned to be in place by August 2025.
- Following satisfactory compliance, the Fire Enforcement Notice which the Trust received in February 2024 has been lifted which is a significant achievement for the Trust.
- There continues to be a focus on the development of the culture of the Trust; the Cultural Transformation Steering Group meets for first time in February 2025. There has been an increase in employee relations cases resulting from people speaking up about poor behaviours which indicates that there is emerging trust in the organisations ability to appropriately respond to staff concerns.
- The Trust continues to meet the urgent care 4-hour standard in its minor injuries unit and the Faster Diagnosis Standard was met in month eight.
- Agency spend has reduced for the third consecutive month but it remains above the cap year to date.
- Financial and operational forecasting is improving but some processes are very manual and there are capacity challenges in our business intelligence team.

Advise

- The committee agreed to recommend to Board the retrospective approval of the Trust's Premises Assurance Model (PAM) for 2024. The PAM, which helps the trusts make informed decisions about the development of their estates and facilities services, has been completed more rigorously than in previous years and improved processes are now in place for the completion of future PAM returns in line with national timescales. The committee has asked for an update in six months' time to provide assurance that there is oversight and ownership from the relevant service areas.
- The committee has considered the Trust's Annual Equalities report 2023/24 which expands on the previously reported and considered Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and pay reports for the Trust. Bullying and Harassment amongst those from a Black and Ethnic Minority (BME) background or who have a disability remains a key concern.
- The committee reviewed the current milestone and resource plan for Trust's current major projects. There is work in progress to prioritise projects and resources, aligning with the operational planning for 2025/26 and the QVH strategy.
- Initial scoping for the outpatient continuous improvement programme has been undertaken. The proposed areas of focus include utilisation of outpatient clinic space, standardising clinic templates and reducing missed appointment rates.

The Trust is being supported by the South East NHS Improvement Support Team. Improving outpatient performance will help support the delivering of targets as set out in the 2025/26 planning guidance.

- The committee reviewed its annual assurance report to the Audit & risk committee and approved its work programme for 2025/26.

Risks discussed and new risks identified

- The committee reviewed the relevant organisational risks, noting that the highest scoring risks are related to compliance with the Trust's governing documents (risk 14) and the Trust breaking even in 2025/26 (risk 137) which both currently score 16.

Recommendation

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