Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 02 July 2020

Session in public
11:00 – 12:30

(via video conference)

MEETINGS OF THE BOARD OF DIRECTORS: July 2020

Members (voting):

Chair	-	Beryl Hobson
Senior Independent Director	-	Gary Needle
Non-Executive Directors	-	Paul Dillon-Robinson
	-	Kevin Gould
	-	Karen Norman
Chief Executive:	-	Steve Jenkin
Medical Director	-	Keith Altman
Director of Nursing	-	Jo Thomas
Director of Finance and performance	-	Michelle Miles

In full attendance (non-voting):

Director of Operations	-	Abigail Jago
Director of Workforce & OD	-	Geraldine Opreshko
Director of Communications and Corporate Affairs	-	Clare Pirie
Deputy Company Secretary (minutes)	-	Hilary Saunders
Deputy Director of Workforce	-	Lawrence Anderson
Lead governor	-	Peter Shore

Annual declarations by directors 2020/21

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.
Non-executive and executive members of the board (voting)							
Beryl Hobson Chair	• Director: Professional Governance Services Ltd • Director, Longmeadow Views Management Co Ltd	Part owner of Professional Governance Services Ltd	NA	Nil	PGS charity clients may contract with NHS organisations, (not QVH)	Nil	Nil
Paul Dillon-Robinson Non-Executive Director	Nil	Nil	Nil	• Trustee of Hurstpierpoint College • Trustee of the Association of Governing Bodies of Independent Schools	Independent consultant working with Healthcare Financial Management Association (including NHS operating game, HFMA Academy and Best possible value facilitator)	Nil	Nil
Kevin Gould Non-Executive Director	• Director, Sharpthorne Services Ltd. • Director CIEH Ltd	Nil	Nil	• Trustee and Deputy Chair, Chartered Institute of Environmental Health • Independent member of the Board of Governors at Staffordshire University • Independent Member of the Audit & Risk Committee at Grand Union Housing Group • Director, Look Ahead care and support	Nil	Nil	Nil

Gary Needle Non-Executive Director	• Director, T& G Property Ltd	Nil	Nil	Chair of Board of Trustees at East Grinstead Sports Club Ltd (registered sport and lifestyle activities charity)	Nil	Nil	Nil
Karen Norman Non-Executive Director	Nil	Nil	Nil	Visiting professor, school of nursing, Kingston University & St Georges, University of London Visiting professor, Doctorate in management programme, complexity and management group, business school, University of Hertfordshire	Nil	Nil	Nil
Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Keith Altman Medical Director	Director, Maxfacs Medical Ltd	Director, Maxfacs Medical Ltd	Nil	Nil	Nil	Nil	
Michelle Miles, Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Jo Thomas Director of Nursing	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other members of the board (non-voting)							
Abigail Jago Director of operations	Nil	Nil		Nil	Nil	Nil	Nil
Geraldine Opreshko Director of HR & OD	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Clare Pirie Director of Communications & Corporate Affairs	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Fit and proper person declarations

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 an executive director or equivalent or a non-executive director of the trust under given circumstances known as the "fit and proper person test".
By completing and signing an annual declaration form, QVH directors confirm their awareness of any facts or circumstances which prevent them from holding office as a director of QVH NHS Foundation Trust.

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board (voting)							
Beryl Hobson Chair	NA	NA	NA	NA	NA	NA	NA
Paul Dillon-Robinson Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Kevin Gould Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Gary Needle Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Karen Norman Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Keith Altman Medical Director	NA	NA	NA	NA	NA	NA	NA
Michelle Miles Director of Finance	NA	NA	NA	NA	NA	NA	NA
Jo Thomas Director of Nursing	NA	NA	NA	NA	NA	NA	NA
Other members of the board (non-voting)							
Abigail Jago Director of operations	NA	NA	NA	NA	NA	NA	NA
Geraldine Opreshko Director of HR & OD	NA	NA	NA	NA	NA	NA	NA
Clare Pirie Director of Communications & Corporate Affairs	NA	NA	NA	NA	NA	NA	NA

Business meeting of the Board of Directors
Thursday 02 July 2020
11:00 – 12:30
via web conference

Agenda: session held in public			
Welcome			
93-20	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
94-20	**Draft minutes of the meeting held on 7 May 2020.** *Beryl Hobson, Chair*	*approval*	1
95-20	**Matters arising and actions pending** *Beryl Hobson, Chair*	*review*	8
96-20	**Chair's report** *Beryl Hobson, Chair*	*to note*	9
97-20	**Chief executive's report** *Steve Jenkin, Chief executive*	*assurance*	12
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
98-20	**Board Assurance Framework** *Jo Thomas, Director of nursing, and* *Keith Altman, Medical director*	*assurance*	28
99-20	**Quality and governance assurance** *Karen Norman, Non-executive director*	*assurance*	30
100-20	**Corporate risk register (CRR)** *Jo Thomas, Director of nursing*	*review*	34
101-20	**Quality and safety report** *Jo Thomas, Director of nursing, and* *Keith Altman, Medical director*	*assurance*	42

Key strategic objectives 3 and 4: operational excellence and financial sustainability			
102-20	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*assurance*	57
103-20	**Financial, operational and workforce performance assurance** *Paul Dillon-Robinson, Committee chair*	*assurance*	59
104-20	**Operational performance** *Abigail Jago, Director of operations*	*assurance*	62
105-20	**Financial performance** *Michelle Miles, Director of finance*	*assurance*	77
106-20	**Budget Setting Methodology Update 20/21** *Michelle Miles, Director of finance*	*information*	85
Key strategic objective 5: organisational excellence			
107-20	**Board assurance framework** *Geraldine Opreshko, Director of workforce and OD*	*assurance*	92
108-20	**Workforce monthly report** *Geraldine Opreshko, Director of workforce and OD*	*assurance*	93
109-20	**BAME disparity work programme and Board Assurance** *Geraldine Opreshko, Director of workforce and OD*	*assurance*	101
Governance			
110-20	**Annual approval of Standing Financial Instructions, Standing orders and Reservation of powers/scheme of delegation** *Michelle Miles, Director of finance and* *Clare Pirie, Director of communications and corporate affairs*	*approval*	108
111-20	**Review of QVH COVID19 Business continuity Terms of Reference for Board and Committees** *Clare Pirie, Director of communications and corporate affairs*	*approval*	223
112-20	**Review of QVH/The McIndoe Centre ToRs for Oversight Group** *Steve Jenkin, Chief executive*	*approval*	227
113-20	**Audit committee assurance update** *Kevin Gould, Committee chair*	*assurance*	230
Any other business (by application to the Chair)			
114-20	*Beryl Hobson, Chair*	*discussion*	-

Questions from members of the public			
115-20	*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 Hilary.Saunders1@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.* *Beryl Hobson, Chair*	*discussion*	-

Document:	Minutes (Draft & Unconfirmed)	
Meeting:	**Board of Directors (session in public)** **Thursday 7 May 2020, 11:00 – 12:30 via videoconference**	
Present:	Beryl Hobson (BH)	Trust Chair (voting)
	Keith Altman (KA)	Medical director (voting)
	Paul Dillon-Robinson (PD-R)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Steve Jenkin (SJ)	Chief executive (voting)
	Abigail Jago (AJ)	Director of operations (non-voting)
	Michelle Miles (MM)	Director f finance (voting)
	Gary Needle (GN)	Non-executive director (voting)
	Karen Norman (KN)	Non-executive director (voting)
	Geraldine Opreshko (GO)	Director of workforce and OD (non-voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
	Jo Thomas (JMT)	Director of nursing (voting)
In attendance:	Hilary Saunders (HS)	Deputy company secretary (minutes)
	Peter Shore (PS)	Lead governor

Welcome

70-20 **Welcome, apologies and declarations of interest**

The Chair opened the meeting. There were no apologies and no new declarations of interest.

All papers would be taken as read. Questions from board members relating to reports had been collated and distributed to the board in advance, and a precis would form part of today's minutes.

It was also noted than following circulation of the board pack, an updated version of the BAF had been distributed and the published version of the board pack updated for the website.

For the record, the Board was reminded of current governance arrangements in place (with supporting terms of reference), which had been implemented in March. These included continuation of board committee meetings, (abridged where appropriate) in addition to Chair/CEO weekly videoconferencing and Chair/NED/CEO sessions increased to weekly.
A NED/Executive buddying system was also in place.

The Programme Director was maintaining a register of decisions taken through the EPPR and executive route to ensure good governance. This work was being overseen by the Finance and performance, and Quality and governance committees.

These arrangements were due for review by the Board at its meeting in July.

Standing items

71-20 **Draft minutes of the meeting held on 05 March 2020**

The minutes of the public meeting held on 5 March were approved as a correct record

72-20 **Matters arising and actions pending**

The Board received the updated list of matters arising and actions pending. In addition, the following issues were clarified:

- That it remained the Trust's aspiration to acquire a full-time MRI scanner but given the current crisis, funds were now likely to have been allocated elsewhere. However, this would remain on the agenda for now.
- The pension tax issue was still not resolved but measures were in place to manage the impact of significantly increased levels of earnings. There was no impact on QVH job

	plans or ways of working, and the Trust was very quiet at present due to the pandemic but further implications could become apparent later in the year. There may be opportunities to increase capacity later in the year, but again this was not known at present. • The main contractor had returned to resolve the theatre roof issue at no additional cost to the Trust; however, we could not be certain of success until the weather began to deteriorate. • One-way text messages had been implemented. Whilst a pilot scheme on two-way texting was underway, the work on virtual clinics had taken priority in recent weeks. • Following discussion in March, the Board was reminded that when the local Emergency Preparedness, Resilience and Response (EPRR) group had reviewed the QVH self-assessment it had received substantial assurance; this was subsequently downgraded by the wider Local Health Resilience Partnership Group (LHRPG) but reasons cited were challenged by the QVH EPRR officer as inaccurate. This challenge was followed up in writing but the Trust had yet to receive a response due to the pandemic. • A reminder of the way in which the medical examiner guidance was implemented at QVH. As part of partnership working, this was included in a fixed term appointment, but since the start of the pandemic, the staff member had been deployed back to BSUH. The Trust would need to await his return before progressing further; however, we had been assured that appropriate support would be provided by BSUH in the interim. There were no further queries and the Board **noted** the update on Matters arising and actions pending.
73-20	**Chief executive's report** <u>Board assurance framework</u> SJ reminded the Board that the overall BAF had been updated and recirculated prior to the meeting today. The Board sought and received additional assurance as follows: • That COVID19 would not be included in the BAF separately; instead, the Trust's approach was to include COVID as an additional dimension on all risks and manage appropriately, in line with national guidance. The block contract was due to continue until July, and the financial position would continue to be reviewed at the Finance and Performance committee. <u>CEO report</u> The Board sought and received additional clarification as follows: • Responding to news that Sussex's status as an Integrated Care System had been approved, the Board queried the impact of this on QVH. The Trust would in future be working closely in partnership with local councils and others providers, and take collective responsibility for managing resources, including funding for workforce, performance etc. the ICS executive would comprise providers, commissioners and specialist commissioners, ambulance services and local authorities. QVH is now actively involved in a way not seen previously and positive relationships have been developed, evidenced in recent weeks with the Sussex-wide response to COVID. • In response to concerns that the ICS may make decisions disadvantageous to the Trust, the Board was reminded that QVH remained a unitary board with the CEO as accountable officer. • Our partnership working with BSUH and Western was continuing and there would be an update on the due diligence exercise at the next board seminar; our long-term strategy would not fundamentally change because of COVID. The Trust's current role as a cold cancer site had been recognised both regionally and centrally and it would be interesting to see how this might continue in the future. It was hoped that a systematic formal assessment would be undertaken after the pandemic to ascertain what changes might be retained. Benefits to date had included a large increase in telephone and video consultations.

	• The integrated dashboard was consistent with the workforce report, which showed turnover as red, but with an improving position. Media report The Board commended the quality of media coverage and congratulated those involved.
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services	
74-20	**Board Assurance Framework** The Board sought clarification regarding KSO1, which highlighted recruitment, and retention and commissioner/provider led changes as the biggest risk. JMT confirmed that workforce has been stable during the pandemic and we have had a sustained focus on health and wellbeing, which has been well received by staff. There may be workforce changes as lockdown lifts and we will be responsive to these and continue to update the BAF/CRR as appropriate. Current risk ratings had increased.
75-20	**Quality and governance assurance** The Board **noted** the contents of the Quality and governance assurance report.
76-20	**Corporate risk register (CRR)** The Board **noted** the contents of the Corporate risk register.
77-20	**Quality and safety report** The Board received the Quality and safety report, seeking additional clarification as follows: • Were any compensating controls required following deferral of doctors' revalidation for a year? KA explained that the GMC had made the decision to defer and that there would be flexibility around notice periods to enable those due to be revalidated in the future. The real impact was on appraisals, which had been put on hold. However, it was relatively straightforward to monitor those doctors with a prearranged connection to QVH and once we were able to resume, we would do. • Last month's doctor's induction had been streamlined which had been made easier due to the fact there had been no rotation in April. • There had been a slight increase in complaints in March; main themes were around communication but none related to COVID. • That the three patients who had a fall last month had been risk assessed on admission, with appropriate follow up undertaken. • The Friends and Family test (FFT) results in the Trauma clinic last month included two patients who scored negative, with one commenting on the amount of the time they had had to wait for treatment. Feedback had been shared with the team. • Staffing continues to be monitored by clinical leads and at four set points during a 24-hour period. No trained shifts have been replaced by HCAs and sickness absence has been covered by staff redeployed from other areas due to cancelling of elective work; agency use has been minimal during the pandemic, relating primarily to mental health nurse cover. • There were no clinical harm reviews in April, partly due to annual leave and partly to the pandemic. All clinical harm reviews identified for April were completed in the first week of May with one case under surveillance. There were no further questions and the Board **noted** the contents of the update.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
78-20	**Board Assurance Framework** The Board noted the contents of the latest BAF for KSO3.

	The backlog of coding, previously recorded as a risk issue on KSO4 had been removed due to work undertaken to date and the fall in activity. The team was using this opportunity to identify solutions for the remainder of this financial year and beyond. The Board noted the new requirement for service reviews to understand efficiencies against payments. MM described work being developed to inform what future services reviews may look like.
79-20	**Financial, operational and workforce performance assurance** The Board received an update from the Chair of the Finance and performance committee following the recent meeting. There was a short discussion around the need for certainty regarding future contracting arrangements to inform our strategic and business planning, and whether the Executive had necessary support, resources and information from commissioners to develop a reasonable assessment projection for next year. The Board was reminded that the block contract was due to continue until July, and the financial position would continue to be reviewed at the Finance and Performance committee. There were no further comments and the Board noted the contents of the update.
80-20	**Operational performance** The Board received the latest operational performance report, and sought and received the following clarification: • That the Association of Breast Surgery (ABS) had published guidance on 23 March standing down breast reconstruction at the time of surgery, which the Trust was observing. QVH would resume immediate reconstruction as soon as permitted. • The Trust was cognisant of an increase in diagnostic waits exceeding 6-weeks; delays were being experienced by cancer patients in all areas of their pathway but risk assessments were being undertaken in line with the pathway variation process and signed off at the Cancer Board. The Trust's Head of Risk and Patient Safety was part of this group. • Waiting lists were being prioritised in the normal way and data was presented within the usual reporting timescales. • Additional data was provided in the report this time, which demonstrated the impact of COVID19 on the referral to treatment (RTT) targets. Clock starts had been reduced by 27%, reflecting an overall reduction in referrals. There was a short discussion around activity restoration and recovery, with the Board seeking assurance that the Trust had the necessary capacity and skills in place for this. SJ assured the Board of the approach to restoration and recovery, describing the seven guiding concepts, which underpin this strategy. These included maintaining staff and patient safety; delivering elective recovery whilst maintaining our system role in supporting COVID-19 for cancer and trauma; a consistent and standardised Trust approach; delivery of service innovation, awareness/ planning of an exit strategy; financial mechanisms and payment and workforce. The Board asked how responsibilities would be allocated between individual organisations and the ICS. SJ reported that the ICS Executive had signed off the terms of reference for the group, which would meet on a weekly basis to set the strategic framework for restoration and recovery (R&R), ensuring alignment. At QVH, the terms of reference for restoration and recovery groups would be developed to agree priorities and implement a phased recovery plan. It was acknowledged that both the Centre and our ICS would need to recognise that we would not have theatre capacity to address the increase in RTT if we continued our role as a cold cancer site. We would also need to reconsider current strategy based on current constraints.

	The Board was supportive of the approach which management was taking, whilst recognising this was a very challenging environment. There were no further questions and the Board **noted** the contents of the update.
81-20	**Financial performance** The Board received the latest financial update. The following questions were raised, and responded to in advance: • A request for clarification on non-pay overspend which was driven by fixed asset impairments. The impairments were the resultant change for the revaluation that the Trust under took in March, this is a requirement and is a technical adjustment on the accounts • A request for clarification regarding the reported £488k of bad debt provision. This was a prediction of the potential level of debt that could become bad; however, it was a subjective assessment and would be reviewed with the auditors. • A request for further detail around annual leave accrual. At year-end, the Trust recorded c£140k of additional accruals for untaken annual leave due to COVID, and a further c£40k for non-covid related reasons, over and above last year, (in 2019/20, annual leave accrual was c£70k). GO reminded the Board that it was usual practice to accrue for annual leave to provide flexibility for those staff unable to take leave without affecting the service. Additionally during the last month of the year, a number of staff had cancelled booked leave after needing to 'socially isolate' for 14 days. Whilst mindful of national guidance for flexibility around terms and conditions, QVH and the Sussex system as a whole was encouraging staff to book leave as normal, reinforcing this from a wellbeing perspective. • Noting that overspend against revised plan was driven by recoding of agency costs which were previously coded against bank, the Board asked if this would materially change information previously provided to the board on both bank and agency usage: The Trust was on plan for pay in line with the revised forecast. Whilst agency was on plan, there was a slight variation between bank and substantive staffing, which was only minimal. Assurance was given by the Director of Finance that there were no material changes to the information previously provided to the Board. • The Finance and performance committee would continue to monitor cyber security following successful completion of the recent project. (All Board members received reports as a matter of course). • Following deferral of the eObs programme and PAS upgrade because of COVID, the Board received an update on plans to get these back on track. • Debtor accrued income is where an invoice has been raised outside of the month, and actually showed a decrease on prior periods. • Regardless of activity, the Trust will only be paid on block payment arrangements; no cost improvement plans would be required in the first four months of the year, but we there was an assumption that these would be introduced from MO05 onwards. However, there were minimal budget reductions this year with an expectation that there would be none within the cost improvement plan.
Key strategic objective 5: organisational excellence	
82-20	**Board assurance framework** The Board noted the contents of the KSO5 BAF.
83-20	**Workforce monthly report** The Board received the regular workforce report. Additional clarification was sought as follows: • An update on plans for August rotation. Whilst informal discussions with the Deanery had begun, and some form of rotation was anticipated in August, it was too soon to confirm

	the detail. National guidance was very clear on flexibility around job descriptions, terms and conditions and the new contract. • Staff health and wellbeing initiatives had been well received. There were also plans for potential PTSD support, which may be required, later in the year. The Trust was also piloting the use of webinar interactive initiatives for mindfulness. • Today's report showed data up to March. However, there were early indications temporary staffing had fallen dramatically in April, partly because of the fall in activity but also because the Trust was redeploying staff from other areas due to cancelling of elective work. • Mandatory and Statutory Training figures were likely to drop, but the Workforce services would continue to promote the use of e-learning. • Sickness absence rates in March were higher than usual because of COVID related illness. The number of staff isolating had not been correctly recorded in March but figures would drop back to levels that are more usual in April. • Assurance that the Trust was actively managing the disproportionate impact of COVID on BAME staff, with updated risk assessments for all staff pending. • The enormous amount of work undertaken by IT to enable more people to work from home was commended. • The Board noted the number of staff in post and current vacancy rates, which showed significant improvement on previous years and commended all those involved. In response to a question from the lead governor GO described the process currently in place for staff testing which was being co-ordinated through the incident room. Following approval by EMT and HMT, it was anticipated that the Trust would be able to introduce its own on-site testing facility within a few weeks, which would speed up test results. On behalf of the Board, the Chair expressed thanks to everyone at QVH, citing not just the work of the clinical staff but also the efforts made by the Executive and all their teams. She asked that a message expressing the Board's thanks be circulated to the whole organisation. **[Action: CP]**
Governance	
84-20	**NHS Provider licence conditions** The Board received a paper setting out the requirement to self-certify that it had complied with the NHS Provider Licence and NHS Acts, and that it has had regard to the NHS Constitution. Following circulation of the reports and in response to a request for additional evidence, the Board had subsequently received a copy of the QVH licence as a reminder of what it covered. Whilst the Trust had received authorisation to delay submission of the annual report and accounts, no such authorisation had been granted regarding self-certification, hence this year's process was out of sequence with the usual cycle All foundation trusts were affected in the same way, with the majority choosing to go ahead with self-certification without further delay. CP was confident that the template declaration was appropriate. MM confirmed that the wording around resources had been used in previous years, and again was appropriate in the 2019/20 financial year. A statement to this effect would also be published to the Trust's website.

	In response to a query from the Board, MM advised that it was for NHS England to define those specialised services which have commissioner requested service designation, and it was not for the Board to make amendments. There were no further questions and the Board **confirmed** that: • It had complied with the NHS provider licence condition • It had taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • It had complied with required governance arrangements (Condition FT4(8)) • It had a reasonable expectation that required resources will be available to deliver the designated Commissioner Requested Services (Condition CoS7(3) over the next financial year but specific factors may cast may doubt on this
85-20	**Audit committee assurance update** The Board received an update from the Chair of the Audit committee. Concerns were raised that senior staff engagement in the risk management internal audit appeared minor and seemingly unrepresentative. Members queried how much assurance was derived from this and to what extent did conclusions and recommendations depend on this. The Chair stated that this had not been highlighted as an issue at the meeting. This audit had also been reviewed by the Quality and governance committee and it was noted that these results were not taken in isolation but considered in conjunction with a range of other measures to gain full assurance. There were no further questions and the Board **noted** the contents of the update.
Any other business	
86-20	The Chair noted that at the next seminar scheduled for 4 June, there would be an opportunity to follow up on items discussed today. The Chair went onto congratulate two board members who would be celebrating birthdays this week, albeit under lockdown.
Questions from members of the public	
87-20	The Chair noted that a question had been raised by one of the governors through PS as lead governor relating to the recent news that the Treasury would be taking over a large proportion of the NHS debt. Additional clarification was sought as to whether this would apply to QVH and if so what were the implications. This matter had been raised at a recent Finance and performance committee meeting but no further information had been received to date. The Chair asked PS to update the governor concerned, and suggested any further details would be communicated to governors via the usual channels.

Matters arising and actions pending from previous meetings of the Board of Directors									
ITEM	**MEETING Month**	**REF.**	**TOPIC**	**CATEGORY**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
1	May 2020	83-20	Workforce	KSO5	A message expressing the Board's thanks be circulated to the whole organisation.	**CP**	**ASAP**	Chair's message to staff in all staff update	**Closed**
2	March 2020	41-20	CRR	KSO1	In absence of Failsafe Officer, manual process to be established to reduce risks of patients being lost to follow up/undue delays to follow up appointments.	**AJ**	**May 2020**	Board reminded that this recommendation came through the fail safe report, however it is not believed to be a priority as there are other ways of providing this assurance. It will be looked at in the longer term but at present management are as certain possible that this is being managed effectively	**Closed**
3	March 2020	41-20	CRR	KSO1	F&PC to consider how to capture impact on performance of those corporate risks which relate to staffing.	**PD-R**	~~**May 2020**~~ **July 2020**	**27 04 20** F&P agreed have agreed to defer until July	**Pending**
4	Jan 2020	10-20	Q&S report	KSO2	Board to receive written update on adult burns service	**KA**	~~**March 2020**~~ ~~**May 2020**~~ **Sept 2020**	Nothing further to report at present. Will be returned to May Board with update after start of talks with BSUH. **07 05 20** Nothing further at present. To be brought forward in September 2020.	**Pending**
5	Jan 2020	11-20	EPRR core standards and statement of readiness	KSO2	Board to receive update as to accuracy of core standard figures shown in January EPPR report	**JMT**	**1 July 2020**	Trust EPRR lead re-escalated this to CCG EPRR lead meeting postponed by CCG due to coronavirus incident **Update 5/3/20** NR noted that new cycle of review is now underway and therefore feedback would inform amended reporting. Will remain on matters arising for regular updates for now. **Update 07 05 20** No further update at present due to pandemic **June 2020** The trust has now received the NHSE letter explaining the reasons for the different assessement of trust compliance from the LHRF. NHSE note that although QVH has remained partially complaint there has been some progress and improvement with individual core standards. The detail of this assessement will be incorporated into the 2019/20 annual report. Action now closed.	**Closed**

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/07/2020**		**Agenda reference:**	**96-20**	
Report title:	**Chair's Report**				
Sponsor:	Beryl Hobson, Chair				
Author:	Beryl Hobson, Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on the Chair, NED and governors activities since the last board meeting.				
Summary of key issues					
Recommendation:	The Board is asked to **note** the contents of this report				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:** ***Outstanding patient experience***	**KSO2:** ***World-class clinical services***	**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board of Directors
Meeting date:	2 July 2020
Agenda item reference no:	96-20
Report from:	Beryl Hobson, Chair
Date of report:	22 June 2020

Chairs Report

1. Introduction

At the very beginning of my report I would like to pay tribute to everyone at QVH who has worked tirelessly over the last few months – those who have been on site all the time and those who are working from home. I can't think of anyone whose work and personal lives have not been affected to some extent and this has been a difficult and sensitive time for everyone.

My last Chair's report was written on 24 February, which seems like a very long time ago and in a different world. Since then we have adjusted the way we do governance – for example by using video conferencing as a board and committees, using reduced agendas and attendees, within a framework which was agreed at the April board meeting.

I have personally missed being able to walk around and see all our teams doing their brilliant work and it is not clear yet when I will be able to do that again. In addition to being able to talk to staff and patients and hear their amazing stories, these 'walkabouts' provide me with a level of assurance regarding governance. I don't usually like the term 'triangulation' but I have realised that this is what I am currently missing and I believe this is the case for the other Non-Executive Directors. As we move into the next phase of restoration and recovery, we will need to work out whether there are other ways to achieve this.

I am sure all of us have been affected by the issues raised by both the disproportionate number of BAME people affected by Covid19 and also Black Lives Matter. Along with Steve Jenkin, I attended a workshop organised by the Sussex Health & Care Partnership (ICS) to hear the views of our BAME colleagues. One of the messages I came away with was that it is not enough for boards to express our commitment to our BAME colleagues, we need to ensure that everyone in our organisation shares and acts on the commitment.
Like many of us I have been considering my personal responsibility and that of our board. I am acutely aware that this has to be a considered and actionable response – not a tick box or token gesture. In addition to the Covid risk assessments that are on today's agenda, we have invited Cavita Chapman Head of Equality, Diversity and Inclusion at NHSE South East Region to meet with our board later this month to discuss our response.

2. Chair's and NED's activities

At the end of March I chaired a Consultants Appointment panel, which appointed three Consultant Orthoplastic Surgeons (and an additional locum). These are joint appointments with BSUH and have been discussed for several years, so it was good to be in a position to reach a conclusion. It was also good to work with our colleagues from BSUH during the appointments process.

The ICS Chairs Oversight group moved online and had two meetings – one was specifically to discuss our response to the BAME issues, which was attended by Gary Needle on my behalf. The other was our regular Chairs meeting – it was heartening to hear the way Sussex health and care organisation had responded to the pandemic. Like QVH, all organisations have had to make substantial changes to the way they interact with patients. The Chairs recognised that whilst we would prefer that the pandemic had not happened, there have been some significant beneficial changes to services which otherwise may have taken years to achieve, for example the rapid move to video and telephone consultations. Gary also attended a Regional Chairs meeting, which outline the current position in the South East region and a desire by the NHS centrally to move rapidly to restoration and recovery.

The NEDs have continued to Chair their sub-committees and have adapted to online chairing. Some of us have also attended meetings of the Covid Activity Planning and HMT Oversight group. The last few weeks have been particularly busy for Executives and NEDs, including the signing off of annual report and accounts and consideration of the quality report. On behalf of the NEDs, Gary Needle is attending the Restoration and Recovery groups relating to our future activity.

3. Governor Activity

Unfortunately we had to cancel the April meeting of the Council of Governors as part of the effort to reduce the burden on our teams. We decided not to do an electronic meeting due to the support that would have been needed from our IT team who were setting up teams to work remotely or from home. However the Governor Representatives have been attending the online board committee meetings and providing feedback through the Governor Monthly update. In addition the Governors Steering Group and Appointments Committee have met online. The July Council of Governors will meet online with reduced attendance by Executives and NEDs.

Unfortunately we were not able to say goodbye in person to several Governors who were standing down at the end of their first or second term. I am grateful for all the support and commitment that the following Governors have made to QVH:

- John Belsey
- Angela Glynn
- Tony Martin
- Glynn Roche
- Joe McGarry
- Tony Tappenden
- John Wiggins
- Mickola Wilson

Board Assurance Framework – Risks to achievement of KSOs

KSO 1 Outstanding Patient Experience	KSO 2 World Class Clinical Services	KSO 3 Operational Excellence	KSO 4 Financial Sustainability	KSO 5 Organisational Excellence
We put the patient at the heart of safe, compassionate and competent care that is provided by well led teams in an environment that meets the needs of the patient and their families.	We provide world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high quality education and training and innovative R&D.	We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner	We maximize existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services.	We seek to be the best place to work by maintaining a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce

Current Risk Levels

The BAF and CRR was reviewed at executive management meetings in June. KSO 1 and 2 were also reviewed at the Quality and Governance Committee WebEx, 18/06/20. KSO 3, 4 and 5 were reviewed 22/06/20 at the Finance and Performance Committee webex. Changes since the last report are shown in underlined type on the individual KSO sheets. The introduction of the an integrated pandemic governance process to ensure the trust is proactively managing the new and emerging risks and the restoration and recovery phases is implemented within the organisation. Additional assurance continues to be sought internally and the evidence of this is referenced in the respective director reports to the July trust board .

	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Target risk
KSO 1	15	12	12	12	9
KSO 2	12	12	12	16	8
KSO 3	20	16	16	16	9
KSO 4	25	25	25	25	16
KSO 5	20	16	16	16	9

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/07/2020**		**Agenda reference:**	**97-20**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	1) Integrated Performance Dashboard Summary 2) QVH media update				
Executive summary					
Purpose of report:	To update the Board on progress and to provide an update on external issues that may have an impact on the Trust's ability to achieve its internal targets.				
Summary of key issues	• Covid-19 – QVH response • BAME staff – health inequalities • VE Day				
Recommendation:	For the Board to **NOTE** the report				
Action required	Approval **Y/N**	**Information Y/N**	Discussion **Y/N**	Assurance **Y/N**	Review **Y/N**
Link to key strategic objectives (KSOs):	KSO1: **Y/N**	KSO2: **Y/N**	KSO3: **Y/N**	KSO4: **Y/N**	KSO5: **Y/N**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:					
Corporate risk register:	None				
Regulation:	N/A				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	EMT				
	Date:	22/06/20	Decision:	Review BAF	
Next steps:					

CHIEF EXECUTIVE'S REPORT
JULY 2020

TRUST ISSUES
VE Day – 8 May

There is nothing quite like the sound of a Spitfire's merlin engine and on 8 May it could be heard roaring above our hospital as we took part in a very special fly past to mark the 75th anniversary of VE Day.

Having been chosen as one of 11 locations to receive the sky high visitor, we were honoured to not only see the magnificent plane do three circles and a roll of honour above the hospital but to see it carrying a very special thank you to the NHS on the underside and cockpit.

Our staff and patients on Canadian Wing had created a banner and coloured in bunting which adorned the front of the site.

Covid-19

Progress since last Board

The trust continues to follow all guidance from Public Health England (PHE), NHS England and Improvement (NHSE/I) and the Department of Health and Social Care (DHSC). We are fulfilling our obligations as a regional surgical cancer hub (breast, head and neck, and skin) across Kent, Surrey and Sussex, as well as for trauma and elective patients. We are enjoying a close working relationship with the McIndoe Centre, part of Horder Healthcare based on the same site, to ensure all our patients receive appropriate care. Since our joint work commenced at the end of March, there have been over 2,000 patients' contacts at the McIndoe Centre.

Advanced infection controls measures continue to be in place, including screening and temperature monitoring at the front door.

The trust continues to work with the Sussex Health and Care Partnership to look at provision for all services and other ways that we can support the wider system.

There have been some recent concerns within the trust around provision of PPE (personal protective equipment) in particular the availability of a particular FFP3 masks although we have secured 12 respiratory hoods for staff members who have failed a 'fit' test. On occasion we have been able to offer mutual aid to our health and social care partners following a request for support.

The trust has been exploring a number of different options with regard to staff testing and at the time of writing will shortly go live with our own regime. This is in line with the national approach to testing and particularly important for the cancer services we are providing.

The IT department has issued equipment to allow remote working for as many staff as possible, with key users being prioritised in line with divisional and directorate requests. In further support of remote working capacity the team has installed additional servers to support increased demands for remote access.

NHS Phase 2

All provider trusts received a letter from NHS Chief Executive Sir Simon Stevens and Chief Operating Officer Amanda Pritchard dated 29 April setting out the Government's expectations as we entered the second phase of the NHS's response, known as the restoration phase. We continue to be in a Level 4 National Incident and we are maintaining our EPRR incident management functions. The expectation for trusts was to fully step up non-Covid 19 urgent services over the next six weeks clearly taking into account full attention to infection prevention and control as the guiding principle.

The correspondence also asked trusts to take the opportunity to 'lock in' beneficial changes that had materialised over recent weeks. Many trusts, including QVH, have delivered a dramatic increase in virtual consultations between consultants and patients. Our clinicians have conducted 14,840 virtual appointments since the beginning of April, the vast majority (93%) by telephone although last month did show an increase in the number of video appointments. QVH is one of the largest users of Attend Anywhere in the South East region (Attend Anywhere is a secure NHS video call service for patients with pre-arranged appointment times only).

In addition, NHS Test and Trace has been launched to ensure that anyone who develops symptoms of coronavirus (COVID-19) can quickly be tested to find out if they have the virus, and also includes targeted asymptomatic testing of NHS and social care staff and care home residents. The process helps trace recent close contacts of anyone who tests positive for coronavirus and, if necessary, notifies them that they must self-isolate at home to help stop the spread of the virus.

At the right time and following decision by Government the NHS will move into its phase three 'recovery' period for the remainder of the 2020/21 financial year.

Restoration

QVH has set up a Recovery and Restoration group to define the approach to recovery. Each of the services is drawing up their own proposals regarding what will be stepped up, this will depend to some degree what the Royal College guidance is and managing the proportion of theatre capacity required for cancer.

The approach takes into account the balance of the organisation's own recovery with the needs of the system, given QVH's role as a cancer hub in the system response to Covid-19.

Workforce challenges are improving and a plan for point of care testing is under development to support patient and staff testing. This is anticipated to go live at the end of June and will support the recommencement of non-urgent services.

The first phase of the QVH plan includes the following:

1. Confirming independent sector capacity to enable continuation of cancer hub and understanding of overall capacity
2. Risk stratification of waiting lists – episode level by the 4 national prioritisation levels and patient level re patient co-morbidities / vulnerable status
3. Determine capacity available – taking into account physical capacity and variable capacity determinants including workforce, PPE, drugs etc
4. Development of service, site and trust level proposals taking into account NHSE and Royal College guidelines
5. Development of operational capacity management processes (capacity hub) to manage and flex capacity through the next phase, taking into account potential changes for both capacity and demand (system and QVH).

A small number of 'guiding concepts' underpin the thinking within our recovery plan:

1. Maintaining staff and patient safety
2. Delivering elective recovery whilst maintaining system role supporting COVID-19 for cancer and trauma
3. Consistent and standardised trust approach
4. Delivery of service innovation
5. Awareness/planning of an exit strategy
6. Financial mechanisms and payment
7. Understanding the workforce challenges

At a Sussex level, chief executives continued to meet virtually each week and a South East regional Restoration Board is in place. QVH continues its incident management structure while the national Level 4 remains in place although the frequency of Gold and Silver command meetings have reduced.

Covid-19 and inequality

Public Health England (PHE) published a report 'Disparities in the risk and outcomes of Covid-19' on 2 June which exposed the stark inequalities that continue to exist in our society. People who have been worst affected by the virus are generally those who had worse health outcomes before the pandemic, including people working in lower-paid professions, those from ethnic minority backgrounds and people living in poorer areas.

In support of the above report PHE engaged more than 4,000 people who represent the views of BAME communities, to gather insights into factors that may be influencing the impact of Covid-19 on these groups and to find potential solutions. This work also included a rapid literature review conducted with the National Institute for Health Research (NIHR). The insights report 'Beyond the data: Understanding the impact of COVID-19 on BAME groups' was published on 16 June and the clear message from stakeholders was the requirement for tangible actions, provided at pace and scale, with a commitment to address the underlying factors of inequality.

Commenting on the publishing of the Public Health England review, the deputy chief executive of NHS Providers, Saffron Cordery said:

"We welcome the publication of Public Health England's rapid review into factors impacting health outcomes from COVID-19.

"This review supports earlier findings by the Office for National Statistics, helping to give us a clearer picture of the disproportionately large toll this pandemic has taken on black and minority ethnic people and communities and the reasons why. Trust leaders are concerned about increased risk to BME staff, reflecting the wider inequalities long faced by BME staff in the NHS workforce, and this report will add to existing resources supporting a more informed response to this challenge.

"We look forward to seeing how the government plans to respond to these concerning findings."

System response

On 5th June, Sussex Health and Care Partnership ICS held a BAME staff engagement event: 'Protecting our Black, Asian and Minority Ethnic (BAME) Communities', which was supported by every CEO in the system and included presentations from representatives of every BAME Staff Network. Board level representation was also secured, including QVH Chair.

There has already been significant learning on the necessary actions to address health inequalities for BAME people, which is being captured and included in legacy plans and will be further developed to ensure that within restoration and recovery the system has an absolute and meaningful impact on health inequalities that existed before COVID19. We are also focussing on the immediate actions required to prevent a similar pattern should a second wave of COVID19 occur.

From the event, a set of leadership commitments were made by the Sussex Health and Care Partnership Leadership Team including:

1. Continued engagement – bi-monthly events to report on progress, led by BAME staff and staff networks, to include a focus on health and well-being; (Critical to the next event is that we shift the focus away from hearing from the leadership team to BAME staff leadership);
2. An Integrated Care System Leadership Team to oversee the workforce race equality standard (WRES) work in the system to ensure collaboration and shared impact and delivery;
3. A focus on resourcing with a specific emphasis on the interaction between senior and middle management, Board diversity and establishing breakthrough objectives;
4. Calling out and challenging where we hear and see overt and covert bias, prejudice, and values that are not in line with the NHS values;
5. To create a BAME Talent Management Programme in the region for peer support, developmental opportunities and recruitment;
6. To establish a Sussex wide BAME Staff Network to harness the opportunities of working together and drive through change.

<u>QVH response</u>
QVH is looking to establish its own BAME network and has engaged support from Cavita Chapman, Head of Equality, Diversity and Inclusion at NHS England and NHS Improvement – South East Region. A Board seminar is being co-ordinated for later this month with Cavita facilitating our approach. Our Board members are determined to accelerate both our improved understanding of issues impacting our BAME patients and staff and our commitment to ensure inclusion in the workplace.

Land sale
Delays have occurred in the potential land sale due to the covid pandemic however in light of the relaxation of the restrictions work will recommence in the coming weeks.

Integrated Performance Dashboard Summary
Our Integrated Performance Dashboard summary (Appendix 1) highlights at a glance the key indicators from all areas within the Trust including safety and quality, finance and operational performance, and workforce, against each Key Strategic Objective. The NHS declared a Level 4 National Incident on 30 January and from 17 March all trusts freed up inpatient and critical care capacity including stepping down non-urgent elective activity; the significant impact of this is reflected in KSO3 on the dashboard. In addition, all trusts are currently under Block Contract arrangements resulting in a break-even position in KSO4.

Board Assurance Framework (BAF)
Attached is the BAF front sheet, the following points are worth noting:

The entire BAF was reviewed at executive management meeting (22/06/2020) alongside the corporate risk register. KSO 1 and 2 were reviewed at the Quality and Governance Committee, 18/06/2020. KSO 3, 4 and 5 were reviewed 22/06/20 at the Finance and Performance Committee. Changes since the last report are shown in underlined type on the individual KSO sheets.

Media

Appendix 2 shows a summary of QVH media activity during April and May 2020; reflecting QVH role as a designated surgical cancer hub for Kent, Surrey and Sussex. The trust also had excellent coverage to mark the 75th anniversary of VE Day on Friday 8 May with a special Spitfire fly pass.

Steve Jenkin
Chief Executive

Integrated Dashboard Summary
Key indictators at a glance - July 2020

Queen Victoria Hospital
NHS Foundation Trust

KSO1 Outstanding Patient Experience & KSO2 World Class Clinical Services		
C-Diff	0	→
MRSA	0	→
E-coli	0	→
Gram-negative BSIs	0	→
Serious Incidents	0	↑
Never Events	0	→
No of QVH deaths	0	→
No of off-site deaths (within 30 days)	2	↓
Complaints	4	↑
Closed <30 days	1	↑

FFT

FFT was suspended national due to COVID 19 however the trust continued to operate a full PALS and complaints service throughout and has designed new patient questionnaire for breast surgery and virtual clinic appointments to seek patient experience of these new pathways. The response has been overwhelmingly positive.

KSO 3 Operational Excellence		
MIU <4hrs	100.00%	→
RTT 18 weeks	59.22%	↓
Cancer 2ww	83.80%	↓
Cancer 62 day	90.09%	↑
Diagnsotics <6weeks	28.09%	↓
52ww	100	↓
(patient choice)	N/A	→
Virtual appointments	7190	→
a) video	6.80%	→
b) telephone	93.20%	→

NHS declared a Level 4 National Incident on 30 January. From late March all trusts freed up the maximum possible inpatient and critical care capacity as well as stepping down non-urgent elective activity, which is reflected here.

Key	Improved Performance	Deteriorating Performance	Remains the same
	↑	↓	→

KSO4 Financial Sustainability		
Income	6079k	→
Pay expenditure	4092k	↑
Non-pay expenditure	1987k	↑
Surplus/Deficit	0	→

The Trust I&E position is breakeven YTD at month 2 under Block Contract arrangements.

Expenditure run rate (both Pay and Non-Pay) in 20/21 is below 19/20 averages and is consistent with current activity levels.

KSO5 Organisational Excellence		
Vacancy rate	9.38%	→
Turnover rate	12.84%	↑
Sickness rate	3.08%	→
Appraisal rate	80.82%	→
MAST	91.91%	→
Q4 Staff FFT (work at QVH)	74.71%	→
Q2 Staff FFT (care at QVH)	95.35%	→

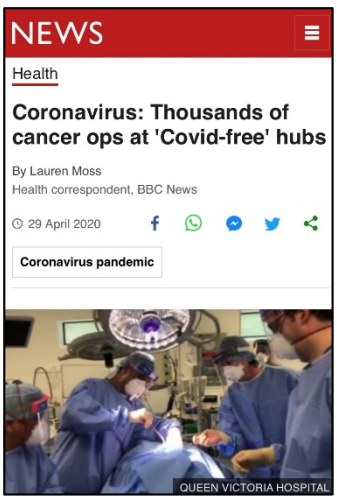
QVH media update – April 2020

Here's a summary of the media activity secured for QVH …

QVH as a designated cancer hub

This month we received a series of national and regional media coverage for our role as a designated cancer centre for the South East during the COVID-19 pandemic. Patients with high risk cancers (head and neck, breast and skin) from across Sussex, Surrey and Kent can continue to receive appropriate and timely treatment where possible at our hospital, and we have put a series of measures in place to ensure the safety of both our patients and staff.

On Wednesday 29 April we were featured on the national BBC News in both the 6pm and 10pm bulletins. Health reporter Lauren Moss highlighted the different ways we are working to treat patients, including virtual clinics, and interviewed some of our senior staff and a patient who travelled 40 miles to have his cancer surgery at QVH. The overarching message was that patients can continue to receive treatment at centres such as ours and that our screening process helps minimise the risk of bringing COVID-19 to the hospital.



The timing of the coverage coincided with news from NHS England that cancer hubs such as ours are being set up in 21 regions across the UK to support patients, and that if you are worried you may have cancer like symptoms, regardless of COVID-19, please seek medical help.

Details of the piece including quotes from one of our patients were included in a story on the BBC News website (pictured left).

The BBC article was also cited the same day on the i's website, referencing us as the first cancer hub to be set up in the South East. In addition the News Health and The Globe websites ran the story.

Again tying in with the announcement from NHS England, Dr Ian Francis, our associate medical director for strategy and cancer, was interviewed on a series of radio stations. This included on Wednesday 29 April national station LBC; BBC Radio Sussex; BBC Radio Kent; and on Thursday 30 April BBC Radio Surrey.

Focus groups have found that both fear of catching the virus and concern not to overwhelm the NHS have put people off seeking care

JACOB KING/AP

CORONAVIRUS

Virus-free 'hubs' to take over cancer care as referrals drop

Kat Lay, Health Correspondent | Chris Smyth, Whitehall Editor

Friday April 24 2020, 12.01am, The Times

The previous week Cancer Research UK published research highlighting the significant drop in the number of patients being diagnosed and referred for cancer treatment, as a direct result of the pandemic.

Following the national announcement of a network of "COVID-19 free hubs" to treat cancer patients, such as ours, and the assurance from NHS England that people with cancer should continue to use the NHS, Dr Ian Francis was interviewed by The Times in its Friday 24 April edition. He explained how we have reconfigured how we work to support patients. The piece also appeared in the print version of the paper.

Daily Mail MORE STORIES

NHS will use network of virus-free 'hubs' to encourage cancer patients and others with serious conditions to go back to hospitals to get treatments

By Ed Riley For Mailonline
09:21 24 Apr 2020, updated 09:44 24 Apr 2020

The Times piece also gained interest from the Daily Mail who ran their own version of the story the same day (pictured).

The following day the Daily Mail ran a follow-up piece about how the NHS may look to redeploy coronavirus capacity and restart routine surgeries. It again mentioned the cancer hubs and referenced QVH.

NHS England instructed hospitals to stop almost all planned care and redirect resources to fighting Covid-19

CHRISTOPHER FURLONG/GETTY IMAGES

CORONAVIRUS

NHS forced to cancel 2 million operations because of coronavirus

Kat Lay, Health Correspondent | Greg Wilford

Wednesday April 29 2020, 9.00am, The Times

We received the second mention within the space of a week in The Times on Wednesday 29 April, referencing us as a cancer hub in a piece about how a COVID-free centre approach could help the growing number of people waiting for elective surgery.

On Thursday 23 April our cancer hub was featured on the ITV Meridian news, using footage we created at QVH. The focus was on the support we are able to provide patients from across the Meridian area and included interviews with our team, one of our patients, and also demonstrated the measures we have implemented including temperature checking visitors to site and CT scans for patients. You can watch the piece back on the ITV website.

Our initial announcement of our role as a cancer hub at the start of the month generated some media attention too. Namely a mention on BBC South East Today on Tuesday 7 April by Mark Norman, health reporter, in his daily round up. Dr Ian Francis was also interviewed by BBC Radio Sussex for the daytime show on Wednesday 8 April and on the Heart Sussex news bulletin on Thursday 9 April. KentOnline also mentioned us in a piece about changes to cancer services in Kent and Medway due to COVID-19.

BBC South East Today also used a clip of a FaceTime interview with Dr Francis on Monday 20 April, talking about a consequence of COVID-19 is that many hospitals do not currently have the capacity to treat cancer patients (pictured).

COVID-19 and sleep

Dr Peter Venn, clinical lead of our sleep disorder centre, was interviewed by BBC Radio Kent on Thursday 23 April about COVID-19 and sleep difficulties. He talked about how our sleep centre helps patients with insomnia and gave some top tips on improving your sleep.

Declan's fundraising for QVH Charity


THE Sun

MORE FABULOUS

YOUNG HEROES Our brave kids overcame horrific childhood illnesses, loss and heartbreak to raise thousands for hero NHS staff

EXCLUSIVE

Rebecca Pocklington
14 Apr 2020, 13:38 Updated: 14 Apr 2020, 14:38

We responded to a request from The Sun who were looking for inspirational young people who had fundraised for the NHS. Ashleigh, whose son Declan is seen by our corneoplastics team, kindly agreed to be interviewed. She explains how after being diagnosed with Stevens-Johnson syndrome (a rare condition that affects the skin and eyes), Declan was referred to our hospital for multiple operations on his eyes. Declan's family arranged a charity football match as a way of thanking QVH and other NHS organisations who had supported him.

Asked why they chose to fundraise for our QVH Charity Ashleigh said: "They're working 24/7 – why you wouldn't support them I don't know. They're amazing to him at the Queen Victoria."

Declan even appeared on This Morning to highlight his incredible recovery
Credit: Ashleigh Bitmead

Declan now has partial sight in his right eye, but was registered legally blind in 2017.

Ad hoc media

We were mentioned in an article in The Grocer about Waitrose, as one of the hospitals to have benefitted from its Easter egg giveaway for our staff.

Connecting with local people through our social media channels

This month we have continued to use our social media channels to provide real-time information and important updates from our hospital in light of the evolving COVID-19 situation. We are also using these channels to thank different staff groups for the part they are playing in supporting our patients, colleagues and QVH.

If you use social media and do not follow us already, please find us on Facebook, Twitter and Instagram.

STOP PRESS: This month some of our media activity was impacted by the Government's lockdown, which saw many of our local publications cease production and furlough journalists. We hope that publications such as the East Grinstead Gazette which has been supportive of our hospital will resume in the future.

QVH media update – May 2020

Here's a summary of the media activity secured for QVH …


dailymail.co.uk

Daily Mail MORE STORIES

Daily Mail's VE Day Spitfire flypast will go over Care for Veterans home, NHS hospital and Colonel Tom Moore's house to salute Britain's war heroes

By Robert Hardman and Xantha Leatham For The Daily Mail
22:26 01 May 2020, updated 22:42 01 May 2020

Poignant Spitfire fly pass marks VE Day anniversary

Our staff and patients were honoured to mark the 75th anniversary of VE Day on Friday 8 May with a special Spitfire fly pass. National paper the Daily Mail asked its readers to nominate an NHS hospital to be involved in an extraordinary opportunity to mark VE Day. They were inundated with suggestions for Queen Victoria Hospital which formed one of 11 special locations across the UK to receive a sky-high visitor.

Announced online on 1 May, and in the print newspaper the following day, the news generated much interest in the fly past and also our hospital's special role within it.


WILL YOU SPOT OUR SALUTE FROM THE SKIES?

A ROUTE WITH 11 VERY SPECIAL LOCATIONS

Words by Xantha Leatham

The Daily Mail ran a series of articles about the event, including more details and a map of its 'salute to heroes' on 6 May and three articles on the day itself -Friday 8 May – all of which mentioned Queen Victoria Hospital. One was specifically about former servicemen, some in their 90s, watching in their uniforms; and another about the fly past and the Red Arrows also taking to the skies. The third piece was more specifically about the locations involved in the fly past itself. We had a journalist from the Daily Mail join us at the hospital to interview our staff (at a socially appropriate distance) about how special the experience was for them. One of our staff was quoted in the final article.

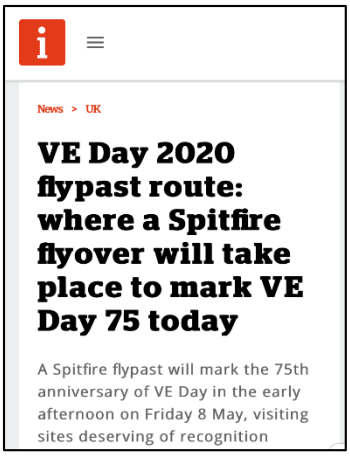
Our involvement in the fly past also gained interest from ITV Meridian (pictured right) and BBC South East Today (pictured below) both of whom covered the event in their news bulletins. A reporter from each programme visited our hospital and carried out socially distanced interviews.


GEMMA FARLEY
Healthcare worker, Queen Victoria Hospital

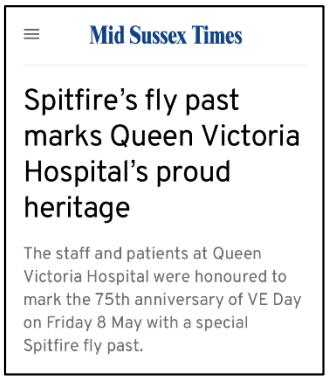

DEBBIE HARRIS
Senior nurse, Queen Victoria Hospital


EMILY GODBEER
Healthcare worker, Queen Victoria Hospital

You can watch the ITV Meridian piece back on its website.



Given the national excitement about the 75th anniversary of VE Day and the fly pass, a series of regional and national press mentioned it and our involvement. These included: the Express and Star; a second article in the Express and Star; The Northern Echo; iNews (pictured); Spirit FM website; Daily Mail article about Katharine Jenkins singing at the Albert Hall; UK Aviation website; Worthing Herald; Bexhill Observer; News Shopper website; Kent Online; Metro website; The Argus; My London website; Get Surrey website; Crawley Observer; Mid Sussex County Times; Kent Live website; Halstead Gazette; Linlithgow Gazette; Local Berkshire website; Pendle Today; Huffington Post (pictured); Kent Live post event; The Argus post event.



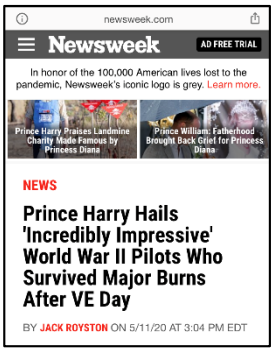
We issued our own press release post event which was picked by the Mid Sussex County Times and the Crawley Observer.

Queen Victoria Hospital received around 40 media mentions thanks to this one event.

Prince Harry and the Guinea Pig Club

Following on the media interest around the 75th anniversary of VE Day, The One Show ran an item with Prince Harry where he hailed 'incredible and uplifting' stories of Second World War veterans and plastic surgery pioneers. Appearing via video link from Los Angeles, Harry spoke of his admiration for war veterans who survived life-changing injuries and went on to inspire others.

As part of the piece he spoke to Maggie Saunders, whose husband Sandy was a member of the Guinea pig Club (and had been so inspired by his treatment by Sir Archibald McIndoe and team, he retrained as a GP); and Andrew Perry (pictured top middle) whose father Jack was the youngest member of the Guinea Pig Club. The piece mentioned the pioneering plastic surgery carried out at Queen Victoria Hospital by Sir Archibald McIndoe, and how the Guinea Pig Club inspired the creation of the CASEVAC Club, a mutual support network and social club for individuals that were severely wounded in combat during the Iraq and Afghanistan conflicts.



The One Show piece generated a range of coverage by other media outlets too. Ones mentioning our hospital included: the Newsweek website (pictured left); ITV website; Daily Mail; Salisbury Journal; In-Cumbria; The Gazette website; The Metro (pictured right); and later in the month on the Daily Star's website.

Support for patients with cancer

We arranged for BBC South East Today to interview one of the patients who was referred to us to receive breast cancer surgery, as part of our role as a specialist cancer surgical centre during COVID-19. Yvonne from Kent was interviewed for a piece which aired on 6 May – sadly not mentioning Queen Victoria Hospital by name.

Yvonne was keen to reassure other people with cancer of the importance of seeking timely surgery and support despite the pandemic, and allowed us to feature her on our website which you can read here.

Our role as a specialist cancer surgical centre was also mentioned on the Cure Today website in a roundup of cancer news, citing the piece on the BBC News website. Also the interview Dr Ian Francis did with BBC Radio Sussex was repeated on Susy Radio on 3 May.

Ad hoc mentions

Queen Victoria Hospital was mentioned at the end of the month twice on the Mail Online website. The first was regarding how hotels are supporting 'Covid heroes' which cites the support our hospital has received from Gravetye Manor in the form of thousands of tulips picked from its grounds. The tulips would have otherwise have been destined for the Manor's rooms had it been able to open.

The second mentioned our burns unit and was regarding the driver of an Aston Martin DB9 supercar receiving severe burns after his car crashed and burst into flames (pictured). This news was also picked up by the Sussex Express website.

We were also mentioned in the Uckfield News website in an obituary for Jean Gilden, whose 50 year nursing career included time at our hospital.

Connecting with local people through our social media channels

This month we have continued to use our social media channels to provide real-time information and important updates from our hospital in light of the evolving COVID-19 situation. We are also using these channels to thank different staff groups for the part they are playing in supporting our patients, colleagues and QVH.

If you use social media and do not follow us already, please find us on Facebook, Twitter and Instagram.

END NOTE: This month many of our local publications continued to pause production and more journalists furloughed. We hope that they will resume in the future.

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed 9th June 2020

Strategic Objective
We put the patient at the heart of safe, compassionate and competent care that is provided by well led teams in an environment that meets the needs of the patient and their families.

Risk 1) Trust is not able to recruit and retain workforce with right skills at the right time.
2.In a complex and changing health system commissioner or provider led changes in patient pathways, service specifications and location of services may have an unintended negative impact on patient experience.

Risk Appetite The Trust has a **moderate appetite** for risks that impact on patient experience but it is higher than the appetite for those that impact on patient safety. This recognises that when patient experience is in conflict with providing a safe service safety will always be the highest priority

Initial Risk	4(C) x 2(L) = 8 low
Current Risk Rating	3(C) x 4(L) = 12 mod
Target Risk Rating	3(C) x 3(L) = 9 low

Rationale for risk current score
- Compliance with regulatory standards
- Meeting national quality standards/bench marks
- Very strong FFT recommendations
- Sustained excellent performance in CQC 2018 inpatient survey, one of eight trust who were much better than national average
- Patient safety incidents triangulated with complaints and outcomes monthly no early warning triggers
- International recruitment continues 19 staff registered and inducted
- Not meeting RTT 18 and 52 week Performance and access standards but meeting agreed recovery trajectories
- Sustained CQC rating of good overall and outstanding for care
- Picker 2019 inpatient survey data received

Future risks
- Unknown impact on patients waiting longer than 52 weeks, CHR in progress
- ~~Future impact of Brexit on workforce~~
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility.
- Developing new health care roles -will change skill mix
- STP strategic plans not fully developed
- Impact of Covid-19 pandemic on patient experience

Future Opportunities
- international recruitment with another local Trust

Controls / assurance
- Robust Governance and clinical quality standards managed and monitored at the Q&GC, CGG and the JHGM, safer nursing care metrics, FFT and annual CQC audits , 6/12 CIP
- External assurance and assessment undertaken by regulator and commissioners
- Quality Strategy, Quality Report, CQUINS, low complaint numbers
- Benchmarking of services against NICE guidance, and priority audits undertaken
- Trust recruitment and retention strategy mobilised, NHSI nursing retention initiative. International recruits now arriving
- Burns and Paediatric services not currently meeting all national guidance. CCG and Regulators fully aware of this, mitigation in place including interim divert of inpatient paed burns from 1 August via existing referral pathway. No inpatient paeds during pandemic
- QVH simulation faculty to enhance safety and learning culture in theatres
- ~~Clear written guidance for safe staffing levels in theatres and critical care~~
- Working with NHS E on inpatient paediatric burns service move and presentation at KSS HOSC chairs meeting / communication with SE burns network, COG, regulators and Healthwatch July 2019
- Compiling Burn Case for Change in collaboration with BSUH AND NHSE
- New R&R governance group approving clinical changes, established amber and green pathways in theatres, staff screening lab being mobilised, comprehensive IPC board assurance document, patient screening pathways updated each time new guidance issues, breast and virtual clinical patient

Gaps in controls / assurance
- ~~International recruitment material benefits to workforce anticipated in Q3 and Q4 2019/20~~ ~~Links to CRR 1094,1077,1035,~~
- Unknown Specialist commissioning intention for some of QVH services eg inpatient paediatric Sussex based service and head and neck pathway 968,1059
- Full patient assurance about management of covid-19 risks associated with hospital attendance/admission
- National pause of FFT

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Date last reviewed: 26th May 2020

Strategic Objective
We provide world class services, evidenced by clinical and patient outcomes. Our clinical services are underpinned by our high standards of governance, education research and innovation.

Risk
Patients, clinicians & commissioners lose confidence in services due to inability to show external assurance by outcome measurement, reduction in research output, fall in teaching standards., or lack of effective clinical governance.

Risk Appetite. The trust has a **low appetite for risks that impact on patient safety**, which is of the highest priority. The trust has a moderate appetite for risks in innovation of clinical practice, research and education methodology, if patient safety is maintained.

Initial Risk Rating 5(C)x3(L) =15, moderate
Current Risk Rating 4(C)x4(L)=16, moderate
Target Risk Rating 4(C)x2 L) = 8, low

Rationale for current score

- Adult burns ITU and paediatric burn derogation
- Paediatric inpatient standards and co-location
- Compliance with 7 day services standards
- Spoke site clinical governance.
- Sleep disorder centre staffing of medical staff and sleep physiologists
- Histopathology and radiology consultant staffing
- Non-compliant RTT 18 week and 52 week position.
- Commissioning and STP reconfiguration of head and neck services
- CCU – network arrangements for CPD and support require further development
- ~~Pension and taxation arrangements threatening work above 10PA contracts~~
- COVID-19. QVH undertaking head/neck cancer, breast cancer, skin cancer. Trauma undertaken at McIndoe Centre by QVH staff
- COVID-19-new urgently developed regional referral pathways, reduced availability of routine surgery (eg, breast reconstruction, orthognathic, dentoalveolar), hon contracts for surgeons from other trusts coming to operate on their cases at QVH
- Restoration & recovery: risk stratification and prioritisation of patients for surgery.

Future Risks

- STP and NHSE re-configuration of services and specialised commissioning future intentions.
- Commissioning risks to lower priority services– sleep, orthognathic surgery
- Commissioning risks to major head and neck surgery

Future Opportunities

- Sussex Acute Care Network Collaboration
- STP networks and collaboration
- Efficient team job planning
- Research collaboration with BSMS
- CEA scheme and potential for incentive
- New services – glaucoma, virtual clinics & sentinel node expansion
- Multi-disciplinary education, human factors training and simulation
- QVH-led specialised commissioning

Controls and assurances:

- Clinical governance leads and reporting structure
- Clinical indicators, NICE reviews and implementation
- Relevant staff engaged in risks OOH and management
- Networks for QVH cover-e.g. burns, surgery, imaging, lower limb and trauma
- Training and supervision of all trainees with deanery model
- Creation of QVH Clinical Research strategy
- Local Academic Board, Local Faculty Groups and Educational Supervisors
- Electronic job planning
- Harm reviews of 52+ week waits
- Temporary diversion of inpatient paediatric burns patients to alternative network providers

Gaps in controls and assurances:

- Limited extent of reporting /evidence on internal and external standards
- Limited data from spokes/lack of service specifications
- Scope of delivering and monitoring seven day services (OOH), particularly those provided by other trusts (RR845)
- Plan for sustainable ITU on QVH site (CRR1059)
- Achieving sustainable research investment
- Balance service delivery with medical training cost (CRR789)
- Detailed prospective partnership agreement with acute hospital (CRR1059)
- Sleep disorder centre sustainable medical staffing model & network

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02.07.2020**		**Agenda reference:**	**99-20**	
Report title:	**Quality and governance assurance**				
Sponsor:	Karen Norman, committee chair				
Author:	Karen Norman, committee chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the board on quality and governance assurance issues arising since the last Board meeting on 07.04.2020.				
Summary of key issues	This report updates the board on assurance issues arising from the Covid-19 pandemic and the establishment of QVH as a designated surgical referral centre for head and neck, breast and skin cancers for the south east. It also highlights areas where further assurance will be forthcoming, remain under review and /or strengthened in relation to: monitoring the rise in waiting lists post Covid-19; processes for monitoring and conducting 'clinical harm reviews' of patients if treatment is delayed; risk management of BAME groups; compliance with infection prevention and control board assurance policies; implementing lessons learned from serious incident reviews in theatres, embedding recommendations of the CQC action plan; the need for a continuous improvement programme; hospital food and our annual quality report.				
Recommendation:	The Board is asked to **NOTE** this report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	**KSO1:** *Outstanding patient experience*	**KSO2:** *World-class clinical services*	**KSO3:** *Operational excellence*	KSO4: *Financial sustainability*	**KSO5:** *Organisational excellence*
Implications					
Board assurance framework:	Committee received updates on relevant BAF summaries and assured of appropriate revisions to the Corporate Risk Register and the BAF reviews, in line with assurance issues raised within the reporting period.				
Corporate risk register:	As above.				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2008 and the CQC essential standards of quality and safety.				
Legal:	As above				
Resources:	As documented in paper.				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to: Board Directors

Agenda item: 99-20

Date of meeting: 18 June 2020

Report from: Karen Norman

Report author: Karen Norman

Date of report: 24 June 2020

Appendices: None

Quality and governance assurance

1) Introduction

This report summarises the items raised in the Quality and Governance Committee (Q&GC) which committee members felt were the most important to bring to the attention of the Board. It should be noted that the committee's agenda was re-prioritised and a number of important (but less urgent) items were deferred to take account of the national guidance: *Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic,* (March 2020). This proved a difficult task, as has managing to ensure what is still (unsurprisingly) a considerable quality and governance agenda is dealt with in shorter meetings, via video-link. This has required us to change how we work to ensure the same rigour, support and challenge on items for our consideration, given the reduction in some external scrutiny. For brevities sake, the committee has focused mainly on exception reports. But in that context, it is important to note that considerable assurance can be taken from items received with respect to the quality and safety of care given to our patients, as well as the support offered to staff in these difficult times. Although 'exception' reporting, we also wish to recognise the exceptional work done by our staff. On behalf of the committee, I wish to place on record our thanks and appreciation to them all for maintaining the quality and safety of care during challenging circumstances and also for transforming aspects of that care and our range of services, as evidenced in assurance received. The positive feedback from patients on our new virtual clinics and our cancer pathways are two examples confirming their effort and hard work is recognised and appreciated by those who matter to us all - the patients we serve.

2) Covid-19 Update

This report updated Q&GC on the issues and risks to the trust, staff and patients faced by the Covid-19 pandemic. The Committee noted that QVH has continued to provide cancer services for head and neck, skin and breast as a regional cáncer hub. Pressure elsewhere in the NHS due to Covid-19 has required changes in patient care pathways to make sure that patients requiring urgent treatment for cancer are prioritised and treated soon as possible. Q&GC were assured that QVH is playing an important role in ensuring this can happen by working in partnership with others. Patients have high levels of satisfaction, commending our staff for their excellent care and service. Cancer patients have expressed relief and gratitude at being able to have their operation performed at QVH.

An increase in non-urgent elective/ level 3 cancer waiting times was noted with concern, with members asking by how much and what the risks are. The executive advised that cancer operations are taking place in line with national & college guidelines. There has also been an increase in patients declining or delaying surgery, particularly those patients with skin cancer. The Trust is co-ordinating clinical harm reviews to monitor and advise these patients.

The temporary transfer of trauma services to Horder Healthcare (TMC) was approved in April 2020. Q&GC noted that provision of this service has been registered with the CQC as a satellite service of QVH. We were also advised that the pandemic integrated governance process has now been signed off by all

relevant parties and is being embedded within the trust. The Committee took assurance from the documentation and details of processes for patient screening provided for scrutiny. It was further advised that since the circulation of that report, new national guidelines had been issued, informing an updated QVH policy, which has been circulated to all staff. This will require all attending our site to wear surgical masks.

With respect to Personal Protective Equipment, (PPE) Q&GC noted with concern that Fit testing and the difficulty in sourcing 'hood masks' posed a risk to anaesthetic cover. The Executive escalated those concerns and confirmed that since the report under consideration, assurance had been given regarding the delivery of additional hood respirators. Staff will be trained in their use and this will reduce the risk of disruption to our theatre schedules.

Reports on workforce confirmed that staff absence from the work place has been around 10%, with wards and departments generally staffed to the agreed requirements. Social distancing remains in operation and a daily briefing to all e-mail to staff keeps them informed of the rapidly changing guidance. The committee took assurance from information provided on staff screening and the principles for screening staff for high risk groups, noting the additional risks to BAME staff and patients. This is a priority for the committee and will be kept under review as a standing agenda item.

Members were provided with a detailed report which assessed our compliance against key criteria in the NHSE infection prevention and control board assurance document. This listed evidence to support where these were in place, any gaps in assurance and any mitigating actions required where these were identified. Q&GC noted the achievement that, at the time of reporting, no QVH patients had yet been confirmed as Covid-19 positive. Committee members were asked to consider whether they were satisfied that having scrutinised the NHSE criteria report, they could assure the board of satisfactory progress with regard to this item, or whether they would w3) ish the detailed papers to be submitted to the board for further scrutiny. Members agreed to confirm assurance to the board on this matter, noting that this is still work in progress. For that reason, it will remain on Q&GC agenda until the recovery and restoration phase is completed.

3) Patient and Staff Safety

Q&GC noted there had been no Serious Incidents (SI's) reported or Formal Internal Investigations (FII) commenced during this reporting period. Additional clinical governance meetings have been established between TMC and QVH (chaired by QVH) which continue to provide oversight of services on the satellite site of TMC.

It was reported that the clinical harm reviews for patients waiting over 52 weeks and cancer patients waiting over 104 days (established in 2018 under the national guidance 'Delivering Cancer Waiting Times') had recommenced. 656 reviews have been completed to date. The majority of cases are Max Fax (Dental) and Plastics. Assurance was given that any unable be confirmed at the time of review as 'no harm' are followed up until point of treatment to ascertain if any harm has been caused. It was reported that there has been no harm identified thus far. This provoked further questions and discussion and it was agreed this item would remain on the agenda for follow up at the next meeting.

A further report was received at the request of the Q&GC on the SI reviews into dentoalveolar incidents reported at our last meeting. It was noted that the departmental meeting noted in the action plan to discuss learning points had not taken yet place due to pressures of managing Covid-19. The Medical Director has written to the whole department to raise awareness of these. Given concerns raised by the lead investigator of the report on the need for culture change, this item will remain on the agenda until all items in the action plan are completed.

The Committee reviewed the report on the Corporate Risk Register, noting that two new corporate risks had been added (Pandemic Flu Covid-19 and NHS Video Consult: system failures). One corporate risk closed (remote site: Lack of co-location with support services for specific services) and three corporate risks rescored. Members expressed concern that a number of items on the risk register required updating and requested that in future these all be completed prior every meeting for assurance. It was also suggested some of those may be better dealt with in the Finance and Performance Meeting and that further consideration will be given to this proposal.

4) Caring and responsive: Patient experience

Q&GC took assurance from the patient experience report covering the period of April 2020 and May 2020. 4 new complaints were received during this time, of which the main themes were communication, cancelled appointments, delayed treatment and overall treatment. None expressed any specific concerns related to the corona virus pandemic. 9 complaints were closed, 3 cases were upheld and 6 cases were upheld in part. It was noted that due to COVID-19, the Parliamentary and Health Service Ombudsman (PHSO) are not accepting any new complaints for consideration during this period.

5) Effective Governance

The committee received a report on clinical governance group from a member who attended as part of our programme of visiting all sub-committees reporting to Q&GC. An update on progress on all sub-group visits year will be produced by the Q&GC secretary for the next meeting, alongside schedule of visits for the coming year. It was noted that some sub-group meetings had needed to be cancelled as a consequence of the pandemic.
The terms of reference for the research and development governance group were approved.
The quality and safety board report was noted. Assurance was taken on most items reported therein and staff commended on providing good care in challenging times. A further meeting will be held to confirm further assurance on matters of concern arising from infection control audits with the Q&GC Chair.
The NICE and clinical audit programmes were received and commended for the number and diversity of audit proposals, assurance taken, with Q&GC noting that further updates will be given during the year for work in progress.
The CQC Action Plan was received and progress noted. Further assurance was sought on how the local leads would ensure completion of the action plan now responsibility for these had been delegated to departmental leads. It was noted that the CQC recommendation regarding a continuous improvement programme had still not been addressed and that the Chair would propose this as a matter for further discussion by the Board.

6) Quality Account 2019/20

This report highlighted details of the numerous services provided and in year achievements of our wards and departments. It was pleasing to note their submissions, their in their work and the benefits to patients. Q&GC commended all those involved and thanked them for their hard work. It noted the areas for improvement and plans for addressing these.

The requirements and due process for approving the Quality Report this year are different from previous years, due to a change in requirement from NHSI/E due to the Covid-19 pandemic. Concerns were raised regarding whether the lack of an independent auditors report constituted a gap in assurance about which Q&GC should be concerned. The purpose of the audit is give further assurance that the Quality Report is in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement. The Executive advised this was not a material gap in assurance. It was accepted that this external assurance was limited, (which was a matter of some concern). The Executive advised they were confident to recommend that QVH has met the guidance for this year's Quality Account and will send a letter of assurance to the members to this effect once the final document has been signed off. Given that i) this report follows the same template as last year, which (with one exception) the auditors confirmed was compliant and ii) the range of other internal and external sources of information available to Q&GC members on which this report is based, the committee approved this report. ii)The helpful discussion and candid debate has identified a number of suggestions for improving the quality report and assurance processes in future years.

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**2 July 2020**		**Agenda reference:**	**100-20**	
Report title:	**Corporate Risk Register**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Karen Carter-Woods, Head of Risk and Patient Safety				
Appendices:	None				
Executive summary					
Purpose of report:	For assurance that the Trust risk management process is being followed; new risks identified and current risks reviewed and updated in a timely way.				
Summary of key issues	Key changes to the CRR this period: ➢ Two new corporate risks added ➢ One corporate risk closed ➢ Three corporate risks rescored				
Recommendation:	Quality & Governance Committee is asked to note the Corporate Risk Register information and the progress from the previous report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	The entire BAF has been reviewed by EMT alongside the CRR, The corresponding KSOs have been linked to the corporate risks.				
Corporate risk register:	This document				
Regulation:	All NHS trust are required to have a corporate risk register and systems in HMT place to identify & manage risk effectively.				
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.				
Resources:	Actions required are currently being delivered within existing trust resources				
Assurance route					
Previously considered by:	The Corporate Risk Register is reviewed monthly by EMT and at Q&GC				
	Date:	27/05/20	Decision:	Reviewed and updated	
Previously considered by:	Q&GC				
	Date:	18/06/20	Decision:	Request for update on the RTT corporate risk referred to F&PC for discussion.	
Next steps:					

Corporate Risk Register Report
April and May 2020 Data

Key updates

Corporate Risks added between 01/04/2020 and 31/05/2020: 2

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
4x4=16	1179	Pandemic Flu Covid-19	CEO & Director of Nursing and Quality
4x4=16	1182	NHS Video Consult: system failures	Information Management & Technology

Corporate Risks closed this period: 1

Risk Score	Risk ID	Risk Description	Rationale for closure	Committee where closure agreed/ proposed
4x3=12	1059	Remote site: Lack of co-location with support services for specific services	There have been no adverse incidents as a result of this risk, new guidance is in place and a CT scanner is now on site	Reviewed by MD

No of Corporate Risks rescored this period: 3

Risk ID	Service / Directorate	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore	Committee where change(s) agreed/ proposed
1166	Safeguarding	Introduction of new Liberty Safeguards Protection (LSP) legislation in 2020	3x4=12	3x3=9	Due to COVID 19 changes to Law on hold at present	Safeguarding Lead
1035	Nursing	Inability to recruit adequate numbers of skilled critical care nurses across a range of Bands	3x4=12	3x3=9	CCU now fully established; international staff have achieved ventilator competencies and embedding into team	DoN review
1182	Operations	NHS VideoConsult: system failures	4x4=16	4x3=12	NHSE inform that major upgrade is scheduled for June	DoO & GM

The Corporate Risk Register is reviewed monthly at Executive Management Team meetings (EMT), quarterly at Hospital Management Team meetings (HMT) and presented at Quality & Governance Committee meetings for assurance. It is also scheduled bimonthly in the public section of the Trust Board.

Risk Register management

There are 73 risks currently on the Trust Risk Register as at 8th June 2020, of which 18 are corporate, with the following modifications occurring during this reporting period (Feb/Mar):

- Two new risks added: both corporate
- Three risks closed: one corporate, two local
- Three risks rescored: all corporate – two reducing to Local RR and one remaining on CRR

Risk registers are reviewed & updated at the Business Unit Meetings, Team Meetings and with individual risk owners including regrading of scores and closures; risk register management shows ongoing improvement as staff own & manage their respective risks accordingly.

Risk Register Heat map

The heat map shows the 73 risks open on the trust risk registers: risks that score 12 or more are managed via the Corporate Risk Register.
Six of the 18 corporate risks are within the higher grading category:

	No harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2		1	10	3	1
Possible 3		2	32	4 ID: 968, 1152, 1170, 1182	
Likely 4		4	8 ID: 1040, 1077, 1117, 1122, 1136, 1139, 1148, 1168	4 ID: 1125, 1163, 1167, 1179	0
Certain 5		1	1 ID1140	0	1 ID: 877

Implications of results reported

1. The register demonstrates that the trust is aware of key risks that affect the organisation and that these are reviewed and updated accordingly.

2. No specific group/individual with protected characteristics is identified within the risk register.

3. Failure to address risks or to recognise the action required to mitigate them would be key concerns to our commissioners, the Care Quality Commission and NHSI.

Action required

4. Continuous review of existing risks and identification of new or altering risks through improving existing processes.

Link to Key Strategic Objectives

- Outstanding patient experience
- World class clinical services
- Operational excellence
- Financial sustainability
- Organisational excellence

5. The attached risks can be seen to impact on all the Trust's KSOs.

Implications for BAF or Corporate Risk Register

6. Significant corporate risks have been triangulated with the Trust's Board Assurance Framework.

Regulatory impacts

7. The attached risk register would inform the CQC but does not have any impact on our ability to comply with CQC authorisation and does not indicate that the Trust is not:

- Safe
- Effective
- Caring
- Well led
- Responsive

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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1182	20/05/2020	NHS VideoConsult: system failures	NHSE has promoted to use of Videoconferencing for OPD appointments using the Attend Anywhere software. This is a national project. QVH has established an internal project team and has run a series of pilot clinics to inform a comprehensive roll out programme across QVH. Unfortunately, Attend Anywhere has failed nationwide on 3 separate occasions in the past 2 weeks.	Business continuity in the event of systems failure□ □	Abigail Jago	Philip Kennedy	Information Management and Technology	12	6	**29/5/20**□ NHSE national lead for Attend Anywhere presented to Regional COVID update meeting and provided assurances around additional support to improve the product stability and a major upgrade is scheduled for June. Several members of QVH Project Group were on that WebEx and agreed we should reduce the likelihood of further failure from probably recur to may recur, which will reduce the overall Risk score.	KSO1 KSO2 KSO3
1179	07/04/2020	Pandemic Flu Covid-19 challenges	Requirement to establish new clinical pathways and work in different ways□ Yet to understand impact on safety, effectiveness & experience with new governance processes in place□ Workforce restraints / issues	*Daily panel to review cases plus bi-weekly review of referrals □ *Daily conference call / Webex to update local and regional issues & activity□ *staff working from home / remotely: IT workstream □ *Review of Ethics panel / guidance which is being developed regionally for difficult treatment decisions□ *SOP for H&N, breast, skin and trauma infection screening pathways□ *Virtual clinics□ *monitoring completion of actions and issues via EPRR Incident Log	Abigail Jago	Nicola Reeves	Compliance (Targets / Assessments / Standards)	16	8	**20.05.20**: DoO established review panel for H&N, breast & skin pathways. Cases for surgery approved at MDT □ Cancer Alliance / NHSE approval of all new pathways / SOPS□ Trust widely utilizing remote access to meetings & multiple staff working from home□ Virtual clinics implemented□ Health & wellbeing initiatives (specific BAME guidance)□ Extensive IPC measures across trust incl PPE, patient / staff screening and sickness absence due to C-19 captured	KSO2 KSO3 KSO5
1170	09/01/2020	Understaffing within Appointments Team	The Plastics/MaxFacs appointments team is carrying two maternity leave posts which has now been exacerbated by several medium term absences and two resignations in quick succession around the Christmas period. □	Additional bank staffing has been sourced and will come on board asap. A wider review of the appointments/reception function is required to ensure the service is resourced and trained to meet the needs of all stakeholders, taking into account the relatively recent implementation of eRS.	Abigail Jago	Philip Kennedy	Compliance (Targets / Assessments / Standards)	12	6	4/2/20: 1xwte bank staff to cover to end of March - currently shortlisting for substantive post□ 'Leadership' post advertised - awaiting JD approval from HR	KSO1 KSO3 KSO4 KSO5
1168	20/12/2019	Significantly reduced Consultant Histopathologist cover	Significantly reduced Consultant Histopathologist cover causing failure to meet turn around times and national cancer targets.	Locum Consultant currently employed until mid January 2020□ Previous consultant covering additional cases on bank basis□ Plans in place for remote reporting by Skin lead at neighbouring trust for ad hoc work.	Abigail Jago	Fiona Lawson	Compliance (Targets / Assessments / Standards)	12	6	**May 2020**: overseas consultant visit / start date on hold due to Covid-19. Work being covered / shared by two consultants currently.□ 14/1/20: 1wte consultant recruited - overseas appointment, start date awaited.	KSO2 KSO3
1167	01/01/2020	Lack of Failsafe Officer	GIRFT and HII recommendations state that every Ophthalmology Department should have a dedicated Failsafe Officer to reduce the risk of patients being lost to follow up and to reduce the risk of undue delays to follow up appointments.□	Current Failsafe duties reside with Business Manager, Service Manager and Service Co-ordinator. However, there is insufficient resource to manage failsafe procedures adequately.	Abigail Jago	Marc Tramontin	Patient Safety	16	8	**May 2020**: Reviewing internal efficiencies to fund post; currently on hold due to COVID□ March 2020: reviewed at business meeting - cost pressure for post not prioritised at this time□ 4/2/20: reviewing internal efficiencies to support; post identified within Business Planning.□ HSIB National report published with multiple recommendations	KSO1 KSO2 KSO3
1163	06/11/2019	Inadequate Consultant radiologist cover	- As of the beginning of December, there will be 1 radiologist covering the entire department for both on-call and business as usual work□ - There will be no radiologist cover for MSK/Neuro CT/MRI□ - OOH is a patient and staff safety risk as 1 consultant cannot cover on-call alone	- outsourcing CT/MRI for neuro/MSK□ - Agency Reporting radiographer to report chest imaging□ - Bank MSK sonographer to aid service provision□ □ OOH remains the largest risk	Abigail Jago	Sarah Solanki	Patient Safety	16	8	**27-04-2020** - bank consultants supporting service. Recruitment on hold until COVID crisis more clear. Global fellowship options have been stopped due to COVID - not possible to rescore currently.□ 04-02-2020 - adverts are back out for the consultant posts. Global fellowship conversations on-going between the clinical lead and the programme team.□ 14-01-2020 - Vacancies to go back out to advert. developing SLA with Worthing for Consultant support 1 day per week. Global fellowship programme also being explored by lead clinician.□ 18-12-2019- new substantive H&N consultant now not coming. one post - candidates may not be suitable and 1 has been withdrawn.□ To support current radiologist, we have a bank consultant sonographer to support the MSK US service. □ MRI/CT reporting normally covered by LC will be outsourced. On-call doctor has agreed to cover weekend on call to help support for the interim period until the beginning of January.□ There is a residual risk to the service if our only consultant has sickness.	KSO1 KSO3 KSO5
1152	02/09/2019	Internal audit - Fire Risk Assessment reviews not taking place	If Fire Risk Assessments (FRA's)are not taking place and they are not being reviewed annually, hazards do not get identified.□ The estate may not be compliant and people may be at risk	FRA's are reviewed on annual basis□ Head of Estates working with the Fire Safety Advisor, re-writing / reviewing FRA's where required.□ Key focus of work since Q1: Hospital Estate is up to date now, with no areas outstanding.□ Calendar reminders in place to ensure that they will not go out of date; Fire Safety Advisor and Technical Services Assistant leading□ Regular training to all staff: high compliance rate, continuously improving.□ □	Michelle Miles	Phil Montague	Estates Infrastructure & Environment	12	6	**03/06/20** FRA still current, up to date and revised to show the changes due to COVID. Further reviews set to commence July 20 and action plans from these reviews will be prioritised as part the upcoming 5 year plan for capital and backlog maintenance programs. Phased upgrade of the fire system was approved for capital program 20-21 along with the continuation of fire door replacements and the compartmentation of the plant room within A-Wing, all cited as previous risks within the FRA□ 06/11/2019 All FRA's now up to date and progressing. □ October:□ Update of all FRA's: □ Start: 1/5/19□ Due: 1/11/19□ Completed: 22/10/19□	KSO3
1148	24/07/2019	Clinical coding backlog	Coding backlog now at significant level □ Potential to impact income recovery□ Clinical indicator data unavailable	-overtime approved□ -agency approved: restraints obtaining agency workers□ -monitoring reports 3x weekly□	Michelle Miles	Banu Thiagaraj	Finance	12	6	09/12/2019□ - Onsite & Remote coding support in place with external company□ - All untrained staff completing their training by Week Ending 15/12/2019□ - EDM new process implemented to reduce time from Discharge to being available on Evolve□ - Options paper being written to look at how to structure service from 2020□ □ 02/09/2019 □ - Agency clinical coders now working during week and weekends□ - Internal staff are working overtime□ - External outsourcing company doing remote coding for all notes on EDM□ - Proposal being produced for a blended onsite and remote coding support from external company□	KSO4

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1140	19/03/2019	Current PACS contract ending in June 2020	QVH is in a consortium for PACS/RIS/VNA with 5 other trusts from Surrey & Sussex. □ Philips provide a managed PACS/RIS/VNA (Vendor neutral archive) service to QVH and the other 5 trusts. The current contract was extended in 2016 to allow the contract to run until June 2020 under the 5+2 terms of the original contract. □ All 6 trusts have stated they want to remain in this consortium and potentially expand it to include another Surrey trust.□ There is now limited time available to re-procure PACS/RIS/VNA before the current contract runs out; without which there will be no PACS system.□ There is currently no project board or business case aligned to this procurement process. □ ESHT has said they are happy to lead on the project, with input from all trusts as and when requested.□ The data in the VNA is known to be incorrect across all sites, and if the S&S PACS consortium approve a plan to move PACS providers then the migration of data may need to occur from PACS to PACS - this will add a delay for migration.□	ESHT have said they will lead on a re-procurement process for the consortium. □ Philips have said they will extend the current contract - costs will need to be agreed as hardware will need replacing.	Abigail Jago	Sarah Solanki	Information Management and Technology	16	4	**27-04-2020** - VNA extension been agreed with contract signed with Hyland. Timelines have slipped for this part. Hyland & Phillips have had communication issues which should improve now named contacts shared. PACS extension meetings still ongoing via online forums. Some costs not clear - Phillips to confirm. Next meeting 01/05/2020□ 04-02-2020 - PACS consortium meeting on30th Jan: presentation from Hyland for the VNA extension. Trusts need to formally agree to this work by mid February at Trust board level as work needs to proceed ASAP to ensure the tight timeline.□ 14-01-2020 - I raised concerns to the programme manager around the timeline as there was a lot that needed to be completed by the 20th Jan and our next meeting is the 30th Jan. I have asked DDOF and others at QVH for any updates (in case they have had meetings that I am not abreast of). I vocalised my concerns to the programme manager around resourcing, business as usual arrangements around migration. Reply sent was not really reassuring as it still had a lot of unknowns on it. Awaiting update locally and we will arrange a local meeting prior to the formal PACS meeting on the 30th.□	KSO1 KSO2 KSO3 KSO4
1139	14/01/2019	Risk to patients with complex open lower limb fractures	Patients with open complex lower limb fractures require time-critical shared care between plastics & orthopaedic service, in line with BOAST 4 and NICE recommendations.□ This is sometimes not achievable with the current configuration of services and available personnel & equipment plus theatre time.	Current SLA in place for plastic surgery provision to BSUH:□ -onsite plastic provision most weekdays□ -when possible, patients receive orthopaedic treatment in BSUH prior to transfer to QVH for soft tissue surgery□ □ Planned SLA: by end of 2019□ - 24/7 cover at BSUH for plastic surgery provision to achieve joint operating to comply with BOAST 4 & NICE recommendations□ - Interim SOP in development for lower limb patients to be transferred to QVH□ Equipment required: 'C-Arm' in Capital Planning 2019/20	Keith Altman	Paul Gable	Patient Safety	12	6	**April 2020**: all posts recruited to - commence July / August□ January 2020: x3 posts to be advertised stat □ Dec: nil further to update□ October: awaiting update from BSUH □ August update: agreement to recruit to three posts and establish rota enabling a robust, sustainable on-call and lower limb trauma service to the region□ July update: Provisional agreement for three new consultant appointments jointly to QVH & BSUH. Temporary diversion of complex lower limb trauma to other network providers. Flowchart and SOP for cases that can be undertaken at QVH developed.□ June update: Director of Strategy and MD met with BSUH regarding QVH proposal for lower limb orthoplastics service; response awaited from BSUH & Western MD's□ May update: discussions with BSUH ongoing □ March update: R/V by Medical Director BC in development for 24/7 Plastics cover. BOAST 4 compliance remains poor; presentation to April Board Seminar	KSO1 KSO2 KSO3
1136	20/12/2018	Evolve: risk analysis has identified current risk within system processes and deployment	There are a significant risk with the current provision of the EDM service within the Trust. The Chief Clinical Information officer has completed a risk analysis which has identified current risk within system processes and deployment.□ □ There are hazards which remain at level 4 and above using the NHS digital clinical risk management risk matrix indicating the need for: "mandatory elimination or control to reduce risk to an acceptable level".□ □ Unacceptable level of risk have been identified in the following areas:□ • documentation availability and scanning quality□ • partial rollout of EDM - operating a hybrid model□ • event packs not sent for scanning□ • system speed□ • E form instability□ • incorrect patient data being uploaded to EDM (internal scanning)	An urgent clinical safety review of EDM was undertaken in May 2018 (version 1.1), this review (version 2.3) is a follow-up from that document. -New project manager appointed in August 2018 & analysis undertaken of the extent of the hazards within EDM: new team built to manage the business as usual, and to plan further rollout of EDM. -Project remediation plan developed to address critical issues and to roll out EDM to all remaining areas.□ -Quality assurance of scanning now in place with improved administration process. □ -On-site Documentation availability process improved with centralisation of pre scan preparation: further work needed to increase collection frequency.□ -Off-site availability of clinical documentation: rollout of laptops with 4G functionality and remote access in place for those sites that do have native connectivity through the host network. □ -Incorrect patient data being uploaded to EDM: centralisation of EDM process has achieved greater quality assurance of scanning (introduction of order communications system - no longer a requirement for reports to be uploaded to evolve)□ - Event packs: existing scanning pickup service is 2 days a week - inevitable that notes will not be available in time for review following discharge from surgery; to avoid notes not being available, the event packs are made available physically.□ -System speed: series of measures being evaluated to address including the log on times to system being reduced by the use of single sign on in "kiosk mode" plus the roll out of faster pc to clinical areas and the upgrade of operating system to windows 10.□ -Eform instability: It is possible for a user to finalise the living form at the end of a treatment episode. The Trust has worked closely with Kainos the provider of the EDM software to develop fixes for the Eform instability. The fixes have been tested and have been uploaded to the live environment. Testing being completed to verify instability issues have been addressed	Michelle Miles	Mr Jeremy Collyer	Patient Safety	12	6	January 2020:□ Issues with eForms within Max-Fax, Sleep and Orthodontics where an error screen is displayed when a user attempts to save a recently typed notation into the eForm: the technology affected is a 'middleware' application provided by a 3rd party - pre-defined escalation route is currently being followed.□ October update: Trust reporting on a monthly basis to NHS digital as part of the TSSM (trust system support model) process.□ Partial deployment remains the single biggest risk: significant progress towards resolving this.□ Go live in plastics: planned for November 18. Prior to this rollout, evolve is to be upgraded to the latest available version in preparation for trust deployment of Windows 10.□ E-form instability issues resolve; completed rollout of iPads to clinical areas.□ Daily pickup of event packs now place.□ □ August update: following the NHS digital feedback, the progress made with scanning volumes, improved training stats and the momentum with preparing Plastics score reduced to 12□	KSO3 KSO4

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1125	30/08/2018	RTT Delivery and Performance	- The Trust's RTT position is significantly below the national standard of 92% of patients waiting <18 weeks on open pathways. This position has reduced further in July following the identified of a cohort of patients that have historically not been included in the RTT waiting list position□ - 52 week position has deteriorated following identification of additional patients	July 18□ -Comprehensive review of spoke site activity has taken plan to identify all patients that should be included in the Trust RTT position□ Data upload now in place to enable the reporting of PTL data from Dartford spoke site that was previously not identified□ Weekly PTL meeting in place (Chair DOO)) that reviews patient level data for all patients >38 weeks for each speciality□ - Additional theatre capacity is being identified through PS (McIndoe) and NHS (ESHT Uckfield theatres)□ Recovery plan in place □ -4 additional validators to start in post 29th August□ -IST supporting capacity and demand work□ - commissioners have identified capacity outside of the trust for dental T1/T2 referrals□ - commissioner are in the process of identifying capacity for other long wait patients	Abigail Jago	Victoria Worrell	Compliance (Targets / Assessments / Standards)	16	9	4/2/20: ongoing reduction in 52 week waits - RTT Action Plan continues; operational overview through weekly PTL meeting.□ 22/11/19: remain behind trajectory with ongoing improvement of RTT position including reduction in numbers of 52ww patients and patients waiting over 18wks; ongoing challenges with patients deferring treatment through choice - score reviewed with Exec Lead and amended□ 11/9/19: ongoing delivery of RTT recovery plan. Trust open pathway performance on track; challenges remain with corneo plastic trajectory due to non-consultant medical cover - full service review underway. 52WW trajectory behind plan due to high levels of patients choosing to defer treatment.□ 5/7/19: R/V with Exec Lead - RTT open pathway performance on track with trajectory; 52 week waits challenges ongoing regarding patient choice - national issue, escalated to NHSI and commissioners□ 5/4/19: R/V with Exec Lead - capacity planning complete; activity to deliver 2019/20 plan has been signed off with Commissioners and on track with revised trajectory□ 8/3/19: 2019/20 capacity planning underway including potential independent sector activity - on track with performance plan□ 14/2/19: Exec lead r/v - RTT plan agreed with commissioners and on track re: 52 wk waits and percentage performance□ Update (Oct '18): RTT validation programme complete. RTT Action Plan in place & being monitored through fortnightly System Task & Finish group, weekly assurance call with NHSI & via internal assurance processes. Revised trajectories being agreed with Commissioners. Clinical Harm Reviews underway.	KSO1 KSO2 KSO3 KSO4 KSO5
1122	16/08/2018	Sentinel Node Biopsy: increase in demand	Rise in demand to perform Sentinel Lymph Node Biopsy for skin cancer□ Not enough capacity in theatres & clinics to undertake them all□	* Extra Clinics□ * Three procedures per week to be undertaken in the McIndoe Unit from September 14th 2018□ *Weekly review of cancer PTL□ * additional capacity in place	Abigail Jago	Paul Gable	Patient Safety	12	9	4/2/20: BC reviewed and expanded for resubmission. Currently reviewing clinic availability exploring triage arrangements.□ Dec update: worsening regional capacity issues - continued increase in referrals and decrease in imaging capacity required prior to SLNB.□ 22/11/19: referrals continue to increase, sustainable skin-service review in progress - cases continue to be outsourced to support capacity□ 11/9/19: Capacity continues to be delivered in independent sector. Options for sustainable capacity being assessed in relation to medical provision changes to support BSUH□ 5/7/19: R/V with Exec Lead - additional independent sector capacity ongoing. BC for substantive consultant post in progress.□ May update: PoaP submitted to EMT - further information requested□ 8/3/19: PoaP being developed for substantive capacity□ 14/2/19: Clarity sought regarding clinical harm monitoring for these patients: advised that the melanoma has already been removed and QVH are providing the secondary surgery.□ The patients where there is a potential risk are the 'incompletely excised' ones - those are tracked and prioritised□ February 7th update: Summary Business case to EMT for 1wte skin consultant□ □ Oct update: outsourced capacity to McIndoe	KSO1 KSO2 KSO3 KSO5
1117	26/06/2018	Inability to meet legislative requirements of the Falsified Medicines Directive	Falsified Medicines directive due to come into force in February 2019, Trust will be unable to comply with the legislation when first in place.□ Under the Directive, all new packs of prescription medicines placed on the market in Europe from February 2019 onwards will have to bear two safety features: a unique identifier (UI) in the form of a 2D data matrix (barcode) and an anti-tamper device (ATD).□ □ Anti-tampering device□ □ Pharmacies, and those who are authorised to supply medicines to the public, will be required to authenticate products, which means visually checking the ATD and performing a verification and decommissioning scan, "at the time of supplying it to the public".	1. Information on actions being gathered.□ 2. On-going discussions at KSS Chief Pharmacists meetings and concerns being fed back to NHS England.□ 3. Nov 18 Quote has been sent form JAC regarding implementation. Included in business planning. □ 4. Planning underway for upgrade to current JAC version. Will include ability to link FMD software although may not initially be switched on.□ □	Abigail Jago	Judy Busby	Compliance (Targets / Assessments / Standards)	12	2	**17/5/20** JAC working on DM+D compliance for system. Other work currently halted due to Covid□ 7/2/20 No change from previous update□ 17/1/2020 JAC upgraded and working well. Waiting for DM+D compliance work to be completed by JAC. Funding for JAC option for FMD compliance submitted in business plan□ 11/10/19 JAC upgrading 16th Oct 2019. Will be able to start working towards FMD compliance once complete□ 27/8/19 Still trying to move forward with JAC upgrade - delays in progress due to JAC. Looking into alternative options.□ July 2019 Moving forward with JAC upgrade □ May 2019 Currently working with JAC to upgrade Pharmacy IT system. FMD software still in testing so a further will upgrade will be needed at at later date once working fully.□ March 2019: Reviewed at the Clinical Support Services Governance meeting (19/03/2019) - □ Software currently not available, this is an issue for all Trusts nationally: work underway externally to devise programme, will not be before December 2019□ 1/10/18 - Information is still being gathered. Concern by all KSS Chief pharmacists that there is not enough information available. Brexit may also affect the data□ 21/11/18 - controls updated - JAC has sent quote for software. Included in business planning	KSO2 KSO3
1077	22/08/2017	Recruitment and retention in theatres	* Theatres vacancy rate is increasing.□ * Pre-assessment vacancy rate is increasing□ * Age demographic of QVH nursing workforce: 20% of staff are at retirement age□ * Impact on waiting lists as staff are covering gaps in normal week & therefore not available to cover additional activity at weekends□ June 2018:□ * loss of theatre lists due to staff vacancies	1. HR Team review difficult to fill vacancies with operational managers□ 2. Targeted recruitment continues: Business Case progressing via EMT to utilise recruitment & retention via social media□ 3. Specialist Agency used to supply cover: approval over cap to sustain safe provision of service / capacity□ 4. Trust is signed up to the NHSI nursing retention initiative□ 5. Trust incorporated best practice examples from other providers into QVH initiatives□ 6. Assessment of agency nurse skills to improve safe transition for working in QVH theatres□ 7. Management of activity in the event that staffing falls below safe levels.□ 8. SA: Action to improve recruitment time frame to reduce avoidable delays	Abigail Jago	Sue Aston	Patient Safety	12	4	January 2020: currently covering long term sickness & mat leave in addition to staff cross covering PAC and recovery. 6 new B5 recruits currently supernumerary: 1 to mid Jan, others to Mid Feb continued recruitment to 3 B5 vacancies one Feb/March timeframe. Working to be at full establishment or as near as by late spring□ Increase in regular bank staff, decreasing agency use□ Dec: Theatres Registered Practitioner vacancies at 4wte. □ Ten new recruits currently working supernumary awaiting PIN / on orientation□	KSO1 KSO2

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1040	13/02/2017	Age of X-ray equipment in radiology	Significant numbers of Radiology equipment are reaching end of life with multiple breakdowns throughout the last 2 year period.□ □ No Capital Replacement Plan in place at QVH for radiology equipment	All equipment is under a maintenance contract, and is subject to QA checks by the maintenance company and by Medical Physics.□ □ Plain Film-Radiology has now 1 CR x-ray room and 1 Fluoroscopy /CR room therefore patients capacity can be flexed should 1 room breakdown, but there will be an operational impact to the end user as not all patients are suitable to be imaged in the CR/Flouro room. These patients would have to be out-sourced to another imaging provider.□ □ Mobile - QVH has 2 machines on site. Plan to replace 1 mobile machine for 2019-2020□ □ □ Fluoroscopy- was leased by the trust in 2006 and is included in 1 of these general rooms. Control would be to outsource all Fluoroscopy work to suitable hospitals during periods of extended downtime. Plan to replace Fluoro/CR room in 2019-2020□ □ Ultrasound- 2 US units are over the Royal College of Radiologists (RCR)7 year's recommended life cycle for clinical use. Plan to replace 1 US machine for 2019-2020□	Abigail Jago	Paul Gable	Patient Safety	12	2	**27-04-2020** -Interim MRI solution is place for up to 2 years. New Ultrasound procured. MES option - asked to present paper - this was done but then everything put on hold due to staff sickness and subsequently COVID planning. This project to start again in the coming weeks.□ 04-02-2020 - The MES option is moving forward but will take around 9-12 months. A framework solution is preferred due to the risk and size of the project. An interim modular MRI solution is being scoped for April onward. We will staff this ourselves and have been recruiting staff. Given the fragility of the Fluoroscopy suite, the trust have decided to purchase this from capital for 20/21. Supply chain have been approached for quotes.□ 14-01-2020 - developing a strategy with procurement around the MES option. Meeting on Friday 10th and actions for both RSM/head of procurement. The CEO has asked for funding for MRI from the government and has local CCG/STP/MP support - no update re centralised funding for MRI.□	KSO1 KSO2 KSO3
968	20/06/2016	Delivery of commissioned services whilst not meeting all national standards/criteria for Burns and Paeds	-Potential increase in the risk to patient safety□ -on-call paediatrician is 1 hour away in Brighton□ -Potential loss of income if burns derogation lost□ -no dedicated paediatric anaesthetic lists	*Paeds review group in place□ *Mitigation protocol in place surrounding transfer in and off site of Paeds patients□ *Established safeguarding processes in place to ensure children are triaged appropriately, managed safely□ *Robust clinical support for Paeds by specialist consultants within the Trust□ *All registered nursing staff working within paediatrics hold an appropriate NMC registration *Robust incident reporting in place□ *Named Paeds safeguarding consultant in post□ *Strict admittance criteria based on pre-existing and presenting medical problems, including extent of burn scaled to age.□ *Surgery only offered at selected times based on age group (no under 3 years OOH)□ *Paediatric anaesthetic oversight of all children having general anaesthesia under 3 years of age.□ *SLA with BSUH for paediatrician cover: 24/7 telephone advice & 3 sessions per week on site at QVH	Jo Thomas	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	4	**May 2020**: as a risk reduction inpatient paediatric services suspended due to Covid-19 pandemic, in agreement with BSUH / QVH lead paediatrician □ Dec: update from commissioners still awaited; re-requested at CQRPM Dec 4th□ Nov: interim inpatient paeds burns divert continues - no reported issues. Update on number of diverts requested from commissioners.□ Working group QVH / BSUH to consider options; adult burns service aligned to provision of major trauma centre at BSUH□ Sept 30th: Review of Paeds SLA & service provision□ DoN met with BSUH W&C CD to discuss impact of inpatient paeds burns move with regards to BSUH paediatrician appetite to continue providing paediatric service at QVH. Further discussions planned once respective Directors briefed.□ July update: KSS HOSC Chairs meeting (10/7) to share interim divert plans - QVH patient pathway continuing to follow established larger burns protocol with patients being treated at C&W or Chelmsford; HOSC supportive of safety rationale & aware that further engagement & review of commissioned pathway required - to be led by NHSE Specialist commissioning. □ June update: Inpatient paeds BC for transfer of services to BSUH not approved. Interim arrangements with Burns Centres commenced. Plan for QVH inpatient paeds burns to go to other providers from 1st August. LSEBN aware & involved in discussions.□	KSO2 KSO3 KSO5
877	21/10/2015	Financial sustainability	1) Failure to achieve key financial targets would adversely impact the NHSI "Financial Sustainability Risk rating and breach the Trust's continuity of service licence. □ 2)Failure to generate surpluses to fund future operational and strategic investment	1) Annual financial and activity plan□ 2) Standing financial Instructions □ 3) Contract Management framework □ 4) Monthly monitoring of financial performance to Board and Finance and Performance committee 5) Performance Management framework including monthly service Performance review meetings 6) Audit Committee reports on internal controls□ 7) Internal audit plan	Michelle Miles	Jason Mcintyre	Finance	25	16	January 2020□ 2019/20 □ Performance M8: deficit of £5.6m YTD; £0.8m less than plan. Clinical income under-recovery has been partially offset by expenditure underspends.□ Full year forecast deficit of £8.4m; £1.0m worse than plan□ Cost savings of £0.8m YTD; Savings of £1.2m identified; £0.5m less than plan□ Finance & Use of Resources – 3 (Planned 4)□ November□ 2019/20 Performance M6: deficit of £4.1m YTD; £61k better than plan. Clinical income under-recovery has been partially offset by expenditure underspends.□ Full year forecast deficit of £8.1m; £0.6m worse than plan □ Cost savings of £1.2m identified; £0.5m less than plan□ Finance & Use of Resources – 3 (Planned 4)□ August □ 2019/20 Performance Month 3 YTD £438k behind plan due to income shortfall □ Current run rate forecast deficit of £11m (□ CIP performance £205k/£178k for YTD Month 3 □ Finance & Use of Resources – 3 (Planned 4)□	KSO4

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**02/07/2020**		**Agenda reference:**	**101-20**	
Report title:	Quality & Safety report				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:					
Executive summary					
Purpose of report:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Summary of key issues	The Committee's attention should be drawn to the following key areas detailed in the reports: • QVH is the first designated cancer surgical hub to be established in the South East of England • Update on COVID-19 screening and testing to minimise risks to patients • Change to regulatory Infection and Prevention and Control Board Assurance framework during COVID-19 • NHSE infection prevention and control board assurance template has been completed, the full version being presented at June Q&GC to outline the measures in place to reduce risk of transmission of corona virus.				
Recommendation:	The Board is asked to be assured that the contents of the report reflect the quality and safety of care provided by QVH during this time				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: *Financial sustainability*	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	The Quality Report contributes directly to the delivery of KSOs 1 and 2; elements of KSOs 3 and 5 also impact on this.				
Corporate risk register:	CRR reviewed as part of the report compilation; the workforce and RTT18 risk impact the most on quality, safety and patient experience.				
Regulation:	The Quality Report contributes and provides evidence of compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's Essential Standards of Quality and Safety.				
Legal:	As above: The Quality and Safety Report uphold the principles and values of The NHS Constitution for England and the communities and people it serves, patients and public, and staff.				
Resources:	The report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	15/6/20	Decision	Assurance **noted** around the sustained quality and safety work in and the additional measures taken as a result of the Covid-19 pandemic	
Next steps:					

Executive Summary - Quality and Safety Report, July 2020

Domain	Highlights
Director of Nursing and Quality	The Trust has redesigned surgical pathways to provide screened pathways of care to enable patient with cancer to have urgent surgery whilst minimising the additional risks of Covid-19 . The specialties we continue to provide this service are head and neck, skin and breast. The temporary transfer of trauma services to Horder Healthcare (TMC) approved in April 2020 also continues and the provision of the service in this way has been registered with the CQC as a satellite service of QVH at TMC. A weekly safety and governance review chaired by the QVH head of risk and patient safety is in place to provide oversight of the trauma service and a review framework for incidents. As the peak of the pandemic has passed the recovery and restoration of services is the current focus. The Trust is now developing detailed recovery plans with the clinical elements of these are being agreed by a multidisciplinary group of clinical and operational staff. This ensures safe oversight of the services being reintroduced, maintenance of infection prevention controls, access to services meets mandated guidance and assists with a uniform approach throughout all the specialties for example reintroduction of clinics at other hospital sites. From a patient perspective we know that patients want assurance that the trust is doing all that it can to minimise the risk of acquiring Covid- 19 during a site visit or inpatient stay. Extensive work to redesign clinical pathways to provide green and amber routes for self isolated and screened patients. The trust has actively have kept the patient at the centre of the service and the trust has continued to seek patients experience of our services throughout this pandemic by maintain a full PALS and complaints service and setting up new patient experience questionnaire for the virtual clinic patients and new breast pathway, all of which have been overwhelmingly positive. There is an extensive integrated governance process to support the trust response to the Covid -19 pandemic which has evolved in the last 2 months to ensure the trust is agile and responsive to the recovery and restoration requirements. This integrated governance approach was recommended by the Hospital Management Team and approved by the Executive Management Team.

Medical Director	The Covid-19 restoration and recovery phase has begun. As a consequence it is important to undertake risk stratification and prioritisation of patients for elective surgery that is going to be undertaken. Consultants have been asked to triage their entire waiting lists in the wake of Covid-19 on the Evolve system. They are asked to indicate the priority level of the procedure (levels 1-4), the type of anaesthesia, co-morbidities and vulnerabilities and finally, the willingness of the patient to have the procedure done. Based on this the managerial staff can stratify patients for future elective surgery. Geraldine Opreshko and I are aiming to develop a mentorship program at QVH for newly appointed consultants. These doctors find themselves entering a new work environment, often in a new trust, with new responsibilities and without the structured support network of a trainee. In addition to trust and department induction, mentorship should provide the support and guidance for the new consultant to reach their full potential and performance in their new role. Mentorship has been shown to bring three main areas of benefit: Professional practice, personal wellbeing and development. The next job planning round is due to start October 2020, and this will be reviewed in light of Covid-19. During the pandemic there have been no known issues with job plan flexibility among the consultant and Staff and associate specialists (SAS) group. In terms of last year's 2019/20 job planning audit, the actions are being worked through with HR, but inevitably the pandemic will have caused delay in their implementation.

Report by Exception - Key Messages

Domain	Issue raised	Action taken
Safe: clinical harm reviews	Clinical Harm Review meetings: Trust continues to review the 52 week breaches against an agreed trajectory with regulators and commissioners to achieve zero 52 week breaches by April 2020. Due to the Covid-19 pandemic the 52 week breaches have increased and the trusts is awaiting guidance on how this will be reported	Clinical Harm Review meetings were established from July 2018 for patients waiting over 52 weeks and cancer patients waiting over 104 days as per the national guidance 'Delivering Cancer Waiting Times'. Membership includes Head of Risk & Patient Safety, Director of Nursing and Medical Director with clinical team representation, this is usually the CD. The majority of cases are Max Fac (Dental) and Plastics and any that cannot be confirmed at the time of review as 'no harm' are followed up until point of treatment to ascertain if any harm has been caused: there have been nil harms identified so far. To the end of May 2020 656 reviews have been undertaken: July: 40 – MaxFac and plastics; Aug: 129 – MaxFac and plastics; Sept: 75 – plastics / Corneo / H&N plus Medway MaxFac; Oct: 35 – MaxFac / H&N / plastics and skin; - Nov: 30 – plastics, MaxFac and Corneo; Dec / Jan: 36 – MaxFac and plastics; Feb: 53 - MaxFac and plastics; March: 32 – plastics; April / May: 10 – MaxFac and plastics; June / July: 55 – MaxFac and plastics (incl. D Valley); August / September: 65; October / November: 37; January 10 Maxfax; Feb / Mar 35 (Plastics & Maxfac); May 14 (Plastics) Patients have been under surveillance so far are all confirmed as no harm; There is one MF patient currently under surveillance. The clinical harm review process will extend into 2020/21 due to the increased numbers of delayed elective care due to the government requirements to cease this work during the pandemic to date.

Safe: first designated cancer surgical hub to be established in the South East of England	QVH was the first designated cancer surgical hub to be established in the South East of England opening in April 2020. The hub model ensures NHS hospitals continue to deliver cancer treatment across the region, with some patients remaining under the care of their Consultant or Cancer Nurse Specialist from their referring Trust with surgery carried out at QVH for each speciality.	This work has been vital in enabling the continuation of cancer care in terms of outpatients, ambulatory care (including see and treat services for skin) and admitted care for patients requiring surgical intervention. Given the nature of the COVID-19 virus and potential complications and mortality in the event of patients having COVID-19 after surgery, strict screening and testing requirements have been implemented to ensure the minimising of risks for patients. In addition patient areas have been segregated to provide separate site provision to ensure that non-screened patients are not managed alongside fully screened and tested cancer patients. Patients must undertake strict self-isolation for 14 days before coming to the Queen Victoria Hospital (QVH) for admission. Patients are advised are unable to leave the house under any circumstances other than an emergency or urgent medical treatment. This includes not attending any shops, not undertaking any physical activity outside of the property boundary and not meeting with or having physical contact with anyone outside of their immediate household. Patients are also required to shield within their household from anybody who is not following this strict self-isolation, where practically possible. Prior to admission patients are swabbed at least 72 hours ahead of their planned date of admission and results are communicated with the Consultant and patient. If patients results are negative they are informed to proceed to admission as planned. For those that have a positive result, patients are required to strictly self-isolate for a further 14 days and are then re-swabbed prior to their rescheduled date for surgery.
Responsive: Coronavirus pandemic-	Minimise infection risk to staff and patients: local testing does not meet QVH's needs in a timely manner	Testing plan developed by a task and finish group, plan presented to EMT and approved in May. A laboratory in the Blond McIndoe centre has been refurbished to Containment level 2 standards and was completed 08/06/2020. The analysis kit including an Optigene LAMP analyser a has been procured. Staff who have experience in this field have volunteered to undertake refresher training and competency assessment to ensure that the trust can process the tests in a timely manner. Testing planned to commence 15/06/2020. The full detail of this scheme was presented as part of the COVID-19 update to Q&GC 19/06/20.

Well- Led: introduction of Regulatory pandemic assurance process	NHSE Infection Prevention and Control Board Assurance framework has been sent to all providers for assurance. The CQC will review this assurance as part of their overarching regulatory requirement during Covid-19	The Covid-19 pandemic has created huge challenges for the delivery of safe healthcare across the country and at CQC we have been trying to find the best way of gathering information to support their regulatory function during this period. A priority at this stage in the pandemic for the CQC is to ensure infection prevention and control measures are effective to reduce the risk of transmission of Covid-19. The CQC plan to explore how trusts have addressed the risks of cross-infection and to discuss how trust boards gains assurance that they are consistently meeting the standards set out in the national guidance. in order to achieve this, the CQC have implemented as emergency support framework (ESF) which facilitates supportive conversations with the Body and will incorporate an exploration on how trust boards are assured of good infection control practice. It is planned that the ESF will commence from June 15th 2020.
Well- Led: Change of CQC relationship team		There have been some changes within the CQC's work portfolios within the South East inspection team with a new relationship owner and inspection manager from 1st July 2020.

Safe - Performance Indicators

Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	Target	Quarter 1 2019/20	Quarter 2			Quarter 3			Quarter 4 2019/20			Quarter 1 2020/21		12 month total/ rolling average
		June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
Infection Control														
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA hospital acquired		0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	0	1	0	1	0	0	0	0	0	0	0	2
Gram negative bloodstream infections (including E.coli)	0	1	0	0	0	0	0	0	0	0	0	0	0	1
MRSA screening - elective	>95%	96%	94%	95%	92%	94%	98%	95%	94%	91%	90%	99%	90%	94%
MRSA screening - trauma	>95%	94%	98%	97%	94%	98%	94%	98%	98%	95%	95%	26%*	61%	93%
Incidents														
Never Events	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Serious Incidents	0	0	0	0	1	0	1	0	2	0	0	0	0	4
Theatre metrics														
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	6	6	3	5	0	0	2	3	4	1	3	2	35
Paediatrics under 3 years: Induction of anaesthetic was between 18:00 and 08:00	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WHO quantitative compliance		98.7%	99.3%	98.1%	99%	99%	99%	99.1%	98.4%	99.3%	99.3%	99.3%	98.8%	99%
Non-clinical cancellations on the day		7	31	29	15	13	12	13	19	5	8	5	1	158
Needlestick injuries		1	1	1	3	1	2	1	1	7	2	0	0	20
Pressure ulcers (all grades)		1	0	1	2	0	0	1	1	1	0	1	0	8
Paediatric transfers out (<18 years)		1	0	0	0	1	0	1	1	1	1	0	1	7
Medication errors														
Total number of incidents involving drug / prescribing errors		13	21	23	26	21	30	11	30	11	6	6	9	207
No & Low harm incidents involving drug / prescribing errors		13	21	23	26	21	30	11	30	11	6	6	9	207
Moderate, Severe or Fatal incidents involving drug / prescribing errors		0	0	0	0	0	0	0	0	0	0	0	0	0
Medication administration errors per 1000 spells		0.6	1.1	0.6	0.6	2.1	0.0	0.0	1.9	0.6	0.8	1.6	2.7	1.1
Harm free care rate (QVH)	>95%	97%	100%	97%	96%	95%	100%	100%	100%	100%	TBC	NC	N/A**	98.3%
- one month delay	>95%	93.8%	94.0%	93.9%	93.9%	94.0%	94.1%	94.0%	93.9%	93.7%	TBC	NC	N/A**	94%
Pressure Ulcers														
Hospital acquired - category 2 or above	15	1	0	1	1	1	0	2	1	1	0	0	1	9
VTE initial assessment (Safety Thermometer)	>95%	100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	96.0%	NC	N/A**	99.3%
Patient Falls														
Patient Falls assessment completed within 24 hrs of admission	>95%	100%	100%	100%	100%	100%	96%	97%	95%	100%	91%	NC	N/A**	97.9%
Patient Falls resulting in no or low harm (inpatients)		2	3	3	1	6	4	3	1	2	3	2	0	30
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	0	0	0	0	0	0	1	0	0	0	0	0
Patient falls per 1000 bed days		1.78	2.58	2.47	0.85	4.64	3.59	2.82	1.75	1.76	3.64	4.57	0	2.55

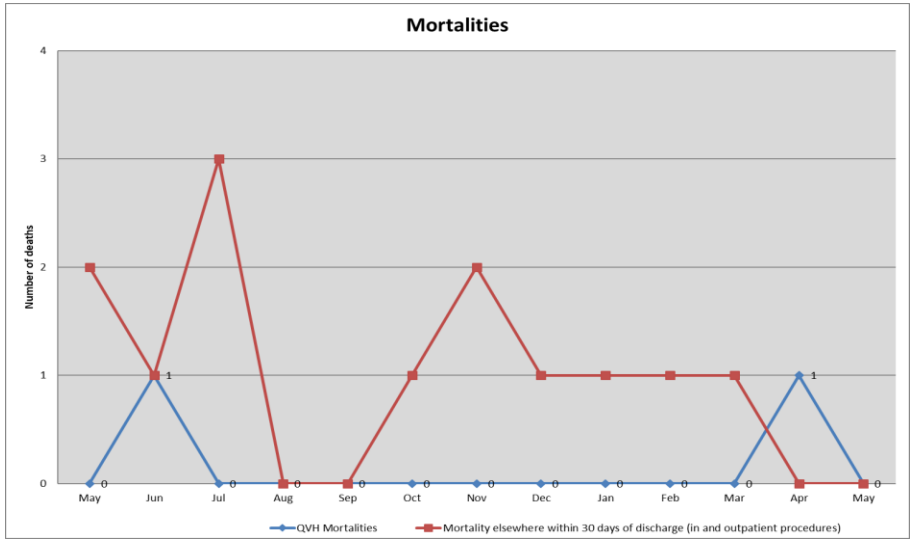
*The process for MRSA screening at TMC has not been effective and a new process has been agreed with the TMC Clinical Nurse Manager which is being implemented during June 2020.

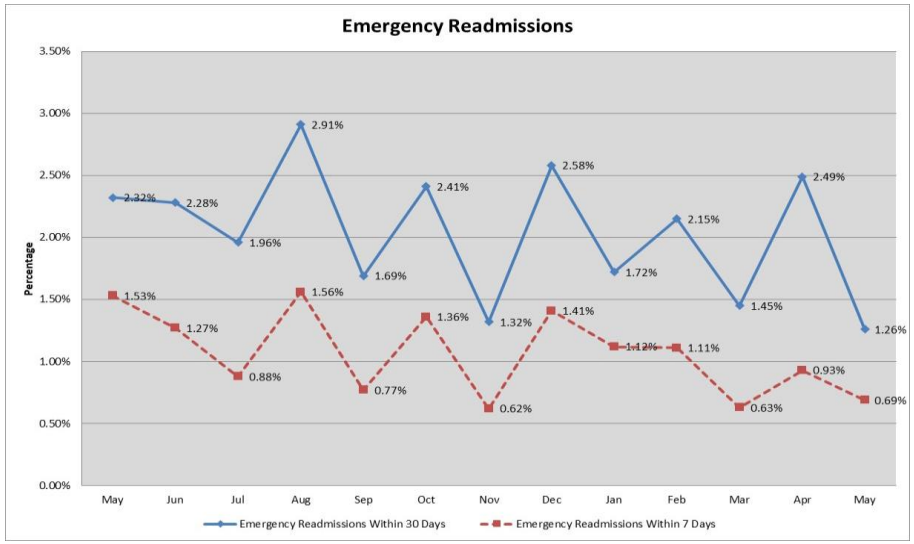
**The national Harm free care rate has ceased and the metrics will be removed

Safe - Performance Indicators, The McIndoe Centre

KPI	Quality Metrics	Target	Apr-20
1	Number of reported MRSA cases	0	0
2	MRSA screening of all elective patients	100%	100.0%
3	Number of reported CDI cases	0	0
4	Number of reported E- Coli cases	0	0
5	Number of reported MSSA cases	0	0
6	Number of reported medication errors	0	0
7	Number of reported patient Falls (No harm)	0	4
8	Number of reported patient Falls (Minor harm)	0	0
9	Number of reported patient Falls (Moderate harm)	0	0
10	Number of reported patient Falls (Major harm)	0	0
11	Number of reported patient Falls (Catastrophic)	0	0
12	Number of reported patient Falls (non- assisted)	0	2
13	% of Falls assessments undertaken on admission	100%	100.0%
14	Number of complaints received	0	0
15	Number of complaints responded to within 48 hours (or agreed timescales)	0	0
16	% of complaints responded to within 48 hours (or agreed timescales)	100%	100.0%
17	Number of re- opened complaints	0	0
18	Confirmation that Horder Complaints report has been sent to Commissioners (Monthly)	Y	Y
19	Number of complaints referred to the Health Ombudsman	0	0
20	Friends & Family Test: % returned	(=/>)20%	N/A
21	Friends & Family Test: % of respondents who would recommend Horder Healthcare	No Target	N/A
22	Number of Never Events	0	0
23	Number of Serious Incidents	0	1
24	Number of Patient Safety Incidents reported	0	23
25	Number of reported Patient Safety Incidents resulting in harm	0	4
26	% of Pressure Damage assessments undertaken on admission	100%	100.0%
27	Number of reported Grade 2 Pressure Ulcers	0	1
28	Number of reported Grade 3 Pressure Ulcers	0	0
29	Number of reported Grade 4 Pressure Ulcers	0	0
30	% of nutrition assessments undertaken	100%	100.0%
31	% of operations with WHO Surgical Checklist correctly completed and signed	100%	100.0%
32	Unplanned readmission to THC within 30 days of discharge	0	1
33	Unplanned return to theatre	0	1
34	Cancellation of procedure on or after day of surgery for non- clinical reasons (i.e. unsuitable for day surgery; ward beds unavailable; list overrun; surgeon unavailable; anaesthetist unavailable;	TBC	0
35	All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non- clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	100%	100.0%

Effective - Performance Indicators





	Quarter 1 2019/20	Quarter 2			Quarter 3			Quarter 4			Quarter 1 2019/20	
	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Number of deaths on QVH site	1	0	0	0	0	0	0	0	0	0	1	0
Number of deaths off- site within 30 days of IP or OP procedure	1	3	1	0	1	2	1	1	1	1	1	2
No of completed preliminary reviews	1	0	0	0	1	1	1	Awaiting coroners report	0	1	2	1
No of deaths subject to a Structured Judgement Review	1	0	0	0	0	0	0	Awaiting coroners report	0	Awaiting coroners report	1	1
No of deaths in patients with co-existing learning difficulties	0	0	0	0	0	0	0	0	0	0	0	0

Nursing Workforce - Performance Indicators, Safe staffing data

In April the actual care hours on shift were 68 hours less hours than planned. The clinical areas have been staffed to safe levels on some shifts there has been more care hours available than required in order to maintain the minimum requirement of 2 qualified nurses per shift. A small amount of flex was factored in to the staffing templates to allow for the staffing of an isolation area at short notice. There were 3 shifts where planned hours did not meet actual hours and the care was completely safe and required no escalation. These were triangulated with safety metrics and incidents recorded on Datix and there is no correlation between these incidents and slightly decreases staffing level on the shift. Apart from agency usage for mental health nurses there was no agency used to cover nursing or HCA posts in April in the ward or outpatient areas.

Combined Staffing exc. Site — *Target 95%* — April-2020

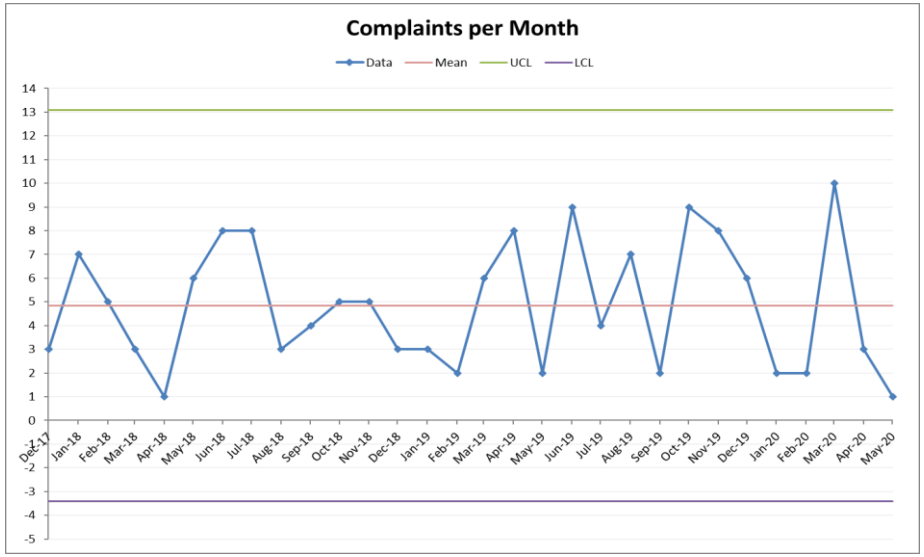
	Planned staff		Actual staff			Planned staff		Actual staff	
	RN	HCA	RN	HCA		RN	HCA	RN	HCA
DAY	4508	2231	4474	2197	*Total Hrs Planned and Actual*	3002	920	2990	908.5
			99.2%	98%	*% Planned Hrs Met*			99.6%	98.8%
		6739		6670	*Total Hrs Planned & Actual - Combined reg & support*		3922		3899
				99.0%	*% Planned Hrs Met - Combined reg & support*				99.4%

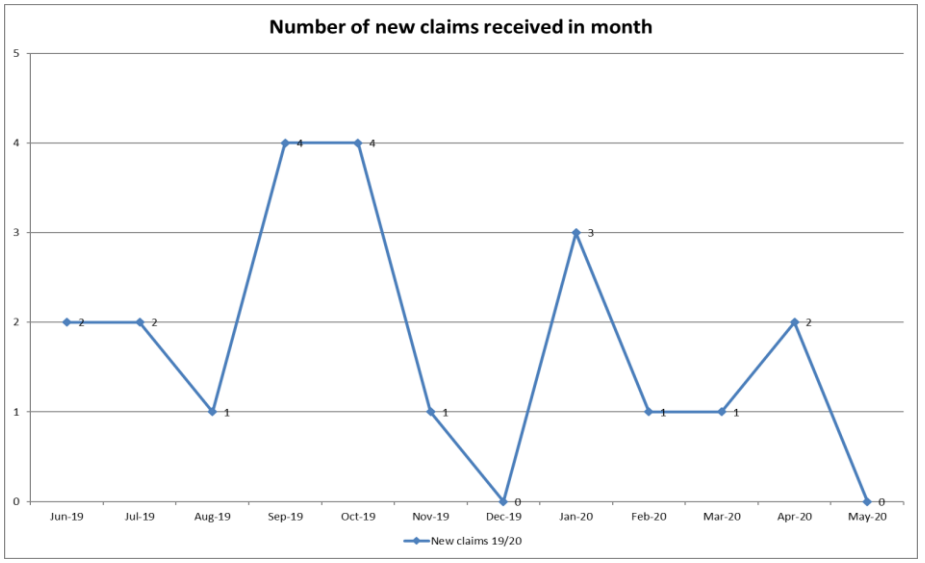
In May the actual care hours on shift were 80 hours less hours than planned. The clinical areas have been staffed to safe levels on some shifts there has been more care hours available than required in order to maintain the minimum requirement of 2 qualified nurses per shift. A small amount of flex was factored in to the staffing templates to allow for the staffing of an isolation area at short notice. There were 5 shifts where planned hours did not meet actual hours and the care was completely safe and required no escalation. These were triangulated with safety metrics and incidents recorded on Datix and there is no correlation between these incidents and slightly decreases staffing level on the shift. Apart from agency usage for mental health nurses there was no agency used to cover nursing or HCA posts in May in the ward or outpatient areas.

Combined Staffing exc. Site — *Target 95%* — May-2020

	Planned staff		Actual staff			Planned staff		Actual staff	
	RN	HCA	RN	HCA		RN	HCA	RN	HCA
DAY	4658	1978	4612	1944	*Total Hrs Planned and Actual*	3266	793.5	3197	759
			99.0%	98%	*% Planned Hrs Met*			97.9%	95.7%
		6636		6555	*Total Hrs Planned & Actual - Combined reg & support*		4060		3956
				98.8%	*% Planned Hrs Met - Combined reg & support*				97.5%

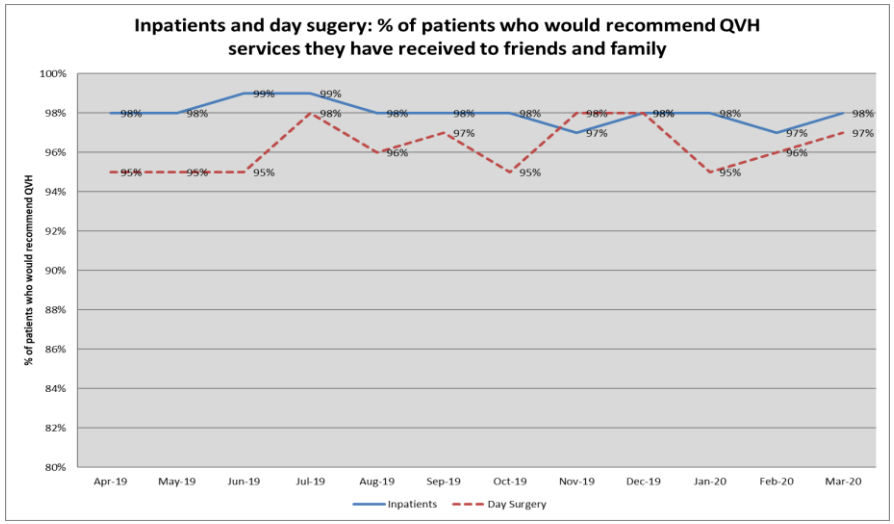
Caring - Current Compliance - Complaints and Claims

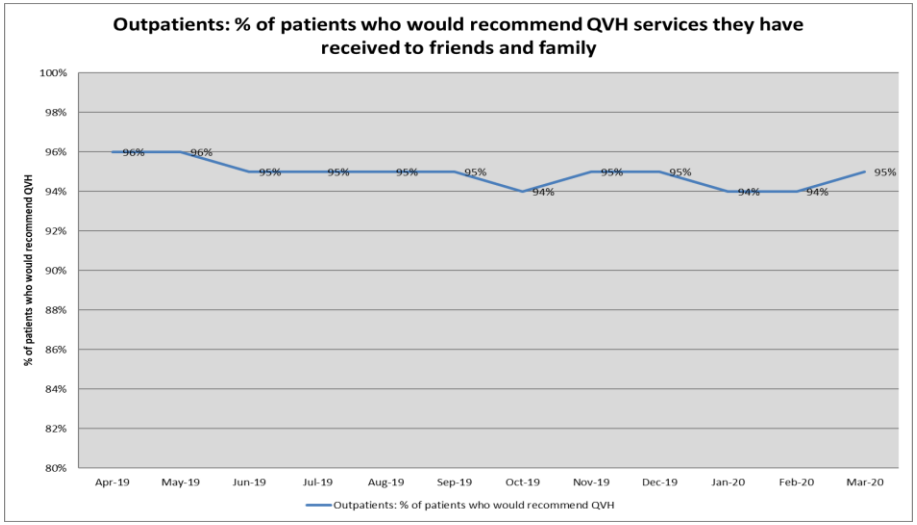


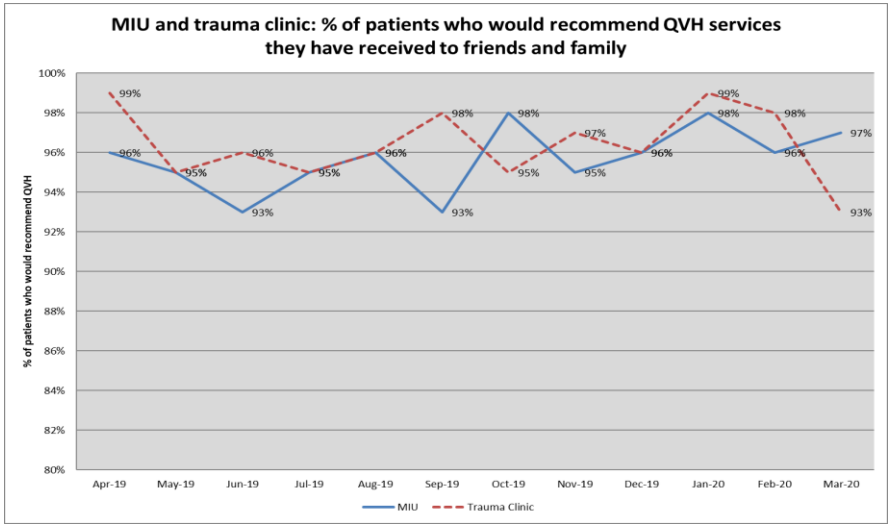


	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Complaints	9	4	7	2	9	8	6	2	2	10	3	1
Complaints per 100 contacts	0.049	0.019	0.037	0.011	0.043	0.042	0.037	0.01	0.012	0.065	0.027	0.009
Number of complaints referred to the Ombudsman for 2nd stage review	0	0	0	0	0	0	0	0	0	0	0	0
Number of complaints re-opened	0	1	1	1	0	0	0	3	0	1	0	1

Caring - Current Compliance - FFT







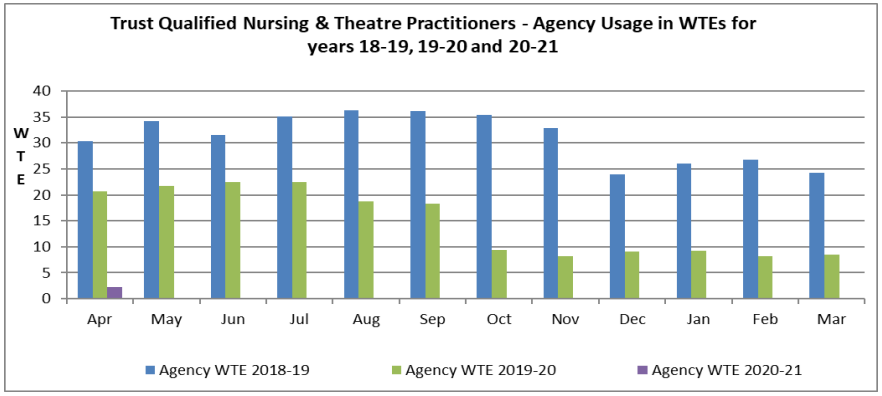
FFT was suspended national due to COVID 19 however the trust continued to operate a full PALS and complaints service throughout and has designed new patient questionnaire for breast surgery and virtual clinic appointments to seek patient experience of these new pathways. The response has been overwhelmingly positive.

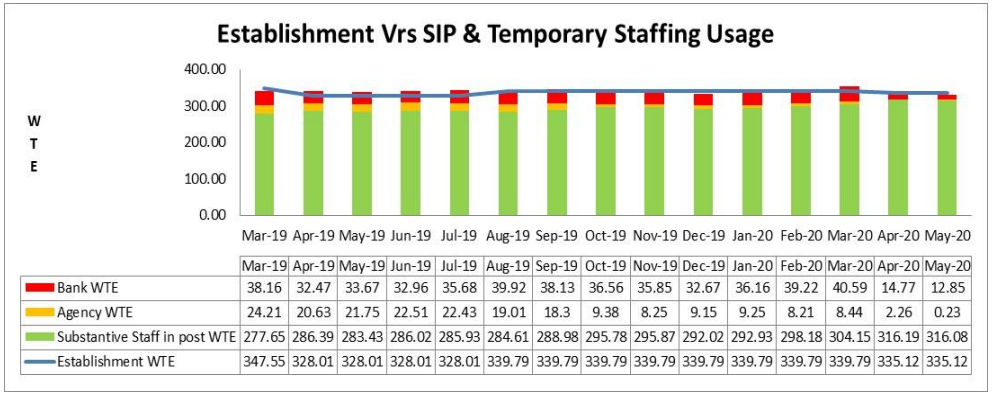
Nursing Workforce - Performance Indicators

ALL QUALIFIED & UQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020-21	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)		328.01	328.01	328.01	339.79	339.79	339.79	339.79	339.79	339.79	339.79	339.79	355.12	355.12	◄►
Staff In Post WTE		283.43	286.02	285.93	284.61	288.98	295.78	295.87	292.02	292.93	298.18	304.15	316.19	316.08	▲
Vacancies WTE		44.58	41.99	42.08	55.18	50.81	44.01	43.92	47.77	46.86	41.61	35.64	38.93	39.04	▼
Vacancies %	>18% / 12%<>18% / <12%	13.59%	12.80%	12.83%	16.24%	14.95%	12.95%	12.93%	14.06%	13.79%	12.25%	10.49%	10.96%	10.99%	▼
STARTERS WTE (Exluding rotational doctors)		2.00	2.56	2.00	4.64	7.43	6.00	2.00	1.51	1.00	5.43	4.41	0.51	2.23	▲
LEAVERS WTE (Exluding rotational doctors)		2.00	4.51	3.00	3.47	2.00	2.00	1.76	1.50	6.00	0.00	1.02	3.91	3.00	▼
Starters & Leavers balance		0.00	-1.95	-1.00	1.17	5.43	4.00	0.24	0.01	-5.00	5.43	3.39	-3.40	-0.77	
Agency WTE (Data From Healthrostor)		21.75	22.51	22.43	19.01	18.30	9.38	8.25	9.15	9.25	8.21	8.44	2.26	0.23	▼
Bank WTE (Data From Healthrostor)		33.67	32.96	35.68	39.92	38.13	36.56	35.85	32.67	36.16	39.22	40.59	14.77	12.85	▼
Trust rolling Annual Turnover %	>=12% / 10%<>12% / <10%	14.68%	15.90%	16.20%	15.22%	12.52%	15.15%	12.46%	9.67%	10.50%	9.94%	9.71%	9.95%	10.27%	▼
Monthly Turnover		0.72%	1.63%	1.08%	1.26%	0.71%	1.51%	0.60%	0.37%	1.44%	1.42%	0.00%	1.31%	1.01%	▼
Sickness Absence %	>=4% / 4%<>3% / <3%	4.24%	4.24%	3.66%	1.86%	2.04%	4.17%	5.11%	4.82%	3.63%	2.67%	6.30%	3.64%	TBC	

Note 1. 2019/20 budget implimented in June 19 backdated to April 19 taken from Finanace Ledger
Note 2. All data taken from ESR unless stated otherwise.
Note 3. Staff included are Qualified Nurses, Emergency Practitioners, Theatre Practitioners, HCA's,Student OPD's, Trainee Nurse Associates/Practitioners,Nurse Associates, Play Specialists, Oversea's Nursing awaiting PIN. Dental Nurses included in figures from 1.4.2020
Note 4. Of Qualified Staff approximately 4wte are Maxilliofacial Nurses and 23.5wte are ODP Theatre Practioners
Note 5. Of Unqualified staff approximately 10.5wte are Dental Nurses





	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Bank WTE	38.16	32.47	33.67	32.96	35.68	39.92	38.13	36.56	35.85	32.67	36.16	39.22	40.59	14.77	12.85
Agency WTE	24.21	20.63	21.75	22.51	22.43	19.01	18.3	9.38	8.25	9.15	9.25	8.21	8.44	2.26	0.23
Substantive Staff in post WTE	277.65	286.39	283.43	286.02	285.93	284.61	288.98	295.78	295.87	292.02	292.93	298.18	304.15	316.19	316.08
Establishment WTE	347.55	328.01	328.01	328.01	328.01	339.79	339.79	339.79	339.79	339.79	339.79	339.79	339.79	335.12	335.12

Medical Workforce - Performance Indicators

Metrics	2017/18 total / average	Target	Quarter 1 2019/20	Quarter 2			Quarter 3			Quarter 4			Quarter 1 2020/21		Year to date actual/ average
			June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	
Medical Workforce															
Turnover rate in month, excluding trainees	21.63% 12Mth rolling	<1%	0.78	1.16%	1.16%	1.54%	1.18%	1.15%	1.25%	1.14%	0.00%	2.93%	0.00%	0.28%	12.6% 12 mth Rolling
Turnover in month including trainees 9%	45.43% 12Mth rolling		0.49	1.45%	12.42%	6.08%	2.82%	1.39%	2.80%	0.70%	9.57%	2.82%	0.70%	0.17%	40.28% 12 mth rolling
Management cases monthly		**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Sickness rate monthly on total medical/dental headcount	1.43%		1.46	0.89%	1.07%	2.34%	1.5%	2.00%	0.99%	0.53	1.55%	1.99%	1.63%	TBC	1.46%
Appraisal rate monthly (exclude deanery trainees)	88.96% Mar 18		83.77%	79.35%	81.62%	86.00%	83.66%	85.53%	89.74%	87.60%	88.44%	91.36%	81.40%	74.85%	92.49%
Mandatory training monthly		**95%**	88%	89%	88.50%	84.81%	84.99%	85.93%	86%	85%	88.50%	86%	87%	87%	86.70%
Exception Reporting – Education and Training			5	8	2	5	2	1	1	0	5	0	0	0	29
Exception Reporting – Hours			2	0	0	5	1	1	2	2	1	0	0	0	14

Medical & Dental Staffing

April induction was re-configured to remove group training and was delivered by the Medical Education Manager (MEM) in staggered small groups.

For August, confirmation has been received that the full rotation will take place, which will require careful planning to ensure social distancing as this is our largest doctors' induction of the year. The Medical Education team are working with trainers, Medical Staffing, the DME and the Guardian of Safe Working to ensure a safe but still meaningful induction can be delivered.

Education	The simulation equipment continues to be invaluable for use for COVID-19 scenarios, preparing staff for a variety of situations that are likely to occur. Following guidance received from HEE, the DME, Medical Education Manager and GOSW are working to ensure that educational and clinical supervision takes place for all trainees. All departments have done an excellent job of adapting their teaching programmes to incorporate small groups, larger rooms and to make use of the available technology for remote sessions. The Junior Doctors' Forum is meeting online monthly to ensure that trainees can raise any issues with the DME and GOSW. The next round of Local Faculty Group meetings and the Local Academic Board will also take place using WebEx to ensure that the educational governance process is maintained.

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed : 21 June 2020

Strategic Objective
We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner.

Risk Appetite The trust has a **low appetite** for risks that impact on operational delivery of services and is working with a range of stakeholders to redesign and improve effectiveness and efficiency to improve patient experience, safety and quality.

Initial Risk 5 (c) x3 (L) =15, moderate
Current Risk Rating 4(C) x 4 (L) = 16
Target Risk Rating 3 (C) x 3 (L) = 9, low

Risk
Sustained delivery of constitutional access standards

Patients & Commissioners lose confidence in our ability to provide timely and effective treatment due to an increase in waiting times and a fall in productivity.

Rationale for current score
- COVID 19 impact – staffing and step down of activity whereby delay will not be of detrimental impact to the patient
- Increased level of patients deferring treatment due to COVID-19
- Underlying capacity challenges for restoration and recovery phase given role of cancer hub
- PPE limitations for Aerosol Generating Procedure activity
- Waiting list size and challenge with long wait patients [CRR 1125]
- Vacancy levels in theatre staffing and theatre capacity – mitigated yet remain a challenge in some areas [CRR 1077]
- Anaesthetic cover for all site requirements (including McIndoe Centre)
- Vacancy levels in sleep [CRR 1116]
- Specialist nature / complexity of some activity
- Late referrals from referring organisations
- Vacancies in non consultant level medical staff in corneo plastics and OMFS [CRR 1143]
- Ongoing medical vacancies in corneo [CRR 1143]
- Sentinel Lymph Node demand [CRR 1122]
- Pension rules impacting medical staff willing to provide additional capacity
- Appointments team vacancies

Future risks
- National Policy changes to access targets e.g. Cancer & complexity of pathways, QVH is reliant on other trusts timely referrals onto the pathway;
- NHS Tariff changes & volatility;
- Future impact of Brexit on workforce
- Reputation as a consequence of RTT

Future Opportunities
- Spoke sites offer the opportunity for further partnerships
- Closer working between providers in STP – networked care
- Partnership with BSUH/WSHFT

Controls / Assurance
- Mobilising of virtual outpatient opportunities to support activity during COVID-19
- Additional reporting to monitor COVID-19 impact
- Restoration and recovery planning underway- phase 1 of plan signed off and weekly group in place
- Agreed system approach to capacity and demand
- Weekly RTT and cancer PTL meetings ongoing
- Development of revised operational processes underway to enhance assurance and grip
- Monthly business unit performance review meetings & dashboard in place with a focus on exceptions, actions and forward planning
- Bank staff for appointments being recruited to

Gaps in controls / assurance
- Variable trust wide processes for booking and scheduling
- Not all spoke sites on QVH PAS so access to timely information is limited
- Shared pathways for cancer cases with late referrals from other trusts
- Late referrals for 18RTT and cancer patients from neighbouring trusts
- Gaps in theatre staffing
- Capacity challenges for both admitted and non admitted pathways
- Informatics capacity
- Impact of patient choice that is a risk to delivery of plan to eliminate RTT waits > 52 weeks
- Orthodontic capacity
- Breast capacity

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance | **Committee: Finance & Performance** | **Date last reviewed 28th June 2020**

Strategic Objective
We maximize existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services

Risk
Loss of confidence in the long-term financial sustainability of the Trust due to a failure to create adequate surpluses to fund operational and strategic investments

Risk Appetite The Trust has a **moderate appetite** for risks that impact on the Trusts financial position. A higher level of rigor is being placed to fully understand the implications of service developments and business cases moving forward to ensure informed decision making can be undertaken.

Initial Risk 3 (C) x 5(L) = 15, moderate
Current Risk Rating 5 (C) x 5(L)= 25, catastrophic
Target Risk Rating 4(C) x 3(L) = 12, moderate

Rationale for current score (at Month 2)

- Break even position for month 2. This was a requirement for all NHS Trusts.
- Uncertainty as to the next steps for the business planning and contract agreement post 31st October and the block arrangements from August till October
- Finance & Use of Resources – 4 (planned 4)
- High risk factor –availability of staffing - Medical, Nursing and non clinical posts and impact on capacity/ clinical activity
- Commissioner challenge and scrutiny post M1-4 Block arrangement
- Potential changes to commissioning agendas
- ~~Contracting alignment agreement~~
- Significant activity drop due to Covid
- Unknown costs of redesigned pathways

Future Risks

NHS Sector financial landscape Regulatory Intervention

- Block income arrangement – future guidance to be released to better understand how these may change and develop over the coming months
- National guidance is developing to understand how the financial regime will impact Trusts over the coming months.
- Capped expenditure process
- Single Oversight Framework
- Commissioning intentions – Clinical effective commissioning
- ~~Sustainability and transformation footprint plans~~
- NHSI/E control total expectation of annual breakeven within the LTFM trajectory (2020/21-2024/25)

Future Opportunities

- New workforce model, strategic partnerships; increased trust resilience / support wider health economy
- Develop the significant work already undertaken using IT as a platform to support innovative solutions and new ways of working
- ~~Improved vacancy levels and less reliance on agency staffing~~
- Increase in efficiency and scheduling through whole of the patient pathway through service redesign
- Spoke site activity repatriation and new model of care
- Strategic alliances \ franchise chains and networks
- ~~Development of accelerated Integrated Care System~~

Controls / Assurances

- Performance Management regime in place and performance reports to the Board.
- Contract monitoring process and CIP Governance processes strengthened.
- Finance & Performance Committee in place, forecasting from month 4 onwards subject to caveats with regards to the NHS environmental changes
- Audit Committee with a strengthened Internal Audit Plan.
- Budget Setting and Business Planning Processes (including capital) to be all approved for all areas.
- Income / Activity capture and coding processes embedded and regularly audited
- Weekly activity information per Business unit, specialty and POD reflected against plan and prior year.
- Spoke site, Service line reporting and service review information widely circulated.

Gaps in controls / assurances

- Structure, systems and process redesign and enhanced cost control
- Model Hospital Review and implementation
- Identification and Development of transformation schemes to support long term sustainability
- ~~Quality improvement (QI) programme to support enable efficiency agenda~~
- Service reviews required to understand efficiencies against payments
- Non achievement of efficiencies to achieve lower cost profile
- Understanding of payment mechanisms in future periods

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**2 July 2020**		**Agenda reference:**	**103-20**	
Report title:	**Financial, operational and workforce performance assurance**				
Sponsor:	Paul Dillon-Robinson, committee chair				
Author:	Paul Dillon-Robinson, committee chair				
Appendices:	NA				
Executive summary					
Purpose of report:	Board Assurance on matters discussed at the F&P meeting on 22nd June				
Summary of key issues	• As has been the practice for the last couple of months, the meeting was shortened and attendance lightened. It will revert to type in July and August. • Workforce statistics remain positive, despite the issues around Covid, and the Committee sought further assurance around BAME risk assessments, shielding and testing. • Finance performance is benefitting from the current block contract arrangements, although there is uncertainty about how long they will last and what will replace them. The committee were keen for the Board to approve an expenditure budget for the year, to provide an element of control. • Operational performance is difficult to assess, because of the current situation, and the increase in RTT and 52ww is recognised and being monitored, but awaiting clarity on the future working arrangement. • Work on Service Line Reporting and service reviews was noted, as was progress on actions form a clinical coding review last autumn.				
Recommendation:	The Board is asked to **NOTE** the contents of the report, the **ASSURANCE** (where given), and the ongoing uncertainty.				
Action required				**Assurance**	
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	**KSO3: x**	**KSO4: x**	**KSO5: x**
	Outstanding patient experience	*World-class clinical services*	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	• KS05: Organisational Excellence – remains major as dependent on a number of factors • KS04:Financial Sustainability– remains at "catastrophic", although block contract arrangements provide temporary relief, whilst a longer-term solution is developed • KS03: Operational Excellence – risk remains high as plans for restoration and recovery are developed				
Corporate risk register:	Reflected in BAF scores				
Regulation:	All areas are subject to some form of regulation – none specific				
Legal:	All areas are subject to some form of legal duty – none specific				
Resources:	Performance is dependent, to a large extent, on availability of staff in various areas of the Trust, and the financial arrangements				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to: Board of Directors
Meeting date: 2 July 2020
Reference no: 103-20
Report from: Paul Dillon-Robinson, Committee Chair
Report date: 22 June 2020

Financial, operational and workforce performance assurance

Background

For the third month in a row the F&P meeting was held with a limited attendance from the executives (Chief Executive and Director of Finance & Performance only), with the agreement that the Directors of Operations and Workforce & Organisational Development would not be required. It was agreed that, going forward, it would revert to include the Directors of Operations and Workforce & Organisational Development. It was also noted that the Trust, whilst working on restoration and recovery arrangements, retained some uncertainty over the expectations for delivery and that this might remain for a few months yet. It was agreed that the committee would continue to meet monthly and accept that it would need to develop what is reported and overseen as these demands became clearer.

1. Workforce performance

Workforce indicators continue to provide a positive message, particularly with regards to the current pandemic and uncertainty amongst staff. Some new staff have joined the Trust and plans continue to recruit overseas nurses.

The committee were keen to ensure that assurance around risk assessments for staff, particularly BAME and those shielding, were being carried out, monitored and action taken. They were also keen that there was monitoring of testing (including antibodies). Assurance was provided that these are priority areas for management attention and steps are being taken to set up a BAME network, which represents around 12% of the workforce with the highest proportion in the medical and dental workforce.

2. Financial performance

The Trust's current block contract arrangements result in a break-even position being reported up to month 2 and there is uncertainty about how much longer this will continue and what arrangements will replace it. At the moment this provides the Trust with sufficient cash and some short-term certainty.

A matter brought forward from a previous meeting was the need for a budget to be set, primarily to act as a control measure for expenditure, but also to support planning for future sustainability and ensure that costs do not escalate before we return to some version of the new "normal". The Board is to be asked to confirm the arrangements, appreciating that income budgets cannot be allocated and that there will be uncertainty around variable costs until future operational arrangements are clear. Staff involved in agreeing budgets are involved in a range of other competing demands on their time, but this is being worked on.

The committee asked for assurance that action was being taken to improve payment to creditors, following a fall in performance, and this was given, with authorised signatories being targeted where there were delays in authorisation of invoices.

Some potential overspends on capital were noted, but assurance given that this was still early in the year and that delays were expected and contingency was not being particularly used up

The need to understand the costs of pathway design, referred to in the BAF, was picked up and it was agreed how critical this was to resolve in taking the Trust forward as a regional cancer centre in the future. Whilst these will require a significant amount of work, the committee agreed that it shouldn't look to be too detailed and therefore over complex.

3. Operational performance

Headline performance figures (RTT, 52ww) continue to decline due to the restricted arrangements in place, although significant work is being carried out at both the hospital site and with the McIndoe. This is an acknowledged problem across the NHS.

Major work is being undertaken on planning arrangements for restoration and recovery, although it is unlikely that full clarity on the objectives / targets and the arrangements will be available for a month or so

4. Other

A report on Service Line Reporting was introduced and there was discussion about how this information should be used to inform decision-making going forward. Were the Trust to move away from a full Payment by Results tariff to a different funding arrangement, there is still value in understanding the costs of service lines and how they compare with benchmarks and therefore where the Trust needs to focus on improvements. The committee will receive results of each of the service reviews being carried out.

A summary of the recommendations from an external audit of clinical coding last year was introduced and the committee were keen to see a detailed action plan with dates for when the department would be operating at a business as expected level.

This was the last meeting attended by Mickola Wilson as the governor representative and she was thanked for her support and best wishes offered as she takes up a non-executive role in another NHS organisation.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**Thursday 2 July 2020**		**Agenda reference:**	**104-20**	
Report title:	**Operational Performance Report**				
Sponsor:	Abigail Jago, Director of Operations				
Authors:	Operations Team				
Appendices:					
Executive summary					
Purpose of report:	To provide an update regarding operational performance				
Summary of key issues	Key items to note in the operational report are: • QVH phase 1 restoration and recovery plan • Current and future impact of COVID-19 on operational performance				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	**KSO3:** ***Operational excellence***	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	BAF 3				
Corporate risk register:	**Risks:** As described on BAF KSO3				
Regulation:	CQC – operational performance covers all 5 domains				
Legal:	The NHS Constitution, states that patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, (i.e. patients should wait no longer than 18 weeks from GP referral to treatment) or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'.				
Resources:					
Assurance route					
Previously considered by:	Finance & Performance Committee				
	Date:	22/6/20	Decision:	Noted	
Previously considered by:					
	Date:		Decision:		
Next steps:					

Operational Performance Report

Abigail Jago, Director of Operations

02 **July 2020**

Board of Directors

Summary and COVID-19

In May the trust continued in the delivery of cancer hub activity, trauma and urgent elective activity. Non urgent electivity remained stood down however planning for the recovery and restoration has been underway.

Recovery planning is driven through 4 recovery groups reporting to the Executive Management Team:

Restoration and Recovery Activity Group – Led by Director of Operations

Restoration and Recovery Clinical Governance Group – Led by Director of Nursing and Quality

Restoration and Recovery Workforce Group – Led by Director of Workforce and OD

Restoration and Recovery Infrastructure Group – Led by Director of Finance and Performance

Recovery and restoration is being developed in 3 agreed phases – restore (to July 2020), recovery (August – March 2020) and sustainability (2021/22 onwards). This will involve site service reconfiguration in addition to the planned restart of services. Patients are to be prioritised in line with national clinical urgency levels. Other key enablers include:

- Risk stratification of admitted waiting list
- Establishing green / amber pathways in theatres to maximise capacity
- Embedding the clinical senate to prioritise patients for admission
- Sign off of PPE and infection control requirements for safe restart
- Implementation of point of care testing

Trust level - Phase 1

Queen Victoria Hospital NHS Foundation Trust

Phase 1
May – July (Restore)

Cancer hub – continue to support activity from across KSS
- Visiting breast surgeons
- Head and neck
- Skin

Trauma – operating from the McIndoe Centre
- Plastics
- Maxfacs
- Eyes

Elective – commencement of elective activity subject to screening and testing / PPE requirements

Phase 1 site reconfiguration

August – year end (Recover)

- To confirm cancer hub status / requirements and capacity
- Phase 2 site reconfiguration
- Step up in elective recovery subject to cancer requirement, second surge and capacity
- Review of additional trauma workload (e.g. Surrey OMFS)

2021/22: Towards sustainability

- Cancer – Establish post cancer hub position in SSCA and K&M CA for QVH for Head and neck / Skin
- Elective – deliver plan for recovery of elective activity
- Trauma Establish role in KSS for delivery of trauma / development of hand unit

Service level – Phase 1

Queen Victoria Hospital NHS Foundation Trust

Corneo plastics

- **Admitted** – P2/3 through clinical senate process. LA / GA
- **Non admitted –** virtual outpatients to continue (AA ocular plastics / phone clinics) / F2F for urgent / diagnostic. Planning for routine F2F where required.

OMFS & Orthodontics

- **Admitted** – P2/3 through clinical senate
- **Non admitted** – orthodontics Non AGP and AGP when PPE available / MOS when PPE available. Patients to be cohorted for AGP/ Non AGP.
- **Spokes activity** – resume subject to PPE availability (provided by spokes)

Plastics

- **Admitted** – P2/3 through clinical senate process / plan to mobilise breast reconstruction
- **Non admitted -** virtual continue / F2F urgent
- **Spoke activity** – to resume subject to PPE availability

Sleep & Community

- Sleep – resuming non AGP service activity subject to PPE availability
- Community – telephone clinics ongoing for rheum cardiology, Parkinsons and CoE. ENT / Respiratory stood down.

CSS

- **Diagnostics** - Services resumed with the exception of orthognathic/ orthodontic/ interventional salivary/ interventional MSK. Dedicated 'vulnerable / >70s list underway.
- **Therapies** – Face to face post op support, continue virtual hand therapy consultant / virtual outpatients in place. Awaiting guidance re domiciliary. Stood down – domiciliary in community .

Performance summary – 19/20 YTD

Queen Victoria Hospital
NHS Foundation Trust

KPI	TARGET / METRIC	TARGET SOURCE	JUL19	AUG19	SEP19	OCT19	NOV19	DEC19	JAN20	FEB20	MAR20	APR20	MAY20
DMO1 Diagnostic waits	99% < 6 weeks	National	99.86%	98.9%	99.11%	99.76%	99.61%	98.18%	98.23%	99.20%	90.07%	72.4%	28.09%
Histology Turnaround Time	90% < 10 days	Local	70%	82%	76%	38%	59%	71%	90%	94%	94%	93%	96%
Imaging reporting	% < 7 days	Local	97.41%	98.42%	97.98%	98.75%	95.8%	99.11%	99.37%	98.8%	98.18%	99.0%	98.6%
RTT – % patients <18 week	Agreed commissioner trajectory	National	80.63%	81.3%	81.62%	82.28	82.9%	82.77%	82.1%	81.37%	78.5%	69.5%	59.22%
RTT52	Agreed commissioner trajectory	National	37	29	25	22	19	15	19	16	18	38	100
Total waiting list size	Reduction in waiting list size	National	10902	10966	10516	10663	10529	10429	10333	10178	10123	9604	9397
Minor injuries unit - % pt treated/ discharge in 4 hrs	95%	National	99.6%	100%	99.26%	99.7%	99.47%	100%	99.89%	100%	100%	100%	100%
Cancer 2WW	93%	National	94.9%	93.1%	89.3%	88.9%	89.5%	96%	93.3%	97.7%	90.8%	83.8%	
Cancer 62 day	85%	National	85.2%	91.2%	82.9%	85.7%	70% (83.3% actual)	80%	83.7%	82.1%	87.8%	90.9%	
Cancer 31 day	96%	National	95.8%	95.9%	94.9%	93.0%	87.1%	94.7%	89.9%	89.5%	94.6%	98.2%	
Faster Diagnosis Shadow Report	75%	National Apr20		70.7%	81.5%	84.4%	88.1%	86.6%	77.2%	88.1%	84.5%	67.4%	

RTT Performance against plan – 2020/21

Queen Victoria Hospital NHS Foundation Trust

	Quarter 4 19/20			Quarter 1 20/21			Quarter 2 20/21			Quarter 3 20/21			Quarter 4 20/21		
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	87.7%	90.3%	92%												
RTT Actual	82.10%	81.37%	78.5%	69.5%	59.22%										
52 week plan	0	0	0	0	0										
Revised plan	15	10	5												
52 week actual (total)	19	16	18	38	100										
52 week patient deferred	13	11	7												

Corneo plastic	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	86.3%	89.4%	92%												
RTT Actual	73.89%	72.79%	69.58%	57.8%	46.57%										
52 weeks actual (total)	0	1	0	1	22										
52 week patient deferred	0	1	0												

OMFS	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	90.1%	90.1%	92%												
RTT Actual	84.13%	83.88%	79.92%	68.0%	54.95%										
52 weeks actual	5	4	2	7	19										
52 week patient deferred	3	3	1												

Plastics	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	87.8%	87.8%	92%												
RTT Actual	80.52%	79.21%	77.07%	70.9%	63.23%										
52 weeks actual	14	11	16	30	58										
52 week patient deferred	10	7	6												

Sleep	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	92%	92%	92%	92%											
RTT Actual	95.25%	95.13%	94.55%	91.2%	83.20%										
52 weeks actual	0	0	0	0	1										

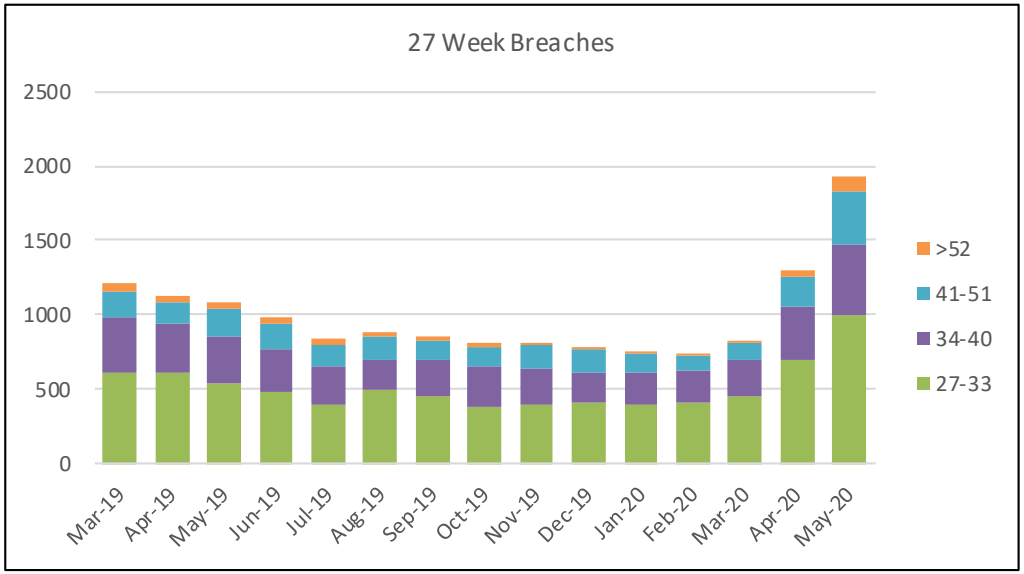
Clinical Support	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Plan	95%	95%	95%	95%											
RTT Actual	96.26%	97.15%	96.34%	92.0%	85.50%										
52 weeks actual	0	0	0	0	0										

RTT18 – Incomplete pathways

Trust level performance

Queen Victoria Hospital NHS Foundation Trust

Weeks wait	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Change from last month
0-17 (<18)	9704	9508	9149	8790	8915	8583	8774	8729	8632	8483	8282	7947	6682	5565	-1117
18-26	1367	1136	1182	1271	1169	1085	1083	984	1008	1089	1149	1344	1625	1903	+278
27-33	606	542	488	402	490	447	380	397	405	403	416	451	702	997	+295
34-40	331	319	286	253	205	243	269	240	209	212	207	248	347	480	+133
41-51	149	176	165	149	158	133	135	160	160	127	108	115	210	352	+142
>52	47	42	39	37	29	25	22	19	15	19	16	18	38	100	+62
Total Pathways	12204	11723	11309	10902	10966	10516	10663	10529	10429	10333	10178	10123	9604	9397	-207
Breaches	2500	2215	2160	2112	2051	1933	1889	1800	1797	1850	1896	2176	2922	3832	+910
Performance	79.51%	81.11%	80.90%	80.63%	81.30%	81.62%	82.28%	82.90%	82.77%	82.10%	81.37%	78.50%	69.58%	59.22%	-10.36%
Clock starts	2929	3291	2993	3240	2923	2947	3152	3099	2407	3152	2790	2128	1163	1353	+190



PERFORMANCE COMMENTARY

- Performance fell 10.3% in month, with the total number of breaches rising in month by 910, driven by COVID-19 related activity reductions
- The clock starts saw the first rise since activity was due down due to the pandemic
- The number of 52wk breaches rose to 100 in month – 84 patients are waiting for a routine TCI, 16 patients are in the diagnostic phase of their pathway

COVID-19 Impact On RTT

Queen Victoria Hospital NHS Foundation Trust

Trust Wide	Average of last 6 months (Sep19-Feb20 inc)	Mar20 actual	Variance from six month Average for March			Apr20 Actual	Variance from six month Average for April			May20 Actual	Variance from six month Average for May		
Open Pathway Weeks Wait			Mar-Ave	Mar/Ave	Var/Ave		Apr-Ave	Apr/Ave	Var/Ave		May-Ave	May/Ave	Var/Ave
0-17 (<18)	8,581	7,947	-634	93%	-7%	6682	-1,899	77.87%	-22.13%	5565	-3,016	64.86%	-35.14%
18-26	1,066	1,344	278	126%	26%	1625	559	152.39%	52.39%	1903	837	178.46%	78.46%
27-33	408	451	43	111%	11%	702	294	172.06%	72.06%	997	589	244.36%	144.36%
34-40	230	248	18	108%	8%	347	117	150.87%	50.87%	480	250	208.70%	108.70%
41-51	137	115	-22	84%	-16%	210	73	153.10%	53.10%	352	215	256.62%	156.62%
>52	19	18	-1	93%	-7%	38	19	196.55%	96.55%	100	81	517.24%	417.24%
Total Pathways	10,441	10,123	-318	97%	-3%	9604	-837	91.98%	-8.02%	9397	-1,044	90.00%	-10.00%
18 week Breaches	1,861	2,176	315	117%	17%	2922	1,061	157.03%	57.03%	3832	1,971	205.93%	105.93%
Clock Start	2,925	2,128	-797	73%	-27%	1163	-1,762	39.76%	-60.24%	1353	-1,572	46.26%	-53.74%
Admitted Clock stops	1,051	820	-231	78%	-22%	292	-759	27.78%	-72.22%	312	-739	29.69%	-70.31%
Non admitted clock stops	1,710	1,324	-386	77%	-23%	913	-797	53.39%	-46.61%	721	-989	42.16%	-57.84%

Trust Wide

Plastics	Average of last 6 months (Sep19-Feb20 inc)	Mar20 actual	Variance from six month Average for March			Apr20 Actual	Variance from six month Average for April			May20 Actual	Variance from six month Average for May		
Open Pathway Weeks Wait			Mar-Ave	Mar/Ave	Var/Ave		Apr-Ave	Apr/Ave	Var/Ave		May-Ave	May/Ave	Var/Ave
0-17 (<18)	2,746	2,511	-235	91%	-9%	2381	-365	86.71%	-13.29%	2246	-500	81.79%	-18.21%
18-26	359	426	67	119%	19%	492	133	136.92%	36.92%	624	265	173.65%	73.65%
27-33	139	160	21	115%	15%	252	113	180.86%	80.86%	324	185	232.54%	132.54%
34-40	80	85	5	106%	6%	118	38	147.50%	47.50%	175	95	218.75%	118.75%
41-51	57	60	3	106%	6%	85	28	150.00%	50.00%	125	68	220.59%	120.59%
>52	12	16	4	130%	30%	30	18	243.24%	143.24%	58	46	470.27%	370.27%
Total Pathways	3,394	3,258	-136	96%	-4%	3358	-36	98.95%	-1.05%	3552	158	104.67%	4.67%
18 week Breaches	648	747	99	115%	15%	977	329	150.85%	50.85%	1306	658	201.65%	101.65%
Clock Start	901	734	-167	81%	-19%	622	-279	69.05%	-30.95%	746	-155	82.81%	-17.19%
Admitted Clock stops	475	368	-107	77%	-23%	199	-276	41.87%	-58.13%	246	-229	51.75%	-48.25%
Non admitted clock stops	390	277	-113	71%	-29%	153	-237	39.21%	-60.79%	135	-255	34.60%	-65.40%

COVID-19 Impact On RTT

Queen Victoria Hospital NHS Foundation Trust

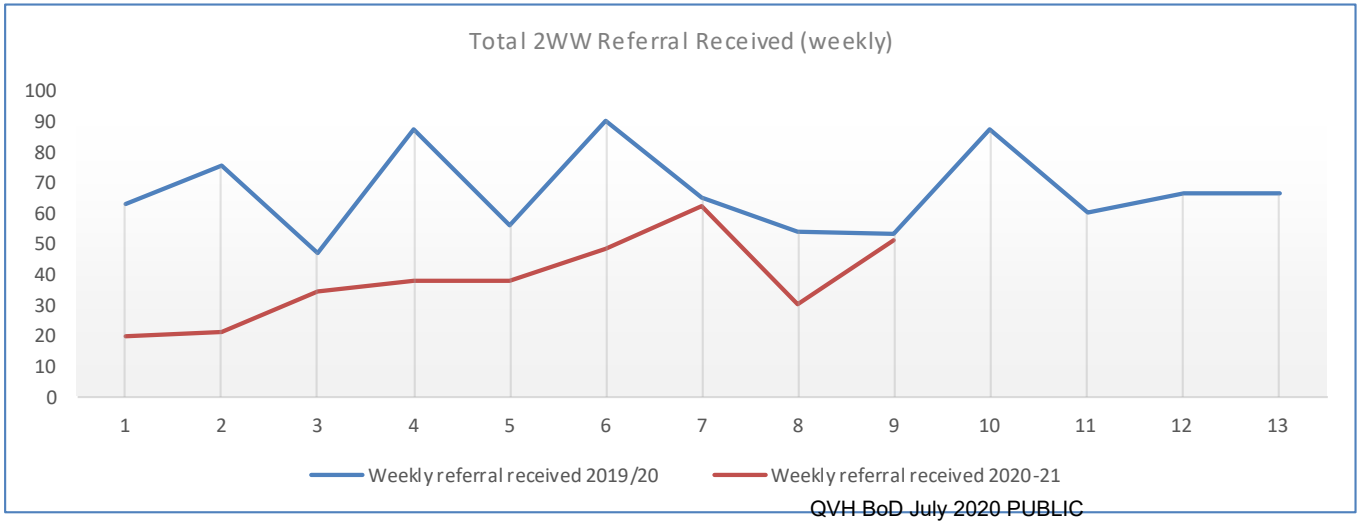
	Trust Wide	Average of last 6 months (Sep19-Feb20 inc)	Mar20 actual	Variance from six month Average for March			Apr20 Actual	Variance from six month Average for April			May20 Actual	Variance from six month Average for May		
	Open Pathway Weeks Wait			Mar-Ave	Mar/Ave	Var/Ave		Apr-Ave	Apr/Ave	Var/Ave		May-Ave	May/Ave	Var/Ave
OMFS	0-17 (<18)	2,722	2,524	-198	93%	-7%	1788	-934	65.70%	-34.30%	1277	-1,445	46.92%	-53.08%
	18-26	322	412	90	128%	28%	500	178	155.20%	55.20%	549	227	170.41%	70.41%
	27-33	114	127	14	112%	12%	183	70	161.23%	61.23%	272	159	239.65%	139.65%
	34-40	55	68	14	125%	25%	102	48	187.16%	87.16%	115	61	211.01%	111.01%
	41-51	32	25	-7	77%	-23%	47	15	145.36%	45.36%	92	60	284.54%	184.54%
	>52	5	2	-3	44%	-56%	7	3	155.56%	55.56%	19	15	422.22%	322.22%
	Total Pathways	3,249	3,158	-91	97%	-3%	2627	-622	80.87%	-19.13%	2324	-925	71.54%	-28.46%
	18 week Breaches	527	634	107	120%	20%	839	312	159.20%	59.20%	1047	520	198.67%	98.67%
	Clock Start	949	666	-283	70%	-30%	225	-724	23.71%	-76.29%	245	-704	25.81%	-74.19%
	Admitted Clock stops	174	119	-55	69%	-31%	31	-143	17.87%	-82.13%	17	-157	9.80%	-90.20%
	Non admitted clock stops	692	589	-103	85%	-15%	519	-173	75.04%	-24.96%	127	-565	18.36%	-81.64%

	Trust Wide	Average of last 6 months (Sep19-Feb20 inc)	Mar20 actual	Variance from six month Average for March			Apr20 Actual	Variance from six month Average for April			May20 Actual	Variance from six month Average for May		
	Open Pathway Weeks Wait			Mar-Ave	Mar/Ave	Var/Ave		Apr-Ave	Apr/Ave	Var/Ave		May-Ave	May/Ave	Var/Ave
Corneo	0-17 (<18)	1,830	1,640	-190	90%	-10%	1347	-483	73.63%	-26.37%	1100	-730	60.13%	-39.87%
	18-26	331	446	116	135%	35%	540	210	163.39%	63.39%	570	240	172.47%	72.47%
	27-33	140	153	13	109%	9%	249	109	177.65%	77.65%	364	224	259.69%	159.69%
	34-40	90	89	-1	99%	-1%	117	27	130.48%	30.48%	178	88	198.51%	98.51%
	41-51	47	29	-18	62%	-38%	75	28	159.57%	59.57%	128	81	272.34%	172.34%
	>52	3		-3	0%	-100%	1	-2	38.46%	-61.54%	22	19	846.15%	746.15%
	Total Pathways	2,439	2,357	-82	97%	-3%	2329	-110	95.49%	-4.51%	2362	-77	96.84%	-3.16%
	18 week Breaches	610	717	108	118%	18%	982	373	161.12%	61.12%	1262	653	207.05%	107.05%
	Clock Start	493	356	-137	72%	-28%	142	-351	28.81%	-71.19%	186	-307	37.74%	-62.26%
	Admitted Clock stops	254	196	-58	77%	-23%	22	-232	8.65%	-91.35%	19	-235	7.47%	-92.53%
	Non admitted clock stops	190	119	-71	63%	-37%	68	-122	35.76%	-64.24%	40	-150	21.03%	-78.97%

Cancer Performance

Queen Victoria Hospital NHS Foundation Trust

Trust Level	Quarter 4 2019-20			Quarter 1 2020-21			Quarter 2 2020-21			Quarter 3 2020-21			Quarter 4 2020-21		
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Two Week Wait	93.3%	97.7%	90.8%	83.8%											
62 Day Referral to Treat	83.7%	82.1%	87.8%	90.9%											
Faster Diagnosis				67.4%											
62 Day Screening	0.0%		0.0%												
62 Day Con Upgrade	87.5%	88.9%	93.8%	100.0%											
31 Day Decision to Treat	89.9%	89.5%	94.6%	98.2%											
31 Day Sub Treat	100.0%	75.0%	100.0%	100.0%											



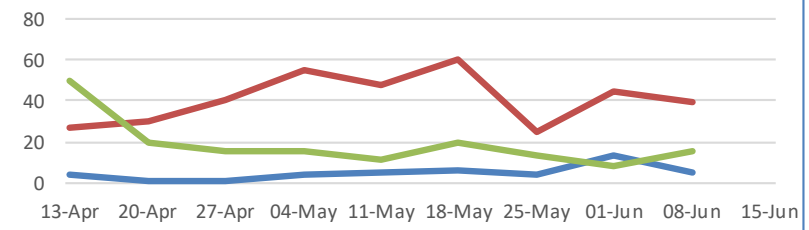
COVID-19 Commentary

- The number of 2WW referrals has declined since the middle of March, with April recording a 61% decrease in the number of referrals.
- Since the outbreak QVH have seen a large decrease in the number of GDP referrals due to the severe reduction in dentistry services.
- The week of 1st July saw a rise in the number of head and neck referrals – first time since the outbreak referrals have been higher than this time last year.
- Skin referrals have remained steady

Cancer Hub Referral Activity

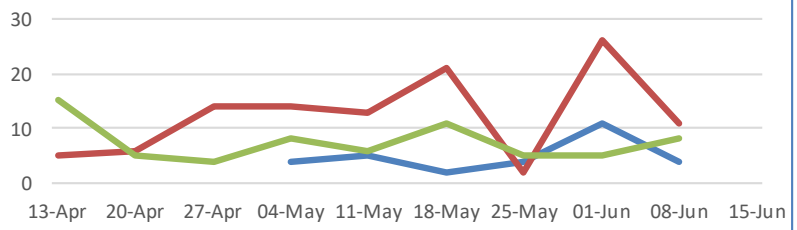
Queen Victoria Hospital NHS Foundation Trust

Total No. Cancer Hub Referrals



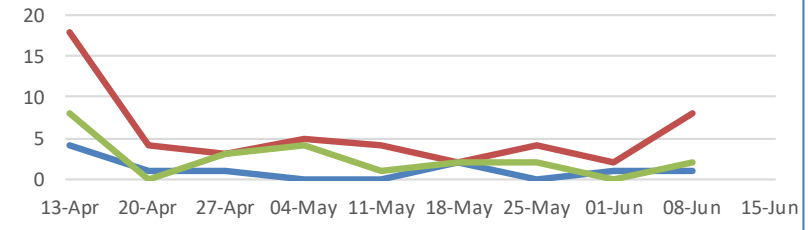
	13-Apr	20-Apr	27-Apr	04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun
Surrey	4	1	1	4	5	6	4	13	5	
Sussex	27	30	40	55	48	60	25	45	39	
Kent	50	20	16	16	11	20	13	8	16	

Breast: Cancer Hub Referral Numbers



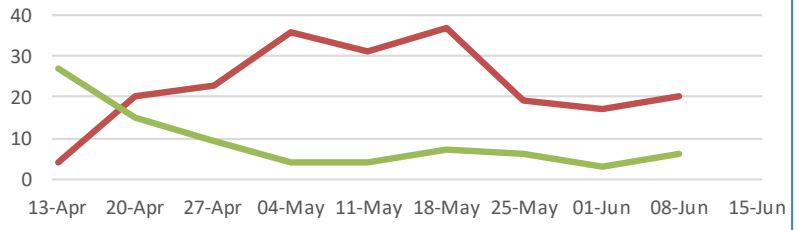
	13-Apr	20-Apr	27-Apr	04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun
Surrey				4	5	2	4	11	4	
Sussex	5	6	14	14	13	21	2	26	11	
Kent	15	5	4	8	6	11	5	5	8	

Head and Neck: Cancer Hub Referral Numbers



	13-Apr	20-Apr	27-Apr	04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun
Surrey	4	1	1	0	0	2	0	1	1	
Sussex	18	4	3	5	4	2	4	2	8	
Kent	8	0	3	4	1	2	2	0	2	

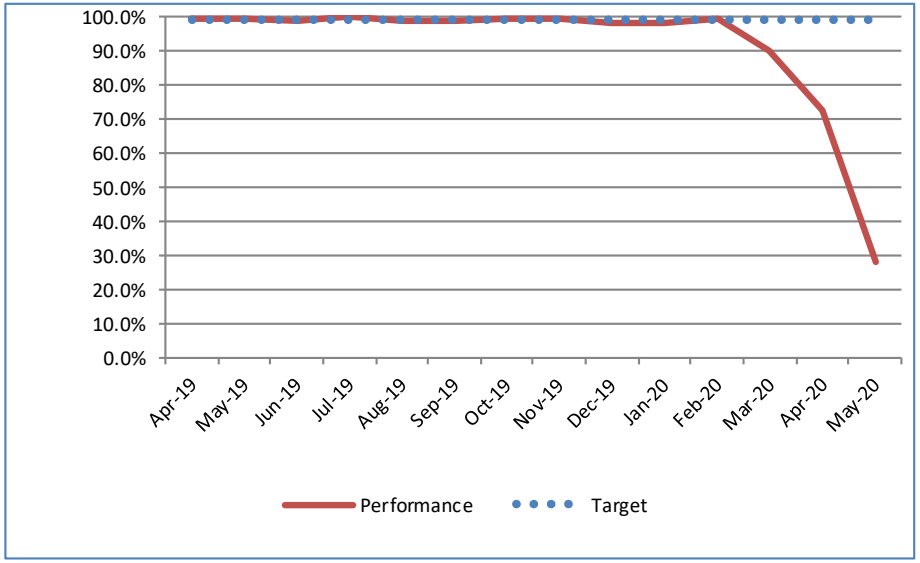
Skin: Cancer Hub Referral Numbers

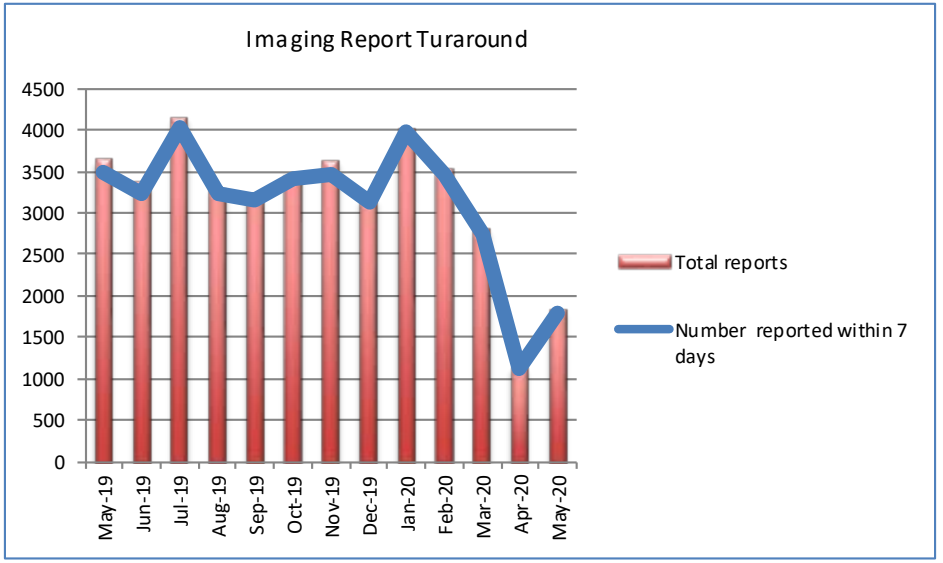


	13-Apr	20-Apr	27-Apr	04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun
Surrey						2		1		
Sussex	4	20	23	36	31	37	19	17	20	
Kent	27	15	9	4	4	7	6	3	6	

Diagnostic Performance

Queen Victoria Hospital
NHS Foundation Trust





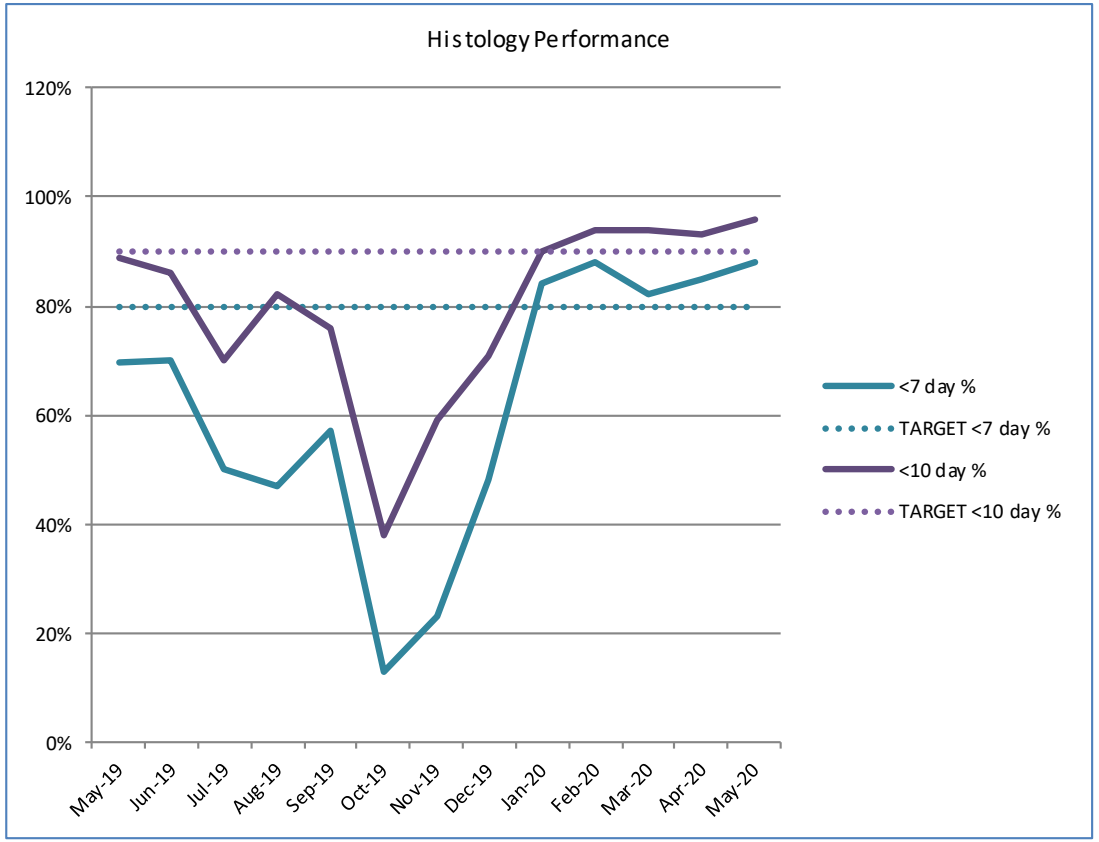
(Last reporting period – Apr20)			(This reporting period – May20)		
Modality / test	Breaches	Perf.	Modality / test	Breaches	Perf.
CT	1	97.50%	CT	35	16.67%
ECHOCARDIOGRAPHY	0	100.00%	ECHOCARDIOGRAPHY	0	100.00%
MRI	1	96.15%	MRI	7	41.67%
NON-OBSTETRIC ULTRASOUND	0	100.00%	NON-OBSTETRIC ULTRASOUND	33	41.07%
SLEEP STUDIES	52	1.89%	SLEEP STUDIES	53	22.06%

PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
Diagnostic Imaging • Fall in performance due to COVID-19 related step down • The majority of CT breaches were cone-bean due to the step of all dental and orthognathic activity • NOUS – routine deferred patients and patient choice impact **Sleep** • In April only 1 patient was seen within the 6 week period out of a total of 53 • In May 15 patients were 6 within 6 weeks out of a total of 68	**Diagnostic imaging** • Anticipate improved performance for MR and ultrasound due to establishing >70 / vulnerable patient dedicated lists and restoration of routine work • Ongoing challenges with CT and interventional work due to stood down activity. **Sleep** • Restoration of services to commence however reliant on PPE and patients willing to attend

Histology Turnaround Time (TAT)

Queen Victoria Hospital
NHS Foundation Trust

Month	Total Specimens Received	Total Cases Reported
Oct-18	1635	1196
Nov-18	1518	1144
Dec-18	1433	1149
Jan-19	1519	954
Feb-19	1413	1004
Mar-19	1413	1004
Apr-19	1322	870
May-19	1317	1024
Jun-19	1383	1422
Jul-19	1526	1171
Aug-19	1362	862
Sep-19	1275	955
Oct-19	1683	1210
Nov-19	1466	1059
Dec-19	1244	1145
Jan-20	1476	932
Feb-20	1337	997
Mar-20	1222	945
Apr-20	467	340
May-20	552	338



PERFORMANCE COMMENTARY

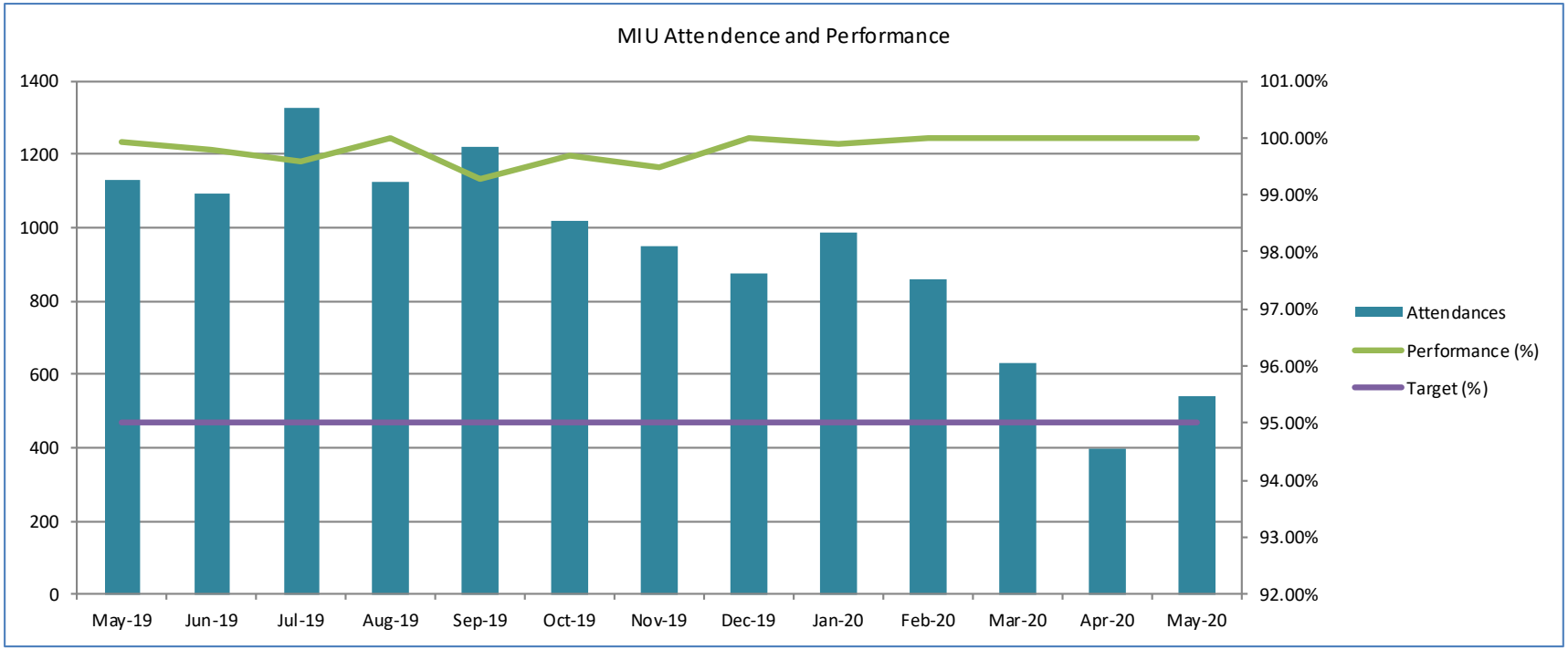
- Improved performance in line with recovery trajectory
- Appointment of one pathologist vacancy. Start date anticipated in September.
- On going cover through temporary staffing arrangements.

FORWARD LOOK / PERFORMANCE RISKS

- Ongoing vacancies present performance risks but mitigated through temporary arrangements in place
- Increase in major Head and neck resections cases anticipated due to cancer hub activity.

Minor Injuries Unit (MIU)

Queen Victoria Hospital
NHS Foundation Trust



PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
• Performance delivery on track	• Ongoing work towards the primary care/integrated service in line with NHSE and CCG proposals. • Decreased attendance mirroring regional picture across the patch with significantly reduced numbers of patients.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 July 2020**		**Agenda reference:**	**105-20**	
Report title:	**Financial performance**				
Sponsor:	Michelle Miles – Director of Finance and Performance				
Author:	Muhammad Khan – Senior Finance Business Partner				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide the Board with overview assurance of the Trust's financial performance.				
Summary of key issues	• The Trust I&E position is breakeven YTD at month 2 under Block Contract arrangements. • Expenditure run rate (both Pay and Non-Pay) in 20/21 is below 19/20 averages and is consistent with current activity levels. • The revenue and income budgets are still being finalised and will be updated in Q1 reporting. • Capital spending is on plan in year. The capital plan has been reviewed by EMT in light of the potential change of priorities due to the COVID pandemic. • The cash position for the Trust is still favourable due to the double payment in April. • Debtors, the overall debtor's position has improved favourable in month by just under £1m. Other debtors less than one year relate to the accrued income for the block payment as this is not invoiced. • Creditors, significant work has been undertaken on the non-NHS creditors to ensure suppliers through the pandemic are paid in a timely way.				
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):			**KSO3:** ***Operational excellence***	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	KS04 – Financial Sustainability				
Corporate risk register:	KS04 – Financial Sustainability				
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	22/06/20	Decision:	Noted	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Trust Finance Board Report
May 2020-21

Michelle Miles – Director of Finance and Performance

202021 M2 - Financial Performance Run Rate

Queen Victoria Hospital NHS
NHS Foundation Trust

Run Rate	2019/20											2020/21	
	2	3	4	5	6	7	8	9	10	11	12	1	2
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Income	5,432	5,998	6,344	6,003	6,596	6,215	5,379	5,504	5,228	5,172	7,899	6,158	6,079
Pay Expenditure	(4,193)	(4,289)	(4,347)	(4,160)	(4,389)	(4,259)	(4,150)	(4,165)	(4,205)	(4,124)	(4,287)	(4,140)	(4,092)
Non Pay Expenditure	(2,405)	(2,449)	(2,262)	(2,586)	(2,416)	(2,494)	(2,175)	(2,447)	(2,320)	(2,195)	(3,655)	(2,018)	(1,987)
Surplus / (Deficit)	**(1,166)**	**(740)**	**(265)**	**(743)**	**(209)**	**(538)**	**(946)**	**(1,109)**	**(1,297)**	**(1,148)**	**(42)**	**0**	**0**

		2019-20											2020-21	
Final Accounts Line	**Board Line**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**1**	**2**
INCOME	Patient Activity Income	-4,992	-5,621	-5,961	-5,572	-6,200	-5,798	-5,023	-4,683	-5,219	-4,824	-7,885	-5,606	-5,663
	Other Income	-440	-377	-383	-431	-396	-416	-356	-821	-9	-348	651	-552	-416
	Comprehensive Income	0	0	0	0	0	0	0	0	0	0	-665	0	0
INCOME Total		**-5,432**	**-5,998**	**-6,344**	**-6,003**	**-6,596**	**-6,215**	**-5,379**	**-5,504**	**-5,228**	**-5,172**	**-7,899**	**-6,158**	**-6,079**
PAY EXPENDITURE	Substantive	3,806	3,761	3,769	3,686	3,831	3,802	3,697	3,729	3,791	3,695	3,879	4,019	3,930
	Bank	212	300	330	249	418	233	236	264	261	297	122	105	142
	Agency	175	227	248	224	141	225	217	173	153	132	286	16	19
PAY EXPENDITURE Total		**4,193**	**4,289**	**4,347**	**4,160**	**4,389**	**4,259**	**4,150**	**4,165**	**4,205**	**4,124**	**4,287**	**4,140**	**4,092**
NON PAY EXPENDITURE	Clinical Services & Supplies	1,296	1,156	1,089	1,317	1,223	1,203	917	1,130	1,128	886	915	785	650
	Drugs	118	119	142	122	125	104	138	129	124	119	115	15	25
	Consultancy	-7	2	1	3	35	8	37	48	21	32	26	56	3
	Other non pay	560	732	645	721	641	758	659	716	710	746	2,119	719	893
	Depreciation and amortisation	295	295	287	286	292	286	286	286	200	276	359	285	285
	Non Operational Expenditure	144	145	100	137	101	135	137	138	137	136	120	158	132
NON PAY EXPENDITURE Total		**2,405**	**2,449**	**2,262**	**2,586**	**2,416**	**2,494**	**2,175**	**2,447**	**2,320**	**2,195**	**3,655**	**2,018**	**1,987**
Grand Total		**1,166**	**740**	**265**	**743**	**209**	**538**	**946**	**1,109**	**1,297**	**1,148**	**42**	**0**	**0**

Income
YTD Patient Activity Income- Block Contract £11.09m YTD, Other Income, £963k of which, £299k LDA, £196k for Provider to Provider contracts (P2P).

Pay
Substantive- Above average but below M1 cost which was higher due to clinical excellence payments in the main.
Bank staffing cost though below average but higher then last month resulting mainly from Additional Medics sessions. Agency cost down in line with activity

on Pay Drugs and Clinical Supplies cost down relative to the activity with main variance within CPAP devices, Outsourcing, sterile Services, Medical and Surgical equipment and disposables

Capital – M2 2020/21

Queen Victoria Hospital NHS Foundation Trust

	Year to Date £'000			Forecast Outturn £'000			
	Plan	Actual	Variance	Original Plan	Revised Plan	Actual	Variance
Estates Projects							
Outpatients department upgrades	0	0	0	200	200	200	0
Replacement theatre pendants	0	0	0	150	150	150	0
Rehab. unit refurbishment	0	0	0	120	120	120	0
Fire door replacements	0	0	0	102	102	102	0
Other	20	20	0	391	485	485	(0)
Total Estates Projects	**20**	**20**	**0**	**963**	**1,057**	**1,057**	**(0)**
Medical Equipment							
Fluoroscopy	0	0	0	396	396	464	(68)
Other	5	5	0	127	146	146	0
Toatl Medical Equipment	**5**	**5**	**0**	**523**	**542**	**610**	**(68)**
Information Management & Technology (IM&T)							
Clincal portal	0	0	0	372	372	372	0
Other	100	100	0	431	513	536	(23)
Total Information Management & Technology (IM&T)	**100**	**100**	**0**	**803**	**885**	**908**	**(23)**
Contingency				**738**	**543**	**452**	**91**
Total 2020/21 Programme	**125**	**125**	**0**	**3,027**	**3,027**	**3,027**	**(0)**
Covid-19 Expenditure	64	64	0		250	250	
Total	**189**	**189**	**0**		**3,277**	**3,277**	

Summary

The 2020/21 capital programme has been set at £3,027k, excluding Covid-19 expenditure. This is QVH's apportioned share of the overall Sussex Health and Care Partnership capital envelope allocated by NHSI/E. It is funded from the Trust's own resources, ie depreciation. Covid-19 related expenditure will be funded by Public Dividend Capital (PDC) granted by NHSE/I.

Initially, EMT gave outline approval for projects totalling £2,289k, leaving an unallocated contingency reserve of 738k. Subsequently a number of items have been authorised from the contingency reserve and the plan has been revised accordingly. Other projects are now expected to exceed plan and are shown as forecast overspends, at present balanced by further reductions in the contingency reserve.

Capital expenditure incurred as a result of Covid-19 will require approval at national level. Forecast expenditure shown here is awaiting final approval.

Balance Sheet – M2 2020/21

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet

	Year to Date £'000				Forecast Outturn			Change	
	Prior Year Outturn	Plan	Actual	Variance	Plan	Actual	Variance	In Month	In Year
Non Current Assets									
Fixed Assets	52,723	52,339	52,339	0	52,339	52,339	0	(297)	(384)
Other Receivables	227	227	227	0	227	227	0	0	0
Total Non Current Assets	**52,950**	**52,566**	**52,566**	**0**	**52,566**	**52,566**	**0**	**(297)**	**(384)**
Current Assets									
Inventories	1,153	1,162	1,162	0	1,162	1,162	0	5	9
Trade and other Receviables	8,543	925	925	0	925	925	0	(1,099)	(7,618)
Cash and Cash Equivalents	2,910	9,572	9,572	0	9,572	9,572	0	1,698	6,662
Total Current Assets	**12,606**	**11,659**	**11,659**	**0**	**11,659**	**11,659**	**0**	**604**	**(947)**
Current Liabilities									
Trade and other Payables	(12,329)	(9,725)	(9,725)	0	(9,725)	(9,725)	0	343	2,604
Borrowings	(7,332)	(7,394)	(7,394)	0	(7,394)	(7,394)	0	(49)	(62)
Provisions	(62)	(62)	(62)	0	(62)	(62)	0	0	0
Total Current Liabilities	**(19,723)**	**(17,181)**	**(17,181)**	**0**	**(17,181)**	**(17,181)**	**0**	**294**	**2,542**
Subtotal Net Current Assets	**(7,117)**	**(5,522)**	**(5,522)**	**0**	**(5,522)**	**(5,522)**	**0**	**898**	**1,595**
Total Assets less Current liabilties	**45,833**	**47,044**	**47,044**	**0**	**47,044**	**47,044**	**0**	**601**	**1,211**
Non Current Liabilties									
provisions for Liabilities and charges	(881)	(881)	(881)	0	(881)	(881)	0	0	0
Non Current liabilties > 1 year	(4,512)	(4,512)	(4,512)	0	(4,512)	(4,512)	0	0	0
Total Non Current Liabilties	**(5,393)**	**(5,393)**	**(5,393)**	**0**	**(5,393)**	**(5,393)**	**0**	**0**	**0**
Total assets Employed	**40,440**	**41,651**	**41,651**	**0**	**41,651**	**41,651**	**0**	**601**	**1,211**
Tax Payers Equity									
Public Dividend Capital	13,106	13,106	13,106	0	13,106	13,106	0	0	0
Retained Earnings	13,645	14,856	14,856	0	14,856	14,856	0	601	1,211
Revaluation Reserve	13,689	13,689	13,689	0	13,689	13,689	0	0	0
Total Tax Payers Equity	**40,440**	**41,651**	**41,651**	**0**	**41,651**	**41,651**	**0**	**601**	**1,211**

Cash held is higher than previous operating balances due to the current operating regime of monthly block payments made in advance (5.9m).
Trade receivables is currently artifically low due to the block income regime of paying in advance (approx £5.9m)]
Note that block income receipts are not invoiced and the PBR billing arrangements have been suspended.
Current Borrowings mainly reflect the NHSi revenue support loans taken to support the previous cash deficit operating position.
These revenue loans of £6.391m will not be payable in cash but plan to be redeemed through the issue of public dividend capital.
Trade payables has reduced in year reflecting steps to authorise payables and also reduced activity.

Cash flow– M2 2020/21

Queen Victoria Hospital NHS Foundation Trust

Cashflow

	Actual £'000		Forcast £'000									
	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Opening Balance	2,911	7,874	9,571	5,543	5,441	4,057	3,302	3,016	3,091	3,059	2,227	2,050
Receipts												
Receipts from contract income	12,826	7,399	5,543	5,543	5,543	5,543	5,543	5,543	5,543	5,543	5,543	5,543
Receipts from other income	132	439	177	798	229	323	264	164	237	180	136	345
PSF Funding	-	-	-	-	-	-	-	-	-	-	-	-
E-Observation Funding from DHSC	-	-	-	-	-	-	-	-	-	-	-	-
PDC For Projects	-	-	-	-	-	-	-	-	-	-	-	-
Interim Cash Loans	-	-	-	-	-	-	-	-	-	-	-	-
Total Receipts	12,958	**7,838**	**5,720**	**6,341**	**5,772**	**5,866**	**5,807**	**5,707**	**5,779**	**5,723**	**5,679**	**5,887**
Payments												
Payments to NHS Bodies	(453)	(254)	(1,105)	(399)	(704)	(320)	(144)	(405)	(336)	(584)	(149)	(361)
Payments to non-NHS bodies	(3,440)	(1,789)	(2,164)	(2,034)	(2,374)	(1,625)	(1,811)	(1,126)	(1,079)	(1,895)	(1,636)	(1,452)
Net payroll payment	(2,333)	(2,261)	(2,227)	(2,254)	(2,341)	(2,279)	(2,305)	(2,311)	(2,207)	(2,322)	(2,285)	(2,271)
PAYE, NI & Levy payment	(1,113)	(1,154)	(1,094)	(1,102)	(1,083)	(1,063)	(1,139)	(1,090)	(1,087)	(1,083)	(1,119)	(1,104)
Pensions Payment	(656)	(683)	(637)	(632)	(631)	(639)	(672)	(677)	(616)	(649)	(645)	(768)
PDC Dividends Payment	-	-	-	-	-	(673)	-	-	-	-	-	(698)
Theatre Loan Repayment	-	-	(470)	-	-	-	-	-	(465)	-	-	-
Interest On Working Capital Loan	-	-	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)
Total Payments	**(7,995)**	**(6,141)**	**(7,719)**	**(6,443)**	**(7,155)**	**(6,621)**	**(6,093)**	**(5,632)**	**(5,812)**	**(6,554)**	**(5,856)**	**(6,674)**
Net Cash Movement	**4,963**	**1,697**	**(1,999)**	**(102)**	**(1,383)**	**(755)**	**(286)**	**75**	**(33)**	**(832)**	**(177)**	**(787)**
Actual Closing Balance	**7,874**	**9,571**										
Forecast Closing Balance			**5,543**	**5,441**	**4,057**	**3,302**	**3,016**	**3,091**	**3,059**	**2,227**	**2,050**	**1,263**
20/21 NHSI Plan	**1,556**	**1,652**	**1,333**	**1,490**	**1,466**	**1,069**	**1,395**	**1,766**	**1,067**	**1,012**	**1,083**	**1,263**
Variance to NHSI Plan	**6,318**	**7,919**	**4,210**	**3,951**	**2,591**	**2,233**	**1,621**	**1,325**	**1,992**	**1,215**	**967**	**(0)**

Summary

.The cash balance at the end of month 2 has a favourable variance of £7.92m against the original plan submitted to NHSi. This is largely due to collections relating to older performance invoices and the advance payment of £5.9m recieved in relation to contracted activity

.The cash position will continue to be reviewed and managed on a daily basis and loan requirements reviewed monthly in liaison with NHSi.

.Financial services will work with commissioners to ensure payments are made in a timely manner and older debts controlled.

Debtors – M2 2020/21

Queen Victoria Hospital NHS
NHS Foundation Trust

Debtors

	Jun 19/20 £'000	Jul 19/20 £'000	Aug 19/20 £'000	Sep 19/20 £'000	Oct 19/20 £'000	Nov 19/20 £'000	Dec 19/20 £'000	Jan 19/20 £000	Feb 19/20 £000	Mar 19/20 £000	Apr 20/21 £000	May 20/21 £'000	In Month Change £000
NHS Debtors													
0-30 Days Past Invoice Due Date	600	603	736	2,417	2,051	778	918	774	2,477	3,570	2,277	345	**(1,932)**
31-60 Days Past Invoice Due Date	253	436	384	(506)	124	601	139	156	(150)	(86)	242	1,769	**1,527**
61-90 Days Past Invoice Due Date	589	(9)	(72)	148	87	385	741	103	75	20	376	(276)	**(652)**
Over 90 Days Past Invoice Due Date	3,204	2,594	2,234	2,348	1,458	1,913	2,062	2,640	2,658	1,935	2,307	2,609	**301**
Total NHS Debtors	**4,646**	**3,623**	**3,282**	**4,408**	**3,721**	**3,677**	**3,861**	**3,673**	**5,061**	**5,440**	**5,202**	**4,447**	**(756)**
Non NHS Debtors													
0-30 Days Past Invoice Due Date	185	62	78	68	76	190	164	245	155	757	709	80	**(629)**
31-60 Days Past Invoice Due Date	0	168	26	17	9	3	10	107	17	7	112	596	**484**
61-90 Days Past Invoice Due Date	478	9	146	28	12	1	3	5	88	17	7	110	**103**
Over 90 Days Past Invoice Due Date	180	595	755	647	674	707	406	422	367	474	461	340	**(121)**
Total Non NHS Debtors	**843**	**833**	**1,006**	**759**	**771**	**902**	**582**	**779**	**626**	**1,256**	**1,288**	**1,126**	**(163)**
Other Debtors Less Than One Year	2,142	2,348	2,262	1,873	2,389	1,976	1,881	1,495	1,558	1,847	7,787	14,008	
Total Debtors	**7,631**	**6,805**	**6,550**	**7,040**	**6,881**	**6,555**	**6,324**	**5,947**	**7,245**	**8,542**	**14,278**	**19,581**	
NHS : Non NHS ratio	*0.85*	*0.81*	*0.77*	*0.85*	*0.83*	*0.80*	*0.87*	*0.82*	*0.89*	*0.81*	*0.80*	*0.80*	

Summary

▪The trade debtor balance reduced by £0.9m (14%) from month 1

▪The month 2 debtor balance of £19.6m is 171% higher than the avarage monthly balance in 2019-20. This is largely due to accurued income of £13.1m for contracted activity in months I and 2. The income for these have been received by the Trust but have not been invoiced for in line with NHSI/E released guidance due to the Covid crisis.

Next steps

▪Financial Services would continue working closely with Business Managers and the Contracting team to ensure billing is accurate, timely and resolutions to queries are being actively pursued.

Creditors- M2 2020/21

Queen Victoria Hospital NHS
NHS Foundation Trust

Creditors

	Jun 19/20 £'000	Jul 19/20 £'000	Aug 19/20 £'000	Sep 19/20 £'000	Oct 19/20 £'000	Nov 19/20 £'000	Dec 19/20 £'000	Jan 19/20 £000	Feb 19/20 £000	Mar 19/20 £000	Apr 20/21 £000	May 20/21 £'000	In Month Change £'000
NHS Creditors													
0-30 Days Past Invoice Due Date	431	710	830	474	636	818	497	665	663	950	1,115	1,182	66
31-60 Days Past Invoice Due Date	179	76	88	593	195	84	483	122	35	485	165	163	(1)
61-90 Days Past Invoice Due Date	319	199	75	74	620	208	138	568	135	44	416	412	(5)
Over 90 Days Past Invoice Due Date	1,080	1,401	1,081	1,048	1,160	1,480	1,541	1,399	1,669	1,806	1,790	1,821	31
Total NHS Creditors	**2,009**	**2,385**	**2,073**	**2,189**	**2,612**	**2,591**	**2,660**	**2,754**	**2,503**	**3,285**	**3,486**	**3,577**	**91**
Non NHS Creditors													
0-30 Days Past Invoice Due Date	900	1,592	1,448	741	1,243	1,316	1,510	1,293	2,080	2,318	993	764	(229)
31-60 Days Past Invoice Due Date	97	253	94	147	229	252	208	109	87	149	170	72	(99)
61-90 Days Past Invoice Due Date	165	75	115	103	95	15	78	238	178	78	20	7	(13)
Over 90 Days Past Invoice Due Date	207	345	263	204	202	163	278	245	117	266	230	111	(119)
Total Non NHS Creditors	**1,368**	**2,265**	**1,922**	**1,196**	**1,769**	**1,746**	**2,074**	**1,885**	**2,462**	**2,811**	**1,414**	**954**	**(459)**
Other Creditors Less Than One Year	(77)	(816)	(858)	(55)	(530)	(214)	(941)	(973)	(860)	(660)	(570)	(716)	
Total Creditors	**3,300**	**3,834**	**3,136**	**3,330**	**3,851**	**4,123**	**3,792**	**3,666**	**4,105**	**5,435**	**4,330**	**3,816**	
NHS : Non NHS ratio	***0.59***	***0.51***	***0.52***	***0.65***	***0.60***	***0.60***	***0.56***	***0.59***	***0.50***	***0.54***	***0.71***	***0.79***	

Summary

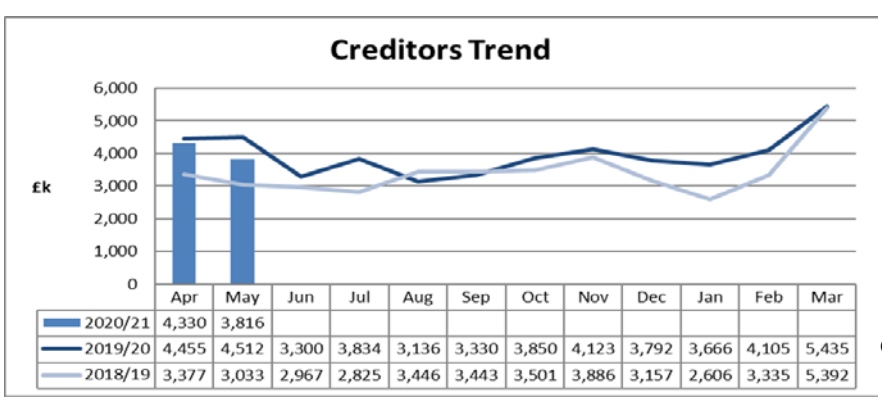
.The trade creditors balance reduced by £0.37m (8%) from month 1

.The Trust's BPPC percentage has reduced in month by 11% and the average days to payment has increased to 27 days. Accounts payable are taking action on invoices awaiting authorisation to address underperformance.

Next Steps

.Financial services are continuing to review areas where invoice authorisation is delayed in order to target and support training needs.

.NHSI/E has released guidance to speed up payments in light of the Covid crisis. The team are working with all budget holder to clear invoices as quickly as possible.



Better Payment Practice Code (20/21) May	2019/20 Outturn No Invs	2019/20 Outturn £k	Current Month No Invs	Current Month £k	YTD No Invs	YTD £k
Total **Non-NHS** trade invoices paid	20,007	41,045	935	2,943	2,549	7,498
Total **Non NHS** trade invoices paid within target	17,187	36,510	746	2,489	2,203	6,619
Percentage of Non-NHS trade invoices paid within target	**86%**	**89%**	**80%**	**85%**	**86%**	**88%**
Total **NHS** trade invoices paid	1,033	5,074	42	262	152	1,007
Total **NHS** trade invoices paid within target	754	3,945	25	128	111	647
Percentage of NHS trade invoices paid within target	**73%**	**78%**	**60%**	**49%**	**73%**	**64%**

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 July 2020**		**Agenda reference:**	**106-20**	
Report title:	**Budget Setting Methodology**				
Sponsor:	Michelle Miles – Director of Finance and Performance				
Author:	Michelle Miles – Director of Finance and Performance				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide the Board with an overview assurance of the Trust's Budget Setting Methodology				
Summary of key issues	The report shows the methodology to be adopted by the Trust for setting the budgets for the financial year 20/21. The paper shows the variations to where the planned budget setting via the Operating Plan Submission differs to the revised approach to be adopted by the Trust. Business planning which supports the Trusts operating plan was suspended due to the Covid pandemic. During this time the way the Trust is funded has been changed to a block contract arrangement and top up facility to take into consideration 'reasonable' costs for Covid. However at present the cost base to the organisation has remained relatively static apart from variable costs such as clinical supplies, agency spend, drugs etc. Over the coming months the cost base will change in line with the restoration and recovery phases for the Trust and the budgets will need to change accordingly to ensure that the Trust is able to maintain cost control in a changing environment. The budget setting process will be reviewed in line with national guidance as issued and will be updated as appropriate during the financial year.				
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):			**KSO3:**	**KSO4:**	**KSO5:**
			Operational excellence	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	KS04 – Financial Sustainability				
Corporate risk register:	KS04 – Financial Sustainability				
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	25/05/20	Decision:	Noted	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Budget Setting Methodology Update 20/21

Michelle Miles – Director of Finance and Performance

Budget Setting Methodology for 20/21

Queen Victoria Hospital NHS
NHS Foundation Trust

Due to the Covid pandemic the NHS has suspended Business Planning for 20/21 and is currently under a block contract arrangement. This block arrangement has now been extended to the 31st of October.

This means that QVH is being paid a fixed amount each month for months April – October. This has been calculated on the costs incurred by the Trust during November 19 – January 20 uplifted for inflation, these payments will be amended over the coming months to ensure that only reasonable costs for covid are being incurred. During this time no Trust is allowed to make a surplus, deficits will only occur when expenditure is out of line to normal run rate trends for spend other than reasonable costs for Covid. This will be monitored through the monthly returns as normal.

The difficulty in setting budgets in 20/21 is that the activity has changed significantly, however fundamentally the staffing remains the same for QVH spend and non pay will reflect the changes for Covid but will also reflect an underspend where activity is currently not being undertaken. Hence the approach to have a clear base to help to try and monitor the changes in activity levels and types over the coming months. This document helps to explain the hybrid approach to budget setting for 20/21, with the knowledge that things may change fundamentally in year.

Budgets will be set in line with the Business Unit Changes, Corporate changes and to reflect Annual Accounts analysis. At present initial drafts will be sent in prior changes hierarchy to be amended and authorised during sign off process.

Suggested way forward for Income, set for full year subject to in year guidance change.

Income

- Budget for Block contract to be set in line with current block payments for months 1-7
- Provider to provider contracts budgets to be set based on current contract levels
- Other income to be reviewed during block contract arrangement period and budget set as appropriate including HEE income etc.
- Balance of Income v's expenditure to be budgeted for top up

When Business Planning Guidance is known, follow national methodology for business planning for NHS Income, tariff, efficiencies etc.

Budget Setting Methodology for 20/21

Queen Victoria Hospital NHS
NHS Foundation Trust

The basis of the submitted operating plan was based on the recurrent full year effect of ongoing operations : establishments and non-pay costs I.E. the forecast outturn adjusting for non recurrent items. This baseline then triangulates with the activity plans which services will be monitored against in the fist instance to understand the changes in activity due to Covid

In essence this removed any variation to the budget, so where

1) Non Recurrent items, these mainly relate to the removal of the payments to other providers for health care. A provision has been created centrally for this in 20/21 and will be released when costs occur. These non recurrent items have been updated for the final year end position. A full review is to be undertaken via EMT for final approval.

2) Cost pressures agreed during Operating planning round. All still seem valid, however further reviews for covid cost pressures to be undertaken. All will be allocated from month 1 with the exception of the PDC and loans which are subject to further review when the national guidance is release. A full review has be undertaken via EMT for final approval.

3) Incremental drift and pay inflation – Pay inflation is 1.7% for 20/21 and 1.2% for incremental drift on average. All will be allocated from month 1 into budgets.

4) Drugs Inflation – 2% again will be allocated from month 1 into budgets.

5) CNST 3.2% in line with notification pre Christmas 2019, allocated from month 1

6) Full review to be undertaken for Non PbR Drugs and devices during the block contract period to ensure in line with last years spend. Also to highlight if costs are in excess for the first 4 months on last years base period.

7) Reserves to be reviewed when BP guidance is issued, but £400k of contingency still to be allocated from month 1.

8) CIP's to be allocated to budgets in line with BP guidance when known. It is likely that these will remain at the same level of 1.6% from month 8.

Pay Analysis

Queen Victoria Hospital NHS
NHS Foundation Trust

Pay Analysis	Sum of Annual budget	Sum of Outturn 2019-20	Sum of Non Recurrent Items- Full Years Value	Recurrent Outturn	20/21 Operating Plan	Budget Change Compared to 20/21 Draft Operating Plan
1.1 PLASTICS	7,211,772	7,266,563	-41,392	7,225,171	7,246,883	35,111
1.2 ORAL	5,134,815	5,219,164		5,219,164	5,184,570	49,755
1.3 EYES	1,909,922	2,045,691	-103,115	1,942,576	1,920,195	10,273
1.4 SLEEP	1,269,840	1,256,021	2,147	1,258,168	1,285,119	15,279
1.5 CLINICAL SUPPORT	7,386,036	7,092,019	-54,291	7,037,728	7,068,699	-317,337
1.6 PERIOPERATIVE CARE	10,185,732	10,231,728	-853	10,230,875	10,261,376	75,644
1.7 OPERATIONAL NURSING	7,184,269	6,931,558	-197	6,931,361	6,870,498	-313,771
2.1 CLINICAL INFRASTRUCTURE	1,147,321	1,003,769		1,003,769	1,011,054	-136,267
2.5 DIRECTOR OF NURSING	2,435,539	2,403,939	-42,907	2,361,032	2,317,933	-117,606
3.1 NON CLINICAL INFRASTRUCTURE	2,082,784	2,118,978	-21,714	2,097,264	2,089,182	6,398
3.2 COMMERCE & FINANCE	2,371,528	2,462,056	-145,782	2,316,274	2,326,593	-44,935
4.1 HUMAN RESOURCES	885,900	814,145	-1,675	812,470	809,861	-76,039
5.4 CORPORATE	1,787,546	1,769,432		1,769,432	1,696,854	-90,692
Grand Total	**50,993,004**	**50,615,064**	**-409,780**	**50,205,285**	**50,088,815**	**-904,189**

Positive = increase to 19/20 budget Negative = decrease to 19/20 budget

The above table is the lower level of detail as to how the budgets will look for pay using the Operating Plan methodology for 20/21. Reserves have been removed to aid review.

19/20 outturn was c£400k better than budget, but reviewing on a recurrent basis with the non recurrent adjustments removed the position was c£800k better than budget.

By setting 20/21 on outturn plus adjustments the budgets for 19/20 will reduce by £900k as detailed above.

When looking at the recurrent outturn overall for 19/20, this was only £116k different (higher) than the proposed 20/21 Operating plan.

If budgets were reintroduced at 19/20, we would increase our budgeted deficit by £904k, which may also increase the actual deficit if posts are recruited to, however the 19/20 is a sound basis to start this financial year as the ledger and ESR are fully reconciled.

Non Pay Analysis

Queen Victoria Hospital NHS
NHS Foundation Trust

Non Pay Analysis	Sum of Annual budget	Sum of Outturn 2019-20	Sum of Non Recurrent Items- Full Years Value	Recurrent Outturn	20/21 Operating Plan	Budget Reduction compared to 20/21 Plan	Comments
1.1 PLASTICS	1,725,218	1,861,396	-462,316	1,399,080	1,326,624	-398,594	£437k relates to purchase of healthcare
1.2 ORAL	2,466,691	2,331,855	-117,237	2,214,618	2,361,954	-104,737	£117k relates to purchase of healthcare
1.3 EYES	1,255,080	1,322,078	-322,891	999,187	1,031,142	-223,938	£337k relates to purchase of healthcare
1.4 SLEEP	1,475,556	1,980,726		1,980,726	2,044,817	569,261	£480k relates to High cost devices & £60k relates to drugs
1.5 CLINICAL SUPPORT	2,803,046	2,497,930	11,344	2,509,273	2,511,882	-291,164	Underspends
1.6 PERIOPERATIVE CARE	2,967,912	3,557,919	-383	3,557,536	3,337,917	370,005	Increase in spend £250k in last 2 months
1.7 OPERATIONAL NURSING	1,026,695	1,016,744	-7,342	1,009,402	1,022,385	-4,310	
2.1 CLINICAL INFRASTRUCTURE	89,305	130,991	-12,370	118,620	121,238	31,933	CIP Target
2.5 DIRECTOR OF NURSING	1,299,968	1,499,194	-1,341	1,497,852	1,465,463	165,495	Med & Surg Maintenance equipment - in cost pressures
3.1 NON CLINICAL INFRASTRUCTURE	3,197,076	3,433,704	-2,852	3,430,852	3,447,005	249,929	£50k patient transport - £170k utility bills
3.2 COMMERCE & FINANCE	1,170,570	1,227,040	-3,584	1,223,456	1,275,565	104,995	Increase in contracts & BI Support
4.1 HUMAN RESOURCES	388,854	383,697	-50,000	333,697	326,848	-62,006	External one off funding
5.4 CORPORATE	118,580	176,393	-304	176,089	165,312	46,732	CIP Target
Grand Total	**19,984,551**	**21,419,668**	**-969,276**	**20,450,391**	**20,438,152**	**453,601**	

The above table is the lower level of detail as to how the budgets will look for non pay using the Operating Plan methodology for 20/21. Reserves have been removed to aid review.

By setting 20/21 on outturn less c£1m of non recurrent items the budgets for 19/20 will overall increase by c£500k as detailed above. The main area which will be affected is clinical support where c£300k will be removed which was underspent in 19/20.

This methodology will also remove unidentified CIP's from 19/20 c£600k in the budgets.

A full review of the excluded devices & drugs will be undertaken to ensure no distortion of reporting in 20/21

Proposed Recommendations

Queen Victoria Hospital NHS
NHS Foundation Trust

The proposed recommendations of Budget Setting for 20/21 is as follows, however needs to be reflective of a significantly fast pace environment subject to renewed guidance, with total clarity on the basis of the assumption and how that triangulates from historic information to forecast activity. The detail of the recommendations can be seen in appendix 1.

Income

- Budget for Block contract to be set in line with current block payments for months 1-7
- Provider to provider contracts budgets to be set based on current contract levels
- Other income to be reviewed during block contract arrangement period and budget set as appropriate including HEE income etc.
- Balance of Income v's expenditure to be budgeted for top up

Pay – Hybrid of Operating plan Submission

As the outturn position would remove posts and part posts it was felt that this would significantly hinder the clarity of the establishment for 20/21. Therefore the starting position of the Pay budget is 19/20 budgets, overspends in 19/20 were all less than £100k and minimal and mainly due to excessive agency therefore no allocation will be made for overspends in 20/21 likewise with the underspends. However the four areas which significantly underspent will be reviewed with the Finance Business Partner, Budget Holder and lead Executive to remove the excess budget and establishment to ensure that the cost base does not increase.

Pay

- 19/20 Budget
- Agreed Cost pressures
- Incremental drift & Inflation
- 20/21 Budget

Non Pay – As per Operating Plan Submission, this includes the removal of the c£600k unidentified CIP in 19/20 as based on outturn

- 19/20 Outturn
- 19/20 Non recurrent items adjustments (Appendix 2) – Mainly due to Purchase of Health care which will be held centrally and allocated as spend occurs
- 19/20 Recurrent Baseline
- Agreed Cost Pressures (Appendix 3)
- Inflation
- CNST
- 20/21 Budget

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Date: 19th June 2020

Strategic Objective
We seek to be the best place to work by maintaining a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce

Risk
- Staff lose confidence in the Trust as place to work due to a failure to offer: a good working environment; fairness and equality; training and development opportunities ; and a failure to act on feedback to managers and the findings of the annual staff survey.
- Insufficient focus on recruitment and retention across the Trust leading to an increase in bank and agency costs and having longer term issues for the quality of patient care

Risk Appetite The Trust has a **moderate appetite** for risks that impact on Organisational Excellence. The engagement and motivation of the workforce, supported by evidence based research, will impact on patient experience

Rationale for risk current score
- National workforce shortages in key nursing areas particularly theatres
- Generational changes in workforce, high turnover in newly qualified Band 5 nurses in first year of employment
- 2-3 years to train registered practitioners to join the workforce
- Over 40,000 nursing vacancies in England, circa 1,700 in SHCP
- managers skill set in triangulating workforce skills mix against activity and financial planning
- SHCP case for change supported by a workforce strategy
- NHS Interim People Plan published, action plan awaited
- Staff survey results and SFFT staff engagement have shown some improvement, and this has continued with the latest 2019 national staff survey results
- Addressing the reasons for retention is challenging as pressures on managers/leaders can lead to a reluctance to adopt new ways of working and support significant change
- Overseas nurses arriving starting to have a positive impact
- KPI's stable even through pandemic
- Availability and willingness of staff to undertake WLI activity

Initial Risk 3(C)x 5(L)=15, moderate
Current Risk Rating 4(C)x 4(L)=16, major
Target Risk Rating **3**(C)x 3(L) = 9 moderate

Future risks
- An ageing workforce highlighting a significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility.
- Developing new health care roles -will change skill mix
- Unknown impact of strategic direction of Trust into management group
- Unknown impact of COVID-19 pandemic on workforce recruitment and retention
- Staff who are shielding/vulnerable, including BAME Staff not being able to return to full duties as pandemic continues with requirement to undertake full risk assessments

Future Opportunities
- Closer partnership working with Sussex Health and Care Partnership. This includes through LWAB whole system leadership and talent management initiatives , best place to work programmes and collaborative resourcing
- Capitalise on our work as a cancer hub as a place to work

Controls / assurance
- more robust workforce/pay controls as part of business planning and weekly vacancy control
- Leading the Way, leadership development programme funded for a further year 2020/21
- All works streams captured in one People and OD Strategy
- monthly challenge to Business Units at Performance reviews
- Investment made in key workforce e-solutions, TRAC, E-job plan ongoing, HealthRoster implemented, Activity Manager underway, capacity of workforce team improved
- Engagement and Retention plan actions ongoing, considerable improvements in some KPI's
- Overseas recruitment continues, but with delays, with nurses on site and most with PIN
- The Trust commissioned an external Well Led review and regularly updates the resulting action plan
- Work to finalise ESR hierarchy with ledger, now regularly aligned for reporting purposes
- Some positive gains from the 2019 NHS Staff survey results and SFFT
- Stay Well Team, health and wellbeing initiative established to support staff through the pandemic

Gaps in controls / assurance
- Management competency in workforce planning
- Continuing resources to support the development of staff – optimal use of apprenticeship levy budget
- Unknown longer term impact on overseas recruitment due to pandemic

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**2 July 2020**		**Agenda reference:**	**108-20**	
Report title:	**Workforce Report – June Report – May Data**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Authors:	Lawrence Anderson, Deputy Director of Workforce Felicity King, Workforce Services Manager				
Appendices:	Workforce Report – KPI's and narrative				
Executive summary					
Purpose of report:	The Workforce and OD report for June 2020 (May 2020 data) is again provided in a different format due to the impact of the pandemic and changes to Committee meetings structure Workforce KPI's and trajectories are provided as usual. The main body of the report provides a narrative to place the KPI's in context and provides the Finance and Performance Committee with an overview of the impact of COVID-19 on different aspects of workforce activity including concerns about the disproportionate impact on staff from a BAME background.				
Summary of key issues	Improving trends in key workforce indicators are generally continuing and are likely to stabilise in some areas due to the pandemic.				
Recommendation:	The committee is asked to note the report				
Action required *[highlight **one** only]*	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	**KSO1:** ***Outstanding patient experience*** ✓	KSO2: *World-class clinical services* ✓	KSO3: *Operational excellence* ✓	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence*** ✓
Implications					
Board assurance framework:	-KSO5. Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care -Engaged and motivated staff deliver better quality care (KSO1)				
Corporate risk register:	Impact of pandemic on workforce availability				
Regulation:	Well Led				
Legal:	n/a				
Resources:	Managed by HR/OD with support from finance, operations and nursing				
Assurance route					
Previously considered by:					
	Date:		Decision:	Information	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Workforce & Organisational Development

Workforce Report – June 2020

(Data Reporting Period - May 2020)

KPI Summary

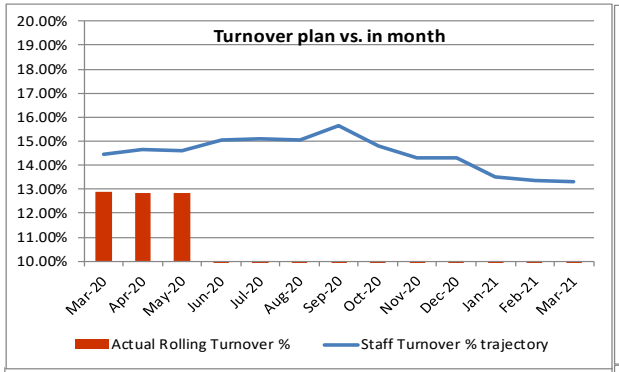
Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020/21			May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Compared to Previous Month
Establishment WTE *Note 1				1000.54	1000.54	1000.54	1000.54	1007.59	1007.59	1007.59	1007.59	1007.59	1007.59	1007.59	1007.59	**1007.59**	◄►
Staff In Post WTE				885.27	885.00	887.06	889.53	890.03	896.27	897.82	893.60	891.18	901.25	914.01	907.53	**913.06**	▲
Vacancies WTE				115.27	115.54	113.48	111.01	117.56	111.32	109.77	113.99	116.41	106.34	93.58	100.06	**94.53**	▼
Vacancies %	>12%	8%<>12%	<8%	11.52%	11.55%	11.34%	11.10%	11.67%	11.05%	10.89%	11.31%	11.55%	10.55%	9.29%	9.93%	**9.38%**	▼
Agency WTE				34.47	34.06	33.40	28.17	23.73	16.06	12.88	15.25	15.53	13.27	13.72	6.22	**3.77**	▼
Bank WTE *Note 2				67.29	69.22	74.90	77.85	76.20	72.24	72.98	63.86	70.34	71.63	72.90	34.07	**31.38**	▼
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	15.67%	16.25%	16.38%	16.42%	14.94%	14.79%	14.55%	13.49%	13.75%	13.65%	12.90%	12.86%	**12.84%**	▼
Monthly Turnover				1.10%	1.28%	1.09%	1.56%	1.33%	1.22%	0.85%	0.38%	1.48%	0.45%	0.96%	0.68%	**1.05%**	▲
12 Month Rolling Stability % *Note 3	<70%	70%<>85%	>=85%	84.04%	81.12%	83.40%	83.52%	82.12%	82.25%	81.95%	81.63%	80.99%	81.35%	85.53%	85.33%	**85.46%**	▲
Sickness Absence %	>=4%	4%<>3%	<3%	2.55%	2.77%	2.58%	1.83%	2.57%	3.25%	3.41%	3.45%	3.01%	3.08%	4.37%	**3.06%**	*TBC*	▼
% staff appraisal compliant (Permanent & Fixed Term staff)	<80%	80%<>95%	>=95%	85.53%	88.19%	87.41%	88.24%	89.01%	84.62%	87.34%	87.94%	87.05%	86.44%	84.36%	81.40%	**80.02%**	▼
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 4	<80%	80%<>90%	>=90%	92.23%	92.71%	92.88%	93.32%	92.51%	92.26%	91.75%	92.46%	92.11%	94.47%	92.35%	91.51%	**91.91%**	▲

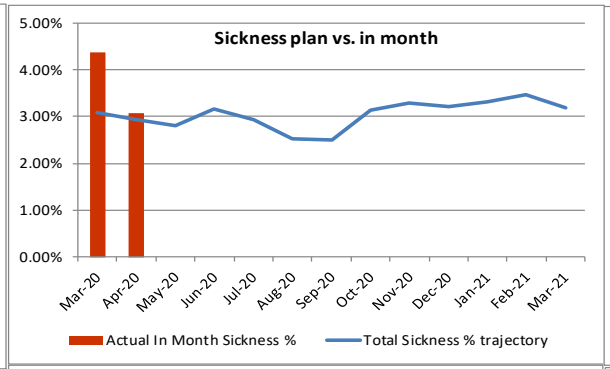
Friends & Family Test - Treatment Quarterly staff survey to indicate likelihood of recommending QVH to friends & family to receive care or treatment	**Measure** Extremely likely / likely % : Extremely unlikely / unlikely %	**2018-19 Quarter 4: Of 182 responses: 96.15% : 1.09%**	**2019-20 Quarter 1: Of 126 responses: 97.62% : 1.59%**	**2019-20 Quarter 2: Of 189 responses: 97.35% : 1.06%**	**2019-20 National Survey Of 572 responses: 92% : 2%**	**2019-20 Quarter 4: Of 344 responses: 95.35% : 2.61%**	Q2 19-20 & Q4 19-20 ▲Responses ▼ Likely ▲Unlikely
Friends & Family Test - Work Quarterly staff survey to indicate likelihood of recommending QVH to friends & family as a place of work	**Measure** Extremely likely / likely % : Extremely unlikely / unlikely %	**2018-19 Quarter 4: Of 182 responses: 73.62% : 13.73%**	**2019-20 Quarter 1: Of 126 responses: 74.60% : 14.29%**	**2019-20 Quarter 2: Of 189 responses: 71.73% : 12.07%**	**2019-20 National Survey Of 560 responses: 72% : 10%**	**2019-20 Quarter 4 Of 344 responses: 74.71% : 10.17%**	Q2 19-20 & Q4 19-20 ▲Responses ▲ Likely ▼Unlikely

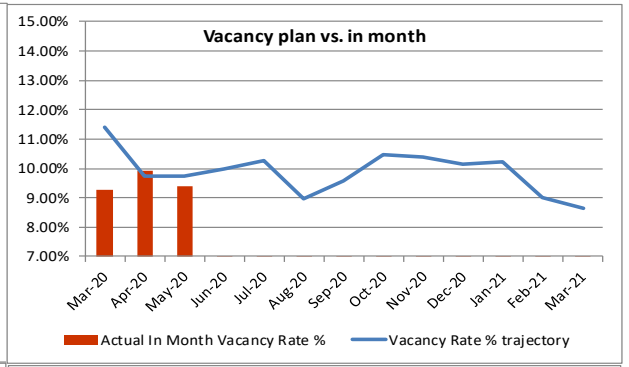
*Note 1 -2019/20 Establishment updated in September 2019 with in year changes
*Note 2 - Bank WTE does not include extra hours worked by medical staff within establishment or overtime worked by all staff groups.
*Note 3 - 12 month rolling stability index added as an additional measure. This shows % of employees that have remained in employment for the 12 month period.
*Note 4 - RAG rating updated in June 2019 for Statutory & Mandatory Training. Compliance changed from 95% to 90% however,individual compliance remains at 100%

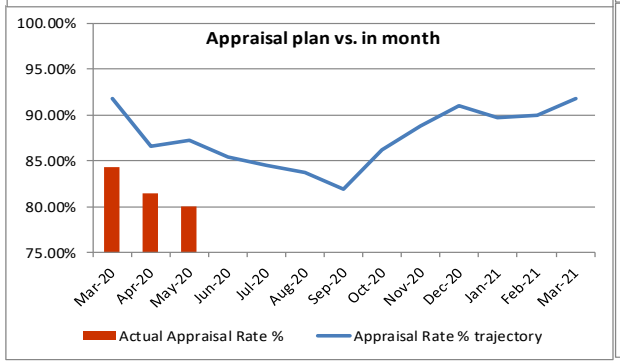
Trajectories

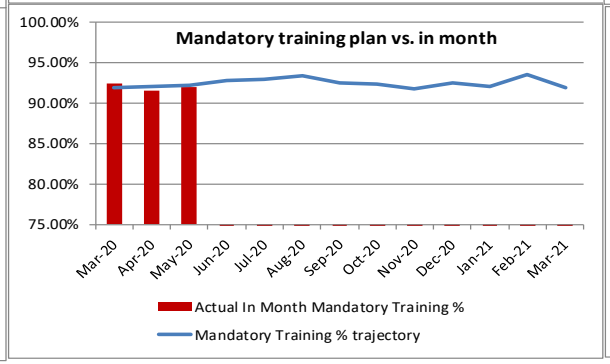
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Staff Turnover % trajectory	14.46%	14.66%	14.58%	15.04%	15.09%	15.06%	15.66%	14.79%	14.29%	14.29%	13.49%	13.38%	13.31%
Actual Rolling Turnover %	12.90%	12.86%	12.84%										
Total Sickness % trajectory	3.08%	2.93%	2.80%	3.15%	2.94%	2.53%	2.50%	3.14%	3.29%	3.21%	3.32%	3.46%	3.19%
Actual In Month Sickness %	4.37%	3.06%											
Vacancy Rate % trajectory	11.39%	9.73%	9.75%	9.97%	10.27%	8.98%	9.59%	10.47%	10.40%	10.16%	10.21%	9.00%	8.63%
Actual In Month Vacancy Rate %	9.29%	9.93%	9.38%										
Agency WTE usage trajectory	18.9	18.6	18.7	17.8	18.0	19.7	17.9	17.7	15.2	14.1	15.7	15.4	17.4
Actual agency WTE usage	13.7	6.2	3.8										
Appraisal Rate % trajectory	91.81%	86.64%	87.20%	85.40%	84.55%	83.71%	81.89%	86.18%	88.76%	90.94%	89.64%	89.91%	91.81%
Actual Appraisal Rate %	84.36%	81.40%	80.02%										
Mandatory Training % trajectory	91.96%	91.98%	92.23%	92.71%	92.88%	93.32%	92.51%	92.26%	91.75%	92.46%	92.11%	93.46%	91.96%
Actual In Month Mandatory Training %	92.35%	91.51%	91.91%										

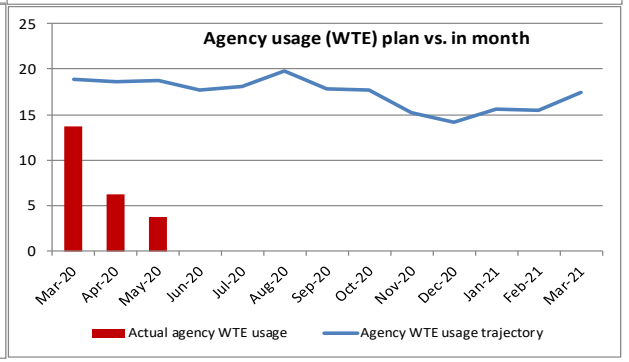












May QVH Workforce Summary for May 2020 Data

Headlines:

- Our staff in post has increased from April. Our May 20 position ended on 913.06 WTE and a vacancy rate of 9.38%
- There were 4.03 WTE starters in May; 2.23wte in Perioperative Services including 1wte HCA and 1.23wte qualified staff. Others were in radiology and plastics. There were more leavers in May totalling 8.55wte 3wte qualified nursing in Perioperative Services, 1.8wte in pharmacy and other leavers were spread across clinical support, corporate and Oral. 3.6wte were retirements, 0.85wte end of fixed term contract, 4.1wte for Voluntary reasons. 2wte retirements in Perioperative Services are planning to return substantively.
- Turnover (12 month rolling) has slightly reduced and remained stable ending the month with a position of 12.84%. Our 12-month rolling stability has remained at the same level as last month at 85.46%.
- Temporary staffing usage has reduced significantly this month in line with the Trust current circumstances. Agency has reduced to the lowest recorded to 3.77wte. Agency usage was seen in Medics Plastic Surgery, Pharmacy, Contracts and Theatres. Qualified nursing usage decreased to an all-time low of 0.23wte. Bank has also reduced from last month in every directorate other than Plastics and Oral where an increase of medical bank was recorded. Qualified Nursing, non-clinical and other AHP and ST&T usage declined. Increases has been seen in HCA and medical and dental usage.
- Trust absence in **April** has reduced to expected QVH levels for this time of year, ending slightly above our KPI at 3.06%. Absence was evenly distributed between long-term and short-term sickness. Increases were seen in Sleep, Access and Outpatients and Plastics all other directorates decreased. Cold cough and Flu had the most absence occurrences with 40, followed by gastrointestinal problems (12 occasions) and Anxiety/stress/depression/other psychiatric illnesses (10 occasions). Of the 40 occurrences for Cold Cough and Flu 31 of these were recorded as COVID - 19 related and of these 12 were new cases in April, rather than absence starting in March and ending in April. Cases were spread across business units but Operational nursing saw the highest with 4 new cases in April.
- Appraisals have decreased this month to 80.02%. Decreases were seen in Access and Outpatients, Plastics, and Corporate that all reported below 75%. All other directorates have increased. Director of nursing has the highest compliance with 97.50%
- MAST has increased on last month to 91.91%. Increases were seen in Operational Nursing, Eyes and Perioperative Services, decreases were seen in other directorates however some only very slightly. Worst performing competencies are Moving and handling level 2 and infection control.

COVID-19 May Summary including support for the BAME workforce

Indicative figures for May 20 suggest sickness figures are 1.93% of which 0.10% was Covid -19 related. Absence figures have reduced as managers are correctly recording as self/household isolation rather than general sickness. In total there were 128 occurrences of self/household isolation for May

We have investigated at QVH whether Covid- 19 is disproportionately effecting our BAME staff compared to staff who identified as white. Our findings are that;

- For May out of the total of 128 isolation occurrences 17 staff members (17.53%) identified as BAME.
- In May of the 5 recorded sickness occasions 0 were from staff who identified as BAME.
- In May it still showed that a larger percentage of staff who self-isolated identified as BAME, these figures will be available for July's report.

The Trust's updated Risk Assessment process has now been embedded and is being used for staff who are shielding, vulnerable or high risk (including BAME). Occupational Health have been in contact with all individuals who have completed and submitted a Risk Assessment or who are shielding to discuss their concerns and anxieties about returning to the workplace.

The trust continues to develop and improve the support provided to our staff. We are currently developing a clear process for people to follow when considering a return to the workplace, and also how to support any anxieties these individuals may have.

The trust continues to strive to provide as much support as possible to our BAME workforce. System wide listening events have taken place, and the Chief Executive and Director of Workforce have written to all staff regarding support mechanisms and events for our BAME staff. The Trust are also in discussions With NHS E/I regarding setting up staff networks to improve the support we are able to offer.

The Trust currently employs 1,101 substantive staff across the organisation. Of these 174 have declared to the Trust that are from a BAME background (15.8%). The Trust has a total of 220 individuals registered on our Bank as bank only workers. Of these 33 have declared that they are from a BAME background (15%).

Recruitment Update

Our Medway overseas nurse arrived on 27 April and is currently working in Theatres as a Band 5 Nurse on a temporary registration until the OSCE process is reopened and she can sit her final OSCE and gain NMC Registration. We have another 3 International Nurses in process still however start dates are on hold due to the current lockdown; we anticipate now with further delays due to COVID19 that 1 from Yeovil will arrive at QVH in December 2020 with the remaining 2 from Medway arriving at QVH in February 2021 following their mock OSCE time with Medway prior to coming here.

A proposed timetable is in place with the intake dates for the 6 nurses from Yeovil on the recently renewed agreement to arrive in February, May and August 2021 with no less than 2 arriving together to allow for a more structured induction to QVH and the ability to "buddy" up these new arrivals from landing in the UK through to gaining their full registration. From talks with those nurses already in post a more focused induction and OSCE preparation; with this time used for Occupational Health checks and ensuring that once full registration is received the nurses are able to work on full duties immediately.

Recruitment remains minimal with interviews still taking place via telephone and WebEx, new starters have also reduced with start dates being delayed until July/August and a significantly reduced number of vacancies being raised through EMT for advertising.

There has also been a significant reduction in bank and agency usage due to utilising our own staff.

Returners to the NHS to support the pandemic

There is no change from last month with in relation to both returners to the NHS, local residents registering for Bank HCA work and 2 final year nursing students working on C-Wing as Band 4 pre-registration nurses.

The decision was taken due to the service provision at QVH that we would not take additional returners and to instead utilise the workforce we have that are currently available where their normal service is reduced.

Maintaining Mandatory and Statutory Training (MAST) (national guidance)

At this time, all face-to-face training has been postponed with a few exceptions, where possible Covid-19 training is offered that covers some clinical required competencies. However, managers and staff are being encouraged to maintain their Statutory and Mandatory Training via eLearning or other available methods. Compliance reports are still issued to show what training needs to be completed.

We have delivered a successful pilot training session via WebEx for Safeguarding Adults and Children Level 2 and hope to run further sessions with our Subject Matter Experts (SME's). The hope is that in conjunction with eLearning, we can offer everyone a chance to dial into a live WebEx training Session hosted by the SME and then the OD & L team can manually award competencies for everyone that logs into the session. This however depends of having either WebEx access or Microsoft Teams functionality to run training sessions. This needs to be agreed and part of the restore and recover IT programme before we can offer/organise sessions from July 2020.

Appraisals

All managers are being encouraged via the workforce brief to have continuous conversations with staff at this time. It is recognised that whilst people are socially distancing and in some cases, working from home, it is important for 1-2-1 conversations' to happen. We are also advising that appraisals must continue to be carried out whilst adhering to social distancing measures and notify Workforce Services once these have been done.

Induction

Induction for new starters continues to be based on small socially distanced groups focused on a bespoke one-to-one input and covers MAST sessions delivered through a variety of methods including eLearning and some additional input for clinical staff based on risk assessments. A report has been written to consider modifying the current induction programme from two days non-clinical and 2 ½ days clinical to 1 day non-clinical and 1 ½ days clinical. There will be an expectation that a variety of delivery methods will be used (including pre-hire eLearning) which will enable us to streamline the programme. We are liaising with Resourcing and workforce services to consider the implications and processes in order to enable this.

For August, confirmation has been received that the full junior doctor rotation will take place, the largest doctors induction of the year. Plans have been finalised for an amended induction programme to ensure social distancing can be maintained. The Medical Education team are working with trainers, Medical Staffing, the DME and the Guardian of Safe Working to ensure a safe but still meaningful induction can be delivered. The Medical Education team are also facilitating the running of the Local Faculty Group meetings via WebEx, to ensure educational governance is maintained. All specialities have adapted their teaching programmes to ensure that education can continue to take place.

-ENDS-

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**2 July 2020**		**Agenda reference:**	**109-20**	
Report title:	**BAME disparity work programme and Board Assurance**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Author:	Geraldine Opreshko, Director of Workforce and OD				
Appendices:	Board Assurance Checklist (BAME disparity)				
Executive summary					
Purpose of report:	To inform the Board of the details of the disparity of the impact of COVID 19 on BAME people and provide a board assessment framework with which to assess progress in supporting our workforce				
Summary of key issues	Research has clearly shown that the BAME workforce is being disproportionately impacted by COVID-19 and that employers must rightly take action to engage with and protect staff that fall into this group. This paper provides a high level overview of the key aspects of the QVH WRES and our actions to date. It also includes a regionally provided Board Assurance checklist. The Board is ask to review this checklist and mitigations which will then be discussed in a dedicated Board seminar hosted by the lead from NHSI/E. The KPIs and progress will be reviewed regularly as part of the governance arrangements of the Trust.				
Recommendation:	The Board is asked to note the report and agree				
Action required *[highlight **one** only]*	Approval	**Information**	**Discussion**	Assurance	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	**KSO1:** ***Outstanding patient experience*** ✓	KSO2: *World-class clinical services* ✓	KSO3: *Operational excellence* ✓	**KSO4:** ***Financial sustainability***	**KSO5:** ***Organisational excellence*** ✓
Implications					
Board assurance framework:	-KSO5. Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care -Engaged and motivated staff deliver better quality care (KSO1)				
Corporate risk register:	Impact of pandemic on workforce availability including the requirement to undertake risk assessments for all vulnerable staff				
Regulation:	Well Led				
Legal:	n/a				
Resources:	Overseen and managed by HR/OD with input, support and engagement from finance, operations and nursing				
Assurance route					
Previously considered by:					
	Date:		Decision:	Information	
Next steps:					

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NHS Foundation Trust

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BAME disparity work programme

Board Assurance Checklist

More than 200 NHS and social care staff have died from COVID-19 (data 9th May). This is a tragic loss of valued health and social care colleagues.

Analysis of deaths of the first NHS and social care staff has shown that BAME staff are particularly affected and account for 21% of NHS staff but 63% of COVID-19 deaths; 20% of nursing and support staff but 64% of deaths and 44% of medics but 95% of deaths.

It is still not clear why this is the case, but research seems to be suggesting it may be partly because BAME staff are more likely to work on the front line in lower graded roles, may be less likely to raise concerns and more likely to be agency staff or night shift workers – groups that may be at additional risk.

QVH, in line with national guidance, included BAME staff as a vulnerable category for our COVID-19 risk assessments to ensure that managers are checking for any workplace factors that may increase risk as well as for any long-term health conditions. This is not an alternative to actually tackling the risks faced by staff, but recognises the evidence that some staff groups, notably BAME, are especially at risk.

QVH workforce race equality standard (WRES) data

The WRES data for 2019/20 is currently being complied in line with national guidelines. The most recent data was provided to Board in November 2019 in the Workforce Diversity Report 2018/19. The report covers the period 1 April 2018 – 31 March 2019. As a reminder:

- % of BAME staff in the workforce rose to 14.8% from 14.2% and there were more senior managers at Band 8a from a diverse ethnic background
- No BAME staff entered a formal disciplinary process, compared to two out of five cases in the previous reference period
- Those from a BAME group were nearly twice as likely to access non mandatory training and 64% of the BAME workforce engaged with the Leading the Way programme, twice the proportion of the rest of the workforce
- The variation between white and BAME experiences in the staff survey continued to improve in relation to harassment, bullying and abuse. However the Trust has a zero tolerance to any such behaviour so this will remain a concern
- The percentage of BAME staff believing that QVH provided equal opportunities for career development declined slightly in that 82.85% of BAME staff agree compared to 90.17% of white staff
- In terms of people reporting perceptions of discrimination at work from their manager/team leader this improved over the previous year at 12.96% compared to 16.07% in 2017/18.

However, this compares poorly to the comparator of white staff group reporting 4.11% so more work needs to be done and we hope will be reflected in the WRES for this year.

QVH Actions during pandemic

Since the concerning evidence of the disproportional impact of COVID-19 on BAME staff has come to light QVH has taken a number of steps to increase engagement with the BAME members of the workforce:

- Our risk assessment for staff deemed as vulnerable in line with Public Health England Guidelines was immediately updated to reflect the vulnerabilities of the BAME workforce
- A guidance document was sent to all staff but targeted at managers to help them have what may be perceived as difficult conversations
- Occupational Health will directly contact/be available for clinical risk assessments for BAME staff
- Guidance issued re the use of vitamin D
- Psychological support available at short notice through the Stay Well Team initiative
- A joint letter from Steve Jenkin and Geraldine Opreshko specifically highlighting our concerns and support for vulnerable staff
- Discussions at EMT, HMT and J/LNC on all issues and concerns.
- Steve Jenkin has sent out a couple of very specific blogs and the last one titled 'Actions that Make a Difference' specifically invited members of the BAME workforce to come forward who were interested in playing an active role in a BAME network. At the time of writing this had elicited at least 15 responses, all in a positive vein
- Steve Jenkin and Geraldine Opreshko have met with the NHSI/E regional Director for engagement and inclusion, Cavita Chapman and her deputy, to discuss the next steps in setting up a BAME staff network at QVH and the value of an EDI lead covering both staff and patients
- A proposal will follow for a Board Seminar facilitated by Cavita to ensure Board understanding of a long term commitment

Board Checklist

The Board checklist below is intended to be used to demonstrate that there is effective Board oversight over the risks outlined. As stated, research clearly has shown that specific staff groups, most notably BAME, are more likely to have health conditions that make then vulnerable to COVID-19. It also shows that BAME staff may be vulnerable to adverse treatment within the workplace which could exacerbate other risks. So it is important to pay particular attention to the risks for these staff.

The list of factors outlined in the table below is intended to support the work that QVH and other organisations has begun and to help ensure that risks form COVID-19 are minimised. There are a small number of these that have metrics (marked with *) and these will form part of the workforce report in future where possible and relevant. We are also likely to be required to report these on a regional basis.

The remainder of the narrative is intended to be a useful aide memoire and is based upon research and experience elsewhere with the NHS. It is important that we demonstrate a duty of care and will appropriately intervene where anything is raised.

This framework will be used as the basis for a Board seminar discussion and will come back to the September Board meeting with further details of the QVH specific actions and response.

Risk	Potential risk mitigation
1. Governance	
1.1 *Is the Board sighted on and has it put in place **appropriate accountability and resource into Covid-19 workforce assessment and support**?	Spot checks on any areas where higher than expected infection rates indicated by data or soft intelligence including concerns to Speak Up Guardians.
1.2 *Does your organisation hold **data** (disaggregated by White/BAME) that will demonstrate the effectiveness of engagement on COVID-19 and BAME staff?	*Collect **data** (disaggregated by White/BAME) on the following: a. Numbers of risk assessments as a proportion of the overall employed workforce b. Overall staff Covid-19 sickness absence (days) c. Proportion of staff (White/BAME) moved following a risk assessment d. Proportion of these groups of staff who have had a risk assessment **i.** returners, **ii.** agency staff, **iii.** newly qualified staff, **iv.** staff returning from sick and permanent night shift staff
1.3 *Is the Board clear on the additional risks BAME staff face? 1.4 Has the board considered the medium-term implications of the impact of Covid-19? 1.5 Is Occupational Health centrally involved in oversight and support?	*Describe how your organisation and system have used this data to influence your preparations for restoration and recovery planning?
1.6 Is there **BAME representation** in senior decision making/oversight? 1.7 Is your BAME Network fully involved in decision making around the risks to BAME staff?	Collect information on demographic make up of Gold Command.
1.8 Is there an emphasis, wherever possible on strong **staff engagement** to both receive suggestions and hear concerns, before significant changes in working practices? Bear in mind research, for example, the Francis Freedom to Speak Up report 2015 and recent reports indicate some groups of BAME staff are less likely to raise concerns either because they don't believe they will be heard or because of possible adverse consequences for them.	Clear, repeated messages from CEO Minimise redeployment of Speak Up Guardians. Ensure staff are signposted to them if they have concerns. Highlight examples where concerns were raised and have been were addressed. Where necessary, remind professional registrants that requirement to raise concerns remains in place.

1.9 Does your organisation hold **data** on staff Covid-19 sickness and staff Covid-19 deaths by department, grade, and protected characteristic? 1.10 Are you being proactive in using such data to triangulate with soft intelligence from areas of concern – and with other workforce data e.g. WRES and WDES - especially data for reported bullying?	Such data, used effectively, can enable early interventions to listen, support and act on concerns
2.0 Risk assessment and deployment	
2.1 Is there a focus to ensure some staff groups are specifically included in risk assessments e.g. **returners, agency staff, newly qualified staff, staff returning from sick or annual leave, and night shift staff**? It is important to ensure these groups are assessed as they may be especially vulnerable (e.g. RCN survey indicates temporary agency nurses are currently much less likely to be offered tests).	Is there clarity about the role of the agency in risk assessments and the role of the Trust in ensure safe working arrangements?
2.2 Is there effective management and governance to **follow up risk assessments** both for individuals and at employer wide basis?	
2.3 Do **deployment decisions** correlate with risk assessments i.e. done fairly and proportionately? There is growing evidence that BAME staff may be disproportionately redeployed to Covid-19 wards.	Monitor such decisions and ensure concerns raised are addressed – especially if deployment is not accompanied by safe PPE and working practices Some trusts have been collecting such data. You may want to do so going forward.
2.4 Are specific steps being taken proactively to ensure **BAME staff are specifically being risk assessed** not just for health risks but for exacerbating workplace treatment factors?	
3.0 Protection	
3.1 Is the **PPE Fit** process effective without disproportionate impact on some staff groups, notably BAME and female staff? Note: HSJ reports that younger female workers are twice as likely to die as other staff NHS Confederation, has published guidance about the use of PPE for staff, which includes information about cultural considerations.	Monitoring should specifically include BAME staff Be clear on consistent response if a staff member 'fails' a fit test - a particular BAME issue.

3.2 Are managers clear that **social distancing** must be observed in role/function including in spaces such as rest areas? How is that validated?	
4. Removal from risk areas	
4.1 Is the default position for staff who could effectively **work from home** or who have vulnerable family members at home that they work from home?	Ensure clarity in policy and monitor
4. 2 In reaching decisions about working from home or site, is there an acknowledgement of risks from travelling on **public transport** which should avoided wherever possible?	Revisit whether additional staff could work from home all or part of the time or be enabled to travel at quieter periods?
4.3 Is **social contact with co-workers** minimised with audit of open plan offices, shared workstations or hub environments and maximum use of homeworking? Are all possible similar steps taken in Outpatient clinics and reception areas?	
5.0 Tests	
5.1 Is there a transparent policy of **prioritisation** to include all staff identified by risk assessment as being at greater risk and any staff with additional exposure e.g. travelling to work?	
5.2 Do all staff know about rapid access testing for symptomatic staff and household members? 5.3 Are testing arrangements in place for staff in isolation or working from home?	Insert link to local test site here
5.4 Are all staff aware of the voluntary screening programme for asymptomatic staff?	Have managers reviewed whether the staff member has a means to access this testing programme and support them with this?
6.0 Engagement, communications and support	
6.1 Are managers confident (and do they get support) in having **honest and difficult conversations with BAME staff** about their circumstances?	Specific support should be offered to managers wherever possible
6. 2 Are BAME staff prominent in decision making on COVID 19 both through staff networks with access at Board level but also via other means e.g. senior BAME managers?	
6.3 Is there a clear **narrative** about this work, including EDI implications, owned by	

leaders and managers who are confident in sharing it?	
6.4 Are arrangements in place through STPs and more widely to identify, understand and **share better practice?**	
7.0 Mental and other health support	
7.1 What steps have been taken to understand the staff needs during and after the COVID 19 pandemic with particular attention to **BAME staff**?	
7.2 What support is in place for staff in **self-isolation** or who are or have been ill with COVID 19?	
7.3 Are staff aware that **psychological suppor**t is available for any staff member concerned about their vulnerability to COVID 19?	
7.4 Staff who do not wish to be withdrawn from an area contrary to their risk assessment–Should there be any staff who have been advised to not work in their current role or location, but who then wish to continue working in a role or location deemed unsafe for them, then the employer's duty of care is likely to be that such an outcome of their risk assessment would result in an instruction to follow the outcome.	

Source of table:

Guidance to support Risk Assessment for staff with potential work related exposure to COVID-19
Produced by COVID-19 BAME Mortality Disparity Advisory Panel, South East Region, NHS England and NHS Improvement
19th May 2020

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**4 July 2020**		**Agenda reference:**	110-20	
Report title:	**Approval of changes to Trust Standing Orders, Reservation of Powers and Scheme of Delegation and Standing Financial Instructions**				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Authors:	Clare Pirie, Director of communications and corporate affairs Michelle Miles – Director of Finance and Performance Hilary Saunders, Deputy company secretary				
Appendices:	Standing Financial Instructions Reservation of Powers/Scheme of Delegation Standing orders				
Executive summary					
Purpose of report:	The purpose of this paper is to seek board approval of changes to Trust's Standing Financial Instructions, Standing Orders and Reservation of Powers/Scheme of Delegation as recommended by the Audit committee				
Summary of key issues	At its meeting on 15 June, the Audit committee reviewed the Trust Corporate governance documents. After consideration of proposed amendments, these documents are now presented to the Board for formal approval.				
Recommendation:	For the Board to approve the revised Standing Orders and Reservation of Powers and Scheme of Delegation				
Action required	Approval	Information	Discussion	Assurance	**Review**
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	These documents are integral parts of the Trust's primary governing documents and are required by the regulator.				
Legal:	These documents were reviewed in detail by the Trust's legal advisors in 2016 and incorporate their advice and good practice recommendations. Changes to date do not have any legal implications.				
Resources:	None				
Assurance route					
Previously considered by:	EMT				
	Date:	01/06/20	Decision:	Proposed changes recommended	
Previously considered by:	Audit committee				
	Date:	15/06/20	Decision:	Proposed changes recommended	
Next steps:	If approved by the Board on 4 July, these documents will take immediate effect.				

Report to:	Board of Directors
Meeting date:	4 July 2020
Reference number:	110-20
Report from:	Clare Pirie, Director of communications and corporate affairs
Authors:	Michelle Miles – Director of Finance and Performance Clare Pirie, Director of communications and corporate affairs Hilary Saunders, Deputy company secretary
Appendices:	Standing Financial Instructions Reservation of Powers/Scheme of Delegation Standing orders
Report date:	16 June 2020

Annual review of corporate governance documents

Background

1. As required under S.12.3 of the Trust's current standing orders, a review of corporate governance documentation is undertaken each year, with recommendations for any changes submitted to the Audit committee prior to formal approval by the Board of Directors.

2. For the purpose of this report, corporate governance documentation comprises the Standing Financial Instructions, Reservation of Powers/Scheme of Delegation and Standing Orders

3. These documents provide a comprehensive framework for the functions of the Trust. All executive directors, non-executive directors and officers of the Trust should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Amendments

At the Audit committee which took place on 15 June, all present, including members of the Board reviewed and agreed the proposed changes, which had been track changed for ease of reference.

Recommendation

The Board is now asked to formally **approve** the attached revised Standing Financial Instructions, Reservation of Powers/Scheme of Delegation and Standing Orders. These will take immediate effect and be published to the Trust's website and intranet.

Queen Victoria Hospital NHS Foundation Trust

Standing financial instructions (also applicable to the Queen Victoria Hospital Trust Charitable Fund)

To be approved by the Board of Directors 2 July 2020

(Will be effective from 2 July 2020)

Contents

1 INTRODUCTION TO STANDING FINANCIAL INSTRUCTIONS

1.1 Purpose of the Standing Financial Instructions

1.1.1 The Standing Financial Instructions ("**SFIs**") explain the financial responsibilities, policies and procedures to be adopted by Queen Victoria Hospital NHS Foundation Trust ("**the Trust**"). These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust, They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness in all financial matter concerning the Trust. These SFIs should be used in conjunction with the Reservation of Powers to the Board and the Delegation of Powers adopted by the Trust.

1.1.2 These SFIs together with the Standing Orders and supported by the Reservation of Powers and Schemes of Delegation (SoD), provide a suite of governance documents for the Trust to operate within, and set the rules under which Directors, Officers and third parties contracted to the Trust are required to work.

1.1.3 These SFIs have been complied under authority of the Board of Directors of the Trust. They have been reviewed by the Audit Committee and by the Board of Directors and have their full approval.

1.1.4 Any questions relating to the SFIs should be referred to the Director of Finance & Performance, Deputy Director of Finance or their nominated Officer. Any questions relating to the Standing Orders should be referred to the Company Secretary. The SFIs and SoD are formally adopted by the Board of Directors and shall be reviewed annually by the Trust.

1.1.5 For the avoidance of doubt, the SFIs and SoD apply to all Trust and Charitable Funds activity, including research and development, training and education, joint ventures and special purpose vehicles, unless specific exceptions are described in the sections of this document covering those areas.

1.2 Interpretation and definitions

1.2.1 Save as otherwise permitted by law, at any meeting of the Board of Directors the Chair of the Trust (of the person presiding over the meeting) shall be the final authority on the interpretation of SFIs (on which he should be advised by the Chief Executive or the Director of Finance) and his decision shall be final and binding except in the case of manifest error.

1.2.2 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SFIs shall bear the same meaning as in the Standing Orders.

1.2.3 In these SFIs:

"**Budget**" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"**Budget Manager**" means the Director or Officer with delegated authority to manage finances (income and expenditure) for a specific area of the Trust;

"**Funds Held on Trust**" means those funds which the Trust holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable;

"**GBS**" means the Government Banking Service;

"**Officer**" means an employee of the Trust; and

"**SoD**" means the Scheme of Delegation.

1.2.4 Wherever the title Chief Executive, Director or other nominated Officer is used in these SFIs, this will include other officers who have been duly authorised to represent them.

1.2.5 References in these SFIs to 'Officer' shall be deemed to include all Officers of the Trust including any contractors/consultants, the Non-Executive Directors, temporary employees, locums and contracted staff.

1.3 Scope

1.3.1 These SFIs apply to all Officers in all locations, including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Trust. Failure to comply with the SFIs and SOs is a disciplinary matter that could result in dismissal.

1.4 Duties

1.4.1 All Officers of the Trust are required to comply with these SFIs. Delegation of duties can be found in the SoD.

1.5 Training and awareness

1.5.1 Post ratification, the document will be published to Trust's intranet and internet pages. The publication of the document will be highlighted to staff via communications issued by the Trust's corporate affairs department.

1.6 Equality

1.6.1 This document and protocol will be equality impact assessed in accordance with the Trust Procedural Documents Policy, the results of which are published on the Trust's internet page and recorded by the Trust's Equality and Diversity team.

1.7 Freedom of Information

1.7.1 Any information that belongs to the Trust may be subject to disclosure under the Freedom of Information Act 2000. This act allows anyone, anywhere to ask for information held by the Trust to be disclosed (subject to limited exemptions). Further information is available in the Freedom of Information Act 2000 Trust Procedure which can be viewed on the Trust Intranet.

1.8 Review

1.8.1 These SFIs will be reviewed on an annual basis from the date of ratification. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

1.9 Discipline

1.9.1 Failure to comply with or breaches of these SFIs will be investigated and may result in the matter being treated as a disciplinary offence under the Trust's disciplinary procedure, and may result in an employee's dismissal. Where such a breach results in clear financial loss, the Officer may be personally liable to compensate the Trust.

2 RESPONSIBILITIES AND DELEGATION

2.1 Overview

2.1.1 Roles and responsibilities of the Board of Directors, Committees, Directors and Officers of the Trust with regards to finance are set out below. Responsibilities are detailed in full in the SoD.

2.1.2 It should be noted that the Board of Directors remains accountable for all of its functions, even those delegated to the Chair, individual Directors or Officers, and should expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2.2 Role of the Board of Directors

2.2.1 The Board of Directors shall exercise financial supervision and control by:

(a) agreeing the Trust's financial strategy;

(b) requiring the submission of and approving annual financial plans, including revenue, capital and financing;

(c) approving policies such as these SFIs, SoD and Standing Orders for the Board of Directors in relation to financial control and ensuring value for money; and

(d) defining specific responsibilities placed on members of the Board of Directors and Officers as indicated in the SoD.

2.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the SoD.

2.2.3 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the SoD adopted by the Trust.

2.3 Role of the Finance and Performance Committee

2.3.1 In accordance with Standing Orders for the Board of Directors, the Board of Directors shall formally establish a Finance and Performance Committee with clearly defined terms of reference, which will provide an independent and objective view of financial and operational performance by:

(a) reviewing, interpreting and challenging in-year financial and operational performance;

(b) overseeing the development and delivery of any corrective actions plans and advise the Board of Directors accordingly; and

(c) receiving, reviewing and providing guidance to the Board of Directors as to the approval of investment programmes, cost improvement programmes and business cases.

2.3.2 The terms of reference for the Finance and Performance Committee shall be considered as forming part of these SFIs.

2.3.3 Where the Finance and Performance Committee feel there is a need to amend or modify the Trust's strategic initiatives in the light of changing circumstances or issues arising from implementation, the Chair of the Finance and Performance Committee should raise the matter at a full meeting of the Board of Directors.

2.4 Role of the Chief Executive

2.4.1 Within these SFIs, it is acknowledged that the Chief Executive is the Accounting Officer of the Trust.

2.4.2 The Chief Executive is ultimately accountable to the Secretary of State for ensuring that the Board of Directors meets it obligation to perform the Trust's functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board of Directors for ensuring that its financial obligations and targets are met.

2.4.3 The Chief Executive shall exercise all powers of the Trust that have not been retained as reserved by the Board of Directors or specifically delegated to a Committee. The SoD identifies functions that he/she shall perform personally and functions delegated to other Directors and Officers. All powers delegated by the Chief Executive can be re-assumed by them, should the need arise.

2.4.4 It is a duty of the Chief Executive to ensure that all existing Officers and new appointees are notified of their responsibilities within these SFIs.

2.4.5 The Chief Executive and Chair must ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.

2.4.6 The Chief Executive is responsible for ensuring 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 The Chief Executive may determine that powers devolved under this document and the detailed SoD be taken back to a more senior level – for example, areas of the Trust that are deemed to be in financial recovery may be given a reduced level of devolved autonomy.

2.4.8 In accordance with guidance issued by the Regulator, the Chief Executive is responsible for ensuring that the Trust provides an annual forward plan to the Regulator each year, together with quarterly reports (or more frequent if required

by NHS improvement), which should be appropriately communicated to the Board of Directors and the Council of Governors.

2.4.9 If the Chief Executive is absent powers delegated to them may be exercised by the acting Chief Executive after taking appropriate advice from the Company Secretary, and consulting with the Chair as necessary.

2.5 Role of the Director of Finance

2.5.1 The Director of Finance is responsible for the following:

(a) advising on and implementing the Trust's financial policies and co-ordinating any corrective action necessary to further these policies;

(b) design, implementation and supervision of systems of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these SFIs;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to report, with reasonable accuracy, the financial position of the Trust at any time;

(d) provision of financial advice to other members of the Board of Directors and Officers; and

(e) preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.6 Corporate responsibilities of all members of the Board of Directors and Officers

2.6.1 All members of the Board of Directors and Officers of the Trust, are severally and collectively responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders for the Board of Directors, these SFIs, SoD and all Trust policies and procedures.

2.6.2 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2.6.3 For any Officers of the Trust who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and Officers of the Trust discharge their duties must be to the satisfaction of the Director of Finance.

2.7 Scheme of delegation

2.7.1 The principles of the SoD are as follows:

(a) no financial or approval powers can be delegated to an Officer in excess of the powers invested in the delegating Officer;

(b) powers may only be delegated to Officers within the organisational control of the delegating Officer;

(c) all delegated powers must remain within the financial and approval limits set out in the SoD;

(d) all powers of delegation must be provided in writing, duly authorised by the delegating Officer. Any variations to such delegated powers must also be in writing.

(e) all applications for short term powers of delegation, such as holiday cover, which are not intended to be permanent must be provided in writing by the delegating Officer, prior to the period for which approval is sought.

(f) any Officer wishing to approve a transaction outside their written delegated powers must in all cases refer the matter to the relevant line manager with adequate written powers, before any financial commitments are made in respect of the transaction.

(g) powers may be delegated onwards unless this is specifically prohibited by the delegator; and

(h) conditions or restrictions on delegated powers, e.g. not allowing onward delegation of those powers, should be reasonable in the circumstances and stated in writing.

3 AUDIT

3.1 References

3.1.1 The Board of Directors shall establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the Trust's auditors.

3.2 Audit Committee

3.2.1 In accordance with Standing Orders for the Board of Directors, the Board of Directors shall formally establish an Audit Committee with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) overseeing internal and external audit services (including agreeing both audit plans and monitoring progress against them);

(b) receiving reports from the internal and external auditors (including the external auditor's management letter) and considering the management response;

(c) monitoring compliance with Standing Orders for the Board of Directors and these SFIs;

(d) reviewing schedules of losses and compensations and making recommendations to the Board of Directors;

(e) reviewing the information prepared to support the annual governance declaration statement prepared on behalf of the Board of Directors and advising the Board of Directors accordingly;

as set out in the terms of reference approved by the Board of Directors.

3.2.2 The terms of reference for the Audit Committee shall be considered as forming part of these SFIs.

3.2.3 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Audit Committee wish to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors.

3.3 Director of Finance's role in audit

3.3.1 In relation to audit, the Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function;

(b) Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) ensuring the production of the annual governance statement, and audited document for inclusion within the Trust's annual report, prepared in accordance with the prevailing guidance from the Regulator;

(d) provision of annual reports including a strategic audit plan covering the forthcoming three (3) years, a detailed plan for the next year, and progress against plan over the previous year, and regular reports on progress on the implementation of internal audit recommendations;

(e) ensuring that there is effective liaison with the relevant counter fraud services regional team or NHS Counter Fraud Authority on all suspected cases of fraud and corruption and all anomalies which may indicate fraud or corruption before any action is taken; and

(f) deciding at what stage to involve the police in cases of misappropriation and other irregularities.

3.3.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transaction, including documents of a confidential nature. This includes work diaries;

(b) access at all reasonable times to any land, premises or members of the Board of Directors or Officers of the Trust;

(c) the production of any cash, stores or other property of the Trust under the control of a member of the Board of Directors of an Officer; and

(d) explanations concerning any matter under investigation.

3.4 Role of internal audit

3.4.1 The internal audit shall:

(a) provide an independent and objective assessment for the Chief Executive, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance arrangements support the achievement of the Trust's objectives;

(b) operate independently of the decisions made by the Trust and its Officers; and of the activities which it audits. No member of the team of the Internal Audit will have executive responsibilities.

3.4.2 Internal audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from fraud, bribery and other offences, waste, extravagance, inefficient administration, poor value for money or other causes.

3.4.3 Internal audit shall also independently assess the process in place to ensure the assurance frameworks are in accordance with current guidance from the Regulator.

3.4.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, including any act which involves the giving or receiving of bribes, the Director of Finance must be notified immediately.

3.4.5 The lead internal auditor will normally attend meetings of the Audit Committee and have a right of access to all members of the Audit Committee, the Chair and Chief Executive of the Trust.

3.4.6 The lead internal auditor will be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Lead Internal Auditor. The agreement shall be in writing and shall be reviewed at least every three (3) years.

3.5 Role of external audit

3.5.1 The Trust is to have an external auditor appointed (or removed) by the Council of Governors based on recommendations from the Audit Committee, who must ensure that external audit is providing a cost effective service that meets the prevailing requirements of the regulator and other regulatory bodies.

3.5.2 External audit responsibilities will vary from time to time in compliance with the requirements of the regulator, and are to:

(a) be satisfied that the statutory accounts, quality accounts and annual report (and the external auditor's own work) comply with the prevailing guidance including relevant accounting standards;

(b) be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources, reported by exception;

(c) issue an independent auditor's report to the Council of Governors, certify the completion of the audit and express an opinion on the accounts; and

(d) to refer the matter to the regulator if an Officer makes or is about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.

3.5.3 External auditors will ensure that there is a minimum of duplication of effort between, them, internal audit and other relevant regulators, recognising the limitations that apply to external audit being able to rely on other work to inform their own work.

3.5.4 The Trust will provide the external auditor with every facility and all information which it may reasonably require for the purposes of its functions.

3.6 Fraud and corruption

3.6.1 In line with their responsibilities, the Chief Executive and the Director of Finance shall monitor and ensure compliance with guidance issued by the Regulator or the NHS Counter Fraud Authority on fraud and corruption in the NHS.

3.6.2 The Director of Finance is responsible for the promotion of counter fraud measures within the Trust and, in that capacity, he will ensure that the Trust co-operates with NHS Counter Fraud Authority to enable them to efficiently and effectively carry out their respective functions in relation to the prevention, detection and investigation of fraud in the NHS.

3.6.3 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist, as specified by the NHS Counter Fraud Authority.

3.6.4 The Director of Finance will ensure that the Trust's local counter fraud specialist received appropriate training in connection with counter fraud measures and that he is accredited by the Counter Fraud Professional Accreditation Board.

3.6.5 Where the Trust appoints a local counter fraud specialist whose services are provided to the Trust by an outside organisation, the Director of Finance must be satisfied that the terms on which those services are provided are such to enable

the local counter fraud specialist to carry out his functions effectively and efficiently and, in particular, that he will be able to devote sufficient time to the Trust.

3.6.6 The local counter fraud specialist shall report directly to the Director of Finance and shall work with NHS Counter Fraud Authority.

3.6.7 The local counter fraud specialist and the Director of Finance will, 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.

3.6.8 The local counter fraud specialist shall be afforded the opportunity to attend Audit Committee meetings and other meetings of the Board of Directors, or its committees, as required.

3.6.9 The Director of Finance will ensure that the local counter fraud specialist:

(a) keeps full and accurate records of any instances of fraud and suspected fraud;

(b) reports to the Board any weaknesses in fraud-related systems and any other matters which may have fraud-related implications for the Trust;

(c) has all necessary support to enable him to efficiently, effectively and promptly carry out his functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of his work;

(d) receives appropriate training and support, as recommended by NHS Counter Fraud Authority; and

(e) participates in activities which NHS Counter Fraud Authority is engaged, including national anti-fraud measures.

3.6.10 The Director of Finance must, subject to any contractual or legal constraints, require all Officers to co-operate with the local counter fraud specialist and, in particular, that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention or detection of fraud.

3.6.11 The Director of Finance must also prepare a “fraud response plan” that sets out the action to be taken both by persons detecting a suspected fraud and the local counter fraud specialist, who is responsible for investigating it.

3.6.12 Any Officer discovering or suspecting a loss of any kind must either immediately inform the Chief Executive and the Director of Finance or the local counter fraud specialist, who will then inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, and corruption or of anomalies that may indicate fraud or corruption then the particular circumstances of the case will determine the stage at which the police are notified; but such circumstances should be referred to the local counter fraud specialist.

3.6.13 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance must immediately notify:

(a) the Board of Directors; and

(b) the auditor.

3.7 Staff expenses

3.7.1 The Director of Finance shall be responsible for establishing procedures for the management of expense claims submitted by Officers on forms approved by the Director of Finance. The Director of Finance shall arrange for duly approved expense claims to be processed locally or via the Trust's payroll provider. Expense claims shall be authorised in accordance with the SoD.

3.7.2 Expenses should be claimed monthly. Any claims older than three months will not be paid unless approval is obtained from the Director of Finance.

3.8 Acceptance of gifts, hospitality and sponsorship by Officers

3.8.1 The Company Secretary shall ensure that all Officers are made aware of the Trust's Standards of Business Conduct Policy, and any additional rules that the Trust may hold or adopt in respect of preventing corruption and complying with the Bribery Act 2010.

3.8.2 All Officers will be responsible for notifying the Company Secretary who will record in writing, any gift, hospitality or sponsorship accepted (or refused) by Officers on behalf of the Trust.

3.8.3 Any offers for gifts, hospitality or sponsorship that do not comply with the Trust's Standard of Business Conduct Policy, should be courteously but firmly refused and the firm or individual notified of the Trust's procedures and standards.

3.9 Overriding Standing Financial Instructions

3.9.1 If, for any reason, these SFIs are not complied with, full details of the non-compliance, any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for action or ratification.

3.9.2 All members of the Board of Directors and Officers have a duty to disclose any non-compliance with these SFIs to the Director of Finance as soon as possible.

4 ANNUAL PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

4.1 Annual business planning

4.1.1 The Chief Executive shall compile and submit to the Board of Directors and the Regulator, strategic and operational plans in accordance with the guidance issued about timing and the Trust's financial duties within the regulator's compliance framework. This will include:

(a) income and expenditure budgets;

(b) consistency with the overall activity and workforce plans and other aspects of the annual plan;

(c) identification of potential risks and opportunities within the plan; and

(d) plans for capital expenditure, including both replace and refresh of existing assets and new projects.

4.1.2 The operational plan shall be reconcilable to regular updates of the financial pro-formas, which the Director of Finance will prepare and submit to the Finance and Performance Committee, the Board of Directors and the regulator.

4.1.3 The Director of Finance will also be required to compile and submit to the Board of Directors such financial estimates and forecasts, both revenue and capital, as may be required from time to time.

4.1.4 Officers shall provide the Director of Finance with all financial, statistical and other relevant information as necessary for the compilation of such business planning, estimates and forecasts.

Budgets, budgetary control and monitoring

4.2 Role of the Board of Directors

4.2.1 In advance of the financial year to which they refer, the Board of Directors will approve Budgets within the forecast limits of available resources and planning policies submitted by the Director of Finance.

4.2.2 Budgets will be in accordance with the aims and objectives set out in the Trust's annual plan.

4.2.3 The Director of Finance will devise and maintain systems of budgetary control incorporating the reporting of, and investigation into, financial, activity or workforce variances from budget. All Officers whom the Board of Directors may empower to engage Officers, to otherwise incur expenditure, or to collect or generate income, shall comply with the requirements of those systems.

4.2.4 The Director of Finance shall be responsible for providing budgetary information and advice and training to enable the Chief Executive and other Officers to carry out their budgetary responsibilities. All Officers of the Trust have a responsibility to meet their financial targets as agreed in the annual plan approved by the Board of Directors.

4.2.5 The Chief Executive may delegate management of a budget or part of a budget to Officers to permit the performance of defined activities. The SoD shall include a clear definition of individual and group responsibilities for control of expenditure. In carrying out those duties, the Chief Executive shall not exceed the budgetary limits set by the Board of Directors, and Officers shall not exceed the budgetary limits set them by the Chief Executive.

4.3 Responsibilities of all budget managers

4.3.1 Control of spending is maintained within budget and if applicable income targets and efficiency targets are achieved, through regular monitoring. Where a Budget Manager is responsible for both income and expenditure targets, the Director of

Finance may agree that a budget manager's accountability is defined as meeting their bottom line contribution target rather than individual income targets and expenditure Budgets.

4.3.2 At the time expenditure is committed there are sufficient resources in their budget to finance such expenditure along with other known commitments and anticipated costs for the remainder of the financial year.

4.3.3 Procedures in relation to procuring or ordering goods and services are adhered to.

4.3.4 Any likely overspending or underperformance against income targets is forecast, understood and escalated through the budget manager's hierarchy to the Director of Finance.

4.3.5 Corrective action is put in place, with the support from the budget manager's designated finance representative, in the event that financial targets are forecast to be missed.

4.3.6 Budgets are used for the purpose for which they were set, subject to the rules of virement (i.e. Budget transfer) as set out in the SoD.

4.3.7 Workforce is maintained within budgeted establishment unless expressly authorised by a manager or a member of the Board of Director within their delegated authority.

4.3.8 Non-recurring budgets are not used to finance recurring expenditure.

4.3.9 No agreements are entered into without the proper authority (for example, leases or service developments).

4.4 Role of the Finance and Performance Committee

4.4.1 The Finance and Performance Committee shall provide the Board of Directors with an in year oversight of the Trust's financial performance against the Trust's annual plan and advise the Board of Directors of any variances.

4.4.2 The Finance and Performance Committee shall keep the Board of Directors informed of the financial consequences of changes in policy, pay awards and other events and trends affecting Budgets and shall advise on the financial and economic aspects of future plans and projects.

4.4.3 The Finance and Performance Committee shall oversee the development and delivery of any corrective actions plans and advise the Board of Directors accordingly.

4.4.4 The Finance and Performance Committee shall oversee the development, management and delivery of the Trust's annual capital programme and other agreed investment programmes.

4.4.5 The Finance and Performance Committee shall report to the Board of Directors any significant in-year variance from the annual plan and advise the Board of Directors on the action to be taken.

4.4.6 Any funds not required for their designated purpose shall revert to the immediate control of the Chief Executive.

4.4.7 Expenditure for which no provision has been made in an approved budget (including expenditure exceeding a delegated Budget) and which is not subject to funding under the delegated powers of virement, shall only be incurred after authorisation by the Chief Executive or the Board of Directors as appropriate.

5 ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance, on behalf of the Trust, will 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 The Director of Finance will prepare annual accounts which must be certified by the Chief Executive. The Director of Finance will submit them, and any report of auditor on them, to the regulator.

5.3 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors in accordance with the appointment process set out in the Audit Code for NHS Foundation Trusts and the NHS Foundation Trust Code of Governance issued by the regulator.

5.4 The Trust will publish an annual report, in accordance with guidelines on local accountability and present it at a public meeting of the Council of Governors. The document will include the audited annual accounts of the Trust.

5.5 The annual report will be sent to the Regulator.

6 BANK ACCOUNTS

6.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by the regulator. The Board of Directors shall approve the banking arrangements.

6.2 The Director of Finance is responsible for all bank accounts and for establishing separate bank accounts for the Trust's non-exchequer funds.

6.3 The Director of Finance is responsible for ensuring payments from commercial banks or Government Banking Service (GBS) accounts do not exceed the amount credited to the account except where arrangements have been made. Further they must report to the Board of Directors all arrangements with the Trust's bankers for accounts to be overdrawn.

6.4 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include the conditions under which each bank and GBS account is to be operated, the limit to be applied to any overdraft and those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.5 The Director of Finance must advise the Trust's bankers in writing of the condition under which each account will be operated.

6.6 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7 FINANCIAL SYSTEMS AND TRANSACTION PROCESSING

Director of Finance's role in financial systems and transaction processing

7.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper and prompt recording, invoicing, collection, banking and coding of all monies due. This includes responsibility for an effective credit control system incorporating procedures for recovery of all outstanding debts due to the Trust. Income not received should be dealt with in accordance with losses procedures.

7.2 The Director of Finance is also responsible for ensuring a procedure is in place for the prompt banking of all monies received.

7.3 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Regulator, the Secretary of State or statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.4 The Director of Finance is responsible for approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

7.5 The Director of Finance is responsible for prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines.

7.6 The Trust shall adhere to the National Tariff system and the regulator and Secretary of State's guidance and codes of conduct.

7.7 The setting of fees and charges other than those within the National Tariff or set by statute, including private patient prices, remains the responsibility of the members of the Board of Directors and budget managers, subject to prior approval of the Director of Finance unless specifically delegated in the SoD.

7.8 All invoices must be raised by Officers within the finance function, unless specifically agreed otherwise by the Director of Finance.

7.9 All Officers must inform their designated finance representative promptly of money due arising from transactions which they initiate/deal with, including providing copies of all contracts, leases, tenancy agreements, private patient undertakings and any other type of financial contract.

7.10 All payments made on behalf of the Trust to third parties should normally be made using the Bankers Automated Clearing System (BACS), or by crossed cheques and drawn up in accordance with these instructions, except with the agreement of the Director of Finance. Uncrossed cheques shall be regarded as cash.

7.11 Official money shall not under any circumstances be used for the encashment of private cheques nor will the trust accept I.O.U's.

7.12 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.13 The holders of safe keys shall not accept unofficial funds for depositing in their safe unless such deposits are in sealed envelopes (signed and dated across the seal) or lockable

containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

Money laundering

7.14 Under no circumstances will the Trust accept cash payments in excess of £1,000 or the equivalent in any other currency, in respect of any single transaction. Any attempts by an individual to effect payment above this amount should be notified immediately to the Director of Finance.

8 CONTRACTS FOR PROVISION OF SERVICES TO CUSTOMERS

8.1 The Director of Finance, supported by other Officers (nominated by the Director of Finance), is responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with the annual plan.

8.2 In carrying out these functions, the Director of Finance should take into account the appropriate advice regarding national pricing and contracting policy, standards and guidance.

8.3 Contracts with commissioners shall be devised to minimise risk. Unless agreed otherwise, contracts with commissioners are legally binding and appropriate legal advice, identifying the Trust's liabilities under the terms of the contract should be considered.

8.4 The Director of Finance is responsible for 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.

8.5 The Trust will comply with its responsibilities under its Licence to maintain an up to date record of commissioner-requested services (as defined in the Licence).

9 CONTRACTS, TENDERS AND HEALTHCARE SERVICE AGREEMENTS

9.1 Overview

9.1.1 The financial value of a project, contract or order against which the thresholds in the SoD apply is the total cost, including (as appropriate) all works, furniture, equipment, fees, land and VAT, for the whole expected life of the contract. Splitting or otherwise changing orders in a manner devised so as to avoid the financial thresholds is forbidden.

9.1.2 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. It is the responsibility of all Officers to ensure value for money at all times and to review all contracts prior to signing (or submitting for signature).

9.1.3 The Director of Finance shall:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained;

(b) be responsible for establishing procedures to ensure that competitive quotations and tenders are invited for the supply of goods and services under contractual arrangements; and

(c) ensure that an electronic register is established and maintained by the Head of Procurement of all formal tenders.

9.1.4 The Trust will ensure policies and procedures are put in place for the control of all tendering activity.

9.2 Directives and guidance

9.2.1 Directives by the Council of the European Union prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SFIs. European Union Directives shall take precedence wherever non-conformity occurs.

9.2.2 The Trust shall comply as far as is practicable with the requirements of any other regulation/guidance issued by the Secretary of State or the Regulator.

9.2.3 If the sources of advice appear to conflict or there is ambiguity as to which advice takes precedence, the head of procurement should be consulted.

9.3 Quotations: competitive and non-competitive

General position on quotations

9.3.1 Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is not reasonably expected to exceed £50,000. Quotes are required on the following basis:

	Threshold Values	Quotes
Works ,Goods & services	Up to £5,000	Best value, supported by 1 written quote
	£5,001 to £50,000	3 written quotes
	£50,001 to OJEU threshold	Competitive tender exercise
	Over OJEU Threshold	EU Directive requirements

Competitive quotations

9.3.2 Quotations should be obtained from the number of firms/individuals shown in the table above based on specifications or terms of reference prepared by, or on behalf of, the Trust.

9.3.3 Quotations should be received in writing or via e-mail.

9.3.4 All quotations should be treated as confidential and should be retained for inspection and attached to the requisition/order for the goods or services.

9.3.5 The Chief Executive or their nominated Officer should evaluate the quotation and select the quote which gives the best value for money and the reasons why should be recorded in a record of quotations.

9.3.6 The Trust's procurement department should maintain a record of quotations.

9.3.7 In circumstances where competitive quotation is not possible due to lack of quotations, the Director of Finance of their nominated Officer will ensure that best

value for money is obtained and the decision to proceed should be recorded in a record of quotations.

9.4 Formal competitive tendering

9.4.1 The Director of Finance shall be responsible for establishing procedures to carry out financial appraisals and shall instruct the appropriate requisitioning Officer to provide evidence of technical competence.

9.4.2 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles, management consultancy services, design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) and disposals; subject to thresholds the SoD.

9.4.3 Formal tendering procedures need not apply to disposals, where expenditure is not reasonably expected to exceed £50,000 or where a nationally agreed NHS contract exists.

9.5 Contracting/tendering procedure

Invitation to tender

9.5.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

9.5.2 All invitations to tender shall state that no tender will be considered for acceptance unless submitted electronically using the Trust's E-Tendering Tool (Delta).

9.5.3 Issue of all tender documentation will be undertaken electronically through the secure website with controlled access using secure login, authentication and viewing rules.

9.5.4 Every tender for goods, materials, services, (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tender must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

9.5.5 Every tender for building or engineering works shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal (JCT) or Department of Environment (GC/Wks) standard forms of contract amended to comply with Concode. When the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or in the case of civil engineering work the General Conditions of Contract recommended by the Institute of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects.

Opening tenders

9.5.6 The Director of Finance shall be responsible for establishing procedures to ensure that tenders are opened and documented appropriately and within an agreed timescale.

Admissibility

9.5.7 If for any reason the designated Officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive or Director of Finance.

9.5.8 Where only one tender is sought and/or received the Chief Executive and Director of Finance shall ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

Late tenders

9.5.9 Tenders received after the due time and date, but prior to the opening of the other tenders, will not be accepted. However, they may be considered if the Director of Finance or their nominated Officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

Acceptance of formal tenders

9.5.10 Any discussion with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender. Any such discussions must be entered through the e-tendering portal unless agreed otherwise with the Head of Procurement. Failure to comply will disqualify the tender

9.5.11 The most economically advantageous tender, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in the contract file or other appropriate record.

9.6 Financial standing and technical competence of contractors

9.6.1 The Director of Finance may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

9.7 Awarding of contracts

9.7.1 Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the following Officers:

(a) Board of Directors;

(b) Chief Executive;

(c) Director of Finance;

(d) Designated budget managers.

9.7.2 The levels of authorisation are in the SoD.

9.7.3 Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in the minutes of the meeting of the Board of Directors.

9.8 Instances where formal competitive tendering or competitive quotation are not required

9.8.1 Where competitive tendering or a competitive quotation is not required (contracts expected to be less than £5,000) the Trust should adopt one of the following alternatives:

(a) the Trust shall use the NHS Supply Chain, NHS Commercial Solutions, Crown Commercial Services or other agreed NHS contracts for procurement of all goods and services unless the Chief Executive or nominated Officers deem it inappropriate or better value for money can be obtained elsewhere. The decision to use alternative sources must be documented; or

(b) If the Trust does not use the NHS Supply Chain, NHS Commercial Solutions, Crown Commercial Services or other NHS contracts where tenders or quotations are not required, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

9.9 Tender reports to the Board of Directors

9.9.1 Reports to the Board of Directors will be made on an exceptional circumstances basis only.

9.10 Waiving of tenders

9.10.1 There are five allowable reasons for waiving tenders, which should never be used to avoid competition or for administrative convenience. It should be noted that approval by this means will not be automatic and all waivers have to be agreed in advance:

(a) in very exceptional circumstances where the Chief Executive and Director of Finance decide that formal tendering procedures would not be practicable and the circumstances are detailed in an appropriate Trust record;

(b) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not regarded as a justification for a single tender waiver action;

(c) specialist expertise is required and is available from only one source;

(d) the task is essential to complete a project and engaging different consultants for the new task would compromise completion of the project; or

(e) for the provision of legal advice in relation to the obtaining of Counsel's opinion.

9.10.2 It should be noted that waiving of tender procedures only applies to internal tender procedures and cannot be applied for contracts with values greater than the OJEU limits.

9.10.3 Waiver request forms are available through the trust intranet or supplied by the Trust's procurement department upon request. Waiver forms must be returned to the procurement department before any official order can be placed on behalf of the trust. A waiver is not required where goods or services have been purchased under a framework where value for money has been sought, and where further competition is not required by that framework.

9.10.4 The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

9.10.5 Where it is decided that competitive tendering is not applicable and should be waived, the waiver and the reasons for it should be documented in an appropriate Trust record and reported to the Audit Committee at each meeting.

9.10.6 Items estimated to be below the limits set in these SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

9.11 Health care services

9.11.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990, as amended, and administered by the Trust. Contracts with other Foundation Trusts', being Public Benefit Corporations, are legally binding and are enforceable in law.

9.11.2 The Chief Executive shall nominate Officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors.

9.11.3 Where the Trust elects to invite tenders for the supply of healthcare services these SFIs shall apply as far as they are applicable to the tendering procedure.

9.11.4 Health care services falls within the 'Light Touch Regime' (LTR) of the Procurement Regulations 2015. Any tendering for these services should be discussed with the head of procurement to identify suitability to the LTR process.

9.12 Compliance requirements for all contracts

9.12.1 The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it and shall comply with:

(a) the Trust's Standing Orders and these SFIs;

(b) EU directives and other statutory provisions; and

(c) Contracts with NHS Foundation Trusts must be in a form compliant with appropriate NHS guidance.

9.12.2 Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.12.3 In all contracts made by the Trust, the Board of Directors shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.

9.13 Disposals

9.13.1 Competitive tendering or quotations procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined, or pre-determined in a reserve, by the Chief Executive or their nominated Officer;

(b) obsolete or condemned articles, which may be disposed of in accordance with the accounting procedures of the Trust;

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis; or

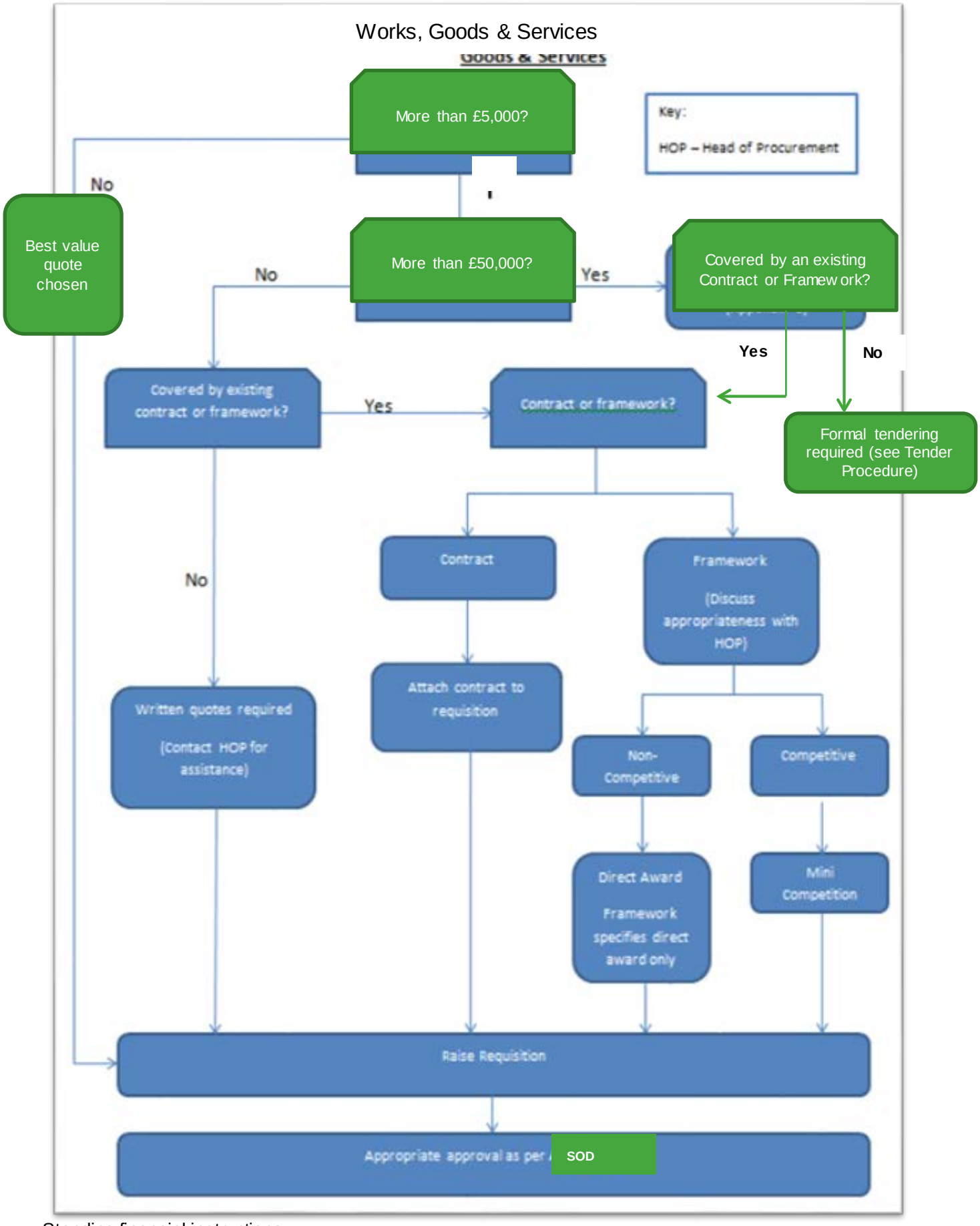
(d) items arising from works of construction, demolition or site clearance, which should be deal with in accordance with the relevant contract.

9.14 In-house services

9.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

9.15 Applicability of SFIs on tendering and contracting for Funds Held on Trust including charitable funds

9.15.1 These SFIs shall not only apply to expenditure of revenue funds but also to works, services and goods purchased from the charitable fund or any Funds Held on Trust.


Works, Goods & Services
Goods & Services
More than £5,000?
Key:
HOP – Head of Procurement
No
Best value quote chosen
More than £50,000?
No
Yes
Covered by an existing Contract or Framework?
Yes
No
Covered by existing contract or framework?
Yes
Contract or framework?
Formal tendering required (see Tender Procedure)
No
Contract
Framework
(Discuss appropriateness with HOP)
Written quotes required
(Contact HOP for assistance)
Attach contract to requisition
Non-Competitive
Competitive
Direct Award
Framework specifies direct award only
Mini Competition
Raise Requisition
Appropriate approval as per
SOD

10 TERMS OF SERVICE, STAFF APPOINTMENTS AND PAYMENTS

10.1 Nomination and Remuneration Committee

10.1.1 In accordance with Standing Orders and the Code of Governance, the Board of Directors shall establish a Nomination and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition and the arrangements for reporting.

10.1.2 The terms of reference shall be considered as forming part of these SFIs.

10.2 Staff appointments

10.2.1 No Director or Officer may re-grade Officers, either on a permanent or temporary nature, or agree to changes in any aspect of remuneration -unless authorised to do so by the Director of Human Resources and Director of Finance; and within the limit of the approved Budget and funded establishment.

10.2.2 No Director or Officer may engage, re-engage, either on a permanent or temporary nature, or hire agency staff, unless within the limit of the approved Budget and funded establishment.

10.2.3 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service, etc., for Officers.

10.3 Contracts of employment

10.3.1 The Board of Directors shall delegate responsibility to the Director of Human Resources for:

(a) 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

(b) dealing with variations to, or termination of, contracts of employment.

10.4 Payroll

10.4.1 The Director of Finance shall make arrangements for the provision of payroll services to the Trust to ensure the accurate determination of any entitlement and to enable prompt and accurate payment to Officers.

10.4.2 The Director of Finance, in conjunction with the Director of Human Resources, shall be responsible for establishing procedures covering advice to managers on the prompt and accurate submissions of payroll data to support the determination of pay including where appropriate, timetables and specifications for submission of properly authorised notification of new Officers, leavers and amendments to standing pay data and terminations.

10.4.3 The Director of Finance will issue detailed procedures covering payments to Officers including rules on handling and security of bank credit payments.

10.5 Advances of pay

10.5.1 Advances of pay will only be made in exceptional circumstances subject to the approval of at least one of either the Director of Finance, the Deputy Director of Finance, the Director of Human Resources and/or the Deputy Director of Human Resources.

11 NON-PAY EXPENDITURE

11.1 Delegation of authority

11.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to Budget Managers.

11.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the financial limits for requisitions and the system for authorisation above that level.

11.1.3 Budget managers may appoint nominees who must be approved by the Director of Finance. The budget manager remains responsible for the actions of nominees when they act in place of the budget manager.

11.1.4 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.1.5 The advice of the Trust's procurement department shall be sought before seeking alternative professional advice regarding the supply of goods and services.

11.2 Choice, requisitioning, ordering, receipt and payment for goods and services

11.2.1 The requisitioner, in choosing the item to be supplied or the service to be performed, shall always obtain best value for money for the Trust. In so doing, the advice of the Trust's procurement department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and/or the Chief Executive shall be consulted.

11.2.2 If the requisition is for a new medical device then an order can only be placed once approval is obtained from the Medical Devices Committee and funding has been agreed.

11.2.3 The Director of Finance is responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms. The Director of Finance must be provided with a copy of all contracts and service level agreements.

11.3 Director of Finance's role in non-pay expenditure

11.3.1 The Director of Finance will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be

obtained; and once approved, the thresholds should be incorporated in these SFIs or the SoD (as appropriate) and regularly reviewed;

(b) prepare detailed procedures for requisitioning, ordering, receipt and payment of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable;

(e) ensure a system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

(f) maintain a list of Officers, including specimens of their signatures, authorised to certify any type of payment. It is the responsibility of Budget Managers to inform the Director of Finance of changes to authorised Officers;

(g) delegate responsibility for ensuring that payment for goods and services is only made once the goods/services are received, except where a prepayment is made; and

(h) prepare and issue procedures regarding Value Added Tax..

11.4 Role of all Trust Officers

11.4.1 All Officers must comply fully with the procedures and limits specified by the Director of Finance, ensuring that:

(a) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(b) where consultancy advice is being obtained, the procurement of such advice must be in accordance with best practice;

(c) no order shall be issued for any item or items to any firm that has made an offer of gifts, reward or benefit to Directors or Officers, other than:

(i) isolated gifts of a trivial nature or inexpensive seasonal gifts, such as calendars; and/or

(ii) conventional hospitality, such as lunches in the course of working visits.

(d) no requisition/order (including the use of purchasing cards) is placed for any item/service for which there is no Budget provision unless authorised by the Director of Finance;

(e) all Officers shall adhere to the procedures regarding verbal orders developed by the Director of Finance. These shall be issued only in cases of emergency by the procurement department following receipt of a

properly completed requisition. The Trust's procurement department will place the verbal order and then issue an official order marked 'confirmation order' no later than the next working day. The Trust's procurement department shall maintain a register of emergency orders issued. Persistent use of this method of purchasing goods or services to circumvent the ordering procedures will result in their withdrawal from use and if the circumstances warrant, the instigation of disciplinary procedures;

(f) orders are not split or otherwise placed in a manner devised so as to circumvent the financial thresholds; and

(g) upon receipt of an invoice that has not been processed by the Trust's finance department, it is immediately passed to the Trust's finance department for processing.

11.5 Prepayments

11.5.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) the financial advantages must outweigh the disadvantages i.e. cash flows must be discounted to Net Present Value (NPV) and the intention is not to circumvent cash limits;

(b) the appropriate Director must make a clear written request to the Director of Finance, which specifically addresses the risk of the supplier being unable to meet its commitments;

(c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangement proceed (taking into account the relevant provisions of these SFIs and the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) the Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the Director of Finance if problems are encountered.

11.6 Official orders

11.6.1 Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

11.6.2 All goods, services or works, including works and services executed in accordance with a contract, shall be ordered using an official order, raised following receipt by the procurement department of a properly authorised requisition via the i-Procurement system and contractors/suppliers shall be

notified that they should not accept orders unless on an official order form. The expenditure items listed below are excluded:

(a) contract taxi services;

(b) courses, conferences and lecture fees if approved via the Staff Development Centre;

(c) rent of property or rooms;

(d) services provided by high street opticians;

(e) utility services – including all communication services; and

(f) travel claims.

11.6.3 Goods and services for which Trust or national contracts are in place should be purchased within those contracts. Any purchasing request made outside such contracts must be referred, in the first instance, to the Head of Procurement for approval.

11.6.4 Goods must not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

11.6.5 The Chief Executive and Director of Finance shall 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. The technical audit of these contracts shall be the responsibility of the Director responsible for the Estates function.

11.7 Contracts with individuals

11.7.1 Directors and Officers have a responsibility to 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 (for example if HMRC later deems the individual to be an employee rather than a contractor).

12 INVESTMENTS, EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND MERGERS & AQUISITIONS

12.1 Investments

12.1.1 The Director of Finance will produce an investment policy in accordance with any guidance received from the Regulator, for approval by the Board of Directors. Investments may include investments made by forming or participating in forming, bodies corporate and/or otherwise acquiring membership of bodies corporate.

12.1.2 The policy will set out the Director of Finance's responsibilities for advising the Board of Directors concerning the performance of investments held.

12.1.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12.2 External borrowing and Public Dividend Capital

12.2.1 The Director of Finance will 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, within the limits set by the Trust's authorisation, which is reviewed annually by the Regulator (the Prudential Borrowing Code). The Director of Finance is also responsible for reporting periodically to the Board of Directors concerning the Public Dividend Capital and all loans and overdrafts.

12.2.2 Any application for a loan or overdraft will only be made by the Director of Finance or by an Officer acting on their behalf and in accordance with the SoD, as appropriate.

12.2.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

12.2.4 All short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement must be authorised by the Director of Finance.

12.2.5 All long term borrowing must be consistent with and outlined in the Trust's current annual plan.

12.3 Special purpose vehicles, joint ventures and mergers and acquisitions

12.3.1 The Board of Directors is responsible for the review and approval of special purpose vehicles, joint ventures with other entities, whether private, public or third sector.

12.3.2 The Board of Directors must approve any mergers or acquisitions. For all the above, advice should be sought from the Trust's finance and commerce teams prior to taking proposals for approval, and it is essential that current legislation, including procurement and competition law as well as the prevailing Health and Social Care Act 2012, is adhered to in the process.

13 CAPITAL INVESTMENT AND ASSETS

13.1 Responsibilities of the Chief Executive

13.1.1 Ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

13.1.2 Being responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to planned cost.

13.1.3 Ensuring that the investment is not undertaken without confirmation, where appropriate, of responsible director's support and the availability of resources to finance all revenue consequences, including capital charges, depreciation and PDC dividend implications.

13.2 Responsibilities of the Director of Finance

13.2.1 The Director of Finance, in conjunction with other member of the Board of Directors as appropriate, shall be responsible for preparing detailed procedural

guides for the financial management and control of expenditure on capital assets, including the maintenance of an asset register in accordance with the minimum data set as specified in Treasury guidance.

13.2.2 The Director of Finance shall implement procedures to comply with guidance on valuation contained within the Treasury's guidance, including rules on indexation, depreciation and revaluation.

13.2.3 The Director of Finance, in conjunction with other members of the Board of Directors as appropriate, shall establish procedures covering the identification and recording of capital additions. The financial cost of capital additions, including expenditure on assets under construction, must be clearly identified to the appropriate budget manager and be validated by reference to appropriate supporting documentation.

13.2.4 The Director of Finance shall also develop procedures covering the physical verification of assets on a periodic basis.

13.2.5 The Director of Finance, in conjunction with other members of the Board of Directors as appropriate, shall develop policies and procedures for the management and documentation of asset disposals, whether by sale, part exchange, scrap, theft or other loss. Such procedures shall include the rules on evidence and supporting documentation, the application of sales proceeds and the amendment of financial records including the asset register.

14 STORES AND RECEIPTS OF GOODS

14.1 Control of stores

14.1.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stocks and stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental Officers, subject to such delegation being within the SOD and being entered in a record available to the Director of Finance.

14.1.2 Stores should be:

(a) Kept to a minimum

(b) subject to a stocktake annually as a minimum

(c) Valued at the lower of cost and net realisable value

14.1.3 The control of any pharmaceutical stocks shall be the responsibility of the designated pharmaceutical Officer.

14.1.4 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager or pharmaceutical Officer. Wherever practicable, stocks should be marked Trust property.

14.1.5 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues and returns to stores, and losses.

14.1.6 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

14.1.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

14.2 Goods supplied by NHS Supply Chain (NHSSC)

14.2.1 For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those Officers authorised to requisition and accept goods from NHSSC. The authorised Officers shall check receipt against the delivery note before forwarding this to the Procurement Department. The Finance Department shall satisfy themselves that the goods have been received before accepting the recharge.

15 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Procedures

15.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to members of the Board of Directors and relevant Officers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking into account professional advice where appropriate.

15.2 Disposal of unserviceable articles

15.2.1 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an Officer authorised for that purpose by the Director of Finance;

(b) recorded by the condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of.

15.2.2 All entries shall be confirmed by the countersignature of a second Officer authorised for the purpose by the Director of Finance.

15.2.3 The condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take appropriate action.

15.3 Losses and special payments

15.3.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

15.3.2 Any Officer discovering or suspecting a loss of any kind must immediately inform their manager, who must immediately inform the Chief Executive and Director of Finance.

15.3.3 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved.

15.3.4 In cases of fraud or corruption, the Director of Finance must inform the Trust's local counter fraud specialist and NHS Counter Fraud Authority.

15.3.5 The Director of Finance must notify the Audit Committee, the Trust's local counter fraud specialist and the external auditors of all frauds.

15.3.6 For losses apparently caused by theft, arson, or neglect of duty, except if trivial, or gross carelessness, the Director of Finance must immediately notify:

(a) the Board of Directors;

(b) the external auditor; and

(c) the Audit Committee, at the earliest opportunity.

15.3.7 The Board of Directors shall delegate its responsibility to approve the writing-off of losses and to authorise special payments in accordance with the 'Reservation of Powers to the Board of Directors' and SoD.

15.3.8 The Director of Finance shall:

(a) be authorised to take any necessary steps to safeguard the Trust's interest in bankruptcies and company liquidations;

(b) consider whether any insurance claim can be made for any losses incurred by the Trust;

15.3.9 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded. The Director of Finance shall report losses and special payments to the Audit Committee on a regular basis.

15.3.10 No special payment exceeding delegated limits shall be made without the prior approval of the Board of Directors, or contrary to any guidance or best practice advice issued by the Regulator or the Secretary of State.

16 INFORMATION TECHNOLOGY

16.1 Role of the Director of Finance in relation to information technology

16.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate and reasonable protection of the Trust's data, programmes and computer hardware for which the Director of Finance is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998, the Freedom of Information Act 2000 and any other relevant legislation;

(b) ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission and output to ensure security, privacy,

accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate audit trail exists through the computerised system and that such computer audit reviews as the Director of Finance may consider necessary, are being carried out;

(e) ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, the Director of Finance must obtain from that organisation assurances of adequacy prior to implementation; and

(f) publish and maintain a Freedom of Information (FOI) Publication Scheme, which is a complete guide to the information routinely published and describes the classes or types of information about the Trust which are publicly available.

16.2 Contracts for computer services with other health service body or other agency

16.2.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another Health Service Body or other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.2.2 Where another Health Service Body or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.3 Risk Assessments

16.3.1 The Director of Finance shall ensure that risks to the Trust arising from the use of information technology are effectively identified and considered and appropriate action is taken to mitigate or control risk. This shall include the preparation of and testing of, appropriate disaster recovery plans.

16.4 Requirements for computer systems which have an impact on the Trust's corporate financial systems

16.4.1 Where computer systems have an impact on the Trust's corporate financial systems, the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with the Trust's policies, including but not limited to the Trust's information technology strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely and that an audit trail exists;

(c) Trust's finance Officers have access to such data; and

(d) Such computer audit reviews are carried out as necessary.

17 PATIENTS' PROPERTY

17.1 The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients (hereafter referred to as "property"), in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 Subject to paragraph 17.1 above, the Trust will not accept responsibility or liability for patients' property brought into the Trust's premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

17.3.1 notices and information booklets;

17.3.2 hospital admission documentation and property records;

17.3.3 the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property.

17.4 The Director of Finance must 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. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.5 Officers should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.6 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of probate or letters of administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18 RETENTION OF RECORDS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with the regulator and/or Secretary of State guidelines.

18.2 The Chief Executive will produce a records lifecycle policy, detailing the secure storage, retention periods and destruction of records to be retained. The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Records and information held in accordance with latest the Regulator and/or Secretary of State guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive. Proper details shall be maintained of records and information so destroyed.

19 RISK MANAGEMENT AND INSURANCE

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with NHS guidelines, which shall be approved and monitored by the Board of Directors.

19.2 The programme of risk management shall include:

19.2.1 a process for identifying and quantifying risks and potential liabilities;

19.2.2 engendering amongst all levels of Officers a positive attitude towards the control and management of risk;

19.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk;

19.2.4 contingency plans to offset the impact of adverse events;

19.2.5 audit arrangements including; Internal Audit, clinical audit, health and safety review;

19.2.6 decisions on which risks shall be included in the NHSLA risk pooling schemes; and

19.2.7 arrangements to review the Trust's risk management programme.

19.3 The Chief Executive will be 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 The Director of Finance shall ensure that insurance arrangements exist in accordance with the Trust's risk management policy.

20 FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 The Standing Orders state the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to its accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all Funds Held on Trust.

20.2 The reserved powers of the Board and the SoD make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Members of the Board of Directors and Officers must take account of that guidance before taking action. These SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

20.3 As management processes overlap most of the sections of these SFIs will apply to the management of Funds Held on Trust.

20.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from exchequer activities and funds.

20.5 The Director of Finance has primary responsibility to the Board of Directors for ensuring that Funds Held on Trust (charitable funds) are administered in line with statutory provisions, the Trust's governance documents and Charity Commission guidance. The Director of Finance will prepare procedural guidance in relation to the management and administration, disposition, investment, banking, reporting, accounting and audit of Funds Held on Trust (charitable funds) for the discharge of the Board of Directors responsibilities as the Corporate Trustee.

Queen Victoria Hospital NHS Foundation Trust

Reservation of powers and scheme of delegation

For approval by the Board of Directors 2 July 2020

Will be effective from 2 July 2020

1. Introduction

1.1. The *NHS foundation trust code of governance* requires the board of directors of NHS foundation trusts to draw up a "schedule of matters specifically reserved for its decision" (2014, A.1.1) 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.

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.

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, Director of Finance and, Medical Director and Director of Nursing).

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. 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. 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. 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.
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 Director of Finance 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 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 Committee.

		2.6.3 Receipt of a recommendation of the Audit Committee in respect of the appointment of Internal Auditors (note: the recommendation in respect of External Auditors is made by the Audit 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.

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 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 Committee
- Nomination and Remuneration Committee
- Charity Committee
- Quality and Governance Committee
- Finance and Performance 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 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; 3.1.1.2 commission appropriate independent review and studies;	SFIs 3.2, SO 5.6

		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 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; 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.	SFI 10.1, SO 5.6

		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. 3.3.3 Receive regular reports from the Director of Finance 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 governance 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 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; 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; 3.5.2.2 estates and facilities strategy and maintenance programme; and 3.5.2.3 information management and technology (IM&T) strategy, performance and development. 3.5.3 The Committee will make recommendations to the Board of Directors in relation to: 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.	

Board member delegation

	Board member	Duties delegated
4.1	Chief executive	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 and director of finance	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.

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	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 through the Regulator and to the local community by: 4.6.1.1 Constructively challenge and contribute to the development of strategy

	Board member	Duties delegated
		4.6.1.2 Scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance 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.

4. 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	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	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.

SO ref	Delegated to	Duties delegated
3.7	Finance director	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.
3.8	Director of nursing	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.

SO ref	Delegated to	Duties delegated
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.
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	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	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.

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SO ref	Delegated to	Duties delegated
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 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	Finance director and Chief Executive	Approve and sign any building, engineering, property or capital document.
11.1	Chief executive /nominated executive director	Approve and sign all documents which will be necessary in legal proceedings.

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

5. 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 / director of finance	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	The chief executive is the trust's accounting officer.
2.4.4	Chief executive	To ensure all existing officers and new appointees are notified of their responsibilities within the SFIs.

SFI ref	Delegated to	Duties delegated
2.4.5	Chief Executive & Chair	To ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.
2.4.6	Chief Executive	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	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	To ensure that the trust provides an annual forward plan to the regulator each year.
2.5.1	Director of finance	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 committee	Provide an independent and objective view of internal control by:

SFI ref	Delegated to	Duties delegated
		• 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; • 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 committee	Where audit committee considers there is evidence of ultra vires transactions or improper acts or important matters that the audit committee wishes to raise, the matter shall be raised at a full meeting of the board of directors.
3.3.1	Director of finance	In relation to audit, the director of finance 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	Director of finance/ 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;

SFI ref	Delegated to	Duties delegated
		• 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.
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 director of finance 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 director of finance. Attend meetings of the audit committee and have right of access to all members of the audit 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 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 and director of finance	Monitor and ensure compliance with guidance issued by the regulator or NHS protect on fraud and corruption in the NHS.

SFI ref	Delegated to	Duties delegated
3.6.2	Director of finance	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.
3.6.4	Director of finance	Ensure the trust's local counter fraud specialist receives appropriate training in connection with counter fraud measures.
3.6.5	Director of finance	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	Director of finance 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	Director of finance	Prepare a 'fraud response plan' that sets out the action to be taken in connection with suspected fraud.
3.6.12 3.6.13	Director of finance	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	Director of finance	To establish procedures for the management of expense claims submitted by officers.
3.7.2	Director of finance	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.

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SFI ref	Delegated to	Duties delegated
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.
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	Director of finance	Report non-compliance with SFIs to the audit committee.
3.9.2	All	To disclose any non-compliance with the SFIs to the director of finance as soon as possible
4 Annual planning, budgets, budgetary control and monitoring		
4.1.1	Chief Executive	Compile and submit to the board of directors and the regulator, strategic and operational plans.
4.1.2	Director of finance	Prepare and submit the operational plan to the financial and performance committee, the Board of Directors and the regulator
4.1.3	Director of finance	Compile and submit financial estimates and forecasts for both revenue and capital to the Board of Directors.
4.1.4	All	To provide the director of finance with all financial, statistical and other relevant information as necessary for the compilation of such business planning, estimates and forecasts.
4.2.4	Director of finance	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.

SFI ref	Delegated to	Duties delegated
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. 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	Approval of expenditure for which no provision has been made in an approved budget.
5 Annual accounts and reports		
5.1	Director of finance	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	Certify annual accounts.
5.2	Director of finance	Prepare annual account. Submit annual accounts and any report of auditor on them to the regulator.
6 Bank accounts		
6.1–6.6	Director of finance	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		

SFI ref	Delegated to	Duties delegated
7.1-7.8	Director of finance	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.
7.12	Director of finance	Approve arrangements for making disbursements from cash received.
7.14	All	Notify the director of finance 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	Director of finance	Negotiating contracts with commissioners for the provision of services to patients in accordance with the annual plan.
8.4	Director of finance	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	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	Director of finance	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	Director of finance	Establish procedures to carry out financial appraisals and shall instruct the appropriate requisitioning officer to provide evidence of technical competence.

SFI ref	Delegated to	Duties delegated
9.5.6	Director of finance	Establish procedures to ensure that tenders are opened and documented appropriately and within an agreed timescale.
9.5.7	Chief Executive/ director of finance	Approval of awarding of contracts for which tendering is deemed not strictly competitive.
9.5.8	Chief Executive/ Director of finance	Where one tender is received will assess for value for money and fair price.
9.5.9	Director of finance	Decision to accept tenders after the deadline but before opening of the other tenders.
9.6.1	Director of finance	Enquiries concerning the financial standing and financial suitability of approved contractors.
9.10.4	Director of finance	Ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.
9.11.2	Chief Executive	Nominate officers to commission service agreements with providers of healthcare.
9.12.3	Chief Executive	Nominate an officer who shall oversee and manage each contract on behalf of the trust.
9.14.1	Chief Executive	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	Present to the board of directors procedures for determination of commencing pay rates, conditions of service etc. for Officers.

SFI ref	Delegated to	Duties delegated
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 contact 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.
10.4.1	Director of finance	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	Director of finance and director of human resources	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	Director of finance	Issue detailed procedures covering payments to officers.
10.5.1	Director of finance, director of human resources	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	Determine the level of delegation to budget managers.
11.1.2	Chief Executive	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 director of finance, and to remain responsible for the actions of nominees when they act in place of the budget manager.

SFI ref	Delegated to	Duties delegated
11.1.4	Chief executive	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.
11.2.3	Director of finance	Responsible for the prompt payment of accounts and claims.
11.3.1	Director of finance	• 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 director of finance 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 director of finance.
11.5.1	Director of finance	Approve proposed prepayment arrangements.
11.2.9	Chief Executive/ director of finance	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.

SFI ref	Delegated to	Duties delegated
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	Director of finance	Produce an investment policy in accordance with any guidance received from the regulator.
12.1.3	Director of finance	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
12.2.1	Director of finance	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	Director of finance	Applications for a loan or overdraft.
12.2.3	Director of finance	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
12.2.4	Director of finance	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	• Ensure adequate appraisal and approval processes are in place for determining capital expenditure priorities.

SFI ref	Delegated to	Duties delegated
		• 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	Director of finance	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	Director of finance	Implement procedures to comply with guidance on valuation contained within the treasury's guidance.
13.2.3	Director of finance	Establish procedures covering the identification and recording of capital additions.
13.2.4	Director of finance	Develop procedures covering the physical verification of assets on a periodic basis.
13.2.5	Director of finance	Develop policies and procedures for the management and documentation of asset disposals.
13.3.1	Chief Executive	Responsible for the maintenance of registers of assets, taking account of the advice of the director of finance regarding the form of any register.
14 Stores and receipts of goods		
14.1.1	Chief Executive	Delegate overall responsibility for the control of stores.
14.1.1	Director of finance	Responsible for systems of control.
14.1.3	Pharmaceutical officer	Responsible for the control of any pharmaceutical stocks.
14.1.5	Director of finance	Set out procedures and systems to regulate the stores including records for receipt of goods, issues and returned to stores and losses.

SFI ref	Delegated to	Duties delegated
14.1.6	Director of finance	Agreed stocktaking arrangements.
14.1.7	Director of finance	Approval of alternative arrangements where a complete system of stores control is not justified.
14.2.1	Chief executive	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	Director of finance	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.
15.1.2	Head of department	Advise the director of finance of the estimated market value of the item to be disposed of.
15.2.1	Director of finance	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 director of finance.
15.3.1	Director of finance	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 director of finance.

SFI ref	Delegated to	Duties delegated
15.3.3	Director of finance	Immediately inform the police if theft or arson is involved in a suspected criminal offence.
15.3.4	Director of finance	Inform the trust's local counter fraud specialist (LCFS) and NHS Protect in cases of fraud or corruption.
15.3.5	Director of finance	Notify the audit committee, LCFS and the external auditors of all frauds.
15.3.6	Director of finance	Notify the board of directors, external auditor and the audit 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	Director of finance	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.
15.2.8	Director of finance	Maintain a losses and special payments register in which write-off action is recorded and regularly report losses and special payments to the audit committee on a regular basis.
16 Information technology		
16.1	Director of finance	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.

SFI ref	Delegated to	Duties delegated
16.2.1	Director of finance	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	Director of finance	Periodically seek assurances that adequate controls are in operation.
16.3.1	Director of finance	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	Director of finance	• 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.
17 Patients' property		
17.3	Chief Executive	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.4	Director of finance	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	Maintain archives for all documents required to be retained in accordance with the regulator and/or secretary of state guidelines.

SFI ref	Delegated to	Duties delegated
18.2	Chief Executive	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	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	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	Director of finance	Ensure that insurance arrangements exist in accordance with the trust's risk management policy.
20 Funds held on trust (charitable funds)		
20.5	Director of finance	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.

7 Financial limit delegation

REF	Duties delegated	Delegated to
1	**Virements (reallocation of budgets)**	
	Within a Business Unit/Directorate	Level 2 Officers responsible for cost centres
	Between Business Units/Directorates	Responsible Directors
	All other virements (e.g. Between revenue and capital)	Responsible Directors AND Director of Finance
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 self-funding business cases and service developments and those within budgetary limits only.**		
2.1	**Revenue expenditure (5 year value)**	
	Up to £200,000	Executive Management Team
	£200,001 to £1,000,000	Hospital Management Team
	Over £1,000,000	Board of Directors

Reservation of powers and scheme of delegation
FOR BOARD APPROVAL AT ITS MEEITNG ON 2 JULY 2020
[Will be Effective from 02 July 2020]

2.2	**Capital expenditure and disposals** Up to £200,000 £200,000 to £1,000,000 Over £1,000,000	 Executive Management Team Hospital Management Team 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.		
3.1	**Capital/revenue expenditure** Up to £5,000 £5,001 to £50,000 £50,001 to OJEU Threshold (contact procurement department for current value) Over OJEU 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 Director of Finance) EU Directive Requirements (Relevant Director AND Director of Finance)

	Note: Written quotes may be accepted via email, and may not be required if a particular requirement has already been completed under a framework whose terms do not require further competition (the Head of Procurement must be consulted and give approval in such cases). "Competitive Procurement Exercise" indicates that the Head of Procurement must be consulted for advice as to the nature of the exercise (e.g. tender, mini-competition against a framework). **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 OJEU threshold refers to the EU Directive threshold for a procurement exercise to include publication in the Official Journal of the European Union (OJEU). As these thresholds regularly change and the Public Procurement Regulations are periodically updated, all Officers must consult the Procurement department for guidance.	
3.2	**Quotation and tenders process waivers** Waiving of tender and quotation procedures for items where estimated expenditure is not expected to exceed EU procurement thresholds.	Director of Finance, (when Director of Finance is unavailable) Chief Executive, or Chief Executive (when Director of Finance has commissioned the item)

3.3	**Opening tenders** Electronic tenders received through DELTA	 Head of Procurement or Deputy Director of Finance (in absence of Head of Procurement)
4 committing expenditure		
4.1	**Revenue and non-capital works expenditure within approved financial plans or business** Up to £5,000 Up to £10,000 Up to £50,000 Up to £250,000 Up to £1,000,000 Over £1,000,000	 Budget Manager Level 2 Manager (Officer) Responsible Director Director of Finance Director of Finance AND Chief Executive Board of Directors

4.2	**Approval of purchase invoices**	
	Up to £5,000	Budget Manager
	Up to £10,000	Level 2 Manager (Officer)
	Up to £50,000	Responsible Director
	Up to £250,000	Director of Finance
	Up to £1,000,000	Director of Finance AND Chief Executive
	Unlimited	Chief Executive on behalf of Board of Directors
4.3	**Granting and termination of equipment leases and credit finance**	
	Trust's employee lease car scheme	Deputy Director of Finance
	Leases/arrangements up to £3,000,000 (total primary lease term payments or credit finance obligations)	Chief Executive
	Over £3,000,000 (total primary lease term payments or credit finance obligations)	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)	Associate Director of Estates
	Where annual charge does not exceed £10,000 and term does not exceed five years	Associate Director of Estates
	Where annual charge exceeds £10,000 or term exceeds 5 years	Director of Finance
	Signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases	Associate Director of Estates & Director of Finance
4.5	**Condemning and disposal**	
	Items obsolete, obsolescent, redundant, irreparable or unable to be repaired cost effectively	Responsible Director
	Up to £5,000 (carrying value)	Director of Finance (may be delegated in specific cases in writing, but no lower than to a level 2 manager)
	Over £5,000 (carrying value)	Director of Finance
	Transfer or sale of assets to another organisation	Director of Finance

4.6	**Losses, write-offs and compensation**	
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 Director of Finance 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 Director of Finance 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 Director of Finance Board of Directors

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 £50,001 to £100,000 over £100,000	 Director of Finance Chief Executive and Director of Finance Board of Directors
4.6.5	Reimbursement of patients monies	Financial Services Manager
4.6.6	Removal expenses, excess rent and house purchase expenses	Director of Workforce
4.6.7	Contractual and non-contractual severance payments and all non-contractual payments, excluding Directors. Up to £20,000 Over £20,000 **Note:** All special payments require Treasury approval and shall be submitted via the Director of Finance to the Regulator for Treasury approval.	 Director of Workforce Chief Executive

4.7	**Expenditure from charitable funds** Up to £1,000 Up to £20,000 Over £20,000	 Two from relevant fund holder, Director of Finance, Deputy Director of Finance QVH Charity Corporate Trustee
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 (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	Associate Director of Estates

	properties.	
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 Up to £50,000 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 Director of Finance Director of Finance AND Chief Executive Board of Directors
5.5		Director of Finance

6 setting of fees, charges and income		
6.1	Private patient, overseas visitors, income generation and other patient related services	Head of Commerce
6.2	Price of NHS contracts Setting fees and charges for contracts up to £50,000 per annum Setting fees and charges for contracts over £50,000 per annum	 Relevant director Director of Finance
6.3	Authorisation of income credit notes £500 £5,000 £50,000 £250,000 £500,000 Over £500,000	 Budget managers Level 2 managers, Financial Services Manager and Reporting and Planning Manager (Officer) Deputy Director of Finance Director of Finance Chief Executive Board of Directors

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	Director of Finance Director of Finance and Chief Executive Board of Directors

Queen Victoria Hospital NHS Foundation Trust

Standing orders for the Board of Directors

For approval by the Board of Directors at its meeting on 2 July 2020

Contents

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 pursuant to the National Health Service Act 2006 ("**the 2006 Act**"). The Foundation Trust is governed by 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 principle 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 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 him/her, 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 he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member; or,

- any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract; or
- those securities of any company in which he/she (or any person connected with him/her) 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 his 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 3.1.4.4 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 his term as a member of the Board of Directors, as they may specify on appointment him. 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.

Finance director

3.7 The finance director 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 finance director 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.

Director of nursing

3.9 The director of nursing shall be responsible for effective professional leadership and management of nursing staff of the Foundation Trust and is the Caldicott guardian. The director of nursing 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 his/her 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 3.8 and (where relevant SO 3.11 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 his/her 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 his/her 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 he/she considers 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 Chainman, 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, his/her 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 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 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 Governance Committee

3. Charity 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 committees[1]

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

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

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 he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Foundation Trust.

6.6 The Chief Executive shall prepare the Scheme of Delegation and Reservation of Powers identifying his/her 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 Finance Director to provide

information to and advise the Board of Directors in accordance with statutory requirements. Outside these statutory requirements, the Finance Director 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 he/she has 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 he/she is 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 he/she 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 his, or of its 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 him 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 himself 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 Finance Director (or an officer nominated by him/her) and the authorisation and countersignature of the Chief Executive (or an officer nominated by him/her 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:	**02 July 2020**		**Agenda reference:**	**111-20**	
Report title:	**Review of QVH COVID19 Business continuity Terms of Reference for Board and Committees**				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Author:	Clare Pirie, Director of communications and corporate affairs				
Appendices:					
Executive summary					
Purpose of report:	The Board is asked to review measures approved in March 2020 which enabled the Trust to focus on immediate needs related to the pandemic.				
Summary of key issues	In March 2020, the Board approved measures to allow the Trust to focus on the immediate needs related to the pandemic and to continue to make decisions if key people were off sick. This paper proposes we revoke some of these provisions as we move into restoration and recovery, with a further review in September.				
Recommendation:	The Board is asked to **APPROVE** the revised terms of reference				
Action required *[highlight **one** only]*	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	**KSO1:** *Outstanding patient experience*	**KSO2:** *World-class clinical services*	**KSO3:** *Operational excellence*	**KSO4:** *Financial sustainability*	**KSO5:** *Organisational excellence*
Implications					
Board assurance framework:	The BAF reflects specific pandemic related issues, and continues to be reviewed with the usual frequency and strong governance				
Corporate risk register:	N/A				
Regulation:	N/A				
Legal:	N/A				
Resources:	This paper is based on sufficient staff resources remaining available for a return to normal governance processes in many areas				
Assurance route					
Previously considered by:	Executive Management Team				
	Date:	08 June 2020	Decision:	Recommended for approval	
Previously considered by:					
	Date:		Decision:		
Next steps:	Assuming approval by the Board these terms of reference will take immediate effect.				

Report to: Board Directors
Agenda item: 111-20
Date of meeting: 02 July 2020
Report from: Clare Pirie, Director of communications and corporate affairs
Report author: Clare Pirie, Director of communications and corporate affairs
Date of report: 09 June 2020
Appendices: NA

Review of QVH COVID19 Business continuity Terms of Reference for Board and Committees

Background

In March 2020, the Board approved measures to allow the Trust to focus on the immediate needs related to the pandemic and to continue to make decisions if key people were off sick.

This paper proposes we revoke some of these provisions as we move into restoration and recovery, with a further review in September.

Executive summary

The table below sets out the original terms of reference approved in March 2020, together with the proposed amendment as we move into the next phase.

Original version March 2020	Proposed amendment
1) The Terms of Reference and Membership, including quorum arrangements, for the Board and its Committees will be temporarily suspended as of 23 March 2020, until further notice.	The purpose of this document was to ensure we could still make decisions at Board level even if key individuals were off sick, propose this temporary suspension remains in place in case of second wave.
2) The Covid 19 business continuity arrangements set out in this document will be reviewed after four months (23 July 2020).	Review at QVH BoD 02 July 2020 Propose set second review date at Board on 3 Sept.
3) During this period, where possible meetings will use telephone / digital technology and members of the public will not be invited to the Board meetings. The lead governor will be invited to join relevant Board meetings as usual.	Propose this should be retained for foreseeable future. We do not currently have sufficient confidence in our technology to resume Board meetings in public with an invitation for public to connect. We are staying in touch with other Sussex trusts who are looking at possibilities for doing this later in the autumn.

4) The primary focus of communication with the Board will be the organisation's response to covid 19, including the safety of patients and the wellbeing of staff.	Propose we delete this. As well as a focus on moving to restoration and recovery we do currently have capacity to cover the full range of the Board's responsibilities.
5) While every effort will be made to maintain the current level of Board member engagement in decision making, matters may be approved or decisions made with a quorum of 1 Executive Director and 2 Non-Executive Directors.	Suggest we remove this and return to normal quoracy requirements
6) Matters for approval or decision based upon the existing Board and subcommittee work programmes which are not directly related to patient safety or staff wellbeing will be managed as follows: • deferred if not urgent or • circulated to Board / Committee members via email for approval, allowing sufficient time for review / response and the decision will be recorded or • discussed via telephone / digital technology with the decision minuted or • discussed by the chief executive or relevant executive director with the Board / Committee chair for Chair's Action	Propose we delete this. Are BoD and subcommittees now able to cover the work programme in usual way?

7) It is possible that those responsible for preparing assurance papers for committees and the Board may not be in a position to do so, therefore all matters for information or assurance which are not focussed on the safety of patients or the wellbeing of staff may be: • put on hold until further notice or • circulated via email	Propose we delete this. Are BoD and subcommittees now able to cover the work programme in usual way?
8) Board and subcommittee secretaries will ensure an accurate record of items considered, approved or deferred is maintained.	This will continue

Recommendation
The Board is asked to **APPROVE** the updated terms of reference. If approved, these will be returned to the Board for further review in September 2020.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 July 2020**		**Agenda reference:**	**112-20**	
Report title:	**Review of QVH/McIndoe Centre (Horder Healthcare)ToRs for Oversight Group**				
Sponsor:	Steve Jenkin, chief executive				
Author:	Suzanne Cliffe, programme manager				
Appendices:	None				
Executive summary					
Purpose of report:	To provide revised terms of reference for the meetings between the Trust and The McIndoe Centre (TMC), that oversee the management of the Trust's patient activity undertaken at TMC				
Summary of key issues	As part of the governance put in place to manage the Trust's response to the COVID19 pandemic, a meeting was established between the Trust and TMC. As this work has progressed, the governance has developed to address the different aspects of the plans. The meeting between the Trust and TMC has focussed on the oversight of the work taking place at TMC and the relationship between the two organisations. The terms of reference have been updated to reflect these changes together with a reduction in the membership and in the sub-groups reporting to it.				
Recommendation:	The Board is asked to approve the amended terms of reference for the QVH and the McIndoe Centre Oversight Group				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services* *X*	*Operational excellence* *X*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:					
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	To be presented and agreed at the QVH and TMC Oversight Group on 26 June 2020				
	Date:	26/6/20	Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	A review date has been set for March 2021 with changes made earlier if needed to reflect the working context.				

Queen Victoria Hospital NHS Foundation Trust and The McIndoe Centre
Oversight Group
Terms of Reference

Title:	**Queen Victoria Hospital (QVH) and The McIndoe Centre (TMC) ~~COVID19 Activity Planning~~Oversight Group**
Date approved and approving body:	Approved by the Board of Queen Victoria Hospital NHS Foundation Trust (QVH) on TBC; and Approved by the Board of Trustees the Horder Healthcare
Accountability:	The QVH and TMC Oversight Group is accountable to the QVH Board and Board of Trustees of Horder Healthcare
Purpose:	To ~~be the decision-making body for~~provide strategic oversight of the work between QVH and TMC in response to the development, implementation and monitoring of the changes required to be taken as part of the COVID19 incident management for the patient activity on both sites. ~~undertaken by the trust~~ To oversee a programme of work that: • makes decisions as to where services will be carried out across both the QVH site and the McIndoe site • makes decisions as to how resources are deployed • assesses the risks and implements mitigating actions • ensures the engagement of, and effective communication with stakeholders • develops and implements the plan • takes account of requirements of regulators including CQC
Chair	Chief Executive, QVH - *Steve Jenkin*
Membership:	**QVH:** Chief Executive - *Steve Jenkin* Director of Operations - *Abigail Jago* Director of Nursing – *Jo Thomas* Director of Communications and Corporate Affairs – *Clare Pirie* ~~Director of HR & OD – *Geraldine Opreshko*~~ EPRR Lead – *Nicky Reeves* Programme Director - *Suzanne Cliffe* Deputy Medical Director~~s~~ – *Tania Cubison, ~~Ian Francis~~* Clinical Directors – *Ken Sneddon, ~~-~~ Martin Jones, Samer Hamada, Tim Vorster* ~~Consultants – *Colin Lawrence*~~ General Manager~~s~~ – *Paul Gable, ~~Kathy Brasier, Phil Kennedy~~* ~~Access and Performance Manager – *Victoria Worrell*~~ ~~Assoc Director of Estates & Facilities – *Phil Montague*~~ ~~Chief Information Officer – *James Cooper*~~ Associate Director of Business Development – *Tony Reeves* **McIndoe** Chief Executive - *Richard Tyler* Associate Director, Business and Commercial Development – *Elin Richardson* ~~TMC MAC Chair – *Mark Pickford*~~ Clinical Services Manager – *Michael Turner*
Attendance	The Chair can agree additional invitees who will be asked to attend meetings in full or for specific items.

Principles:	The QVH & TMC Oversight Group~~M CAPG~~ will act in accordance with the following principles. • ensure we have clearly identified the issues we are seeking to solve before developing potential solutions • aim to deliver high quality safe and sustainable services • support the accountabilities of QVH and McIndoe as required • act in line with regulatory compliance • make the most of the assets we have building on existing areas of good practice and clinical/service excellence • ensure we work in partnership across the system with commissioners and stakeholders to support the achievement of our purpose • take an open book approach; sharing the knowledge, information and data that will enable us to achieve our purpose
Quorum:	A quorum shall consist of two from McIndoe and three from QVH one of which is an Executive Director. Deputies will count towards the quorum.
Frequency of meetings:	Routine meetings will be held weekly as a minimum. Additional meetings may be scheduled, with the agreement of the chair, to expedite action in respect of any urgent issues arising in the interim period.
Administration:	The QVH & TMC ~~M CAPG~~Oversight Group will be supported by Executive Assistant of the Chair.
Sub-groups:	The QVH & TMC Oversight Group~~M CAPG~~ will oversee the work of the sub-groups – ~~- Cancer~~ - Trauma - Clinical Governance ~~- Elective~~ - ~~Virtual Outpatients~~
Reporting:	Minutes and/or a summary report of the matters considered by each meeting of the QVH & TMC Oversight Group ~~M CAPG~~ will be reported to the trust board.
Review:	Terms of Reference to be reviewed in March 2021~~July 2020~~ or sooner.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**2 July 2020**		**Agenda reference:**	**113-20**	
Report title:	**Audit Committee Assurance update**				
Sponsor:	Kevin Gould, Audit Committee Chair				
Author:	Kevin Gould, Audit Committee Chair				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide assurance to the board in relation to matters discussed at the Audit Committee meeting on 15 June 2020				
Summary of key issues	The Committee reviewed the annual report and accounts and recommended them to the Board for approval.				
Recommendation:	The Board is asked to **NOTE** the contents of this report.				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience* √	KSO2: *World-class clinical services* √	KSO3: *Operational excellence* √	KSO4: *Financial sustainability* √	KSO5: *Organisational excellence* √
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	None				

Report to:	Board of Directors
Meeting date:	15 June 2020
Reference number:	113-20
Report from:	Kevin Gould, Chair
Author:	Kevin Gould, Chair
Appendices:	N/A
Report date:	22 June 2020

Audit Committee report
Meeting held on 15 June 2020

1. The Committee reviewed the draft annual report and accounts.

2. KPMG provided its findings for its audit of the annual accounts and a draft management representation letter.

3. The Committee recommended the report and accounts along with the management representation letter to the Board for approval subject to completion of outstanding items from KPMG and receipt of its draft long-form audit report (which was subsequently received).

4. The Committee received an update on the Quality Report which is not subject to external audit this year.

5. The Annual internal audit report and Head of Internal Audit Opinion was received from the Internal Auditor, RSM. The conclusion was that the Trust has an adequate and effective framework for risk management, governance and internal control, although some potential enhancements have been identified.

6. The Committee reviewed standing orders, standing financial instructions and reservation of powers/scheme of delegation and recommended them to the Board for approval.

7. The meeting scheduled for 17 June was postponed to 29 July to allow for further audit work to be completed.

There were no other items requiring the attention of the Board.