NHS
Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 5 August 2021

Session in public
10:30 – 13:00

MEMBERSHIP: MEETINGS OF THE BOARD OF DIRECTORS August 2021

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 (interim)	-	Nicky Reeves
Director of Finance and performance	-	Michelle Miles

In full attendance (non-voting):

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

Annual declarations by directors 2021/22

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 (PGS) Director Long Meadow Views management Company Limited	PGS may have clients who are NHS related organisations (eg Royal Colleges) of who provide services to the NHS (eg charities)	48% share of PGS	Nil	None (apart from declarations above)	Nil	Family members are directors of PGS (see above)
Paul Dillon-Robinson Non-Executive Director	Nil	Independent consultant (self-employed) – see HFMA	Nil	Nil	NIL	Independent consultant working with the Healthcare Financial Management Association (including NHS operating game, HFMA Academy and coaching and training)	Chair of the Audit, Risk and Assurance Committee for one of the organisations within the MoD Non-executive member of the ARAC for Rural Payments Agency, and for Defra. Non-trustee member of Finance Risk and Audit Committee of Farm Africa Governor at Hurstpierpoint College and trustee of the Association of Governing Bodies of Independent Schools.

							Churchwarden for Parish of Buxted & Hadlow Down, trustee of Friends of St Margaret, and St Marks House School trust
Kevin Gould Non-Executive Director	Director, Sharpthorne Services Ltd	Nil	Nil	Independent Member of the Board of Governors, Staffordshire University Independent Member of the Audit & Risk Committee at Grand Union Housing Group Director, Look Ahead Care & Support Trustee, Centre for Alternative Technology	Director, Look Ahead Care & Support	Nil	Nil
Gary Needle Non-Executive Director	T&G Needle Property Development Ltd	Nil	Nil	Chair of Board of Trustees, East Grinstead Sports Club	Nil	Nil	Nil
Karen Norman Non-Executive Director	Nil	Nil	Nil	Nil	Visiting Professor, Doctorate in Management Programme, Complexity and Management Group, Business School, University of Hertfordshire Visiting Professor, School of Nursing, Kingston University and St George's, University of London	Nil	Nil
Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Keith Altman Medical Director	MaxFacs Medical Limited	Nil	Nil	Nil	Nil	Nil	Nil
Michelle Miles, Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Nicky Reeves Director of Nursing	Nil	Nil	Nil	Trustee of McIndoe Burns Support Group	Nil	Nil	Nil
Other members of the board (non-voting)							
Abigail Jago Director of operations	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Lawrence Anderson 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 persons declaration

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

Register of fit and proper person declarations

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

Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 05 August 2021
10:30 – 13:00

Agenda: session held in public			
Welcome			
93-21	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**page**
94-21	**Patient story**	*Assurance*	-
95-21	**Draft minutes of the meeting held on 06 May 2021** *Beryl Hobson, Chair*	*approval*	1
96-21	**Matters arising and actions pending** *Beryl Hobson, Chair*	*review*	9
97-21	**Chair's report** *Beryl Hobson, Chair*	*to note*	10
98-21	**Chief executive's report** *Steve Jenkin, Chief executive*	*assurance*	13
Strategy			
99-21	**Future organisational arrangements – strategic case** *Steve Jenkin, Chief executive*	*discussion*	27
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
100-21	**Board Assurance Framework** *Nicky Reeves, interim Director of nursing, and* *Keith Altman, Medical director*	*assurance*	44
101-21	**Quality and governance assurance** *Karen Norman, Non-executive director*	*assurance*	46
102-21	**Corporate risk register (CRR)** *Nicky Reeves, interim Director of nursing*	*review*	52
103-21	**Quality and safety report** *Nicky Reeves, interim Director of nursing, and* *Keith Altman, Medical director*	*assurance*	58
104-21	**6-monthly nursing workforce review** *Nicky Reeves, interim Director of nursing*	*assurance*	95
105-21	**Research and innovation strategy** *Keith Altman, Medical director*	*to note*	107
Key strategic objectives 3 and 4: operational excellence and financial sustainability			

106-21	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*assurance*	116
107-21	**Financial, operational and workforce performance assurance** *Paul Dillon-Robinson, Committee chair*	*assurance*	118
108-21	**Financial performance** *Michelle Miles, Director of finance*	*assurance*	121
109-21	**Operational performance** *Steve Jenkin, Chief Executive*	*assurance*	129
110-21	**Radiology PACS procurement** *Ian Francis, Imaging lead; director of clinical strategy and deputy medical director.*	*approval*	139
Key strategic objective 5: organisational excellence			
111-21	**Board assurance framework** *Lawrence Anderson, Interim director of workforce and OD*	*assurance*	155
112-21	**Workforce monthly report** *Lawrence Anderson, Interim director of workforce and OD*	*assurance*	156
Governance			
113-21	**Annual review of SFIs, SOs and Scheme of Delegation** *Michelle Miles, Director of finance and Performance*	*approval*	169
114-21	**Motion to rescind changes to Governor Steering Group ToRs** *Beryl Hobson, Chair*	*approval*	280
115-21	**Audit committee** *Kevin Gould, Committee chair*	*assurance*	285
Any other business (by application to the Chair)			
116-21	*Beryl Hobson, Chair*	*discussion*	-
Members of the public			
117-21	*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*	-

118-21	*Further to paragraph 39.1 and annex 6 of the Trust's Constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the board to discuss issues of a commercially sensitive nature.* *Beryl Hobson, Chair*	*approval*	

	Minutes (Draft & Unconfirmed)	
Meeting:	**Board of Directors (session in public)** **Thursday 6 May 2021, 11:00 – 13:15 via videoconference**	
Present:	Beryl Hobson (BH)	Trust Chair (voting)
	Paul Dillon-Robinson (PD-R)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Steve Jenkin (SJ)	Chief executive (voting)
	Keith Altman, (KA)	Medical Director
	Abigail Jago (AJ)	Director of operations (non-voting)
	Michelle Miles (MM)	Director of finance (voting)
	Karen Norman (KN)	Non-executive director (voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
	Nicky Reeves (NR)	Interim Director of nursing (voting)
	Gary Needle (GN)	Non-executive director (voting)
	Geraldine Opreshko (GO)	Director of workforce and OD (non-voting)
In attendance:	Hilary Saunders (HS)	Deputy company secretary (minutes)
	Lawrence Anderson (LA)	Deputy Director of Workforce
	Sheila Perkins (SP)	Freedom to speak up guardian **[item 61-21]**
Public gallery:	Five members of the public, including public governors	

Welcome

60-21 **Welcome, apologies and declarations of interest**

The Chair opened the meeting, welcoming those in the public gallery. She went on to welcome SP who would be providing the board with their regular FTSU update and LA, who was observing today's meeting.

It had not been possible to identify a patient for the regular patient story item this month.

There were no apologies; it was noted that the lead governor was not in attendance today as he was on holiday.

There were no new declarations of interest.

As usual, the board had been invited to submit questions in advance of today's meeting to ensure the most efficient use of time.

Standing items

61-21 **Freedom to speak up**

SP noted that since the last board meeting only six people had spoken up; given the current climate she had been expecting more.

The Board received the latest report. A common theme of the report was ineffective communication, and SP was asked what might be done to improve this. She noted that a lot of the problems stemmed from misperceptions, assumptions and beliefs. Supporting staff to recognise communication as a two-way process often helped to address the issue.

Although SP had yet to review the 2020 staff survey results in detail, she had a strong sense from her roles both as FTSU guardian and psychological therapist that two-way communication remained a problem, with a perception of 'them and us' - although when pressed, staff were unable to define who 'they' were. The staff survey results were included in today's board papers and GO highlighted that some challenges related specifically to COVID and remote working across the whole of the NHS; these would be addressed at system level. The Board also noted the survey reported an increase in the number of staff who felt confident in reporting unsafe clinical practice.

The Chair reminded the Board that traditionally during times of crisis, managers need to manage differently but hoped they should be able to revert to a more collaborative style in the near future.

Despite improvements, the FTSU national survey found that a gap remained in how valued by middle management guardians felt, when compared to senior leaders. SP hadn't experienced this

	at QVH. She did, however, suggest that the FTSU guardian role could be promoted again to raise its profile. The report had shown that staff were confident to raise concerns without anonymity; the Board questioned whether there were advantages in anonymity in resolving issues. SP had not received any anonymous speak ups but reminded the board of the many options available for staff to raise concerns in addition to FTSU. Her experience was that requests for confidentiality were harder to manage and she often worked with staff to overcome this. The Director of Nursing and FTSU guardian worked closely together in ensuring that staff felt empowered to speak up without fear of repercussion. In response to a question, the Board was assured that there was no link between the six cases reported. The Trust would continue to work on the root causes of poor communication as part of the overall staff survey action plan which might include supporting managers' communication style as part of their development. There were no further questions and the Chair thanked SP for her update. The next report would be in six months' time, but the Board were welcome to contact SP in the meantime.
62-21	**Draft minutes of the meeting held on 04 March 2021** The minutes of the meeting were **approved** as a correct record, subject to the wording under item 47-21 to be expanded to show that funding for the fixed term locum consultant post had been secured from the Kent and Medway Cancer Alliance, and was not funded by the Trust.
63-21	**Matters arising and actions pending** The Board received the latest Matters Arising update.
64-21	**Chair's report** The Board received the latest report on Chair, NED and governor activities since its last meeting. There were no questions. The Chair went on to announce her retirement with effect from 30 September this year. She reminded the Board that when she agreed to Council's request to extend her term of office to provide continuity as we discussed possible merger, the expectation was that this would be for six months. Due to the delayed strategic case, which was unlikely to be reviewed until the summer, next steps would now take longer. The Chair committed to serving the Trust to the best of her ability in the meantime, noting there was still a lot of work to do. Staff were being notified this morning and governors would be advised later today. The CEO paid tribute to the Chair, noting her skills, knowledge and integrity. During her tenure, QVH had undergone two full CQC inspections, the most recent of which had highlighted strong, visible culture where patients are truly valued as individuals, which had stemmed from her leadership. The Trust's leadership team now had the skills, knowledge, experience and integrity that they needed to lead the Trust thanks to her. The senior independent director concurred, noting that the Chair had always demonstrated value-based leadership and that all Board colleagues have been grateful for the support she has offered. She would be hugely missed. BH thanked her colleagues for the tribute.
65-21	**Chief Executive's report** SJ presented his report highlighting in particular the role the Trust had played as a cancer hub during the second wave of the pandemic and the positive feedback received from visiting surgeons. The Board went on to discuss various aspect of the report, including: • Asking the CEO what he was most proud of with regard to the staff survey, SJ responded that regardless of staff survey results he was grateful to all staff for their significant contribution over the last 12 months. The number of staff participating in the 2020 survey had risen and the survey's core question relating to the staff Friends and Family Test had increased by 2% to 94%; very few other trusts in the country had achieved this. SJ was also proud of the BAME

	network development and appointment of its co-chairs. There had also been good engagement with the local Equality and Diversity network. • SJ's priority for improvement this year focused on team working which had been a challenge this year, due in part to the impacts of remote working. The Team Brief, the Trust's method of communicating with all staff, had been suspended at the beginning of the pandemic but had started up again. Whilst working from home had not impacted on productivity, some other challenges would be taken into account in the longer term. • The recent ICS report required provider organisations to engage in formal collaborative arrangements to enable them to operate at scale. SJ reminded the Board that QVH was already a member of the Sussex Acute Collaborative Network, and that he was a representative on the Sussex Mental Health Collaborative Network. • CEOs in the Sussex Health & Care Partnership had already held one face to face meeting with a further planned for later in the month. A national recruitment drive was currently underway for an ICS chair. • Operational planning guidance had been welcomed and it was good to see staff wellbeing at the centre. Trusts and partners were already looking at what could be done; local workforce plans were being developed, underpinned by fully costed and national workforce plans. QVH continued to take the health and wellbeing of staff seriously; balancing the significant waiting list against the need to support staff was key. Additional funding to manage backlog of care was welcome. There were no further questions, and the Board **noted** the contents of the update.
66-21	**Overarching strategic corporate risks** The Board considered a report highlighting the Trust's three strategic corporate risks highlighting the following: • That the process of developing the strategic case would be a key mitigation in exploring the sustainability risk to the Trust. SJ reminded the Board that no integrated dashboard had been included in this month's report as work was underway to implement a new dashboard relevant to the current working context. • The Executive Team will continue to monitor and measure the impact of initiatives taken to mitigate these risks, including resumption of the Performance Review meetings. There were no further questions, and the Board **noted** the contents of the update.
Key strategic objectives 1 and 2: outstanding patient experience and world class clinical services	
67-21	**Board Assurance Framework (BAF)** The Board received the latest BAF reports for KSOs 1 and 2. Noting that these highlighted workforce risks, the Board sought assurance as to what action the Trust was taking in respect of retention, and succession planning for staff due for retirement. • KA noted that QVH attracted very strong candidates when recruiting; this also mitigated against the risk of staff leaving. • NR noted that the Board already reviews retirement data twice a year; these reports show areas where risks are greatest around retirement and robust plans are in place to mitigate. • A reminder that the recent international recruitment programme had brought in nurses at Band 5 who were considerably below retirement age. • A reminder of the ongoing attraction and retention plans; these included apprenticeships which provide staff with additional accredited education and learning and played a key part in retention. QVH does well in terms of how it is using the apprenticeship levy; as a small trust, it works successfully as a consortium across the system. There were no further questions, and the Board **noted** the contents of the update.
68-21	**Quality and governance assurance** The Board **received** the latest Quality and governance assurance report.
69-21	**Corporate risk register** The Board received the latest corporate risk register. Noting two new risks in Sleep Services, the Board sought and received assurance as to the actions the Trust was taking in mitigation. In particular the deputy medical director was currently operating as interim clinical director to provide

	additional medical oversight, and the board also noted the range of actions - both immediate and longer term - to address the challenges. The Board was advised of recent orthoplastic surgeon appointments; the CRR would be updated to reflect this. There were no further comments, and the Board **noted** the contents of the update.
70-21	**Quality and safety report** The Board received the latest quality and safety report, seeking additional assurance as follows: • Actions taken in response to the recent cluster of C. Diff infections which included very detailed analysis of the situation. • Noting that the Infection Prevention lead is also the out of hours on call lead, the Board queried the long-term sustainability of this position. NR stated that this would not be sustainable long term and was in fact one of the issues that has been highlighted as part of potential merger discussions. • Previous Board papers have reported on the reduced paediatric cover at the Trust during the pandemic, paediatric service level agreements are now operating as normal. Telephone support had continued throughout the hiatus. • There were no particular themes regarding the slight increase in patient complaints in March, although they might be linked to additional COVID controls in place. The Board also noted in contrast the substantial number of plaudits received by patients and their families in testament to the compassionate care shown by staff. There were no further comments, and the Board **noted** the contents of the update.
71-21	**7-day services assurance** The Board received a bi-annual 7-day services report. It received assurance of the action plan, noting that this was continually re-audited with results reviewed by Q&GC and the Board. The Board suggested this report might also go to the Joint Hospital Governance Group. A correction to the date on the second page of the report was flagged, which should have read 2021/22.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
72-21	**Board assurance framework** The Board received the BAF for KSO 3 with the only change relating to risks to capacity to deliver system ICS requirements; this was not just in respect of service but also managerial and business intelligence capacity. In response to a query, AJ advised that late referral from other trusts was not a new risk, and the Trust escalates such cases through our various cancer alliances. As organisations begin to address the cancer backlog there is likely to be an increase in late referrals. Some delays may relate to patient choice or complex pathways and there are a number of measures in place to manage these. The cancer register tracks the patient pathway and weekly discussions with providers help but won't mitigate against all risks. Late referrals are already built into recovery trajectories. The Board reviewed KSO4 BAF, noting additional information relating to submission of year end data. Guidance for 2021/22 had now been received. Like a number of providers working under the current block contract arrangements, QVH had made a small surplus this year.
73-21	**Financial, operational and workforce performance assurance** The Board received a report from the Chair of the finance and performance committee. Assurance was sought as to support being offered by the Trust to staff with families in India, Bangladesh and other countries particularly affected by the pandemic at present. This had been recognised at meeting. Whilst no specific issues had been reported through Workforce, the director of nursing was working with the heads of nursing to ensure that staff with concerns would receive the pastoral care and support they needed. BAME co-chairs were liaising with network members, also reminding them of support available if required. There were no further comments, and the Board **noted** the contents of the update.

74-21	**Operational performance** The Board received the latest operational performance report, seeking the following clarification: • Main challenges to the recovery plans were theatre capacity for surgical activity. There were also some capacity challenges around outpatient orthodontic activity. • 68% of patients waiting over 78 weeks have a 'to come in' (TCI) date; this was a good number but could fluctuate. We have now stepped down activity as a cancer hub, however independent sector (IS) capacity is still uncertain, and so theatre capacity remains a challenge. • Despite access to increased Elective Recovery Funding (ERF) this assumes access to IS capacity. This is not without risk and will be a stretch but is the right thing for our patients and the expectation of the ICS. • Access to the IS remains uncertain; in contrast to the first wave, IS providers have more control of what they will offer, resulting in less availability this year. Discussions are ongoing but these are not only around physical capacity but also staff availability. Plans are predicated on weekend working. There were no further comments, and the Board **noted** the contents of the update.
75-21	**Procurement of Central Sterile Service Department (CSSD) Outsourced Service.** The Board considered a proposal to award the Sterile Service contract to the incumbent supplier; as the value was above the threshold within our scheme of delegation, board approval was required. The Board sought the following clarification: • Assurance that best value has been tested: MM agreed to circulate additional information but, in the meantime, advised that the framework provider is a procurement hub with professionals who run OJEU competitions on behalf of the NHS. • With public spending and procurement there is always a potential risk of challenge; however, two existing suppliers who might have provided the service were not on the framework so would not be eligible to challenge. • A full OJEU tender would be required which due to the complexity of the procurement and lack of skilled staff at the Trust, could take up to 12 months to complete. Moreover, the transition process of a new provider would take two years to ensure seamless handover. • The contract price is a continuation of the current contract, with the price increasing each year against standard inflation as previously agreed. At the time of the original tender, Steris provided the best value to the Trust but with no other providers on the framework it is not possible to compare pricing. This was a large contract for the Trust and the Board was keen to undertake sufficient due diligence before making a decision. It was **agreed** that MM would circulate additional information and a decision would be recorded at the next Finance and performance committee, with input from all board members not just those members of the committee. **[Action: MM]** In the meantime, the Board asked about the status of the Trust contracts register which better supports the planning around the tender process. MM advised that whilst the team work hard to manage this within current resources, without additional resource there was a likelihood of further slippage. A new Contract Manager has been appointed to provide additional support for tendering the CSSD contract via OJEU next time around which should be achieved within the right timeframe.
76-21	**Business Planning and Budget Setting Update 2021/22** The Board received business planning and budget setting proposals for approval for H1 2021/22 (the first half of the financial year, quarters 1 and 2). The Trust was required to reach break-even at the end of H1. The plan had been triangulated with workforce and activity. The Board considered the report seeking additional clarification: • Guidance on funding arrangements for H2 was yet to be published; the normal business planning round was anticipated for 2022/23 from December. • Key areas targeted for the £800k efficiency requirements were not fully scoped out but a number of workstreams were feeding into this. • As discussed under the operational performance report, the c£4m Elective Recovery Fund income triangulates with the activity plan; clearly there would be challenges due to efficiency and capacity issues and phasing of non-pay. Rigorous monitoring would be required to ensure

	we remained on track. The ERF is based on complexities of case load and there is a real need to maximise capacity. • Pay budgets had been discussed at length at F&PC; non-pay budget is phased for the stepped increase in activity and the pay budget will include reduction for vacancies. • A significant number of patients are long waiters and although the Trust will commit to treating as many patients as possible, this was a very ambitious recovery plan, particularly in light of workforce challenges. • The H1 position will be carefully monitored through F&PC, and the Board will be alerted to any issues. • The Trust is also working as part of the ICS, which will be scrutinising waiting lists as well as financial performance. There were no further comments, and the Board **approved** the business planning and the budget for H1.
Key strategic objective 5: organisational excellence	
77-21	**Board Assurance Framework** The Board noted the contents of the KSO5 BAF. There were no comments. The Chair noted that this would be GOs final public board meeting before retirement. On behalf of the Board, she thanked GO for all she had achieved over the last 5 years, including the huge improvements to workforce policies and procedures. GO was always willing to address the difficult issues and had been a fantastic asset to the organisation.
78-21	**Workforce monthly report** The Board received the latest workforce report and commended GO in particular on the successful international recruitment and staff vaccination programmes. Responding as to whether the current situation in India would affect our overseas recruitment plans, GO advised that we were nearing the end of our contractual arrangement; the business planning process would review future requirements and at this stage a decision would be made as to future contracting. There were no further comments, and the Board noted the contents of the update.
79-21	**Staff survey results** GO presented the results of the 2020 staff survey. At the time of the last public board meeting these were still embargoed; however, results had been considered at the board's private session and the March F&PC. The Board sought additional clarification: • The Equality, Diversity and Inclusion metrics were disappointing given the focus on the BAME network over the last 12 months but were reflected across the whole of the NHS. The Diversity action plan has been reviewed by F&PC and picks up actions around addressing a wide number of areas. Progress will be reviewed in the annual plan which comes to Board in November. • The staff survey breaks down results for specific localities which identify varying outcomes. Performance review meetings have been reinstated and general managers will report on actions addressing any specific issue. Updates will be provided to the Board within the Workforce report and not through individual action plans. • GO confirmed that she was already working with the Deputy Director of Workforce and Organisational Development lead to provide support to FTSU and BAME leads in relation to programmes of work. The Chair thanked GO for her update, the contents of which were **noted** by the Board.
Governance	
80-21	**QVH governor representative roles** The Company Secretary presented a report which demonstrated that the Trust fully delivers the requirements for governors to hold NEDs to account. In addition, the Trust also currently has in place arrangements for governors to observe Board sub-committees; whilst this arrangement has

served us well to date it is now subject to review, given that issues under discussion can be sensitive and also identify patient information. Meetings should take place without distractions and follow up questions using FOI and other routes, as has been the case lately. The Board was also reminded that NHS Providers had clearly advised against this practice; stating: '…*in terms of what constitutes good practice we have a clear view that board committees should not be open to governors'.*

The Board considered the report, commenting as follows:

- Whilst the system has worked well until now, it also carries with it risks which include confusion of roles, conflicts of interest and a reluctance of committee members to enter into detailed debate. Currently, there are also risks around confidentiality with some of the new intake of governors stating they do not recognise the need to keep information confidential. Whilst the Trust keeps very little out of the public domain, information posted to social media recently had been manipulated to give an unfair and inaccurate picture.
- The Trust values openness, honesty and transparency but there is now a very real concern that we may no longer be able to operate as we have done in the past. The most recent Council meeting had been very challenging with comments expressed around bullying behaviour, followed immediately afterwards by an FOI around bullying. A further example was where information relayed to governors regarding the transfer of burns services from QVH (under consideration since 2009) had been skewed and instead cited on social media as the Trust being disingenuous with regard to the proposed merger.
- Changes to wider system working are being implemented and committees should provide a safe space where members can address concerns in confidence. The senior leadership team should feel they can apply an appropriate level of rigour otherwise debate will be stifled, and meetings lose their value.
- A reminder that the role of governor representatives (GRs) on committees is not to challenge and join the debate, but to observe; there must be real clarity around the role if it is to continue. It is likely that there may be parts of the meeting where it will not be appropriate for GRs to be present.
- It will be difficult to differentiate in advance which parts of the report are in the public domain and which are confidential. This could become problematic for Chairs in deciding what papers can be shared in advance.
- It is clear that there are some governors who do not want QVH to merge at any cost. Whilst discussions around the merger are strategic the operational work of the Trust must be allowed to continue unfettered, and much work goes on outside meetings.
- That the arrangement might be allowed to continue but if risks start to outweigh benefits this should be reviewed again.

The Chair concluded that GR roles have previously worked well in helping governors understand the work of the Trust, with governors being both responsible and diligent. Whilst understanding and sharing the concerns expressed around confidentiality, the Chair was prepared to continue to manage NHS Provider's guidance on a 'comply or explain' basis. However, to address concerns expressed today this would be subject to the following caveats:

- Governor Representatives will be required to sign a confidentiality agreement.
- The only channel for disclosure of information is the Governor Monthly Update. The practice of checking reports in advance with the committee chair and company secretary will continue.
- Committee chairs will consider what information can be provided ahead of the meeting; confidential information cannot be transmitted to non-NHS email addresses.
- An unusually wide range of declarations of interest have been registered by the current Council of Governors. Before nominating themselves for a role, governors should seek assurance in advance that they have no conflicts which may preclude them from standing. Whilst some conflicts may be manageable, others will not.

Whilst the report stated that any decision will be reviewed in 3 years' time, the Board agreed that any breach of confidence or reduction in committee effectiveness would be subject to immediate review as to whether this arrangement could continue. Any decision to withdraw this arrangement would apply to all committees. It was noted that any further review would not need to return to a public board meeting for decision.

The Chair thanked all members of the Board for their willingness to try to make this work.

81-21	**Self-certification of NHS Provider licence conditions** The Board received a report setting out the requirement to self-certify that it has complied with the NHS Provider Licence and NHS Acts, and has had regard to the NHS Constitution. After due consideration the Board **confirmed**: • 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.
82-21	**Update to QVH Board of Directors effectiveness review:** **Q&GC self-effectiveness review and ToRs for approval** The Board **noted** the update to the March report on board effectiveness and **approved** the terms of reference for the Quality and Governance committee for the next 12 months.
83-21	**Annual board declarations of interest/Fit and proper person test** CP confirmed that the Board's annual declarations of interest/fit and proper person statements had been received for 2021/22 and recorded on the Trust register. These were included in the board pack and published to the Trust's website and would be updated throughout the year as required.
84-21	**Audit committee** The Board received a report following the recent Audit committee meeting. KG also asked the Board to note that the committee had received a verbal update on the status of staff declarations of interest; this had included a small number of individuals who had not yet made a declaration despite follow up at executive director level. The Trust would continue to focus on ensuring these individuals complied fully with the policy and regulations.
Any other business	
85-21	There was none.
Questions from members of the public	
86-21	There were none.

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 2021	75-21	CSSD procurement of outsourced service	KSO4	Additional information to be circulated prior to final decision to be deferred to May F&PC, with input from all board members.	MM	End May		Pending
2	March	38-21	CEO report	Standing items	Detailed analysis of high level strategic risks to be presented.	SJ	May	Discussed at May BoD	Closed
3	March	43-21	GoSW	KSO2	Update on dedicated rest areas for medical staff to be provided to BoD.	KA	May	Rest area to be located around surgeons' mess; preferred provider appointed for contract work, anticipated start date end of May and last approximately 4 weeks. Positive feedback from JCNC at progress of this work.	Closed

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/08/21**		**Agenda reference:**	**97-21**	
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 Chair, NED and governor activities since the last Board meeting.				
Summary of key issues					
Recommendation:	For the Board to **NOTE** the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	**Board of Directors**
Meeting date:	5 August 2021
Agenda ref:	97-21
Report from:	Beryl Hobson, Chair
Date of report:	27 July 2021

Chair's Report

1. AGM

We were delighted to welcome over 70 guests to our virtual AGM in July. We heard from the CEO about the work of the hospital over the last year and our future plans. We also welcomed our new audit partner, Dean Gibbs who provided an overview of the audit and was complimentary about the QVH finance team, who had supported the audit and ensured that our accounts were one of the earliest laid before parliament.

Mr Simon Mackey gave an interesting overview of the work of our breast reconstruction team, emphasising the work of everyone involved, from the initial show and tell sessions through to the final post-reconstruction tattooing and nipple reconstruction. This was an ideal opportunity to showcase the specialist work undertaken by the Trust.

In my opening remarks at the AGM I paid tribute to the Guinea Pig Club on their 80th anniverary. Whilst there are just a few of the Guinea Pigs still alive, their memory will live on due to the hard work of Bob Marchant and East Grinstead Museum with their 'Rebuilding Bodies and Souls' exhibition.

2. Mims Davies, MP

The CEO and I meet regularly with our local MP to update her on developments and issues relating to QVH. On this occasion, a focus was on the development of the strategic case for potential merger.

3. Project Wingman

Project Wingman was established in 2020 as a direct response to the covid pandemic, to explore how grounded aircrew could support NHS staff during the crisis. They put a call out to the airline community with the idea of taking crew into NHS hospitals to look after NHS staff during their breaks, in dedicated lounges. An incredible 6,500 airline crew answered their call for volunteers, from across every UK airline. They offer their time, knowledge and skills to serve and support NHS staff, providing vital well-being and mental health support. For smaller hospitals they use a converted double decker bus. In April this year QVH had a visit from the Wingman bus, and last week we had a return visit. I was honoured to cut the ribbon on their 2nd bus which was making its debut here. A particular highlight was meeting Emma Henderson MBE, one of the founders of Project Wingman, who joined me in declaring the bus open for business.

4. Admin and Clerical leadership development group

I was delighted to present a session to this group based on lessons I have learned in my leadership journey so far. It was great to meet with so many of our admin managers who are seeking to develop their skills and qualifications.

5. Consultants appointments

Throughout my time at QVH I have chaired the consultant appointment panels, which includes the Medical Director, senior clinicians, the CEO and general managers. In recent months we have made some excellent consultant appointments in plastic surgery, orthodontics and radiology. I know that they will all make a significant contribution to the specialist services provided by QVH.

6. Governors

In July we said goodbye to some of our governors, who had made a significant contribution to the work of the Council of Governors. At the last board meeting, we agreed to continue the longstanding system of inviting governors to observe board sub-committees. Following a recent election there are some new faces as governor representatives and we look forward to them providing assurance to their colleagues about the quality of debate and challenge at board sub-committees.

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

KSO1 and 2 were reviewed at the Quality and Governance Committee, 21/06/2021. KSO 3, 4 and 5 were reviewed at the Finance and Performance Committee 28/06/2021. The trust finances continue to be break even due the national requirement and we await further national /regional instruction regarding the financial flows. Changes since the last report are shown in underlined type on the individual KSO BAFs. The integrated pandemic governance process has been embedded and the trust is proactively managing the new and emerging risks identified as part of the restoration and recovery phase. Additional assurance continues to be sought internally and the evidence of this will be referenced in the respective director reports to the August trust board .

	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Target risk
KSO 1	12	12	12	12	9
KSO 2	16	16	16	16	8
KSO 3	16	16	16	16	9
KSO 4	25	20	20	20	16
KSO 5	16	16	16	16	9

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/08/2021**		**Agenda reference:**	**98-21**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	1) Integrated Dashboard 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	• George Cross for the NHS • Our People – congratulations to three people • System assurance • New Secretary of State for Health and Social Care				
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:	BAF reviewed at EMT			
	Date:	05/07/21	Decision:	
Next steps:				

CHIEF EXECUTIVE'S REPORT
AUGUST 2021

NHS receives the George Cross

The National Health Services of the United Kingdom have been awarded the George Cross by Her Majesty The Queen. The award comes in recognition of 73 years of dedicated service, including for the courageous efforts of healthcare workers across the country battling the COVID-19 pandemic.

WINDSOR CASTLE

It is with great pleasure, on behalf of a grateful nation, that I award the George Cross to the National Health Service of the United Kingdom.

This award recognises all N.H.S. staff, past and present, across all disciplines and all four nations. Over more than seven decades, and especially in recent times, you have supported the people of our country with courage, compassion and dedication, demonstrating the highest standards of public service.

You have our enduring thanks and heartfelt appreciation.

Elizabeth R

The George Cross - the highest civilian gallantry award, equivalent to the Victoria Cross - has only been bestowed collectively twice before, and this is the second time it has been awarded collectively by Queen Elizabeth II.

Prime Minister Boris Johnson said:

"We wouldn't be where we are today without our health services. NHS staff have cared for us and our friends and family on the frontline of a pandemic for over a year, and I have witnessed their courage first-hand.

"Thanks to their devotion and duty our NHS has saved countless lives, and the George Cross is a symbol of the nation's gratitude. I know the whole of the UK is behind me in paying tribute and giving thanks for everything the NHS has done for us not only in the last year, but since its inception."

The George Cross is the UK's highest civilian gallantry award, equivalent to the military Victoria Cross. It sits at the top of the UK's honours system, jointly with the Victoria Cross. It is given for acts of the greatest heroism or of the most conspicuous courage in circumstances of extreme danger. The George Cross was instituted in 1940.

TRUST ISSUES

Project Wingman

Project Wingman was founded at the start of the pandemic, to set up and run 'first class style' mobile airport lounges in hospitals, crewed by current or ex-aviation workers who volunteer their time to help.

Following a successful two week visit to QVH back in April/May, Project Wingman revisited from 26 July with their brand new second bus which was officially launched by our Chair Beryl Hobson, pictured alongside Project Wingman chief executive and co-founder Emma Henderson MBE.

Nurses' Day (12 May) and Operating Department Practitioners (ODPs) Day (14 May)

Nurses' day is observed around the world on the anniversary of Florence Nightingale's birth, to mark the contributions that nurses and healthcare assistants make to society. At QVH we also highly value the role of our ODPs and this year we held an event onsite, hosted by our director of nursing, to combine the two occasions and thank our staff.

.

Our People

Geraldine Opreshko retired last month from her role as Director of Workforce and Organisational Development after five years with the trust. During her time, Geraldine introduced new processes and systems aimed at improving our approach to capturing data and efficiencies. In particular during her time, we saw improvement in our recruitment and retention rates including our overseas staff, progression in our staff survey results, development of the Leading the Way initiative, and expansion of medical education including simulation training. Lawrence Anderson has been with us for just over a year as Geraldine's deputy and has agreed to take on the interim director role.

Jag Dhanda, our consultant maxillofacial/head and neck reconstructive surgeon, who has been appointed professor of surgery at Brighton and Sussex Medical School (BSMS). Jag, who divides his time between QVH and UHSussex (Brighton) will co lead the academic surgical group at BSMS with Professor Mahmood Bhutta and Professor Mansoor Khan and will be the programme director for two new masters programmes in reconstructive surgery and dental implant surgery, which will have links with our team at QVH. Through his new role, Jag hopes to deliver more multicentre interventional clinical trials and continue to develop and promote the use of virtual reality in medical and surgical training which has gained interest across the world.

Kelly Stevens, Head of Quality and Compliance has successfully completed her Master's in Business Administration (MBA) programme from the Open University Business School. The programme is designed to take participants on a personal journey where you will challenge limits, cross boundaries and change the way you think.

Kelly was sponsored by QVH through the apprenticeship scheme at ICS level.

Paul Drake, Consultant Plastic & Reconstructive Surgeon and Chief Clinical Information Officer for QVH has been accepted onto the Digital Health Leadership Programme (NHS Digital Academy) Cohort 4.

The year-long programme that is set to commence in September 2021, results in the attainment of a Postgraduate Diploma in Digital Health Leadership, awarded by Imperial College London.

Possible merger University Hospitals Sussex and QVH
Both trusts have continued to work on the strategic case which is being considered at this meeting. Staff engagement sessions have continued with meetings with the orthodontic team, sleep team, consultants, matrons, volunteers (two sessions), and ambassadors group (three sessions) since the last Board meeting. In addition, the Chair and CEO met with our local MP Mims Davies on 18 June.

Integrated Performance Dashboard Summary
Our Integrated Performance Dashboard (Appendix 1) has been slightly changed to reflect the new planning guidance around recovery plans. A revised Staff Friends and Family Test incorporating nine questions was introduced nationally from 1 July, and will be included in future dashboards.

Board Assurance Framework (BAF)
The entire BAF was reviewed at executive management meeting (05/07/2021) alongside the corporate risk register. KSO 1 and 2 were reviewed at the Quality and Governance Committee, 21/06/2021. KSO 3, 4 and 5 were reviewed 28/06/21 at the Finance and Performance Committee. Changes since the last report are shown in underlined type on the individual KSO sheets.

Media
A summary of QVH media activity (Appendix 2) during months April, May and June 2021, reflecting particular interest around cancer.

SUSSEX ICS
System Assurance
NHS England and NHS Improvement's approach to oversight for 2021/22, reinforces system-led delivery of integrated care. This reflects the vision set out in the NHS Long Term Plan, *Integrating care: Next steps to building strong and effective integrated care systems across England*, the White Paper *Integration and innovation: Working together to improve health and social care for all*, and aligns with the priorities set out in the 2021/22 Operational Planning Guidance.

The new NHS System Oversight Framework will:

a) provide clarity to integrated care systems (ICSs) on how NHS England and NHS Improvement will monitor performance; set expectations on working together to maintain and improve

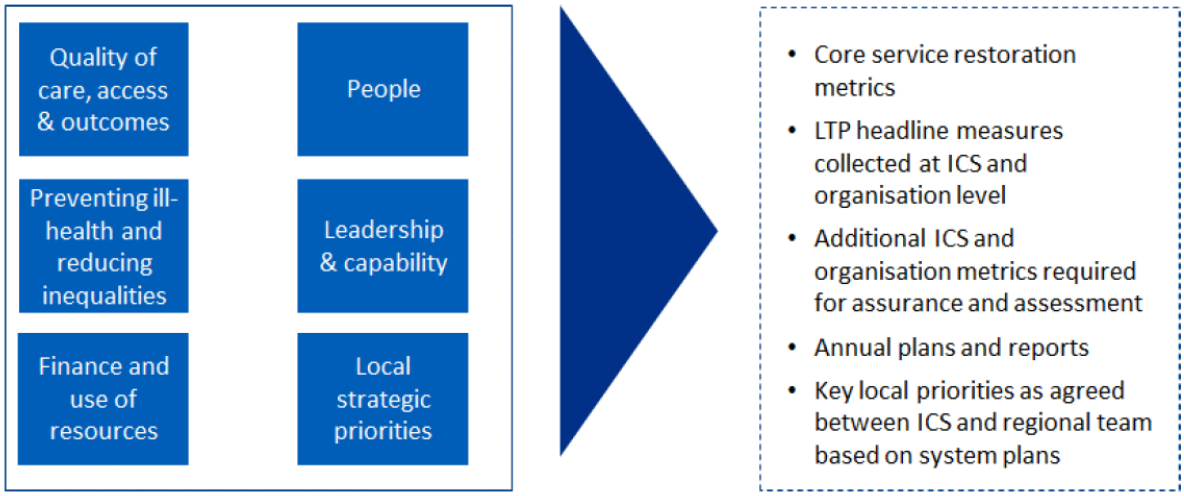
the quality of care; and describe how identified support needs to improve standards and outcomes will be co-ordinated and delivered

b) be used by NHS England and NHS Improvement's regional teams to guide oversight of ICSs at system, place-based and organisation level as well as decisions about the level and nature of delivery support they may require
c) describe how NHS England and NHS Improvement will work with the Care Quality Commission (CQC) and other partners at national, regional and local levels to ensure our activities are aligned.

The purpose of the proposed new framework is to:

a) align the priorities of ICSs and the NHS organisations within them
b) identify where ICSs and organisations may benefit from or require support to meet the standards required of them in a sustainable way, and deliver the overall objectives for the sector in line with the priorities set out in the 2021/22 Operational Planning Guidance, the NHS Long Term Plan and the NHS People Plan
c) provide an objective basis for decisions about when and how NHS England and NHS Improvement will intervene in cases where there are serious problems or risks to the quality of care

Figure 1: Scope of the NHS System Oversight Framework for 2021/22



The Sussex ICS have agreed that the approach and purpose of System Oversight will always be focussed on the quality of health and care that our population experience with regards access, experience and outcome, and always ensure that health inequalities are reduced. The segmentation of any NHS organisation should represent the care the population can expect to receive and is a marker of our efforts to deliver our core purpose:

a) improving population health and healthcare
b) tackling unequal outcomes and access
c) enhancing productivity and value for money
d) helping the NHS to support broader social and economic development

In addition to planning and providing health and care services for its resident population, the Sussex ICS is also responsible for the quality and level of care received by patients outside of Sussex at any of its provider organisations. For QVH, this includes patients in Surrey and Kent, where many patients who are treated at the trust, outside of the Sussex area.

NATIONAL SCENE

New Secretary of State for Health and Social Care

Sajid Javid has been announced as the new health and social care secretary after the resignation of Matt Hancock on 26 June. On the day of his appointment, Deputy chief executive Saffron Cordery from NHS Providers said:

"Trust leaders will welcome the rapid appointment of Sajid Javid as the new secretary of state for health and social care. He now has number of important tasks facing him.

"His immediate challenge is to steer the NHS as it navigates this latest phase of the COVID-19 pandemic while providing the health sector with the support it needs to clear the substantial backlog of care.

"Workforce pressures will also be top of the in-tray for the new secretary of state. We have asked so much of our staff during the past year and they need rest and reward to tackle burnout, boost morale and prepare for the challenges ahead. Not only must the secretary of state look at the pay deal being offered to those on the frontline, but we would urge him to negotiate a fully funded workforce plan to tackle the significantly high levels of vacancies within the service and ensure a sustainable pipeline of staff.

"The secretary of state's appointment also comes during a very important year for the NHS. There is important legislation waiting in the wings, heralding the biggest reforms to the health service in over a decade. Sajid Javid will also need to ensure the needs of the NHS are represented ahead of the upcoming comprehensive spending review where major decisions about public spending will be made. This includes future funding of the NHS, long-term investment in capital for heath and care and critically, a decision on the future of social care."

Pay award

The Department of Health and Social Care has accepted the recommendations of the independent NHS Pay Review Body and the Review Body for Doctors' and Dentists' Remuneration for a 3% pay raise for NHS staff.

The award covers most staff groups, including nurses, paramedics, consultants, and dentists in England. It does not apply to junior doctors who continue on a separate multi-year deal with rises of 2% per year.

We await clarity that the rise is fully backdated to 1 April 2021 and fully funded by government so we do not see money diverted away from other priorities that could impact on patient care.

Integrated Care System (ICS) Design Framework

We continue to work with partners across our system to improve care for our local communities and plan for the implementation of the proposals set out for legislation on integrated care systems from April next year. NHS England and NHS Improvement published the Integrated Care System (ICS) design framework on 16 June setting out the ambitions for function of the partnerships, governance and management arrangements, elements of good practice, the financial framework and roadmap to implementing new arrangements ahead of new legislation due to come into effect in April 2022. The design framework will be supplemented by further information and guidance later this year to support detailed planning.

Care Quality Commission - A new strategy for the changing world of health and social care
The Care Quality Commission (CQC) has published a new strategy that will place more emphasis on patient experience. The CQC has also pledged to make inspection less time consuming for providers and to focus on how providers interact with one another rather than just upon individual providers. The strategy proposes that ratings will evolve to reflect patient experience and to be more flexible in re-inspecting services to update ratings. It also pledges to improve the way the CQC assesses how patients and users are encouraged to speak up and to look at how patients and communities are involved in designing services. Former health secretary Matt Hancock also confirmed that the CQC will be given powers to rate integrated care systems for safety and quality from April 2022.

Steve Jenkin
Chief Executive

Integrated Dashboard Summary
Key indictators at a glance - August 2021 (reporting M3)

NHS
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	1
No of off-site deaths (within 30 days)	3
Complaints	4
Closed <30 days	6
FFT	
In patients	98%
Outpatients	96%
MIU	94%
Day surgery	96%
Hand trauma	97%

KSO 3 Operational Excellence

MIU <4hrs	99.05%
RTT 18 weeks	77.59%
Cancer 2ww	98.50%
Cancer 62 day	89.20%
Diagnsotics <6weeks	94.07%
52ww	370
Recovery activity	
Day case	93.00%
Elective inpatient	93.00%
First outpatients	113.00%
Follow-up outpatients	102.00%
Outpatient therapies	111.00%
Non-elective	104.00%

QVH continues to provide additional capacity for surgical cancer treatments on behalf of organisations from Kent, Surrey and Sussex impacting capacity for non urgent activity until the end of March

Key	Improved Performance	Deteriorating Performance	Remains the same

KSO4 Financial Sustainability (YTD)

Income	22,368k
Pay expenditure	13,385k
Non-pay expenditure	7,781k
Surplus/Deficit	1,202k

The financial position reflects the trust internally reported position. Monthly phasing of the plan is misaligned to the Provider Finance Return (PFR), with plan alignment reached at M6.

Block regime in H1, ERF estimated income £2.2m is within the position/ The trust is awaiting agreement and confirmation on actual performance, no clawback has been assumed in the YTD position.

Guidance for H2 will be published in September. Indicative efficiency target of 3%.

KSO5 Organisational Excellence

Vacancy rate	9.89%
Turnover rate	12.20%
Sickness rate	3.04%
Appraisal rate	83.72%
MAST	92.35%
Q2 Staff FFT (work at QVH)	
Q2 Staff FFT (care at QVH)	

QVH media update – April 2021

SpiderMan style wound dressing
Baljit Dheansa, our consultant plastic surgeon, was quoted in an article in The Times about a medical gun that spins out a protective web to cover burns and wounds. It is hoped that the product called SpinCare, which 'spins' a breathable mesh that mimics the structure of real skin, will help patients recover without the need for potentially painful bandage changes. Our burns team have been trialling the wound covering on some of our patients with the intention of evaluating is efficacy and publishing their research.

A shorter piece about Queen Victoria Hospital's trialling of SpinCare also appeared in The Sun on Sunday.

QVH is 'doing all it can' to treat patients quickly
Following the release of figures from the Nuffield Trust about the number of patients nationally who have been waiting a year or more for operations, we received some local media interest on how Queen Victoria Hospital fared. Both the Mid Sussex Times and the West Sussex County Times ran an article using figures from the Nuffield Trust whilst highlighting how during the pandemic Queen Victoria Hospital became a specialist surgical cancer hub, treating patients referred to us from other hospitals across Sussex, Surrey and Kent with high risk cancers. However, we are doing everything we can to treat our patients as safely and quickly as possible.

At the end of this month, the Mid Sussex Times ran another article stating how cancer patients referred to our hospital are being seen within the two-month target time, despite performance hitting a record low nationally. NHS data shows that in February 87.5 per cent of cancer patients at Queen Victoria Hospital started treatment within 62 days of an urgent GP referral. This was up from 85.3 per cent in January.

Sun protection is serious
Paul Banwell, former QVH consultant plastic surgeon is quoted in an article in the Daily Mail about sunburn and skin cancer. The piece which references his involvement in setting up our melanoma and skin cancer service, talks about how a woman named Jackie has had malignant melanoma twice despite never holidaying abroad. Mr Banwell talks about how episodes of sunburn from as far back as childhood are a significant predictor of future skin cancer formation. The article was also cited on the nation.lk website.

Operating theatres team leader shortlisted for national award
The news that Kokila Ramalingam, our specialty team lead for plastic and reconstructive surgery, has been shortlisted for a prestigious National BAME Health & Care Award, received local media attention. Up for the "Compassionate and Inclusive Leader – Role Model" award, Kokila has been recognised for her proactive approach in anticipating the needs of patients coming for surgery; her bravery and consistency in challenging more senior clinical staff to meet required standards; her gentle determination; and her commitment to supporting incoming overseas nurses. The Mid Sussex Times and the InYourArea website both ran an article.

Prince Philip and the Guinea Pig Club
Following the passing of HRH Prince Philip, the Duke of Edinburgh, The Telegraph ran an article in its print and digital publication, about his involvement in the Guinea Pig Club. After the death of Sir Archibald McIndoe, The Duke was appointed president of the Guinea Pig Club, a role he "held with pride" until his retirement from public duties in 2017. Bob Marchant, the Club's honorary secretary, is quoted in the piece regarding working with McIndoe and the founding of the Club at our hospital.

ITV Meridian also ran a piece and story on its website about The Duke of Edinburgh's involvement with the Guinea Pig Club; including an interview with Bob. It mentioned how he opened our new burns unit in 1995 and The Duke's admiration for the Club's qualities of being stoic and resilient in the face of great danger and adversity.

Mum's determination to hug her children
We were mentioned in an article in The Mirror about how Sue Neil is dreaming of hugging her children again after sepsis resulted in all four of her limbs being amputated. After being transferred from intensive care, Sue came to our hospital for ten months. She underwent procedures on her arms and legs, and also reconstruction on her face as the sepsis had spread. Sue is now determined to learn to walk and a fundraising appeal has been launched to pay for new bionic arms.

For many people, plastic surgery is not about vanity
Nora Nugent, our consultant plastic surgeon and clinical lead for burns, was the subject of an article in The Irish Times, as part of its businessperson awards features. She explains how those not involved in the field sometimes misunderstand plastic surgery. Our hospital is referenced in relation to Nora's NHS work, which includes burn care, breast reconstruction after breast cancer, and some skin cancer work.

Press releases
We issued the following press releases this month which you can read via the links below:

- Operating theatre team lead shortlisted for national award
- GB Paralympian and Strictly star gets behind QVH Charity challenge

We also published the following information on our website:

- Coronavirus information and advice for our patients and visitors – updated standing item
- What's happening about the possible merger?
- Visiting patients on our wards during the COVID-19 pandemic – update

QVH media update – May 2021

Supporting patients with cancer
Siva Kumar, our consultant plastic surgeon and clinical director for plastics was interviewed by BBC Radio Sussex in a piece about how Queen Victoria Hospital has been supporting patients with high-risk cancer from across Sussex, Surrey and Kent since the start of the pandemic.

Siva explained how we have been working with other hospitals to provide timely treatment for patients with breast, head and neck, and skin cancer, whilst ensuring we continue to support patients with other conditions who need our specialist services, including through an increase in virtual consultations.

One of our skin cancer patients spoke about his experience of coming to Queen Victoria Hospital for surgery during the pandemic and what a positive experience he had. To complete the piece, David Johnson, one of our heads of nursing, spoke about the role our nurses play. This included taking on additional responsibilities such as swabbing patients in the community before they come to our hospital for surgery.

The piece, recorded on site whilst following all social distancing guidelines, aired on 14 May and was part of a series looking at the way the NHS has continued to treat patients who did not have COVID during the pandemic and beyond.

However, not everyone who has potential symptoms of cancer is seeking medical support when they need it. The Mid Sussex Times ran an article using nationally available figures which showed the number of imaging scans carried out at Queen Victoria Hospital between March last year and February this year was down on 2019/20 figures. Figures at many trusts including those in Sussex and Surrey were also down on previous years.

As Ian Francis, imaging lead and our director of clinical strategy, explained in our response quoted in the piece: “Whilst we have seen fewer referrals for scans during the pandemic, as we are able to see and treat more patients demand for our radiology services will continue to increase.” We encourage anyone with symptoms to visit their GP because the earlier cancer is diagnosed, the sooner it can be treated.

5K May challenge for our QVH Charity

To promote the latest fundraising challenge in aid of our QVH Charity – 5k May – our charity received a series of promotional support on local radio station Meridian FM. This included an interview with Andy Mellington, one of consultant plastic surgeons, on the Meridian Sports Show on 4 May about why he was getting involved.

Camilla Slattery, our head of fundraising and voluntary services, was also interviewed on the Community Show on 17 May to encourage more people to take part. The challenge asks people to take part in a 5km challenge of their choice (run, swim, cycle, walk), donate £5 to QVH Charity and nominate 5 friends to do the same.

Project Wingman flies in

We were fortunate to receive a two-week visit by the team from Project Wingman and their Wellbee wellbeing bus at the end of April/start of May. Project Wingman was founded at the start of the pandemic, to set up and run 'first class style' mobile airport lounges in hospitals, crewed by current or ex-aviation workers who volunteer their time to help. BBC Radio Sussex recorded a piece on the bus whilst it was at our hospital, including an interview with two of the crew. The piece about the project and what the crew through about being at our hospital aired on 26 May.

Cousins injured in pub explosion
Queen Victoria Hospital was mentioned in a series of national and regional media following a heater exploding at a pub. Two cousins were reported to have sustained life changing injuries after being "engulfed in flames". We were named as the hospital where one of the cousins is being treated.

Media outlets to feature the news include The Sun; The Daily Mail; Metro; Daily Record; LadBible; Yahoo News; Joe.co.uk; Daily Gazette/Essex County Standard (and a follow-up piece regarding a fundraiser for the cousins); Clacton and Frinton Gazette; the Halstead Gazette; Basildon Canvey and Southend Echo (and a follow-up piece regarding a fundraiser for the cousins). It was also covered by the New York Post.

Mother and son injured in suspected gas explosion
This month we were also mentioned in a series of national and regional media regarding Ethel Hanford aged 99 and her son Donald aged 75, who suffered burns to their faces after a suspected gas explosion at Ethel's home in Kent. The articles state that Donald was being referred to our burns unit for treatment.

Media outlets to feature the news and mention Queen Victoria Hospital included The Daily Mail. The news also featured in The Mirror and the Kent Live website although we were called East Grinstead Hospital.

False widow bites result in hospital stay
Philip Oakley's battle against false widow spiders taking over his workshop resulted in him becoming one of our patients, according to a range of national media. Outlets to run the story about his plight against his eight legged enemies included The Mirror; The Sun; The Daily Star; and Wales Online. The news also received some international interest and was featured on the Noticias Caracol website.

Passing of Arthur Sidney Woolf
The death of one of the last remaining members of the Guinea Pig Club, Arthur Woolf aged 99 years old, featured in a range of media titles. One that specifically mentioned his connection to Sir Archibald McIndoe and our hospital, referenced here as East Grinstead Hospital, was the Express and Star.

Press releases
We did not issue any press releases this month. However, we did publish the following information on our website:

- Show your appreciation this Nurses' Day
- Why I became an operating department practitioner
- Coronavirus information and advice for our patients and visitors – updated standing item.

QVH media update – June 2021

Promoting QVH Charity
Following on from local radio station Meridian FM's support of QVH Charity's 5k May fundraising challenge last month, Camilla Slattery, our head of fundraising and voluntary services, returned for a follow-up interview on 24 June. Thanking everyone who took part in the May challenge, she explained two further opportunities to get involved in supporting QVH Charity – the NHS Big Tea in July (a chance to brew and say a national thank you) and the Walk for Wards 5k or 10k event in September supporting NHS charities in Sussex.

Teenager referred following assault
Queen Victoria Hospital was mentioned in two articles in the Hastings and St Leonards Observer (second link is here) regarding the assault of three teenagers in Hastings, one of whom was referred to us for further treatment. The story was also linked on a variety of other news sites including thefreelibrary.com.

Cousins injured in pub explosion
Following last month's coverage by a number of national and regional media following a heater exploding at a pub and one of the two cousins who was injured being referred to Queen Victoria Hospital, the news has continued to circulate online. One website to feature a piece was GruntStuff.com which picked up on information circulated by the South West News Service. It does however move us geographically to London.

Fascinating history of now derelict building
Lincolnshirelive.co.uk ran an article about Rauceby Hospital, originally known as Kesteven County Asylum, which became a hospital dedicated to Royal Air Force service men during WWII. Surgery was led at the then No. 4 RAF Hospital Rauceby by Sqn Ldr Fenton Braithwaite and Sir Archibald McIndoe. Queen Victoria Hospital is referenced in the piece in relation to McIndoe working with his cousin, Sir Harold Gilles, to perform ground-breaking operations at our hospital, and also in relation to the Guinea Pig Club which included some men who received surgery at Rauceby.

Press releases
We did not issue any press releases this month. However, we did publish the following information on our website:

- Visiting patients on our wards during the COVID-19 pandemic – updated standing item
- New issue of QVH News is out now!

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 August 2021**		**Agenda reference:**	**99-21**	
Report title:	**Future organisational arrangements – strategic case**				
Sponsor:	Steve Jenkin, chief executive				
Author:	Clare Pirie, director of communications and corporate affairs				
Appendices:	NA				
Executive summary					
Purpose of report:	The purpose of the Strategic Case is to consider the strategic rationale for change.				
Summary of key issues	Challenges faced by QVH - fragile clinical services; fragile support functions and financial sustainability Strategic options evaluation gave a preferred option that QVH and UHSussex come together via merger by acquisition. One of the main potential benefits of this option is that it provides a long-term, sustainable future for QVH hospital and staff allowing strengthening of corporate functions and reducing existing QVH fragilities. As there are elements of the strategic case that are commercially sensitive, the full Strategic Case will be considered in private.				
Recommendation:	The Board is asked to **DISCUSS** the contents of the report.				
Action required	Discussion				
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	This paper is concerned with the long term future of QVH and is relevant to all elements of the Board assurance framework				
Corporate risk register:	This paper is relevant to elements of the corporate risk register particularly related to sustainable staffing, operations and finances				
Regulation:	The paper gives consideration to regularity requirements				
Legal:	The paper gives consideration to legal requirements				
Resources:					
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:	As there are elements of the strategic case that are commercially sensitive, the full Strategic Case will be considered in private.				

Report to:	Board Directors
Agenda item:	99-21
Date of meeting:	5 August 2021
Report from:	Steve Jenkin, chief executive
Report author:	Clare Pirie, director of communications and corporate affairs
Date of report:	28 July 2021
Appendices:	NA

Future organisational arrangements – strategic case

1. Introduction and background

1.1. QVH and UHSussex (Brighton and Sussex University Hospitals NHS Trust, BSUH, as predecessor organisation) have had a long-standing collaborative relationship and strong clinical links have existed between BSUH and QVH for many years. QVH considers its clinical links with UHSussex amongst its primary relationships, and the two trusts have a number of shared posts and service level agreements in place.

1.2. QVH is a specialist trust providing high quality services for which patients are prepared to travel considerable distances. Patient and staff are very positive about the compassionate and skilled care provided at QVH, but running as a standalone organisation is increasingly challenging. Over the last few years the Board has been considering how to remain wholly independent and can see no way that this can be achieved.

1.3. Without the range of clinical services on site usually found in an acute trust, QVH has contracts for a range of support services. The cultural difference between a service contract and belonging to the same organisation is significant, with clear benefits to reducing time needed for negotiating and monitoring contracts.

1.4. As a small organisation, QVH often has only one person responsible for a role. In some functions it is possible to schedule around planned leave but in others, such as safeguarding or PALS and complaints, even pre-arranged absence is difficult.

1.5. QVH has a growing financial deficit and while staff have worked hard to address that, there are no more easy wins, and the Board of QVH is clear that the Trust will not jeopardise safety or quality through cuts.

1.6. In November 2019, the QVH Board acknowledged that it could not continue to function independently in its current form, and agreed to explore a more formal arrangement with what is now UHSussex.

1.7. The Strategic Case has been developed by UHSussex and QVH together with the support of NHSEI to determine the best approach to working together and the best future organisational form.

1.8. The board of QVH will consider whether the preferred option would help to:

- further develop and invest in services
- maintain and build on QVH's excellent record for patient experience, clinical outcomes and safety

- continue to provide services to patients from the wide area covered currently (including Kent and Surrey as well as patients who travel much further for our care)
- continue to deliver world class research and innovation
- secure the future of the hospital in East Grinstead

1.9. The purpose of the Strategic Case is to consider the strategic rationale for change. If there is a decision to proceed to full business case (FBC) then there is a great deal more detailed work to do before the boards of both organisations are asked to take a decision on whether or not merger should go ahead. This will include further engagement with staff, people who use our services, our commissioners, other healthcare providers, and other stakeholders such as charities closely linked to our work. Both organisations will be explaining what merger would look like, and seeking views on what improvements we should seek to achieve in merger and what concerns we need to address.

2. National and local context

2.1 The long-term vision of the NHS nationally and locally is dependent on NHS organisations working collaboratively to deliver service transformation and create sustainable services.

2.2 Along with other Sussex trusts, QVH and UHSussex operate within the Sussex Integrated Care System and work closely with partner health and social care organisations. The Sussex Health and Care Partnership Strategic Delivery Plan: Response to the NHS Long Term Plan includes the formation of the Sussex Acute Collaborative Network (SACN). The SACN's role is to strengthen strategic partnership between acute trusts, foster collaborative working in development of sustainable services and oversee a programme of work operating across the ICS.

2.3 QVH is a specialist NHS hospital in East Grinstead, West Sussex, and was established as a Foundation Trust in July 2004. The Trust employs circa 1,000 people. In May 2019 the Trust maintained its overall CQC rating of Good and outstanding for caring.

2.4 University Hospitals Sussex was formed on 1 April 2021 from the merger of Brighton & Sussex University Hospitals NHS Trust (BSUH) and Western Sussex NHS Foundation Trust (WSHFT). UHSussex employs nearly 20,000 people across five main hospital sites in Sussex, and has an operating budget of more than £1 billion. The Trust runs seven hospitals in Chichester, Worthing, Shoreham, Haywards Health and Brighton and Hove, as well as numerous community and satellite services. As a new organisation the Trust has not yet had a CQC inspection and until the next inspection WSHFT's CQC ratings stand for the Trust as a whole. At the last CQC inspection in 2019 the Trust maintained its overall rating of Outstanding.

3. Case for change

3.1. In October 2020 QVH published a document called *Securing the long term future of QVH,* setting out the reasons why change is needed, and describing the three key challenges which need addressing in order to continue to develop world class services and outstanding patient care.

3.2. The challenges faced by QVH are primarily due to the small size of an organisation delivering specialist services and can be summarised as fragile clinical services; fragile support functions and financial sustainability.

4. Fragility of clinical services

4.1. There are a wide range of clinical services required to support the specialist services delivered at QVH. For most large organisations these are part of the overall infrastructure that is in place on acute hospital sites. However, due to the size of QVH and the limited range of clinical specialties delivered, QVH does not have the full range of clinical services that would be found in a bigger teaching or general acute hospital.

4.2. In order to remedy this QVH relies on other organisations to provide these services through a range of arrangements to support the delivery of high quality safe care. Currently, QVH has Service Level Agreements (SLA) with a range of different providers including the following with UHSussex;

- Paediatric consultant cover
- Pathology
- Microbiology
- Imaging services
- Support for critical care services
- Support for elderly care
- Support for cardiology
- PACS management
- General medical support

4.3. However, having access to a contractual service from an NHS body is not as flexible and therefore as comprehensive to meet the demands of patients as accessing services from within an organisation. Services delivered in this way involve a level of bureaucracy between organisations and can mean services are not as agile as they could be, and services need to be agile particularly in times of changing demand and circumstances, as seen through COVID-19 pandemic.

4.4. In some cases it is not possible to purchase or contract with other organisations to deliver the service required and therefore there are a number of services that have greater challenges to delivery of safe care and compliance with national service specifications.

4.5. For QVH, as a small specialist mainly surgical hospital, issues of compliance with national specifications relate to both adult and paediatric inpatient burns services, critical care and paediatric inpatient services.

4.6. Whilst robust mitigations are in place to limit the clinical risks, the level of risk appetite against the required criteria and the increased costs of providing a safe service, including accessing support services from other NHS providers, significantly impact on the position of the Trust.

4.7. The absence of a full range of support services on site creates challenges and fragility across QVH clinical services including burns, critical care and paediatric inpatient services which face significant challenges to delivery of safe care and compliance with national service specifications.

4.8. It is recognised that although QVH provides an excellent service the burns service does not meet the National Burns Care Standards (2018) and is non-compliant with 32 of the 317 standards. The standards specify that adult and paediatric burns units must be co-located with a number of other clinical services that are not available on

the QVH site. The position has been recognised by the Trust and its commissioners and the service has been in formal derogation since 2013. Whilst appropriate admission thresholds and transfer criteria for burns patients are well established and can mitigate some of the potential clinical risk, the current levels of clinical cover on the QVH site mean that there is an increased requirement to transfer patients to other providers so they can receive the specialist medical care and access other clinical services that are not available 24 hours a day at QVH.

4.9. The clinical risks for paediatric burns were such that in August 2019 the service temporarily suspended acute inpatient admissions of paediatric burns and children are now admitted to other burns centres outside the region.

4.10. The critical care service does not meet all the Critical Care Service Specification Standards (2019) with a self-assessment identifying compliance with 64 standards, 3 partially met and 18 not met. Challenges include the availability of some support services including on site medical cover, out of hours radiology cover, general surgical cover and ECHO, and the prohibitive cost of collection and submission of data for National Intensive Care National Audit and Research Centre audit. A review by South East Critical Care Network in 2019 found no evidence to suggest poor performance or patient outcomes, and there were no concerns about quality or safety. However, it concluded that whilst the inability to meet a portfolio of national standards does not prohibit the delivery of critical care, it does necessitate discussion with commissioners about expectations of care delivery and future commissioning intentions.

4.11. QVH provides a paediatric surgical and burns service for children from the age of one to 16 years. The service has challenges meeting standards related to, among others, co-location with medical paediatric services, co-location or timely access to other services, availability of paediatric HDU and PICU and paediatric anaesthesia**.** Appropriate admission criteria, the quality and training of staff on site and the service level agreement arrangement with the Royal Alexandra Children's Hospital in Brighton mitigates some of the potential clinical risk, and in this context the Trust ensures children who require an inpatient stay are risk assessed to ensure QVH can deliver safe quality care within the constraints of the medical cover available**.**

5. Fragile support functions

5.1 The size of the Trust means that in a number of areas there is just one person who is responsible for a role in the organisation. This provides a challenge with being able to cover periods of work pressure, annual leave, sickness, and gaps between members of staff leaving the trust and new recruits starting.

5.2 The small size of the Trust and the specialist nature of its work mean that there is limited scope for career progression resulting in staff having to leave to gain further experience and promotion. In addition, this also means staff are highly competent within a specialist range of skills but have limited exposure to a sufficiently broad range of skills in some clinical areas and that this knowledge and experience can only be gained by moving to a different hospital trust.

5.3 There are posts within the Trust where one person is responsible for an activity and this impacts both clinical and non-clinical roles creating a number of issues. This includes:

- The inability to share expertise, experience and ideas within a team. This results in developing ways of doing things in isolation, recognising that there may be other, better ways of doing them.

- A lack of other people with appropriate levels of expertise and seniority to pass work to during periods of absence. Some functions are put on hold when a key individual is absent, and this can have a significant personal impact on the individual themselves. Bringing in agency or locum cover for annual leave adds time and expense in training and familiarisation with the role.

- Some posts have multiple roles or areas of responsibility including multiple statutory or corporate roles that might sit with several individuals or even have their own dedicated teams in a larger trust (for example, complaints, PALS and litigation) to day-to-day responsibilities that might be shared across more people in a larger team (such as data reporting, managing rosters and ordering consumables).

- Pressure points or times of the year that are especially busy impact more significantly on an individual than across a team, including administrative support that could be deployed to support individuals at times of need.

- The impact of having sole responsibility for a function has on staff wellbeing and life outside of work, leading to cancelling leave or work while on leave, unable to switch off fully from work and anxiety about taking sick leave.

5.4 QVH therefore lacks some of the opportunities that can come with larger organisations such as larger teams with overlapping roles or support arrangements providing a more stable basis on which support functions can be provided. These non-clinical functions include but are not limited to:

- Leadership and management teams
- IT services
- HR functions
- Finance and Procurement
- Corporate Governance
- Adult and Paediatric Safeguarding
- PALS and Complaints

5.5 These challenges are not limited to non-clinical services, and clinical services facing similar issues with lack of scale and flexibility include infection control and prevention, dietetics, imaging and nurse specialist roles.

5.6 As a Foundation Trust QVH is legally required to meet the same requirement for standards and reporting as a much larger organisation, and this leads to a disproportionate level of overhead costs compared to other trusts. For example the most recent Corporate Services benchmarking report (2018/19) demonstrates QVH is consistently in the third or fourth national quartile for its corporate functions, meaning the cost of providing these functions is higher per £100m income than most other trusts.

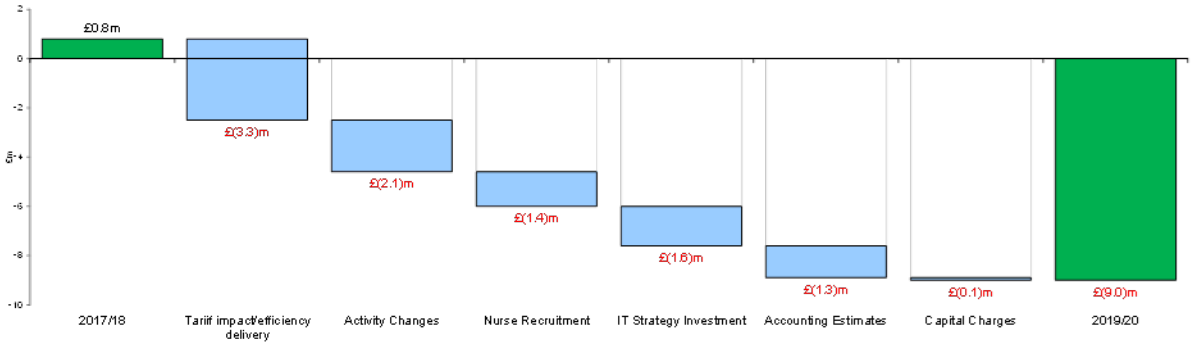
6. Financial sustainability

6.1 Until 2017/18 QVH had delivered a break-even or surplus position, but recognised that this was secured through non-recurrent means in prior years. In 2018/19 and 2019/20 QVH reported an adverse deficit position against its plan and the control totals set by NHSI. QVH has worked hard to secure efficiencies but it is not possible to close the financial gap as a standalone organisation without impacting quality.

6.2 The financial position in 2020/21 showed an improvement under the interim financial framework that was applied during the COVID-19 pandemic. Under this financial framework, which has also extended into the first six months of 2021/22, provider organisations are funded via block payments and a series of top-up payments that reflect historic expenditure levels. The Board of QVH are aware that this level of income will not be maintained and that the underlying position continues to be a deficit projection.

6.3 The reasons for the deteriorating financial position are multiple. The chart below tracks the financial position of QVH from a small surplus of £0.8m in 2017/18 to a deficit of £9.0m in 2019/20 demonstrating the key drivers of the financial deterioration.

QVH Drivers of the Deficit



The key drivers are summarised below.

Driver	Summary
Tariff impact and efficiency delivery	Requirement to deliver real-terms cost savings (national efficient requirement) across two years as a small trust - QVH was able to deliver 61% of what was required. The market forces factor was rebased in 2019/20 and had an adverse impact on income and will continue to have an adverse effect for five years. Non-elective trauma tariff changed and created an income gap. Above average inflationary increases related to premiums for the national clinical negligence scheme for trusts and medical and surgical equipment. As QVH was not able to deliver its full national efficiency requirements and therefore unable to access the national financial recovery fund, it was unable to mitigate these pressures.
Activity Changes	Constant activity over last three years. Case-mix change with minor injuries activity increasing and non-elective (trauma) reducing. Elective and outpatient overall unchanged but reducing maxillofacial activity. No service change or cost release in services reducing activity. Premium rate or outsourced activity to reduce elective backlog via additional capacity.

Driver	Summary
Nurse recruitment	Incurring additional costs for substantive nursing posts that had not previously been covered.
IM&T investment	Upgrade and modernisation of IM&T infrastructure impacting non-pay and depreciation charges on the capital investment.
Accounting estimates	In year benefit of 2017/18 stocktake improved the position that year non-recurrently. Temporary bad debt provision in 2019/20, subsequently reduced in 2020/21.
Capital charges	Increased public dividend capital and financing costs.

6.4. The majority of the drivers are recurrent and will not only continue to impact on QVH financial performance but in certain cases will increase in impact. The small size of QVH and the related inability to be agile when responding to tariff or activity changes will create further challenges as the financial framework in 2021/22 reverts to planning assumptions aligned with NHS Long Term Plan (LTP) and as there is increasing requirement for restoration and recovery of services.

6.5. QVH medium-term financial planning forecasts that this deficit will increase to £9.6m by 2023/24, at the end of the LTP period. This projection includes an assumption that QVH delivers the national efficiency requirement of 1.1%. It should be noted that historic efficiency delivery has been below 1.1% per annum so there is a risk of further deterioration in this projection.

6.6. The LTP expects all organisations to be in recurrent balance by 2023/24. In order to achieve this QVH would need to deliver efficiencies in excess of 4.6% per annum with a high of 5.5% in 2023/24. Delivery of efficiency at this level is considered to be stretching and would be more so in a small organisation. It is therefore unlikely that QVH can deliver a balanced financial position whilst remaining as a separate provider organisation.

7. Strategic options analysis and evaluation

7.1 An options appraisal tested three options against five strategic tests and six implementation tests.

7.2 The three options appraised are:

1. The organisations operate separately (‘do nothing option’)
2. Organisations come together as one organisation (merger by acquisition)
3. Clinical collaboration supported by management contract

7.3 The strategic tests were designed to test options against strategic themes of:

- Provision of high quality care
- Clinical sustainability
- A clear future for staff
- Financial sustainability
- Optimising a future for services across the system

7.4 The implementation tests were designed to test options against:

- Legality of the option

- Alignment to both Boards' strategic direction
- Alignment to the systems strategic direction
- Governance and management capacity to deliver
- Transaction costs
- Implementation difficulty and permanency

7.5 The outcome of the options appraisal process gave a preferred option that QVH and UHSussex come together via merger by acquisition. The main features of this option are one Board and one set of Board subcommittees, one Council of Governors and one organisational structure with support for clear lines of accountability from Board to the frontline. This option would mean all UHSussex staff and QVH staff will be employed by one trust (UHSussex).

7.6 One of the main potential benefits of this option is that it provides a long-term, sustainable future for QVH hospital and staff allowing strengthening of corporate functions and reducing existing QVH fragilities.

7.7 The option supports high quality care by facilitating improved working across Sussex clinical teams, helps support services at QVH which are currently fragile, including burns, critical care, and paediatric services and allows for integration of services which are at risk of being isolated, thus improving their long term sustainability.

7.8 The merger of the trusts would help improve the efficiency of corporate services through greater economies of scale and the reduction of duplication, facilitate greater clinical alignment and support which creates the opportunity to make services more financially sustainable and will eliminate the need for Service Level Agreements between the two trusts, which are expensive and inefficient.

7.9 A summary of evaluation by criteria is shown below.

Criteria	Evaluation
Provision of high quality care	Merger scores the highest as it offers opportunities to maintain quality services at both trusts and facilitates the future development of services. In both other options organisational barriers to change remain and there are limited levers for change. There is significant overlap between these considerations and the clinical sustainability test.
Clinical sustainability	Although many of the clinical sustainability challenges will not be solved by the change in organisation form itself, a merger would give a significantly better platform for services working together, and within a financially sustainable organisation. There is significant overlap between these considerations and provision of high quality care test.
A clear future for staff	The opportunities and certainty merger would offer QVH staff means merger scores significantly higher than the other options. The other options score poorly and similarly as both essentially maintain the status quo in terms of certainty and lack of long-term plan for staff, and that existing fragilities and lack of opportunities remain.
Financial sustainability	Merger offers the best opportunity for addressing the financial challenges, although merger alone will be insufficient to fully resolve them. Collaboration via management contract scores better than separate organisations as it does allow reduction in Board resources and there may be efficiencies in corporate

Criteria	Evaluation
	services but this option is limited in its ability to make significant improvements as QVH remains a separate statutory organisation.
Optimise a future for services across the system	Merger as a permanent and long-term solution offers the greatest benefits in relation to optimising the operational delivery of services and does most to help support opportunities identified in the Sussex Acute Review. The other options are scored equally as collaboration via management contract offers little more than QVH is currently able to do by itself at the moment.
Is it allowed?	All options are allowed and permissible.
Does it align to the Boards' strategic direction?	The scores reflect that QVH Board recognises that change is required and merger offers a permanent strategic solution. UHSussex recognises that merger is in the best interests of the system, but this acquisition is not a UHSussex strategic goal in itself.
Does it align to the system's strategic direction?	Merger is consistent with the ICS strategic direction. Neither of the other options are desirable from a system perspective; collaboration via management contract would only temporarily resolve the issues and doing nothing would not address the issues set out in the case for change.
Governance and management capacity	Doing nothing scores well as the model is a well-established Foundation Trust model. Merger scores slightly higher as it has an overall similar structure, as a Foundation Trust, but also improves resilience and management capacity at QVH. Collaboration via management contract scores poorly as it increases complexity and effort compared to both the other options and introduces time consuming governance arrangements.
Transaction costs	Both merger and the collaboration via management contract options are expected to incur significant transaction costs. Based on experience of UHSussex the costs of merger are likely to be significantly higher than a management contract. There are no transaction costs associated with do nothing so a maximum score is achieved for this option.
Implementation difficulty and permanency	The do nothing option is the least complex and difficult; however it cannot be regarded as permanent, so will result in complexity and difficulty at some future point. Both merger and collaboration via management contract are complex and difficult, with the merger process the most difficult of all. However, merger is the only option which results in a permanent solution and therefore merger scores slightly higher.

8. Preferred option – merger by acquisition

8.1 The preferred option is merger by acquisition where the trusts become one trust expanding the geographical footprint of UHSussex to include QVH catchment area. The description below provides an outline of what a merged organisation would constitute at high level. The specific detail of merger will be developed as part of the next stage (full business case and post transaction integration planning).

8.2 As the acquiring trust, the UHSussex Board would become responsible for all QVH operations and governance, including subcommittee audit, finance and performance and quality structures. As an enlarged Foundation Trust there would be a single Constitution and one Council of Governors, with membership of UHSussex extended to QVH staff, and QVH patients and community would be invited to become members. Alongside the single Board there would be one Executive Team and a

single clinical operating model providing clear lines of accountability from Board to the frontline. Consideration would need to be given to on-site management arrangements at QVH as part of the clinical operating model. Corporate functions could be consolidated achieving economies of scale across the new larger Trust and providing resilience in fragile support services.

8.3 Patient First would be the improvement methodology and strategy deployment approach across the whole Trust and there would be one, potentially strengthened, quality governance and audit approach.

8.4 A single financial framework and budget would be in place and UHSussex would become responsible for all predecessor contracts, assets and liabilities. Transaction and overhead costs between the two Trusts should be reduced with the removal of existing SLAs.

8.5 As a single organisation there would be a single vision, values and strategy, with the Trust acting as one voice at system level. Merger could support consolidation and retention of acute and specialist services across the larger Trust and QVH services would benefit from becoming part of a University Teaching Hospital.

8.6 Future service development could be enhanced overall as a result of the capacity and capability infrastructure in the new trust and within a single clinical strategy. The clinical operating model would determine operational management delivery in the new trust and merger gives the opportunity to integrate services, potentially making them more resilient.

8.7 There is also the potential to maximise capacity across a wider infrastructure in Sussex, giving greater sustainability whilst still providing both local services and specialist services outside of Sussex.

8.8 A merger would mean all UHSussex and QVH workforce are employed by one clinically and financially sustainable employer. One organisational development framework would cover the whole workforce. A permanent future for QVH staff via merger may improve recruitment and retention and will provide access to all in-house training and development in a large teaching trust. There may also be the opportunity to develop job flexibility and pathways across a bigger organisation.

9. Benefits of merger (preferred option)

9.1 The potential benefits of the preferred option are described here in terms of the key system themes identified in the options appraisal, and linked to both the QVH and the UHSussex strategic aims.

System Theme	Key potential benefits of the preferred option
Provision of high quality care	• Facilitates improved working across clinical teams in Sussex, improving patient care benefitting patients through improved access • Supports the future development of services across the whole geography of the new Trust • Maximises capacity across a wider infrastructure and joint executive planning of services may result in better clinical integration
Clinical Sustainability	• Helps support services at QVH which are currently fragile, including burns, critical care, and paediatric services

	• Allows for integration of services which are at risk of being isolated, thus improving their long term sustainability • Brings a proven improvement methodology and approach to QVH • Allows for further development of research and innovation in a university trust
A clear future for staff	• Provides a long term, sustainable future for QVH hospital and therefore for QVH staff • Provides further opportunities for training and rotation of staff to improve both recruitment and retention • Helps strengthen corporate functions at QVH, reducing their fragility
Financial Sustainability	• Helps improve the efficiency of corporate services through greater economies of scale and the reduction of duplication • Facilitates greater clinical alignment and support, which creates the opportunity to make services more financially sustainable • Eliminates the need for Service Level Agreements between the two trusts, which are expensive and inefficient • Facilitates access to investment for specialist services and associated research and development
Optimise a future for services across the system	• Strengthens the provision of head and neck services in Sussex • Provides QVH services with greater influence at system level • Facilitates future strategic planning as services are under one Board • Helps to secure the future of services in Sussex through a strong and stable organisational form

10. Strategic Risks of Merger (preferred option)

10.1 The merger presents a number of strategic risks to the separate trusts and the system as a whole. The following are the most significant strategic risks:

- Clinical sustainability and quality of care
- Financial sustainability
- Culture
- Management capacity
- Reputation

10.2 Clinical sustainability and quality of care

The preferred option of merger does not in itself resolve the challenges related to delivering some clinical services on the QVH site that were outlined in the case for change, in particular burns, critical care and paediatric inpatients.

10.3 However, merger would support the strengthening of the network in which the QVH services operate and would provide more integrated management of services that are currently linked only via service level agreements. Merger would also facilitate delivery of actions resulting from the clinical reviews described below. The operation

of QVH and UHSussex services within one clinical operating model and under the governance of one organisation would lead to an integrated approach to the implementation of any recommendations.

10.4 There is an additional risk that focusing on QVH services would detract UHSussex from responding to its own clinical priorities.

10.5 Financial Sustainability
Joint working across a number of areas should allow services to be delivered more sustainably across both clinical and non-clinical services. However there is a risk that the merger of the trusts could lead to a deterioration of the financial position of UHSussex. UHSussex have an agreed Medium Term Financial Plan (MTFP) and is a financially sustainable Trust; QVH has a number of significant financial challenges.

10.6 Culture
The organisations have different cultures. QVH has a strong internal culture that may make integration with UHSussex challenging, particularly due to the geography and the specialist nature of some of the services at QVH. Organisational Development and strong communication and engagement should help mitigate this risk but it is nonetheless a strategic risk to the merger.

10.7 Management Capacity
Bringing two organisations together through merger requires a significant level of management time. UHSussex have started to integrate the legacy organisations following merger in April 2021, and are developing the new clinical operating model for the new Trust, which will be followed by an aligned corporate operating model.

10.8 Reputation
There are risks to the reputation of both trusts in closer collaboration. For UHSussex there is a risk related to inheriting services that are in derogation and have sustainability challenges. From a QVH perspective there is wide support at local level for the Trust and becoming part of a larger organisation may damage its brand and this connection with its local community.

11. Review of clinical services

11.1 If the decision is taken to proceed to full business case, then in parallel with this work the trusts will jointly review specific clinical services across QVH and UHSussex where there are either opportunities to collaborate or fragilities of service to address. The relevant output from these reviews will form part of the FBC.

12. Financial Assessment

12.1 UHSussex has a sustainable financial position that builds upon the medium term financial trajectories of predecessor trusts. The financial sustainability has been tested both through detailed medium-term financial planning within the ICS and with the support of NHSEI and subsequently through the recent transaction assessment by NHSEI.

12.2 The strong financial performance in WSHFT and the more rapid improvement against the control total trajectory in BSUH has allowed both organisations to plan for the future and invest in service improvement. This level of financial performance has only been sustained through consistent delivery of efficiency savings in excess of the national efficiency requirement.

12.3 QVH delivered a break-even or surplus position until 2017/18. Delivery of this position in 2017/18, and the surpluses in prior years included reliance on a number of

non-recurrent or technical items that were not sustainable. In 2019/20 the deficit was £9.0m.

12.4 A key factor in this deterioration has been the small size of QVH and the challenges of both maintaining sustainable and clinically safe services, and being agile in responding to changes in national payment mechanisms or demand. The interim financial framework in place during COVID-19 has masked these challenges, however QVH recognise that as the financial framework reverts to the planning principles in the NHS Long-Term Plan, QVH will face an increasing financial challenge.

12.5 The QVH medium-term financial planning forecasts the deficit will increase to £9.6m by 2023/24, at the end of the LTP period. The LTP expects all organisations to be in recurrent balance by 2023/24. In order to achieve this QVH would need to deliver efficiencies in excess of 4.6% per annum with a high of 5.5% in 2023/24.

12.6 Delivery of efficiency at this level is considered to be stretching and would be more so in a small organisation. It is therefore unlikely that QVH can deliver a balanced financial position whilst remaining as a separate provider organisation.

12.7 At FBC the medium term financial projections of both trusts will be revisited to update any underlying assumptions and to assess any residual impact of COVID-19 on the underlying financial position.

12.8 Benchmarking data suggests there is the potential through merger to achieve financial efficiencies of £1m to £2m in relation to collaboration and sharing of functions. This opportunity is related to the current position of QVH where it consistently benchmarks above (worse than) median meaning the spend on corporate services at QVH is disproportionate for its relative size. Delivering a balanced position for QVH will require the efficiency from each of these opportunities to be maximised. This will only be possible if QVH is integrated into a larger organisation that has both the economies of scale and the delivery infrastructure to support this level of efficiency.

12.9 The clinical reviews to be undertaken jointly by QVH and UHSussex in line with the FBC may derive some level of financial benefit by closer working and addressing inherent fragilities, but at this stage no assumptions are included on the outcome of this work.

12.10 The main risk to the financial plan is the ability to deliver significant cost savings over multiple years whilst managing the integration of multiple hospital sites, business as usual operational pressures and the restoration, recovery and reformation of services after COVID-19. The interim financial framework in operation during 2021/22 and changes to this framework from October 2021 will also create a level of uncertainty.

12.11 Both trusts expect to incur programme costs and costs in the areas of due diligence, legal fees and organisational development. For the FBC granularity of costs will be required.

13. Stakeholder Engagement

13.1 Both trusts have undertaken stakeholder engagement activities as part of the development of this Strategic Case. QVH has built on the extensive engagement that has been undertaken over the last few years while the future of the trust has been under discussion. Engagement has been undertaken with QVH governors, system partners, MPs and councillors, QVH members and the public, and QVH staff. The

main concerns raised have been about the ongoing availability of QVH's specialist services to the wide area served currently.

13.2 Due to the position of UHSussex having recently gone through merger, UHSussex has concentrated engagement efforts on the Strategic Case including sessions with NEDs, governors and staff.

13.3 The two trusts have worked together and have agreed a plan to develop a full communication and engagement strategy to support the development of the FBC. This engagement will include listening to the hopes and fears of staff and other key stakeholders; working to build understanding of the merger across a range of internal and external audiences; minimising uncertainty or confusion for patients, staff, system partners and the wider public; developing a common vision, values and culture for closer working; and enabling staff of both organisations to shape and become advocates for the merger and the benefits that can be realised as a result.

14. Legal, Competition and Regulatory Requirements

14.1 The proposed transaction between QVH and UHSussex is classed as an acquisition under Section 56A of the NHS Act 2006. This is where a Foundation Trust (UHSussex) acquires another Foundation Trust (QVH). This results in the dissolution of the acquired Trust (QVH) and the transfer of all its assets and liabilities to the acquiring Trust (UHSussex).

14.2 As a 'small' transaction the transaction is not subject to review by NHSEI but an application to NHSEI is required to be completed by both UHSussex and QVH for NHSEI to be able to issue a Grant of Acquisition, the legal process to combine the two organisations. The Grant of Acquisition includes documents to show the requirements of Section 56A have been met including a copy of the proposed Constitution of the acquiring Trust (UHSussex) and evidence the majority of the council of governors of each Foundation Trust involved has approved the application.

14.3 The Competition and Markets Authority (CMA) has a statutory duty under the Enterprise Act 2002 to refer relevant mergers for an in-depth investigation if it believes there is a realistic prospect that the merger would result in a substantial lessening of competition. UHSussex and QVH have consulted with NHSEI on the requirements to engage with CMA. The Health and Care Bill currently before Parliament would exempt mergers between NHS Trusts/FT from the Enterprise Act.

14.4 The trusts do not consider that the proposed transaction needs to be referred to the CMA at this time. Further work and engagement with NHSEI will be undertaken as part of the FBC development when merger and legislative timescales are clearer.

14.5 QVH will seek assurance regarding the position of UHSussex in relation to operational performance, clinical safety, quality and finances. The purpose of this is to provide assurance that QVH staff and services would be joining a sustainable and high quality organisation.

14.6 A merger would mean the following changes in the legal format of both organisations;

14.6.1 UHSussex would submit an amended constitution for the enlarged Foundation Trust as part of the request for a Grant of Acquisition.

14.6.2 The current governors of QVH would automatically cease their roles on completion of the proposed transaction.

14.6.3 Members of QVH would automatically cease on completion of the proposed transaction. Members cannot automatically be made members of UHSussex. UHSussex would work with QVH public members and staff members to give opportunities to become UHSussex members.

14.6.4 UHSussex CQC and NHS Resolution registration would be submitted for effect from transaction date.

15. Delivery and Programme Management

15.1 The Strategic Case is the first stage of the transaction process. If successful and approved by both Boards it will be followed by a Full Business Case (Stage 2) before final approval which includes the regulatory and legal processes (Stage 3).

15.2 Following the review of the Strategic Case, if approved both trusts will progress the development and agreement of the Heads of Terms which will support, with the structure and authority for joint working, development of the Full Business Case. The Heads of Terms will provide a basis for the final Transaction Agreement with an expectation that this will be available for agreement alongside the Full Business Case.

15.3 The trusts will jointly review specific clinical services across QVH and UHSussex where there are opportunities or fragility to inform potential service configuration. The relevant output from these reviews will form part of the FBC.

15.4 Governance for the programme is provided by the Joint Oversight Group and the Joint Executive Group, with the Executive Group reporting to the Oversight Group. The purpose of both groups is to oversee the programme of work needed to manage the process for the potential future relationship between QVH and UHSussex.

15.5 The programme governance arrangements will be revised following approval of the Strategic Case to ensure continued robust governance that facilitates a joint approach to project management, timely decision making and regular reporting.

15.6 A dedicated project management team will be established to manage the merger, which is consistent with the approach to the recent UHSussex merger.

16. Decision making on whether to proceed to FBC

16.1 As there are elements of the strategic case that are commercially sensitive, the full Strategic Case will be considered in private.

16.2 The Strategic Case outlines the current position and challenges at QVH and how merging with UHSussex could provide the opportunity for QVH to secure a viable and sustainable future for its patients and staff.

16.3 With approval of the Strategic Case the Board would be committing to developing a full business case for the merger by acquisition of QVH by UHSussex to the detail required to allow the Board to make a final decision.

16.4 The board of QVH will consider the capacity and resources needed for merger and whether the preferred option would help to:

- further develop and invest in services
- maintain and build on QVH's excellent record for patient experience, clinical outcomes and safety

- continue to provide services to patients from the wide area covered currently (including Kent and Surrey as well as patients who travel much further for our care)
- continue to deliver world class research and innovation
- secure the future of the hospital in East Grinstead

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed 8th June 2021

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 may not be able to recruit or retain a workforce with the right skills and experience due to uncertainty of the potential merger
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 **low 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 2019 inpatient survey, trust continues to be in the group who performed much better than national average
- Patient safety incidents triangulated with complaints and outcomes monthly no early warning triggers
- Not meeting RTT18 and 52 week Performance and access standards but meeting agreed recovery trajectories
- Sustained CQC rating of good overall and outstanding for care
- Clinical Harm Review process in place

Future risks
- 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**~~
- Impact of Sussex partnership plans on QVH clinical and non clinical strategies
- ~~**Impact of Covid-19 pandemic on patient experience**~~

Future Opportunities
- Developing new healthcare roles – will change skill mix
- Potential merger could offer significant opportunities for development of the workforce

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
- 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.
- 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. Inpatient paeds on exception basis
- QVH simulation faculty to enhance safety and learning culture in theatres
- ~~Reviewing~~ Burn Case for Change being **developed** in collaboration with BSUH AND NHSE
- 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 questionnaire introduced.

Gaps in controls / assurance
- 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.~~
- ~~Outcome of KPMG work unknown at this time~~

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Date last reviewed: 2nd June 2021

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
1. Potential for harm to patients due to long waits for surgery
2. Maintaining safe & effective clinical services evidenced by excellent outcomes & clinical governance
3. Developing a robust research & innovation strategy along with potential collaboration with BSMS if there is a future merger

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.

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.
- Consultant medical staffing of Sleep Disorder Centre, Histopathology and Radiology
- Non-compliant RTT 18 week and increasing 52 week breaches due to COVID-19
- Commissioning and ICS reconfiguration of head and neck services
- Restoration & recovery: risk stratification and prioritisiation of patients for surgery and loss of routine activity
- Sussex Clinical Strategy Review

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

Future Risks
- ICS 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
- ICS networks and collaboration
- Efficient team job planning
- Research collaboration with BSMS
- New services – glaucoma, virtual clinics & sentinel node expansion, transgender facial surgery
- Multi-disciplinary education, human factors training and simulation
- QVH-led specialised commissioning
- E-Obs and easier access to systems data
- Possible merger with Western/BSUH

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
- Local Academic Board, Local Faculty Groups and Educational Supervisors
- Electronic job planning
- Harm reviews of 52+ week waits
- Diversion of inpatient paediatric burns patients to alternative network providers

Gaps in controls and assurances:
- Link between internal data systems & external audit requirements & programs
- Creation of QVH clinical research strategy
- Limited data from spokes/lack of service specifications
- Achieving sustainable research investment
- Sleep disorder centre sustainable medical staffing model & network
- Inadequate Consultant radiologist cover (CRR 1163)
- Significantly reduced Consultant Histopathologist cover (CRR 1168)
- ~~Maxillofacial trauma service (CRR 1209)~~
- Repeat prescriptions in Sleep (CRR 1164)

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	06/05/2020 and 26/72021		**Agenda reference:**	**101-21**	
Report title:	Quality and Governance Assurance				
Sponsor:	Karen Norman, Committee chair				
Authors:	Karen Norman, Committee chair Gary Needle, committee member and SID				
Appendices:	none				
Executive summary					
Purpose of report:	To update the board on quality and governance assurance issues arising since the last Board meeting. To provide assurance with respect to reports received from its sub-committees and workstreams in the extraordinary annual meeting held on 26 July 2021				
Summary of key issues	This report provides assurance and notes areas of concern arising from the work of its subcommittees, notes approval of the annual quality report and the attainment of our quality priorities. It also updates the Board on issues (by exception) regarding patient safety, clinical harm reviews, clinical risks, the Evolve project, the GIRFT report on learning from litigation claims, the nursing workforce report and assurance on the quality of our patients' experience. It notes the need to address the risks associated with non-compliance with antibiotic prescribing guidelines. The report **notes** the development of the QVH risk strategy.				
Recommendation:	The Board is asked to **NOTE** this report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Highlight 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 Committee received updates on the relevant BAF summaries and was 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 the Health and Social Care Act, 2008, and the CQC essential standards of quality and safety.				
Legal:	As above				
Resources:	N/A				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	101-21
Date of meeting:	05/08/2021
Report from:	Karen Norman, committee chair
Report authors:	Karen Norman, committee chair Gary Needle, committee member and SID
Date of report:	26 July 2021
Appendices:	NA

Quality and governance committee assurance

Introduction

1. **Quality and governance assurance**
   The Quality and Governance Committee (Q&GC) wish to bring the following matters of exception from those considered at our meetings to the attention of the Board.

2. **Feedback from local governance group visits.**
   Q&GC is back on track to ensure that each sub-committee receives a visit from a Q&CG member at least once a year, after visits had been paused during the pandemic. Assurance was taken that most committees had continued to meet to deal with priority business associated with keeping patients and staff safe. Reports were received from the members who visited the Clinical Governance Group, Strategic Safeguarding Group, Patient Experience Group, Nursing Quality Forum, and the Infection Prevention and Control Group (IPC). Each report summarised: key issues covered, the quality of accompanying papers, any matters relating to Trust strategy, policy and guidelines, audit and research items, items requiring referral to Q&GC, items for which additional information or assurance was sought, and any recommendations for further consideration by the sub-group/ Q&GC. Assurance was taken with respect to most reports, with relevant sub-committees commended for progress against their terms of reference during a challenging year. Recommendations were made and accepted with respect to reviewing and updating the modus operandi and terms of reference for the Medical Devices Group. The Information Governance Group were asked to provide further assurance regarding outstanding matters on their action log. Progress against the latter will be included in the sub-committee action logs and reviewed at the next Q&GC meeting.
   Further assurance was taken from the chair of the IPC meeting with respect to the handling of the recent Clostridium difficile (C.diff) outbreak and lessons learned.
   Non-Executive members also confirmed that their regular attendance at the Nursing Quality Forum had proved an informative and useful source of additional assurance whilst ‘compliance in practice’ visits had been paused. They thanked the Interim Director of Nursing and team for affording them the opportunity.

   Q&GC also received, noted and took assurance from the minutes from the following sub-committees:
   - Clinical Governance Group Minutes
   - Infection, Prevention & Control Group
   - Medical Devices Group

Research & Development Governance Group
Patient Experience Group
Strategic Safeguarding Group
Information Governance Group Minutes
Medicines Management Optimisation and Governance Group

3. **Quality Report and Q4 Priorities Update / 2021/2**
The committee received the annual quality report, noting it was no longer a requirement that this be formally submitted as part of the annual account, nor subject to external audit (as was the case pre the covid pandemic). Q&GC took assurance from confirmation that the report had nonetheless been prepared in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement, in line with best practice. Q&GC commended all those involved, noting that despite the pressures of managing the pandemic, staff had also managed to develop and improve many services in impressive ways. Members thanked all those involved for their hard work and commitment during a challenging year. Assurance was taken with respect to the quality of services provided and high levels of patient and staff satisfaction with respect to these. Q&GC also noted the areas for improvement and plans for addressing these, which, where relevant, will be included in the work plan for next year.

The committee **approved** the Quality report, subject to minor amendments. These were subsequently circulated to all board members for final ratification and approval.

With respect to the Q4 priorities update, Q&GC **noted** the achievements set out in the paper. It suggested that for future priorities, further consideration be given to clarify metrics to better track progress for the purpose of reporting by exception.

4. **Quality & Safety Board Report**
Q&GC sought further assurance regarding a recent audit which identified poor compliance with antimicrobial prescribing guidelines. Whilst recognising this is a worldwide problem, this gave cause for concern. It was agreed that further work on this issue needed to be expedited to improve local compliance. The Chief Executive, Medical Director and Interim Director of Nursing have formed an Antimicrobial Stewardship Group, chaired by the MD and formed of relevant stakeholders from which an action plan will be developed. They will report their progress at the next Q&GC meeting. A repeat audit of prescribing practice will be conducted to measure the impact of changes made.

Q&GC **received** the first draft of the **risk and quality strategy** and commended work done on this important document. Suggestions made for the next draft will be taken into consideration, with a view to further discussion of the document at a forthcoming board seminar in where the board to review our ‘risk appetite’ in the light of new healthcare challenges.

5. **Update on Evolve Project (EDM).**
Q&GC took assurance from this comprehensive and helpful report, taking note of areas of risk and mitigation associated with the project. Further assurance was requested (and given) with respect to risks associated with clinical errors related to EDM. It was confirmed that there may be alternative ways to secure missing information. It was also emphasised that the Trust would completely support clinicians in extenuating circumstances if patient information was unavailable when required. With respect to the remaining risks cited in

the paper, assurance was taken from the clinical lead that these have been addressed and significant progress has been made. It was noted that some senior clinicians have provided positive feedback about the system. Further challenges may arise when the EDM team expands, and more paper processes are made digital. However, it is anticipated that as individuals become more accustomed to using digital methods, risks will decrease. Q&GC **noted** the report and requested a further update in six months.

6. **Patient Experience/ Get It Right First Time (GIRFT).**
This report included details of a new best practice guide for helping trusts to learn more from NHS negligence in the drive for better patient safety. With the cost of harm for clinical negligence claims from incidents in 2019/20 expected to cost the NHS £8.3 billion, the Getting It Right First Time (GIRFT) programme and NHS Resolution have produced Learning from Litigation Claims, offering trust clinicians, managers, and legal teams a practical and structured approach to claims learning, and sharing examples of best practice from across England. The aim is to maximise what can be learned from litigation, for the benefit of patients and to curb escalating costs. Q&GC took assurance from the recent case review of 36 historical cases of patient claims against Queen Victoria Hospital as part of this initiative in which a few repetitive themes were noted. This summarised what went wrong and what could be learned to improve patient experience. Q&GC welcomed the fact that the full report and recommendations had been shared with the clinical directors and the intention that in future, each new claim will be sent to them for review and to oversee.
Q&GC **noted** the report.

7. **Draft Nursing Workforce Review Board Report**
The workforce review was reviewed by Q&GC for assurance, in advance of submission to the next Board. Q&GC took assurance from data provided with respect to reviewing the nurse staffing levels required in order to provide safe, high quality and cost-efficient care, evidence of the safe provision of patient care (as benchmarked against “Model Hospital” data) and actions taken with respect to managing vacancy rates in individual clinical areas. Risks have been identified with respect to the potential number of retirees in coming years and further assurance was sought with respect to medium- and long-term workforce planning, particularly in theatres and highly specialist areas. Assurance was given that recent succession planning initiatives have proved useful in preparing a number QVH staff into more senior roles.
Q&GC commended the report, noting areas of good practice, ongoing risks and mitigation. It **recommends** this paper to the board for approval.

8. **Report from Extraordinary Meeting to Receive Annual Reports 2020/21 26 July 2021**
Q&GC met to receive the annual reports from all its main sub-committees and workstreams as identified on its 2019/20 annual workplan. Q&GC were able to take **substantial assurance** from these reports, with the following exceptions noted below. It was noted that it is testament to the quality of our staff that despite the challenges of the pandemic, with few exceptions, high quality care has been maintained and our patients remain highly satisfied with the services provided. Detailed reporting and assessment of quality parameters was maintained, and most reports evidenced a clear, open, and transparent reporting of issues of concern. This was taken as further assurance of an attitude consistent with a culture of continuous improvement, as evidenced by example in most reports.

9. Reports received:

9.1 Patient Safety Annual Report 2020/21

Q&GC **noted** the report. **Assurance** was **taken** with respect to the safety of patient care. It noted work done on clinical harm reviews as a means of managing the risks associated with the significant rise in waiting lists and that to date, these had not identified any cases of serious clinical harm. Whilst noting the difficulties in finding benchmark comparators due to our clinical specialisms, further assurance was given with respect to plans to further develop comparative data reporting, as noted below.

9.2 Health & Safety Annual Report 2020/21

Q&GC **noted** the report. **Assurance** was **taken** with respect to health and safety. **Assurance** was **given** with respect to plans to further develop comparative data reporting, as noted below.

9.3 Infection Prevention & Control Annual Report 2020/21

Q&GC **noted** the report and **supported** the **recommendations** made**. Assurance** was **taken** from the detailed evidence provided regarding our infection control rates, risks and management during the pandemic and additional assurance provided by the bi-monthly updates of compliance against the standards set out in the NHSE Infection prevention and control board assurance framework. Further **assurance** was **given** with respect to plans to strengthen compliance with antibiotic prescribing practices.

9.4 Clinical Audit Annual Report 2020/21

Assurance was **taken** with respect to the achievement of most of the objectives and evidence of strong clinical commitment from our staff to auditing and improving their work. It is intended that future reports will show how audits undertaken support the QVH key strategic objectives.

9.5 Research & Development Annual Report 2020/21

Q&GC **noted** the report. **Assurance** was **taken** regarding Research and Innovation (R.I) activity and the new R&I strategy, which Q&GC **recommends** to the board. Further **assurance** was **given** about ensuring ethical approval of all research carried out at QVH under the direction of our R&I department.

9.6 Safeguarding (Adults & Children) Annual Report 2020/21

Q&GC **noted** and **took assurance** from the report and **supported** the recommendations.

9.7 Patient Experience Annual Report 2020/21

Q&GC **noted** the report, **taking assurance** with respect to the quality of our patients' experience.

9.8 Emergency Preparedness, Resilience & Response Annual Report 2020/21

Q&GC **noted** the report, **taking assurance** on our response to, and management of, the Covid pandemic. It **noted** that for wider EPPR standards, we were only **partially compliant**, the challenges in meeting these, and the actions being taken to ensure that those within our jurisdiction are addressed.

9.9 Information Governance Annual Report 2020/21
Q&GC **noted** the report. **Assurance** was **taken** regarding information governance.

9.10 Medical Devices Annual Report 2020/21
Q&GC **noted** the report. **Assurance** was **taken** regarding medical device management. Further **assurance** was **given** on actions to ensure all staff are up to date with relevant training, post the pandemic.

9.11 Medication Safety Annual Report 2020/21
Q&GC **noted** the report. **Assurance** was **taken** regarding medication safety.

9.12 Antimicrobial Annual Report 2020/21
Q&GC **noted** the report. Further **assurance** was **sought** regarding poor compliance with antibiotic prescribing guidelines. Reassurance was given. A re-audit is planned to monitor progress.

9.13 Appraisal & Revalidation Annual Report 2020/21
Q&GC noted the report and that appraisal and revalidation of doctors had paused during the pandemic, in line with national guidance. **Assurance** was **given** that these have recommenced and the intention to complete these by the required deadlines.

9.14 Guardian of Safe Working Annual Report 2020/21
Q&GC **noted** and **took assurance** from this report regarding the safety of the junior doctor rota and review of education issues raised by the junior doctors to the Guardian at Junior Doctor Forum.

10. Lessons learned for annual reports 2021/22.
Q&GC took the opportunity to conduct its own improvement cycle, reflecting on how the above reports were structured, noting techniques used by authors which had enhanced the degree of assurance taken. It was agreed that these techniques would be developed these further this year for more consistent use. These included: i) further consideration to presentation of data to give greater clarity on the significance of numbers presented, along with a more detailed narrative with respect to actions required as a consequence, ii) clearly defined SMART objectives for the year, with an annual summary of progress against each, iii) further consideration for developing statistical process control charts more widely, and iv) the importance of securing a quality improvement framework to support staff in the process of developing and improving their clinical practice and services. Q&GC will discuss these further in a seminar planned in the autumn.

The Chair would like to recognise the achievements of all Q&GC members, the authors of the reports, and staff in QVH and for their commitment to maintaining and developing our quality improvement culture, which has helped keep our patients and staff safe this year. I thank you all.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05 August 2021**		**Agenda reference:**	**102-21**	
Report title:	**Corporate Risk Register**				
Sponsor:	Nicky Reeves, Interim Director of Nursing				
Author:	Karen Carter-Woods, Head of Risk, Clinical Quality & 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	Following the December 2020 Board Seminar, the Corporate Risk Register is now divided and reviewed in two subcommittees of the Board, Quality & Governance and Finance & Performance. The full corporate risk register is bought to board for review and discussion Key changes to the CRR this period: • One new corporate risk added • Three corporate risks closed • No risks rescored				
Recommendation:	The board 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:	Quality and governance committee				
	Date:	21 June	Decision:	Patient safety risks noted	
Previously considered by:	Finance and performance committee				
	Date:	28 June	Decision:	All risks noted with the exception of patient safety.	
Next steps:					

Corporate Risk Register Report
February and March 2021 Data

Key updates

Corporate Risks added between 01/4/2021 and 31/05/2021: 1

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
4x3=12	1218	Covid-19 Impact on Operational Delivery	Director of Operations

Corporate Risks closed this period: 3

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
4x3=12	1167	Lack of Failsafe Officer	R/V with handler Post recruited to and Failsafe Officer now in post
4x4=16	1179	Pandemic Flu Covid-19 operational challenges	Current position different to content of this Risk; closed and new risk opened (1218)
4x4=16	1125	RTT Delivery and Performance	Changed situation and focus post C-19 in line with National planning guidance; closed and new risk added (1218)

Corporate Risks rescored this period: Nil

Risk ID	Service / Directorate	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore

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

Risk Register management

There are 65 risks on the Trust Risk Register as at 4th June 2021, of which 17 are corporate, with the following modifications occurring during this reporting period (April and May 2021 incl):

- One new corporate risk added
- Three corporate risks closed
- No risks rescored

Risk registers are reviewed & updated at the Specialty Governance 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 17 corporate risks open on the trust risk register as at the end of May 2021.
One of the corporate risks are within the higher grading category:

	No harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2					
Possible 3				**6 ID: 834, 968, 1163, 1192, 1210, 1218**	**0**
Likely 4			**5 ID: 1040, 1077, 1136, 1148, 1168,**	**0**	**0**
Certain 5			**5 ID:1140, 1189, 1164, 1198, 1199**	**1 ID: 877**	**0**

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
1216	05/05/2021	Covid-19 Impact on Operational Delivery	Impact of covid-19 on service delivery, recovery and performance.	Suite of SOPs to enable safe service delivery and recovery plans in to support performance requirements.	Abigail Jago	Kathy Brasier	Compliance (Targets / Assessments / Standards)	10	8		KSO3
1217	30/04/2021	Possible merger	Misinformation from outside the Trust or misinterpretation of information made available by the Trust impacts on confidence in sustainable future of hospital.□ Recruitment and retention issues and concerns from referring clinicians/patients about beginning long term treatment programmes. Increased demands for information through FOI requests and other routes impacts on delivery of core business	Frequent and ongoing staff briefings and engagement. □ Programme of work with governors. □	Steve Jenkin	Claire Pirie	Compliance (Targets / Assessments / Standards)	12	6		KSO3 KSO5
1215	08/04/2021	Theatre Surgical Air Systems	Failure of main theatres surgical air systems, this system is for the surgical air tools and theatre pendant brakes.	Temporary air brake system installed using bottled air cylinders, J Cylinder sizes. This is a very limited options to allow the air brakes to operate and to prevent the pendants from rotating during procedures.	Michelle Miles	Phil Montague	Estates Infrastructure & Environment	12	8	**08/04/2021** Surgical air equipment was reviewed by our incumbents medical air and gas providers and they supplied a replacement costing for this unit for lifecycle earlier in the year, this cost is now being reviewed for the urgent replacement of the equipment.	KSO1 KSO3 KSO5
1214	07/04/2021	Theatre Boilers - reduced capacity	Currently there are two heating boilers out of four that have failed serving the main theatres. These boilers operate on demand with only 2 running at any one time, meaning that if a further boiler fails this could cause heating loss to the theatres	Daily checks of plant and operation of heating plant controlled to prevent over working of the remaining boilers	Michelle Miles	Phil Montague	Estates Infrastructure & Environment	12	6	Update **07/04/21** This project has been under review with a M&E designer specialist with full tender documents being drafted and being put together with the tender and replacement imminent. Specific time lines however will be supplied once all the documents have been prepared by the M&E designer and forwarded to the relevant stakeholders.	KSO3 KSO5
1213	09/02/2021	Pandemic Flu Covid-19 Clinical Challenges	Staff required to work in different ways:□ National guidance being updated on regular basis:□ Adverse impact on patient experience – particularly linked to restricted visiting and infection control recommendations:□ Potential Covid-19 outbreaks in either workforce or patient cohorts	R&R governance meetings weekly:□ Open door IPACT policy:□ Generic email address for queries or concerns □ Case by case management regarding visiting restrictions□ Asymptomatic staff testing both via Lateral Flow and Optigene□ Patient screening pre admission□ Optigene screening for trauma patients□ Management of "accompanying" carers with patients coming to OPD□ Remote check in to avoid numbers in waiting rooms□	Nicola Reeves	Karen Carter-Woods	Patient Safety	12	8	**May 2021**: awaiting Government Guidance re last stage of lifting restrictions□ March 2021 R&R Governance meeting fortnightly. CCG support for recent nosocomial issue with C Diff. Updated visitor guidance in place	KSO1 KSO2
1196	09/12/2020	Inability to deploy a flexible CCU workforce across the green and amber pathways which are split across two areas in QVH.	* Potential for there being insufficient trained staff to care for a critical care patient.□ * potential for cases to be cancelled * Possible reputational damage due to being unable to cover amber pathway and patients being refused. * Stress to workforce endeavoring to cover at very short notice. * Staff reluctance to cover □	Refusal of admissions when staffing unsafe	Nicola Reeves	David Johnson	Patient Safety	15	8	**May 2021** Band 6: 0.14 vacancy □ Band 5: 3.58 WTE vacancy □ Also vacancies on HNU - CCU backfilling□ Unsuccessful recruiting apart from one post CCU□ March 2021: Band 5: 1.08 WTE vacancy □ Band 6: 0.75 WTE vacancy □ When HNU opens vacancy will increase for band 5 to 3.58 WTE □	KSO1
1194	09/03/2021	Medical Workforce Sleep Unit	Risk to long-term stability of diagnosis and prescribing for patients in Sleep Unit due to age profile >60 years and retired status of majority of existing substantive medical workforce. Requires succession planning.□	Current Workforce <60 years old/not retired:□ 1 PA - respiratory and sleep disordered breathing - locum/bank□ 8 PA - Associate Specialist Registrar sleep disordered breathing and sleep - bank/locum >2 years.□ Succession/strategy planning underway.	Abigail Jago	Philip Kennedy	Compliance (Targets / Assessments / Standards)	15	9	**May 2021**: interim CD oversight in place. Action Plan developed and being implemented	KSO3
1192	09/10/2020	Inability to provide full pharmacy services due to vacancies, sickness and covid vulnerable pharmacist	Delays to indirect clinical services (e.g. updating policies / guidelines / audit/ training)□ Unable to move forward with non-clinical initiatives e.g compliance with falsified medicines directive, EPMA introduction□ Delays in projects e.g. EPMA and supporting new services□ Pharmacist vacancy rate increasing and inability to recruit□ Loss of long established staff□ Unable to support any new work elsewhere in Trust	1. All technical staff in post apart from 0.2WTE band 2 assistant. Vacancy money used for bank staff.□ 2. Pharmacy clerk new to post but is progressing well.□ 3. Pharmacist assistants have completed apprenticeship and could dispense if needed to help reduce pharmacist to cover technicians.□ 4. Long term locum in post along with part-time bank pharmacists□ 5. Chief Pharmacist working addition bank hours.□ 6. Retired bank technician helping cover some vacancies and leave. Medicines management technician working on wards supporting pharmacist when possible.□ 7. Recruited new bank pharmacist who can work 1 day a week□ 8. Direct clinical work a priority.□ 9 Second locum pharmacist in place and working well covering wards and dispensary □	Abigail Jago	Judy Busby	Patient Safety	12	8	**30/4/21** Appointed 0.6wte band 7 for 2wte vacancy from current locum. New WTE locum starting 5-5-21 to cover remaining vacancy and support sleep work.□ 30/3/2021 2wte band 7 pharmacist posts out to advert. 0.8wte band 7 covering band 8a mat leave started but 0.4wte band 7 now left. Bank part time band 2 started to help in office with contracts. MSO post to be readvertised after easter. Band 2 and band 5 JDs to be completed. Looking for new band 7 locum to cover remaining pharmacist vacancies and additional work to support sleep prescribing□ 24/2/21 0.4wte band7 pharmacist handed in notice making 2wte vacant. Amalgamated all the 3 job descriptions to make rotation in hope will be more appealing. Job description gone to panel. Awaiting fixed term mat leave cover to start (delay in completing HR checks). Didn't appoint to MSO post - person offered cannot work enough hours - bank covering some duties. Writing band 5 technician job description as part of restructure. reviewing band 2 assistant job description for avert as apprentice from start. Bank and agency covering vacancies□	KSO1 KSO2 KSO3 KSO4 KSO5
1189	08/12/2020	Workforce succession planning: radiology	- 50% of the workforce at / approaching retirement age. - difficulties recruiting: Lack of ultrasound / radiographer/Radiologist workforce nationally□ - multiple failed recruitment drives previously and currently	-Bank /staff/ agency □	Abigail Jago	Sarah Solanki	Compliance (Targets / Assessments / Standards)	15	9	**07-05-2021** - band 5 staff member handed notice in today. We now will have 2.6 WTE vacancies. 1.6WTE band 6 - vacant for over a year. 1 suitable applicant being interviewed soon. Last band 5 vacancy took 1 year to recruit. Band 7 staff can only cover clinical and not really do any required admin due to this. Agency support likely requirement for coming months as team burnt out. 4 staff covering CT on-call position unlikely to improve if we cannot recruit.□ 22-04-2021 Working with other trust staff (education and learning) and AHP faculty staff to scope apprenticeship and acceptance criteria as this remains unclear from university of Sussex. Need to scope US training post. Have engaged with universities to build higher profile amongst student cohorts.□ 9/3/21: reviewed at RPC meeting - Radiology Services Manager is exploring potential of apprenticeship post and / or US training post.□ 22-02-2021 - bank CT/MRI radiographer started today. Stall to apprenticeship due to course being deferred until September next year. □ 28-01-2021 - Recruitment premium not yet approved but we have had an experienced CT/MRI radiographer apply to join the bank - very good appointment - recruitment paperwork going through. Have been working with Katherine Bond about developing an apprenticeship role BC to train RDA to become radiographer. Regional paper submitted to trusts about a possible funded overseas recruitment drive. Awaiting further information re this.□ 21-12-2020 - applied for recruitment premium to be added to MRI/CT vacancies. Awaiting confirmation. Have a person interested in bank work (MRI experienced) - awaiting feedback on interview. Awaiting approval from workforce team etc. Also developing BC re radiography apprenticeship - starting Sept 2021.□ We have had a band 5 job out since last year. Only just recruited into. Band 6 radiographer jobs also since end of last year. Only recruited 0.4WTE out of 2.0WTE. Ultrasound vacancy - we trained someone in the time the vacancy was unfilled. Consultant posts vacant since December 2019. Still vacant.□ 1.0WTE (2 part time) of US team can retire at any point.1.6WTE (3 staff) of Radiographer workforce can retire at anytime. □	KSO1 KSO2 KSO3 KSO5
1184	26/03/2021	Repeat prescriptions in Sleep Services	The consultants are spending more and more time as patient numbers increase, having to complete prescriptions including Controlled Drugs (without seeing patient)on a monthly basis for patients requiring off licence medication GP's refuse to prescribe. Sometimes the consultants are not present to carry out these prescriptions resulting in patients being without meds. Patients are having to travel long distances to collect the medication from pharmacy	Attempting to set up shared care agreement which has been on-going for 3 years□ Working with Pharmacy to develop a 'monitoring pharmacist' for repeat prescriptions□ Request patient inform us in a timely manner of requests for repeat prescriptions□ Business Case in planning for dedicated pharmacist in Sleep□ □	Abigail Jago	Philip Kennedy	Patient Safety	15	8	**May 2021**. Locum appointed and undergoing induction□ 23/04/21□ EMT have agreed to support a Principal Pharmacist post, to work closely with Sleep and manage prescription related issues, including progressing the shared care agreements with CCG/ICS. A JD has been drafted and will be submitted for formal Grading before going to external advert. Chief Pharmacist has also been asked to source locum Pharmacist support in the interim.	KSO1 KSO2 KSO3
1183	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	12	9	**07-05-2021** - risk will not be closed until all contractual paperwork complete and contracts in place.□ 22-04-2021 - paper written for BM to outline current position. Score reduced to 12. Locum wants to join trust to cover fixed term. Bank consultant wants to become permanent for 5 PAs. Once contractual work secured and in place (likely August), this risk can be closed.□ 22-03-2021 - The on-call is now being outsourced to a company meaning the consultant who was covering can take leave. We have a fixed term locum who is keen to stay and a bank consultant who also wants to stay and support the service. Currently, we have better resiliency for medical workforce.□ 22-02-2021 - on-call moving to outsource model in March. Policy update for March CGG presentation and then HMT approval. This will mean IF can take meaningful A/L moving forward. Fixed term locum wants to remain. Global fellowship stalled due to pandemic.□ 28-01-2021 - on-call provision to change to outsource model for CT. Medica have been chosen to move forward. This should enable more meaningful leave ability for consultant. Cover in post 1 day per week. 1 bank H&N consultant 3 days per week. 1 agency consultant covering general/MSK vacancy. Global fellowship discussions ongoing but no progress due to pandemic. □ 21-12-2020 - have engaged with NHSSC for outsource delivery model for on-call and have had some initial response. Discussions held with global fellowship program and on-going support from Bank□ 23-11-2020 - on call provision paper submitted to EMT and approved - meaning that on-call provision will change to an outsourced model for radiologist cover. This will involve a procurement process but ultimately will de-risk on-call service as there will always be cover. □	KSO1 KSO3 KSO5
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□ -Coding team have been supported by external outsourcing company to reduce the backlog and develop in house processes□ -Internal staff are gaining confidence and experience and their output is increasing□ -Activity has been low due to COVID so the backlog is reduced□ -Operational issues regarding availability of notes remain□ -Proposal for blended onsite and remote coding support strategy has been drawn up and sent on for approval ('REMT 'R'&P'): □	Michelle Miles	Mary Gwynn	Finance	12	8	**07/05/2021** - encoder integration work complete and testing will begin this month. Monmouth support remains at reduced level and planning for support procurement underway.□ 29/03/2021 - Encoding software (Medicode) installed in test environment and integration work planned. Monmouth support reduced to test how in house team cope with current activity levels but will be closely monitored.□ March 2021□ - Two new starters currently attending coding standards course.□ - Implementation of encoding software underway - PO raised and approved, IT approved, planning in progress.□ - Funding for support contract approved in business case submitted in business planning.□ - Process to write specification for support required has begun□ - Mentoring for experienced and trainee staff planned□ - Two members of staff identified to undertake ACC qualification to become senior clinical coders.□	KSO4
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	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.	Michelle Miles	Sarah Solanki	Information Management and Technology	15	4	**22-04-2021** - VNA work not complete. Less risk to QVH due to current level of available storage. PACS demos and site visits occurring last week and next week. Staff giving feedback on demos. one of the excluded PACS providers have raised their concern over the procurement process as they feel unfairly treated however, this is being formally addressed by letter of reply to them. Head of procurement shared reply letter today and asked for PACS project team if they supported wording. CI/CRS/Mid/lead radiologist have voiced support. PACS PM is scoping other hidden costs not yet outlined within the project so costs may be made clearer. DOF asked to sign RIS call off contract by 30th March. Prospective GO live for RIS 1st July.□ 22-03-2021 - VNA work still not complete. Less risk to QVH due to current level of PACS storage. OBS documents sent back from QVH for PACS procurement part. Moderation meetings occuring this week. RIS contract sign off needed by 31-03-2021. Documents being checked by CIO. Timelines for data migration etc. remain aggressive. □ 22-02-2021 - OBS document has gone out to the framework to the 3 vendors. Planned OBS scoring for team in March. Placeholders sent. VNA work moving forward slowly. CRIS BC awaiting BC approval confirmation from remaining trusts. Background work is going on for the CRIS project.□ 28-01-2021 - VNA risk comms this week indicated the risk issue has now been sorted but needs to be end to end tested by each trust. If successful - possibility for QVH to start migration in February. RIS BC approved at QVH & ASPH - awaiting approval from other boards. Project to progress.	KSO1 KSO3 KSO3 KSO4
1134	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	Michelle Miles	Mr Paul Drake	Information Management and Technology	12	4	**May 2021**: it is anticipated that risks related to scanning turnaround, eForm stability, and system speed will be reduced with the new scanning contract and evolve upgrade that are planned for this year. Access to documentation will be improved with increased eForm development, which will begin when the new EDM team is in place. EDM rollout has almost reached completion, with the inclusion of therapies. Risks related to upload errors and inappropriate retention of event packs remain, and we continue to work with clinical and admin teams to reduce this risk□ February 2021□ Therapies now has a set go live date. The business case for the scanning options has now been approved via HMT.□ October 2020□ The BAU for evolve is now transferring over to the Operations team with support from the implementation team.□ August 2020□ The completion of the roll out of evolve is due to be October of 2020. BAU for evolve is now developing with the structure being reviewed between DoO & DoF with support from both the CIO and CCIO.□ 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.□	KSO3 KSO4
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	Claire Ziegler	Patient Safety	12	4	**29.05.2021**. International recruits X 6 now received their PINs, completed their supernumerary/orientation within admissions/discharge unit and now have embarked on their theatre orientation (6-8 weeks) Recovery have 2 x band 2 HCA leavers due to career development opportunities (will remain on bank).□ 2 further overseas nurses to join the peri-op department w/c 31.05.2021. □ Staffing pressures due to sickness and maternity leave.□ Adverts currently out for existing vacancies. □ 23/04/21:□ Pre assessment staffing position is improving with a Band 6 relocated to PAC from theatres□ Vacancies Theatres: International recruits X 6 have passed their OSCES and are awaiting their PIN. Working supernumerary with the admission/discharge unit of the department and will begin their rotation into theatres and recovery. Recovery have recruited paediatric band 6 however still remains 3 WTE down. 2 additional overseas nurses and currently in Medway and doing their OSCE and will transfer to QVH upon completion. 2 RN resignations for career progression.□ Weekend waiting list initiative theatre lists running ad hoc□ 5/2/21: International recruits x 6 commenced in (supernumerary)posts - Osce's in March. Recovery remains 3wte RN's short, bank / agency backfill. Overall much improved position from early last year.□	KSO1 KSO2
1044	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/Fluoro 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	Sarah Solanki	Patient Safety	12	9	**22-04-2021** - RSM has been working on the specifications with PM. Dental specs still need compiling. Estates team engaging with companies about completion of a QS report to establish if proposed site suitable for MRI modular build. Provisional plans completed show the unit would work in that location and above point of link corridor would benefit from a small extension. Framework still not formally approved - planned for 23rd April after delays. Timeline for MRI potentially difficult to fulfil by April 2022 therefore extension with current provider may be required. Need to agree contract term eg. 10/15/20 years. Suggested we scope all then decide. □ 22-03-2021 - template specification documents shared with RSM today. RSM to arrange meeting with PM to go through equipment banding, etc. RSM has scoped Prospective site for MRI with estates and PM. Estates and RSM scoped size of unit required. PM/estates communication around services / power requirements needed. the framework that can support MES should be completed by 31-03-2021.□ 22-02-2021 - Project manager has spoken to framework representative today re MES. framework representative shared some documentation for us to use. PM to organize next meeting. No formal news re allocation of NHSEI shared assets currently. □ 28-01-2021 - Brief MES meeting held this week with commercial solutions framework lead. Project stages and timelines talked through. DoF identified the need for a project manager - to be scoped. Next steps are for framework lead to share Slide deck, asset register template to be shared by commercial solutions to SS, and for Estates to have plans of the building etc. ready to move forward. NHSEI - loaned QVH 2 mobile xray machines. Emailed at the end of Nov to notify that these assets may be transferred to the trust. formal outcome to be expected in the next 2 weeks for central NHS re the assets.□ Jan 21: Business case for MES approved at EMT. To be taken forward with DOF as executive lead.□ 21-12-2020 - Delay to Fluoro room finish date due to broken fuse in PDP box - issue caused by contractor we believe. Fix completed by estates electrician. NHSEI may hand over ownership of loaned portable equipment. Awaiting confirmation. □ 3-11-2020 - New funded US on site, commissioned and working. MES paper submitted to AJ and due to be discussed at EMT in coming weeks. Still large risk around multiple pieces of old equipment and general lack of on-going capital replacement. Fluoro room is due for completion the week before Christmas.□ 02-11-2020 - some delays to building works in fluoro room due to more reinforcement needed in the floor (set back 1 week). The lead screen manufacturer has had to temporarily shut their factory due to COVID outbreak. Soonest they can open is 9th November. This may impact timeline but is outside of our control. I will keep in contact with manufacturer for updates.□ MES BC now has financials back so need to add this into document and send to execs for them to assess prior to resubmission to EMT. □	KSO1 KSO2 KSO3

988	20/06/2016	Delivery of commissioned services whilst not meeting all national standards/criteria for Burns	-Potential increase in the risk to patient safety:□ -o/n-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 scalled 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	Nicola Reeves	Liz Blackburn	Compliance (Targets / Assessments / Standards)	12	4	February 2021: reviewed at Paeds Governance meeting - nil to update:□ 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 CORPM 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 CBW 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
87	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	20	16	February 2021: Month 9 achieved plan and the Trust is forecasting to hit plan as a minimum. Work is still underway at the center to understand if the Covid Capital will be paid and also the loss of Non NHS Income. December 2020: Month 7 achieved plan, however the plan includes £5.2m of ICS topup to achieve break even plan.□ October: Due to current NHS financing arrangements the position for the organisation has improved - rescored to 20. However due to the underlying financial deficit that the Trust is facing this is still a significant risk to the Trust.□ August 2020:□ The current financial regime of block contract has remained in place. At present due to the significant reduction in spend on both pay and non pay the Trust is in a breakeven position in line with national guidance. Work is being undertaken in conjunction with the ICS on the phase 3 funding streams into the Trust. In addition, further work is underway to highlight vacant and non backfilled posts.:□ □ June 2020:□ At present the Trust is operating under a block contract arrangement. Due to the national guidance the Trust is reporting a break even position. Further guidance is awaited with regards to the length of time for the block contract arrangements and any amendments to the current values. While the Trust would still be facing a deficit in the old financial regime, it is unclear at this present time as to the level of the current deficit.:□	KSO4
834	09/09/2015	Non compliance with national guidelines for paediatric care.	Unavailability of a Paediatrician to review a sick child causing :□ 1. Harm to child:□ 2. Damage to reputation:□ 3. Litigation	1. Service Level Agreement with BSUH providing some Paediatrician cover and external advice. □ 2. Consultant Anaesthetists, Site practitioners and selected Peanut Ward staff EPLS trained to recognise sick child and deal with immediate emergency resuscitation.□ 3. Policy reviewed to lower threshold to transfer sick children out :□ 4. Readmission of infected burns criteria reviewed to raise threshold for admission:□ 5. Operating on under 3 year olds out of hours ceased unless under exceptional circumstances:□ With regards to SLA for paediatrician cover, □ 1. Continuous dialogue with consultants and business managers:□ 2. Annual review meeting - Sept/October 2015:□ Forward plan: to address areas of highest risk of complications with improved collaboration with BSUH to deliver inpatient Burns care to children in the Royal Alex hospital in Brighton. Aiming for Sept 2016:□ □ Audit of all transfers out carried out on monthly basis and reviewed during Paediatric meeting.□ Burns outcomes monitored during LSEBN/M&M annual review. Data reviewed by all the local burns services.□ Current strict control of cases and comorbidity permitted on QVH site:□ Use of PEWS to enable identification and early management and referral of unwell children	Keith Altman	Dr Edward Pickles	Patient Safety	12	4	March 2021: r/v DoN and Head of Patient Safety - SLA under review:□ February 2021: r/v DoN and Head of Patient Safety - rescored to CRR:□ January 2021: due to C-19 there are currently no paediatricians onsite at QVH - 24/7 cover for advice by telephone is available.□ July 2020: meeting held with BSUH & they continue to support this service:□ 23/5/19:BC reviewed at Board and by Exec Team in BSUH - not approved. Alternative plans under discussion.□ 19/11/18: R/V at Paeds Gov meeting - Business Case in progress, to be submitted to CGG January 2019:□ 24/5/2018: r/v with MD - Darzi fellow in post to lead pathway and joint programme board established.□ 22/1/18: MOU agreed by BSUH & QVH Boards; formation of clinical working group underway:□ SLA with BSUH remains under re-negotiation: 3 days per week agreed for 52 weeks P.A.□ 24/7/17: reviewed with Exec lead - Paeds burns care to be first priority in Brighton partnership MOU	

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05 August 2021**		**Agenda reference:**	**103-21**	
Report title:	Quality & Safety Board Report				
Sponsor:	Nicky Reeves, Director of Nursing and Quality				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	Infection Prevention and Control Team BAF				
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 Board's attention should be drawn to the following key areas detailed in the reports: • Positive feedback from patients treated here during the pandemic whilst we were functioning as the cancer hub. • Inclusion of a SPC summary table of key metrics • Resolution of Clostridium Difficile cluster identified in two wards during February and March • QVH has received additional funding from HEE relating to PGME Training Recovery				
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:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	**World-class clinical services**	**Operational excellence**	**Financial sustainability**	**Organisational excellence**
Implications					
Board assurance framework:	The Quality Report contributes directly to the delivery of KSO 1 and 2, elements of KSO 3 and 5 also impact on this.				
Corporate risk register:	CRR reviewed as part of the report compilation –and the workforce and RTT18 risk impact the most on quality, safety and patient experience.				
Regulation:	The 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 Quality and Safety Report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	21/06/21	Decision:	Noted	
Next steps:					

Executive Summary - Quality and Safety Report, July 2021

Domain	Highlights
Director of Nursing and Quality	Safety of our patients and staff continues to be the primary focus for the Trust whilst also maintaining a positive patient experience. There have been numerous pieces of positive feedback from patients cared for including fantastic feedback from patients treated here during the pandemic whilst we were functioning as the cancer hub. QVH continues with LAMP (Optigene) testing of staff to identify asymptomatic Covid positive people and has also utilised Lateral Flow testing for those unable to access LAMP. The Clostridium Difficile cluster identified in two wards in the Trust during February and March is now resolved. In addition, the Covid Infection control BAF is included in appendix 1 for information - updates are highlighted in yellow to reflect changes in national guidance and QVH actions.
Medical Director	**Medical Staffing** Expressions of interest have been sought from the consultant body for a Deputy Medical Director for Clinical Strategy and Cancer and for a Director for Clinical Governance. It is hoped to interview for these posts in June 2021. Tania Cubison in her role as Deputy Medical Director has taken on the Clinical Lead role for the Sleep service on an interim basis to steer through changes in the service, especially with regard to the medical workforce. **Medical Appraisal** Medical appraisal is now continuing as usual following postponement due to the pandemic last year. Appraises are permitted to use a simpler appraisal form if they wish to provide their information to their appraiser. There will be more revalidation recommendations this year, again due to the pandemic, and these can be made on the basis of 4 appraisals in the previous 5 year cycle as long as all the required supporting information has been brought to appraisals and discussed. **Job planning** A new job planning round is about to begin and it is hoped that it will be completed by the autumn. A consistency panel will be formed of the Medical Director (Chair), Director of Operations, Director of HR and a Clinical Director to inform the process and also to ensure that job plans are consistent and this panel will sign them off. It is expected that team job planning will be an important consideration in this round and will also be supported by the panel.

Report by Exception - Key Messages

Domain	Issue raised	Action taken
Responsive: Quality and Safety	Cluster of falls noted in Q3 and 4 within one clinical areas	Following identification of a cluster of falls within a department, a falls working group has been commenced led by a Head of Nursing . A number of measures have been implemented, and a head of nursing is now reviewing all datixes relating to falls to ensure there is a consistent approach to review and learning.

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	Q1 2020/21		Q2 2020/21			Q3 2020/21			Q4 2020/21			Q1 2021/22		12 month total/ rolling average
		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	
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	0
Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	0	0	0	0	0	0	0	0	3	4	0	0	7
Gram negative bloodstream infections (including E.coli)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA screening - elective	95%	90%	98%	81%	83%	90%	83%	99%	93%	99%	94%	95%	94%	95%	92%
MRSA screening - trauma	95%	61%	84%	94%	99%	98%	99%	100%	99%	95%	96%	94%	97%	96%	96%
Incidents															
Never Events	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Serious Incidents	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1
Theatre metrics															
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	2	3	4	3	3	2	3	3	4	0	5	2	8	40
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	0
WHO quantitative compliance		99%	99%	98%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Non-clinical cancellations on the day		1	1	0	6	4	5	7	8	0	0	2	5	3	41
Needlestick injuries	0	0	0	0	0	3	0	0	3	4	3	3	2	1	19
Pressure ulcers (all grades)(Theatre metric)		1	1	1	0	0	0	0	0	0	0	1	0	0	3
Paediatric transfers out (<18 years)		0	1	0	2	0	0	0	1	1	0	1	0	0	5
Medication errors															
Total number of incidents involving drug / prescribing errors		11	10	5	1	7	16	7	6	6	9	10	3	9	89
No & Low harm incidents involving drug / prescribing errors		9	9	4	1	6	12	7	5	6	8	8	3	9	78
Moderate, Severe or Fatal incidents involving drug / prescribing errors		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medication administration errors per 1000 spells		2.1	0.9	0.8	0.0	0.6	2.2	0.0	0.6	0.0	0.7	1.1	0.0	0.0	0.6
Pressure Ulcers Hospital acquired - category 2 or above		1	0	2	0	0	0	1	2	0	1	0	2	0	8
VTE initial assessment (Safety Thermometer)	95%	91%	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	97%	97%	99%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	95%	100%	100%	100%	100%	100%	97%	97%	100%	100%	93%	100%	100%	100%	99%
Patient Falls resulting in no or low harm (inpatients)		0	2	4	3	3	2	5	4	4	6	2	1	3	39
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient falls per 1000 bed days		0.8	4.6	3.6	2.8	1.9	1.8	3.6	4.7	0.0	5.3	8.4	4.0	3.7	3.7

*MRSA April 20 - the revised score following a meeting between QVH & MCIndoe and screening process reviewed.

nc = not collected or not reported

Safe - Performance Indicators

Quality Metric	Latest month	Current Performance	Target	Variation	Assurance	Average
MRSA - Elective	Jun 21	96.0%	95.0%			96.5%
MRSA - Trauma	Jun 21	98.0%	95.0%			96.2%
Serious Incidents	Jun 21	1.0	0			0.2
Total no of incidencts involving drug/prescribing errors	Jun 21	5.0	0			13.9
Falls per 1000 bed days	Jun 21	4.3	0			2.8
Pressure ulcers per 1000 bed days	Jun 21	0.0	0			0.5
Complaints	Jun 21	7.0	0			5.0

There are no changes in any of the metrics causing concern. We have consistently had a lower level of drug/prescribing errors since the start of Covid 19.

For all these key metric we are neither consistently achieving or falling short of our target, but is subject to random variation.

SPC limits calculated using data from September 2017 to date.

Nursing Workforce - Performance Indicators, Safe staffing data

Peanut ward - In April there were 15 overnight cases on 13 occasions and there was one occasion when the ward was unable to accept an inpatient overnight. In May there were 11 patients overnight on 11 occasions. There were no nights in May when the ward was not able to accept an inpatient.

April safe staffing data demonstrates compliance across all the bands with staffing levels above 95% of the required template. Staffing levels are reviewed on a regular basis and as a minimum three times a day. Use of the Safe Care Live module is also supporting the team to make real time staffing decisions.

Combined Staffing exc. Site — *Target 95%*

Apr-21

	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
DAY	5095	253	2266	5094.5	253	2265.5	*Total Hrs Planned and Actual*
				100.0%	100.0%	100%	*% Planned Hrs Met*
			7613			7613	*Total Hrs Planned & Actual - Combined reg & support*
						100.0%	*% Planned Hrs Met - Combined reg & support*

	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA
NIGHT	4117	126.5	1185	4117	126.5	1173
				100.0%	100.0%	99.0%
			5428			5417
						99.8%

May safe staffing data demonstrates compliance across all the bands with staffing levels above 95% of the required template. Staffing levels are reviewed on a regular basis and as a minimum three times a day. Use of the Safe Care Live module is also supporting the team to make real time staffing decisions.

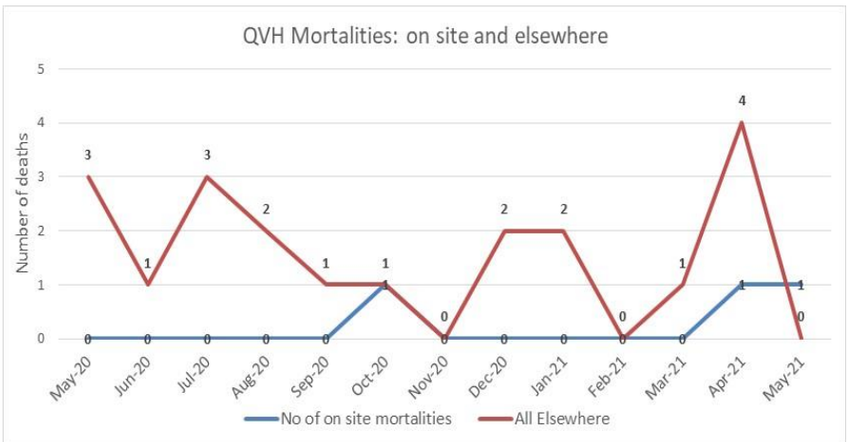
Combined Staffing exc. Site — *Target 95%*

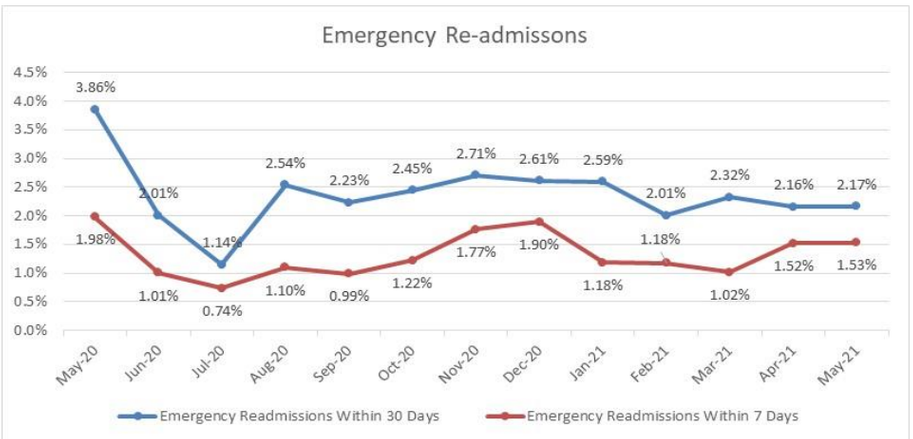
May-21

	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
DAY	5118	230	2208	5072	230	2162	*Total Hrs Planned and Actual*
				99.1%	100.0%	98%	*% Planned Hrs Met*
			7556			7463.5	*Total Hrs Planned & Actual - Combined reg & support*
						98.8%	*% Planned Hrs Met - Combined reg & support*

	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA
NIGHT	4278	218.5	1173	4209	218.5	1116
				98.4%	100.0%	95.1%
			5670			5543
						97.8%

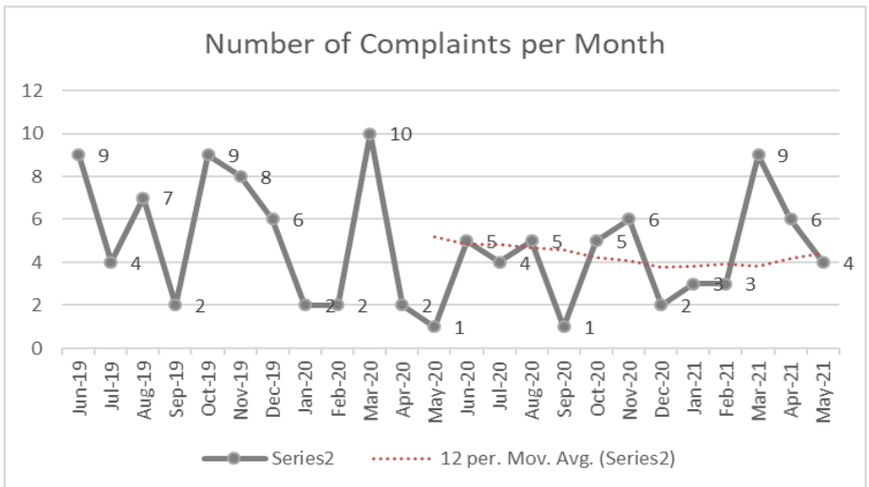
Effective - Performance Indicators

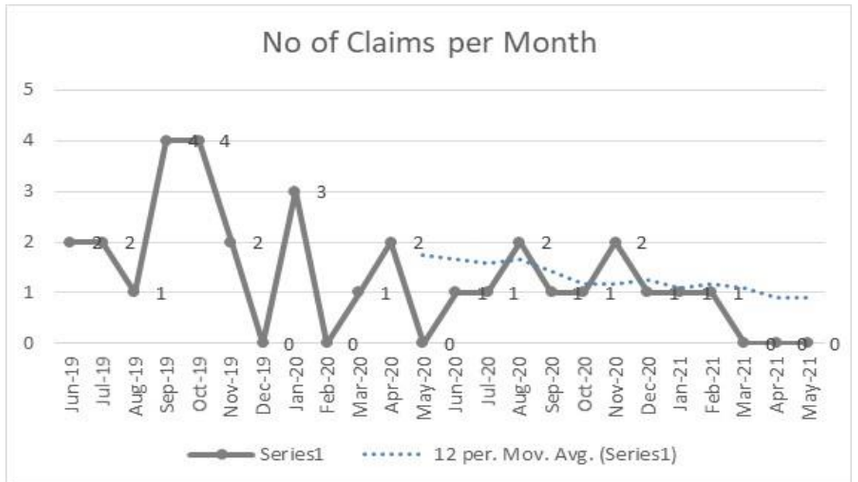




Mortalities Report			Q1 2020/21		Q2 2020/21			Q3 2020/21			Q4 2020/21			Q1 2021/22	
			May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Mortalities within 30 days of an inpatient episode or outpatient procedure	Inpatient	No of on site mortalities	0	0	0	0	0	1	0	0	0	0	0	1	1
		No of mortalities elsewhere	3	0	2	2	1	1	0	1	1	0	0	1	3
	Outpatient		0	1	1	0	0	0	0	1	1	0	1	3	1
	All Elsewhere		3	1	3	2	1	1	0	2	2	0	1	4	4
Reviews		Completed Preliminary Reviews	3	1	3	2	1	2	0	2	0	0	0	1	1
		No of deaths subject to SJR	0	0	0	0	0	1	0	0	0	0	0	1	3
No of mortalities in patients with learning difficulties (inpatients only)			0	0	0	0	0	0	0	0	0	0	0	0	0

Caring - Current Compliance - Complaints and Claims





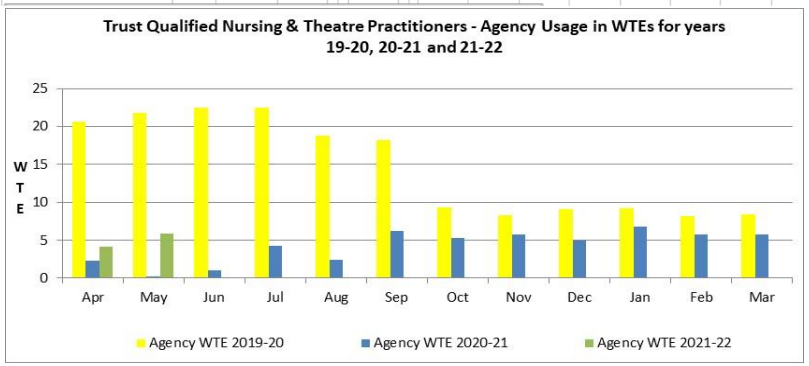
	Q4 2019/20		Q1 2020/21			Q2 2020/21			Q3 2020/21			Q4 2020/21
	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Number of complaints	5	4	5	1	5	6	2	3	3	9	6	4
Complaints per 1000 spells	0.40	0.27	0.35	0.06	0.28	0.33	0.12	0.20	0.20	0.50	0.32	0.22
Number of claims	1	1	2	1	1	2	1	1	1	0	0	0
Claims per 1000 spells	0.08	0.07	0.14	0.06	0.06	0.11	0.06	0.07	0.07	0.00	0.00	0.00
Number of cases referred to PHSO	0	0	0	0	0	3	0	0	0	0	0	1

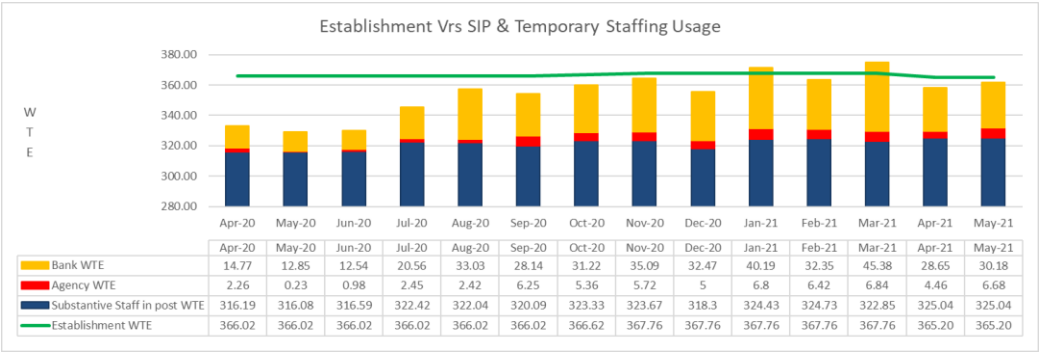
Nursing Workforce - Performance Indicators

ALL QUALIFIED & UQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020-21			May -20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)				366.02	366.02	366.02	366.02	366.02	366.62	367.76	367.76	367.76	367.47	367.47	365.20	365.20	◄►
Staff In Post WTE				316.08	322.52	322.42	322.04	320.09	323.33	323.79	318.30	324.43	324.73	322.85	325.04	325.04	◄►
Vacancies WTE				49.94	43.50	43.60	43.98	45.93	43.29	43.97	49.46	43.33	42.74	44.62	40.16	40.16	◄►
Vacancies %	>18%	12%<>18%	<12%	13.64%	11.88%	11.91%	12.02%	12.55%	11.81%	11.96%	13.45%	11.78%	11.63%	12.14%	11.00%	11.00%	◄►
STARTERS WTE (Excluding rotational doctors)				2.23	5.01	0.61	2.00	2.00	3.63	3.00	0.00	11.56	1.00	1.00	6.15	2.00	▼
LEAVERS WTE (Excluding rotational doctors)				3.00	0.00	2.32	2.75	1.00	1.00	4.61	4.36	4.18	0.00	2.88	3.80	0.87	▼
Starters & Leavers balance				-0.77	5.01	-1.71	-0.75	1.00	2.63	-1.61	-4.36	7.38	1.00	-1.88	2.35	1.13	
Agency WTE (Data From Healthroster)				0.23	0.98	2.45	2.42	6.25	5.36	5.72	5.00	6.80	6.42	6.84	4.46	6.68	▲
Bank WTE (Data From Healthroster)				12.85	12.54	20.56	33.03	28.14	31.22	35.09	32.47	40.19	32.35	45.38	28.65	30.18	▲
Trust rolling Annual Turnover %	>= 12%	10%<>12%	< 10%	10.27%	8.67%	8.48%	8.23%	7.79%	7.44%	8.36%	9.21%	8.90%	8.98%	9.34%	9.33%	8.58%	▼
Monthly Turnover				1.01%	0.00%	0.77%	0.91%	0.33%	0.33%	1.51%	1.10%	1.14%	0.00%	0.95%	1.26%	0.29%	▼
Sickness Absence %	>=4%	4%<>3%	<3%	2.21%	1.67%	3.30%	2.54%	2.94%	3.82%	3.87%	4.50%	4.48%	3.13%	3.30%	2.30%	TBC	

Note 1. 2020/21 budget updated September 20 backdated to April 20 to show most current position. March 20 Establishment updated as queries resolved. Both taken from Finance Ledger
Note 2. All data taken from ESR unless stated otherwise.
Note 3. Staff included are Qualified Nurses, EmergencyPractitioners, Theatre Practitioners, HCA's,Student OPD's, Trainee Nurse Associates/Practitioners,NurseAssociates, Play Specialists, Oversea's Nursing awaiting PIN, Dental Nurses included in figures from 1.4.2020





	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Bank WTE	14.77	12.85	12.54	20.56	33.03	28.14	31.22	35.09	32.47	40.19	32.35	45.38	28.65	30.18
Agency WTE	2.26	0.23	0.98	2.45	2.42	6.25	5.36	5.72	5	6.8	6.42	6.84	4.46	6.68
Substantive Staff in post WTE	316.19	316.08	316.59	322.42	322.04	320.09	323.33	323.67	318.3	324.43	324.73	322.85	325.04	325.04
Establishment WTE	366.02	366.02	366.02	366.02	366.02	366.02	366.62	367.76	367.76	367.76	367.76	367.76	365.20	365.20

Medical Workforce - Performance Indicators

Metrics	Quarter 1 2020/21	Quarter 2			Quarter 3			Quarter 4			Quarter 1 2021/22		12 month rolling
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	
Medical Workforce													
Turnover rate in month, excluding trainees	1.12%	0.00%	3.28%	1.01%	1.06%	0.87%	1.08%	1.08%	0.00%	2.70%	30.18%	0.55%	16.25%
Turnover in month including trainees 9%	1.42%	0.71%	15.26%	4.07%	5.98%	0.55%	2.07%	0.69%	3.26%	6.77%	8.02%	0.35%	47.29%
Management cases monthly	0	0	0	0	0	0	1	0	0	0	0	0	1
Sickness rate monthly on total medical/dental headcount	0.65%	0.31%	0.55%	1.56%	2.42%	2.03%	1.71%	1.67%	1.24%	TBC	1.21%	TBC	1.31%
Appraisal rate monthly (including deanery trainees)	62.05%	57.74%	74.51%	77.27%	75.25%	85.88%	76.14%	76.83%	78.05%	83.81%	62.00%	66.67%	N/A
Mandatory training monthly	86%	86%	86%	81%	80%	82%	85%	85%	82%	81%	83%	85%	N/A
Exception Reporting – Education and Training	0	1	0	1	0	1	0	0	0	1	0	2	6
Exception Reporting – Hours	0	5	0	4	0	1	0	2	3	1	2	2	20

Medical & Dental Staffing

The April doctors induction successfully welcomed new trainees in OMFS, Radiology and Plastics. For August, the plan is to return to an induction programme similar to pre-Covid, with additional speakers and a formal welcome to the Trust from the Chief Executive. August induction is likely to be the biggest induction of the year, with over 20 new starters across all specialties.

The most recent Junior Doctors' Forum took place in April and was well attended. Plans are now in place to use the remaining fatigue and facilities money to renovate the old bar area of the Surgeon's Mess to create a welcoming area for trainees to meet, relax and de-stress.

	All specialties are continuing to deliver teaching, making use of the available technology and larger rooms to allow for social distancing. The new HEE Education contract is currently with HEE and it is expected to be returned to the Trust for signing shortly. There will also be a new format for the financial statements of funding from HEE, and the Medical Education Manager will work with colleagues in Finance to ensure that the funding is correctly allocated when received.
Education	The next round of Local Faculty Group meetings are underway, with the Local Academic Board meeting planned for July. The Trust has received additional funding from HEE relating to PGME Training Recovery, with some clear guidelines on how the funding can be used. The Director of Medical Education and Medical Education Manager will be consulting with clinical tutors to ensure that this is used to create the maximum benefit for QVH trainees.

Publications approval reference: 001559

Infection prevention and control board assurance framework

June 30th, 2021. V1.6

Updates from V1.5 highlighted

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related; guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of

controls. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure:
• local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;
• the documented risk assessment includes:
  ○ a review of the effectiveness of the ventilation in the area;
  ○ operational capacity;
  ○ prevalence of infection/variants of concern in the local area.
• triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;
• when an unacceptable risk of transmission remains following the risk assessment, consideration to the
	• Each area has been assessed to ascertain safe pathways for patients with clear green and amber routes identified.
	• Evidence of planning evident through 'Restoration and Recovery' meeting minutes with SOP's produced throughout pandemic for individual services, departments and specific re-starting of procedures.
	• Ventilation reviewed in key green areas with improvements made through the purchasing of air scrubbers
	• All elective admissions are PCR screened pre-
		• Due to the age of the site and infrastructure most departments are without mechanical ventilation with only natural ventilation achieved through windows and doors being opened
		• There is no way to confirm patients are completing the required isolation period pre-admission and are therefore exposing the Trust to Covid-19 by not following infection control instructions
			July 2021 update
			Air scrubbers installed within the CCU to improve ventilation and air flow and potentially increase capacity to facilitate 'amber' CCU level admissions
			
			All departments assess the patient flow to ensure green and amber patients follow different pathways. AGP's are performed in side rooms with guidance on fallow time given.
			Guidance given to reduce fallow time for green patients by utilising on site LAMP (Optigene) Sars-Cov2 testing to ensure

extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given; • there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative; • that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance; • resources are in place to enable compliance and monitoring of IPC practice including: ○ staff adherence to hand hygiene; ○ patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; ○ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical; ▪ b) non-clinical setting;	admission and isolated as per national guidance • High risk/vulnerable patients are isolated for an extended period of time pre-admission • Strict admission criteria's in place for green areas • All trauma patients are Sars Cov 2 tested on arrival with entry to departments dependent on the result • Clear guidance and SOP in place for isolation routes for high risk patients or those confirmed positive • Infection control advise on PPE/RPE requirements for all positive cases due to low numbers being admitted • All staff are instructed on correct application and removal of PPE with guidance published on what PPE should be worn in each area, FIT testing Trust database held to ensure staff are FIT tested • Regular communication sent to all staff and updated on		patients not Covid-19 positive at the time of procedure

○ monitoring of staff compliance with wearing appropriate PPE, within the clinical setting; • that the role of PPE guardians/safety champions to embed and encourage best practice has been considered; • that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace; • additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team; • training in IPC standard infection control and transmission-based precautions is provided to all staff; • IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training; • all staff (clinical and non-clinical) are trained in: ○ putting on and removing PPE; ○ what PPE they should wear for each setting and context; • all staff (clinical and non-clinical) have access to the PPE that protects them	visitor/patient forums to reinforce the need for social distancing and the continuing need to wear face coverings whilst within the Trust • Waiting areas continue with reduced numbers, staff and rest areas are socially distanced with staff reminded to stagger break times to facilitate this • All elective admissions are assessed as to whether they are urgent i.e. cancer surgery. Patients are pre-assessed and given instructions to self-isolate for 14 days they are then swabbed for COVID 72 hours before admission. • During core hours trauma patients requiring GA's are swabbed from throat and nose which is tested using Optigene, a negative result is required before surgery • Separate theatre areas are available for patients who are not swabbed due to low risk surgery		

for the appropriate setting and context as per national guidance; • there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace; • IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way; • changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted; • risks are reflected in risk registers and the board assurance framework where appropriate; • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens; • the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep; • the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board;	e.g. hand trauma • Patients with suspected or confirmed Covid-19 are cared for in a designated • area with full precautions- due to cancer hub corona 'lite 'status of the site this has not been required at time of completing this document which shows the screening measures are working. • Patients who remain inpatients are screened again at day 3 and all those being discharged to a healthcare environment are screened no greater than 48 hours before discharge • Fluid resistant surgical masks are available in all departments for staff to wear anyone non able to tolerate masks is referred to occupational health • All areas re-starting patient facing work are assessed to ensure staff are aware of the right PPE they need		

• the Trust Board has oversight of ongoing outbreaks and action plans; • there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	• FIT testing is an ongoing process to ensure all staff who are required to wear FFP3 are safe to do so, for those who are unable to be FIT tested there is a supply of air powered hoods available for use. • All requirements for PPE are in line with current PHE recommendations		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas; • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas; • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance;	• There are no designated COVID-19 wards due to cancer hub/corona 'lite' hospital status , however anaesthetic staff, CCU staff and ODP's have been running SIM training to care for the unwell COVID-19 patient with a designated area set up that could be used to safely isolate and care for a patient with COVID-19 • Decontamination will be done in the COVID-19 ward area by the nursing staff designated		**July 2021 update** No changes made. Trust already compliant with the stipulated changes in the document evidence of this included in evidence section

• assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk; • cleaning and decontamination is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses; • manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products as per national guidance; • a minimum of twice daily cleaning of: ○ areas that have higher environmental contamination rates as set out in the PHE and other national guidance; ○ 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails;	cleaners allocated to minimise risk of spread • Decontamination and terminal cleans are done in line with the national standards of cleanliness and PHE guidance. Utilising the Hydrogen peroxide mist system alongside robust cleaning with detergent and chlorine based • Cleaning has been increased in key areas of the Trust by the in-house domestic team, such as main corridors, focusing on high touch areas such as public bathrooms, taps and door handles. • All waste and linen is disposed of in line with PHE guidance and with full discussion with our waste and linen providers. • Where possible single use equipment is used, is not possible all equipment is cleaned following the terminal clean process. • Reusable sterile equipment is		

○ electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards; ○ rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff; • reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing or repair equipment; • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken; • single use items are used where possible and according to single use policy; • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and	decontaminated and sterilised by Steris • All re-usable patient equipment is cleaned between each patient use and then at regular intervals e.g. weekly/monthly depending on type of equipment and storage space in line with the guidance laid out in the National standards of cleanliness • Decontamination and Disinfection policy in place which details cleaning guidance. • All equipment requiring servicing or repair must have a decontamination form completed and attached to it before work undertaken • Cleaning of patient equipment is documented in ward based cleaning charts		

that actions in place to mitigate any identified risk; • cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment; • where possible ventilation is maximised by opening windows where possible to assist the dilution of air.			
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements for antimicrobial stewardship are maintained • mandatory reporting requirements is adhered to and boards continue to maintain oversight	• Antimicrobial stewardship continues with a new antimicrobial pharmacist in post. Monthly reporting continues. • Antibiotic prophylaxis and alternative antibiotic therapy discussed with consultant microbiologist • All mandatory reporting continues as normal with quarterly reports produced for Board.	• There has been no onsite Consultant Microbiology cover since February 2020 • Antimicrobial pharmacist has left the Trust	**July 2021 update** Lack of onsite Microbiology present raised at quarterly pathology review meeting and SLA being reviewed Antimicrobial task and finish group established and meeting twice a month to look at non-compliance with antimicrobial prescribing and identify ways to improve

			Antibiotic prescribing still monitored by pharmacy staff with Infection control team conducting quarterly reviews
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • national guidance on visiting patients in a care setting is implemented; • areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access; information and guidance on COVID-19 is available on all trust websites with easy read versions; • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved; • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	• Visiting is restricted in line with PHE guidance. • Plan in place for EOLC to allow compassionate visiting • Signage throughout the trust marking ward areas closed to visiting and do not enter signs • Clear guidance available on Trust website for all patients and visitors on current Covid-19 guidance		July 2021 update Regular communication sent out to all staff reminding them of the need to social distance and continue wearing face coverings Infection control maintain an increased availability to provide assurance and guidance to staff on Covid requirements with the incident control centre which continues to be staffed 7 days a week Clear guidance given around when to isolate and to undertake PCR testing A risk averse approach to ill health in staff is maintained to minimise

• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)			the risk of spread of covid-19 within the trust Staff continue with, as a minimum weekly Optigene testing for clinical staff and every other week for non-clinical for prevalence. Lateral flow screening twice weekly is offered as an addition
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases; • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non Covid-19 cases to minimise the risk of cross-infection as per national guidance; • staff are aware of agreed template for triage questions to ask;	• The Trust has been separated to create COVID-19 clear areas for all elective admissions who have undertaken the required isolation and screening. • There is separate area for trauma and elective patients who are non-symptomatic but have not under taken the isolation and screening • All patients are met at the front entrance where they are temperature checked and then directed to the appropriate area.		**July 2021 updates** No changes made, Trust compliant with previous and updated guidance

• triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible; • face coverings are used by all outpatients and visitors; • individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation; • clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with	• Any patient with symptoms whilst an inpatient is transferred to a designated area to await swab results. • If a patient presents with symptoms then the reason for admission /attendance is assessed as to whether they need to be seen on that day if it is deemed urgent then they are cared for in a designated area. • All in patient's elective or trauma are swabbed. All patients returning to care home are screened 48 hours in advance • Patients deemed to be clinically vulnerable are put into increased isolation preadmission and treated through separate green areas within the Trust • Side rooms are prioritised for infection control requirements with immunocompromised patients being prioritised for isolation		

separate spaces, but there is potential to use screens, e.g. to protect reception staff. • isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative; • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly; • there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document; • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.			
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate	• All staff have received training to ensure they are working in a safe environment. • Communication to staff around social distancing, hand		**July 2021 update** No changes made

entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas; • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe; • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • a record of staff training is maintained; • adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk; • hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ○ hand hygiene facilities including instructional posters; ○ good respiratory hygiene measures; ○ staff maintaining physical and social distancing of 2 metres	washing, good respiratory etiquette has been reinforced • All staff are now screened for Covid-19 on a rolling basis. High risk areas are screened more regularly on a weekly basis. This is monitored on a departmental basis and overseen by a dedicated research team • All staff providing care have been trained on the use of PPE with physical demonstrations and posters produced to ensure they know which PPE to use when and how to put it on and take it off correctly. All staff are FIT tested before they can use an FFP3 mask • Re-use of PPE is in place following PHE guidance with clear instructions on decontamination of PPE. • Monthly hand hygiene and uniform audits are undertaken. • Staff are reminded of		

wherever possible in the workplace unless wearing PPE as part of direct care; ○ staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace; ○ frequent decontamination of equipment and environment in both clinical and non-clinical areas; ○ clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas. • staff regularly undertake hand hygiene and observe standard infection control precautions; • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance;	the importance of hand hygiene and the correct wearing of uniforms/work clothes and scrubs. • Colour coded scrubs are in place to show designated areas of the Trust • All staff have been provided information and communication around the symptoms of COVID- they or a family members displays any of them. –Staff screening is available. • IPC team keep numbers of staff trained , individual training is recorded by staff member • PPE has not needed to be reused at this time. CAS alert guidance would be followed if the situation were to change • The trust follows the national PPE guidance and has a QVH visual guide as well displayed in all clinical areas. Spot check are undertaken by IPC team • This monitoring		

• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas; • staff understand the requirements for uniform laundering where this is not provided for onsite; • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms; • a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals); • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported; • robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the	continues as per normal process • Guidance has been provided to staff via daily bulletins • Numerous reminders have been sent to staff and updates have included new symptoms to look out for		

documented recording of outbreak meetings.			
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff; • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas; • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate; • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance; • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	• If a patient is suspected of or confirmed to be COVID-19 positive then there is a designated area that they will be cared for, this has been set up with a clear entry and exit room, donning and doffing areas, shower facilities for staff, areas to care for the symptomatic well patient and the deteriorating patients. This area is distanced from other areas within the Trust to minimise the risk of spread. • Any patient with an infectious organism would be managed as per standard infection control precautions. • Departments relocated to different areas within the Trust in order to facilitate trauma patients being brought back to		**July 2021 update** No changes made

	site whist still being able to segregate green and amber patients • All areas assessed by the MDT including department leads, IPACT and estates		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals; • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance; • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available; • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data); • screening for other potential infections takes place;	• All staff required to screen patients have been given training on the correct way to swab a patient. Staff are trained on the approved way to label and package swabs to ensure safe transport to the laboratory for testing. • Patient screening is done either preadmission in line with the national cancer pathway or on admission for all overnight stays, on discharge if the patient is being discharged to a care home facility or if the patient displays any symptoms of Covid-19.		**July 2021 update** No changes made. All staff continue to be screened for prevalence through optigene screening weekly for clinical staff and every other week for non-clinical. If indicated screening is increased for staff in certain areas. This is supported with staff using twice a week lateral flow tests available through the national testing system.

• that all emergency patients are tested for COVID-19 on admission; • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise; • that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission; • that sites with high nosocomial rates should consider testing COVID negative patients daily; • that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge; • that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation; • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	Staff displaying symptoms are screened following PHE guidance • Trust policy on screening patients for other infections remains in place. • Staff testing lab is now in place with a 2 week prevalence having been completed showing a 0% rate of Covid carriage amongst all staff groups. Regular testing continues with frequency being dictated by area worked.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • staff are supported in adhering to all IPC policies, including those for other alert organisms; • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff; • all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance; • PPE stock is appropriately stored and accessible to staff who require it.	• The infection control team has increased visibility in all wards and departments to ensure staff feel supported with all IPC policies and changes in guidance • The IPACT has provided contact details for out of hours advice to maintain a constant support and advice ethos • Any changes in PHE guidance is disseminated in a timely manner to fit with the Trust environment • All waste is disposed of in accordance with PHE guidance and following assurance from the waste providers • Stores of PPE is monitored, stored and controlled by the supplies department in a way that ensures staff have appropriate access.		**July 2021 update** No changes made
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:	• Staff are risk assessed by their department leads to identify safe		**July 2021 update** 6 further members of staff completed FIT

• staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported; • that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff; • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally; • staff who carry out fit test training are trained and competent to do so; • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used; • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation; • those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods; • members of staff who fail to be adequately fit tested a discussion	working practices on an individual basis following guidance from PHE • HR have developed and circulated extensive health and wellbeing information and tips. • We currently do not have reusable respirators within the Trust but all staff required to wear a disposable respirator are FIT tested to do so and a log maintained. • Any staff member who tests positive is given information about isolation and keeping well, they are able to contact the infection control team at any time for further advice or support. Support is offered via incident control room and line manager. Return to work advice follows national guidance and this is confirmed with IPC Team or EPRR lead if any queries re this		tester training to ensure all required staff have access to FIT test training

should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm; • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health; • following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record; • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board; • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency			

care pathways as per national guidance; • all staff to adhere to national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas; • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone; • staff are aware of the need to wear facemask when moving through COVID-19 secure areas; • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing; • staff who test positive have adequate information and support to aid their recovery and return to work.			

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05 August 2021**		**Agenda reference:**	**104-21**	
Report title:	**Six Monthly Nursing Workforce Review Board Report**				
Sponsor:	Nicky Reeves, Interim Director of Nursing				
Author:	Liz Blackburn, Head of Nursing				
Appendices:	2				
Executive summary					
Purpose of report:	To update the Board on the current nurse staffing levels as required by the National Quality Board				
Summary of key issues	The nursing workforce paper reviews the nurse staffing levels required in order to provide safe, high quality and cost efficient care. Safe provision of care is evidenced in this paper Vacancy rates in individual clinical areas are identified Care hours per patient day have been benchmarked against "Model Hospital" data Potential number of retirees are detailed per clinical area for context				
Recommendation:	Q&GC is requested to **approve** the report to forward to the next Board meeting				
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:	Links to all 5 KSOs				
Corporate risk register:	Workforce risks are on CRR and there are currently two risks identifying insufficient nursing numbers				
Regulation:	Compliance with regulated activities in Health & Social Care Act 2008 and National Quality Board Guidance				
Legal:	As above				
Resources:	No additional resources required to produce this report				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	21/06/21	Decision:	Noted	
Next steps:					

Nursing Workforce Review – May 2021

1. Purpose

This paper provides assurance to the Board that the National Quality Board; Safe sustainable and productive staffing paper, an improvement resource for adult inpatient wards in acute hospitals (Edition 1, January 2018) has been reviewed and referenced against QVH nursing workforce deployment (Appendix 1).

This paper will give an overview of the standard nursing metrics and will give detail on the changes and challenges due to Covid-19.

This paper covers staffing in theatres, inpatient and outpatient areas of the organisation and reviews the outcomes of a range of initiatives taken to improve the nursing and theatre practitioner workforce regarding recruitment and retention.

2. Covid-19 pandemic, Second surge and Vaccination

As in the first phase of the pandemic, the QVH remained a cancer hub with the reconfigured wards now embedded within the Trust. At times, nursing staff have been required to work in environments and with patient groups that may be unfamiliar. We have followed Nursing and Midwifery Council (NMC) regulatory guidance to support this and maintain safe staffing.

Deployment

Internal deployment – Staff were deployed to deliver vaccinations to the QVH workforce and additional external priority groups to meet the National Vaccination requirements.

External deployment - Staff were offered the opportunity to work with our neighbouring Trusts to provide support during the Second surge. A Nursing Associate currently working in Critical Care took the opportunity to work in Intensive Care at Eastbourne Hospital for two months. A Matron working on the Burns Unit worked at the Nightingale Hospital in London for a month. Nursing staff from the Trust were deployed to work in the National Vaccination Hub in Crawley. Two staff per day, seven days per week were utilised to meet the targets set by the Covid-19 National Vaccination Programme.

During this time safe staffing metrics continued to be monitored to ensure safe staffing levels were maintained. In addition, daily site meetings allowed for further reallocation of staff as required.

The health and well-being of staff has continued to be a priority in supporting both our staff working on site and those either working from home or shielding. Regular team meetings were held via MS Teams and well-being tips and advice were shared.

Training and education

In order to build confidence and competence in the workforce, statutory and mandatory training focussing on basic life support skills, vaccination training and Covid-19 simulation training continued. 20 staff attended a “Covid-19 Remote Learning for Critical Care” course, this one day course provided the basic knowledge and skills to work in Critical Care to allow a rapid response during surge. The flow of patients through Critical Care both ‘green’ and ‘amber’ was assessed and reconfigured to support increased amber admissions should it be required. In addition, the Critical care nursing bank rate was enhanced to acknowledge the specialist skills required to work in this area. As a result, on call shifts were created to meet the higher patient demands and were filled appropriately with skilled staff.

The benefits of having appropriate staffing levels are well evidenced and include safer care, greater patient and staff satisfaction and align with the Trust’s key strategic objectives;

- Outstanding patient experience
- World class clinical services

- Operational excellence
- Financial sustainability
- Organisational excellence

The data in this report is based on a number of sources including finance ledgers, ESR, Safe Staffing, local templates and establishment information.

3. Recruitment and Retention

We have continued to recruit to our nursing workforce throughout this period in order to support the existing staff and meet of our increased patient activity both elective and trauma. The following have been recruited in the Trust over this reporting period:

- 5.92 WTE qualified nurses
- 14.27 WTE unqualified staff

Our international recruitment is ongoing and we welcomed six new international nurses in to Theatres. Four are fully registered and two are awaiting their NMC registration following their successful OSCE. A further two nurses are expected in theatres in April 2021.

Below is the leaver and starter information for the nursing workforce with a net recruitment of 3.16 WTE over the reporting period.

1st October 2020 to 31st March 2021 leaver and starter data for information.

ALL QUALIFIED & UNQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020-21	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)		366.62	367.76	367.76	367.76	367.47	**367.47**	◄►
Staff In Post WTE		323.33	323.79	318.30	324.43	324.73	**322.85**	▼
Vacancies WTE		43.29	43.97	49.46	43.33	42.74	**44.62**	▲
Vacancies %	>18% 12%<>18% <12%	11.81%	11.96%	13.45%	11.78%	11.63%	**12.14%**	▲
STARTERS WTE (Excluding rotational doctors)		3.63	3.00	0.00	11.56	1.00	**1.00**	◄►
LEAVERS WTE (Excluding rotational doctors)		1.00	4.61	4.36	4.18	0.00	**2.88**	▲
Starters & Leavers balance		2.63	-1.61	-4.36	7.38	1.00	**-1.88**	

Sourced via ESR data

4. Incident Reporting

There were nine datix incidents reported during this period in relation to staffing. Four of the nine were related to safe staffing levels on the Burns Ward and Head and Neck Unit. These incidents specifically related to a higher acuity of patients within the wards. The Head and Neck Unit had been opened to meet the needs of our service as a South East Cancer Hub. The Burns ward had an unusually high number of admissions during that period. A further four incidents related to insufficient staffing to be able to accept an amber CCU admission. As a result of this our CCU admission criteria were reviewed, a flowchart was created to address;

the triage of CCU patients; bed identifying tools; and staffing flowchart. One incident was related to deployment of CCU staff resulting in us being potentially unable to accept an amber CCU referral. All incidents were investigated and closed with no patient harm, and staffing levels reviewed to meet the needs of the patients.

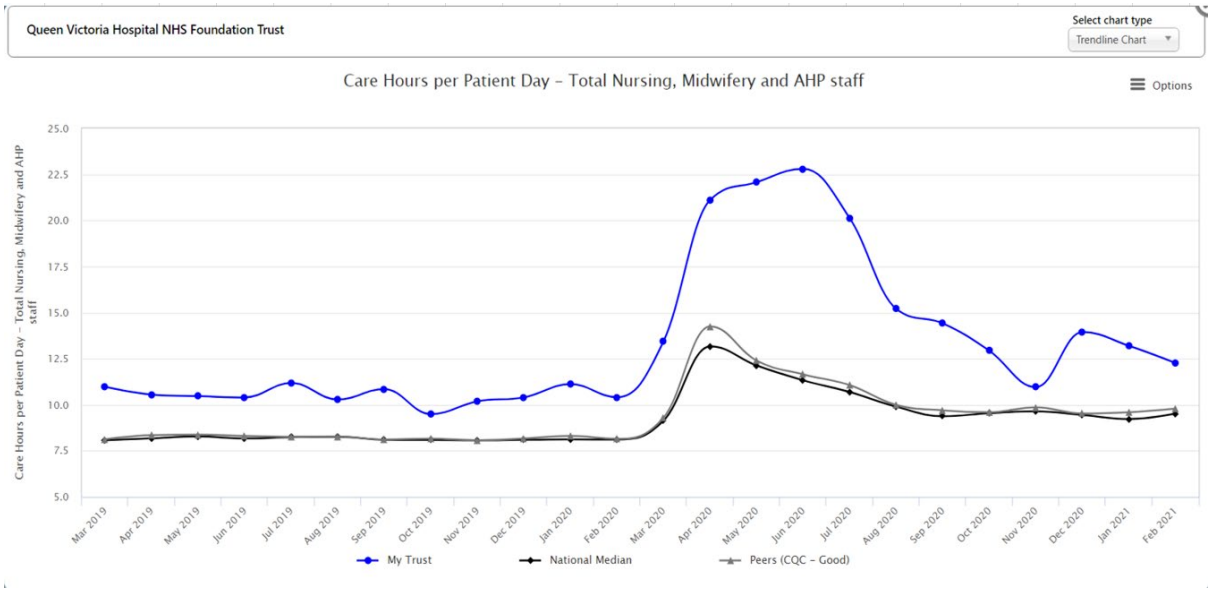
CCU staffing was added to the Corporate Risk Register (CRR) due to the inability to deploy a flexible CCU workforce across the green and amber pathways which are split across two geographical areas in QVH. The Board Assurance Framework (BAF) risk rating for key strategic objectives captures the risk that Trust may not able to recruit or retain a workforce with the right skills and experience due to uncertainty of the potential merger.

Workforce updates continues to be a feature at every public board which includes details on nursing recruitment and retention triangulated with patient safety metrics and complaints information.

4. Care Hours Per Patient Day (CHPPD) and safe staffing metrics

CHPPD provides a view of both registered and non-registered staff that deliver care in a ward-based setting. This allows the appropriate skill-mix and nurse-to-patient ratio to be considered when deploying the clinical staff. It is calculated by adding the hours of Registered Nurses and Health Care Assistants available in a 24 hour period and dividing that by the total number of inpatients recorded at midnight.

This is benchmarked nationally through the NHSE/I 'Model Hospital'. As the graph below shows, the Trust is above the national median, and this is reflective of our specialist services. During the pandemic, Critical Care have been required to staff two geographical areas thus requiring more staff per patient to accommodate this. The Head and Neck Unit takes higher acuity patients and requires a nurse to patient ratio higher than an average ward. Similarly, the Burns Ward during the reporting period experienced high inpatient numbers needing complex dressing changes also which required additional staffing to manage the dependency.



Our safe staffing metrics are captured daily and reported on a monthly basis.

5. Establishment reviews and budget setting

The Interim Director of Nursing undertook staffing reviews with the Heads of Nursing, Ward Matrons and Theatre manager, these were further reviewed and discussed with HR and the

Finance department. These staffing establishments have taken in to account changes during the pandemic. These include reduced bed numbers to allow for social distancing, the ability to accept unscreened CCU patients, staffing for the Covid-19 testing pod and staffing for the Head and Neck Unit.

The staffing establishments have been benchmarked as described in previous workforce papers against national standards, AFPP theatre guidance, RCN guidance, Intensive Care Society standards and surrounding burns services.

Ward and Outpatient areas as at 31st March 2021 (excl non clinical support roles)
The table below is a summary of staffing establishments including registered and non-registered workforce, excluding non-clinical, admin and clerical posts. The percentages of vacancy have been RAG rated as follows:

Department	Total Recruitable (Substantive WTE incl 12% uplift)	WTE Staff in post March 2020	WTE Staff in post 31st March 2021	Change in staff in post Increase Decrease	Number of vacant posts 31st March 2021	% Vacant posts 31st March 2021
Burns Ward	20.93	18.59	19.55	+0.96	1.38	7%
Canadian Wing	45.18	41.49	44.75	+3.25	0.43	1%
Corneo OPD	18.66	16.16	16.16	0	2.5	13%
Critical Care	25.82	23.86	22.73	-1.13	3.09	12%
MaxFax OPD	22.53	20.21	18.41	-1.80	3.84	17%
Peanut Ward	17.86	17.26	17.40	+0.14	0.46	3%
Plastics OPD	14.43	11.71	13.59	+1.88	0.84	6%
Peri-op	157.42	126.26	124.78	-1.48	32.64	20.7%

These numbers exclude non clinical support roles for the purposes of comparison. Key:

% Vacancy	RAG
Less than 12%	Green
12.1% to 18%	Amber
Above 18.1%	Red

The following gives additional information regarding recruitment and retention in the specific clinical areas.

Peri Op including Pre assessment
Six new international recruits are supernumerary in theatres, and are supporting the team in Day surgery. Any vacancies are actively being recruited, working on ODP apprenticeship in order to retain our own staff and career progression.

Canadian Wing
The trust has funded an additional ward Matron for Canadian Wing which has helped to stabilise the workforce and provide senior leadership for both Ross Tilly (Trauma) and Margaret Duncombe ward (Elective).

Burns Ward
The recruitment of a new ward Matron has provided further stability in the Burns workforce.

Critical Care

Critical Care has adapted its workforce to meet the needs of the pandemic. Initially green patients were cared for on the CCU footprint, with Amber patients being cared for on a side room in the Burns ward. Since January, the Amber patients are now admitted in to the 'old Burns 'treatment room' space.

Paediatrics

The paediatric ward establishment has been set using RCN guidance for staffing paediatric units. The ward continues to run an on call service at night and will only open in the event that a patient requires overnight care otherwise staff go off duty at 00.00. The establishment remains stable.

Corneo Outpatients Department

Corneo has a stable workforce and has developed a range of specialist roles to meet the needs of their patient group.

Max Fax Outpatients Department

Max Fax have a stable workforce.

Plastics Outpatients Department

Plastics Outpatients has worked flexibly to provide staff for the Covid-19 Testing pod and community testing.

6. Post Covid-19 Staffing

The previous ward configuration has been embedded and estates work to Peanut (old Ryecroft Ward) have been completed. Burns ward remains in the old Peanut footprint providing side rooms for each patient. The Head and Neck Unit is in the process of recruitment, a number of staff from Canadian Wing have already been recruited and are being trained in the care of complex head and neck patients. Opening initially with four beds and increasing to eight once at full establishment.

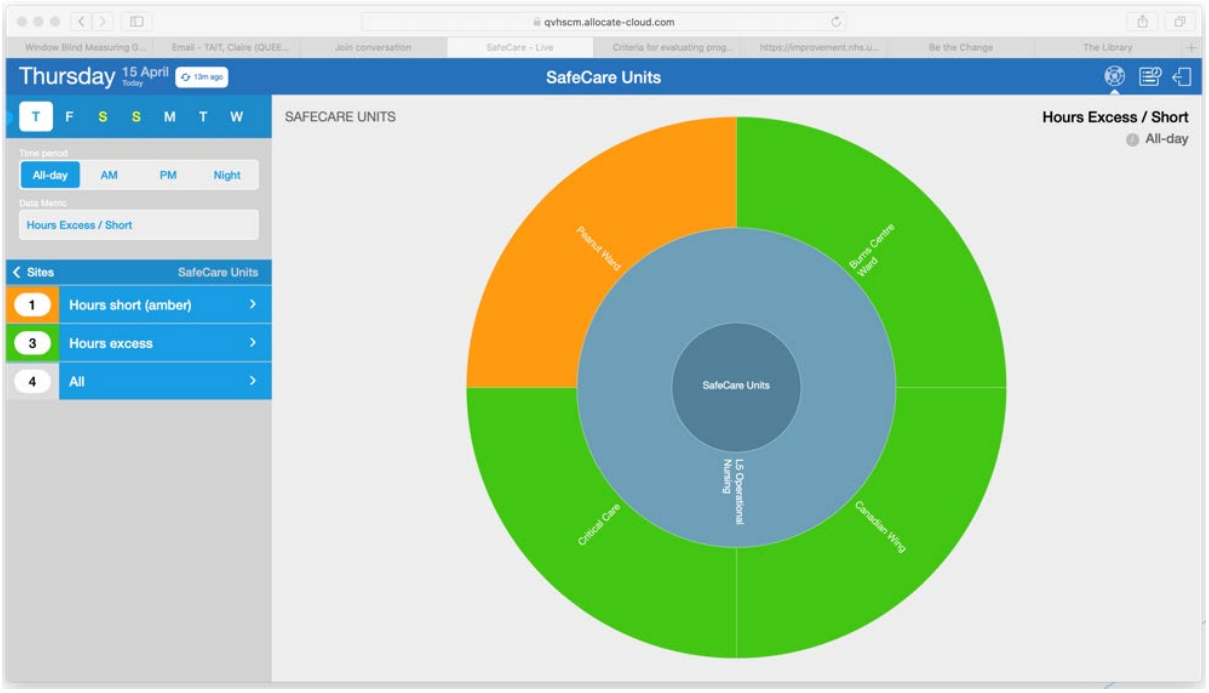
Margaret Duncombe continues to provide beds for our elective work, including plastic surgery, ophthalmology and maxillofacial surgery. Ross Tilly is designated as amber and provides care to Trauma cases and patient who have not been able to isolate pre operatively.

Establishment changes for the financial year 2021/22 will be outlined in the next workforce paper.

Safe Care live is a daily staffing software programme which matches staffing levels to patient acuity, providing control and assurance from bedside to board. It allows comparison of staff numbers and skill mix alongside actual patient demand in real time, in order to make informed decisions and create acuity driven staffing. This piece of software has been underutilised within the Trust and therefore a steering group was set up to re-launch the system for the inpatient areas. The group has so far re-launched Safe Care Live for both CCU and Peanut, providing training for staff and reviewing the staffing models in each area to ensure it is appropriate to their workload.

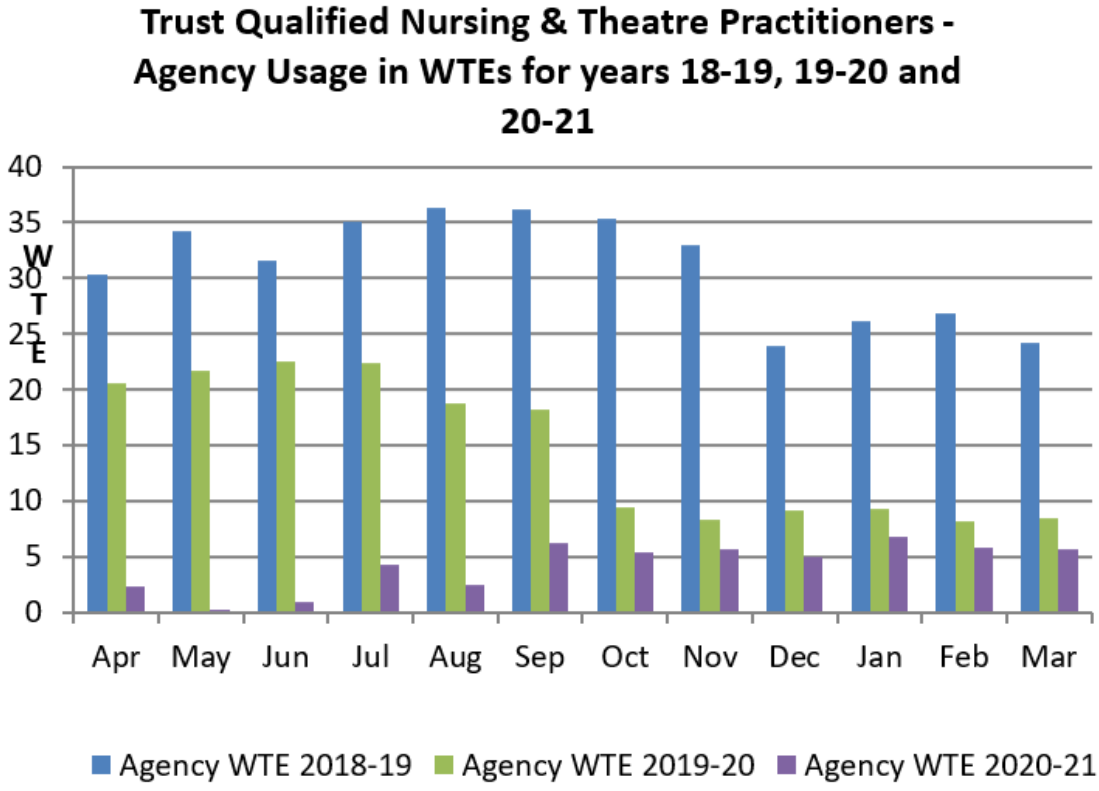
The group are now working on getting it rolled out in Canadian Wing, Burns and Head and neck and hope to have this completed by August 2021. This will then allow full utilisation of the software which will aid in daily decision making regarding beds and staffing. This will be of particular value for the Site team to give them a live overview of the bed occupancy and staffing levels within the Trust. The aim is to also use the software as the basis for bed meetings so that everyone is seeing the same data on their portable devices. As regular use continues, Safe Care will start to be able to provide meaningful data which in future can be used in quality metrics and for guiding workforce planning.

Live overview of bed occupancy and staffing levels



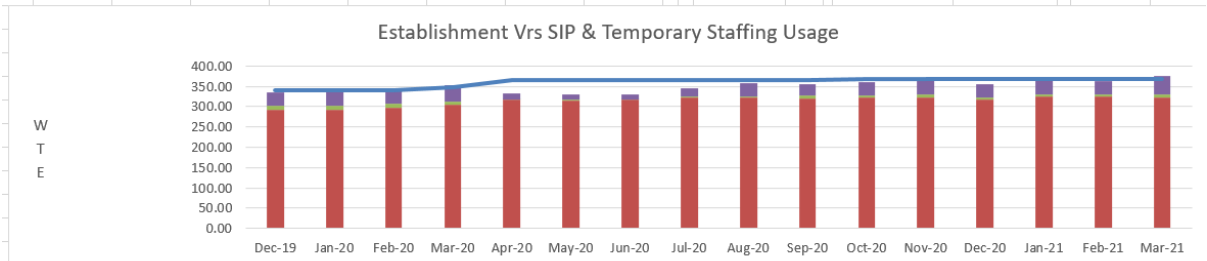
7. Temporary Staff usage

Agency usage remains below previous years, and is carefully monitored through the e roster system. As trauma and elective activity has increased, agency usage over the monitoring period has increased to meet the needs of the service.



Sourced via ESR data

All temporary staff receive a local induction to their area. The chart below outlines our bank and agency usage in relation to our establishments.



	Dec-19	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
Bank WTE	32.67	36.16	39.22	40.59	14.77	12.85	12.54	20.56	33.03	28.14	31.22	35.09	32.47	40.19	32.35	45.38
Agency WTE	9.15	9.25	8.21	8.44	2.26	0.23	0.98	2.45	2.42	6.25	5.36	5.72	5	6.8	6.42	6.84
Substantive Staff in post WTE	292.02	292.93	298.18	304.15	316.19	316.08	316.59	322.42	322.04	320.09	323.33	323.67	318.3	324.43	324.73	322.85
Establishment WTE	339.79	339.79	339.79	347.57	366.02	366.02	366.02	366.02	366.02	366.02	366.62	367.76	367.76	367.76	367.76	367.76

Sourced via ESR data

There are 4 points throughout the day where staffing and safety are reviewed, at 08.00, 10.00, 15.30 and 20.00 via the site handover and bed meetings chaired by the Site Practitioner team with multidisciplinary input.

The Heads of Nursing attend the 08.00 handover and the 15.30 bed meeting giving further assurance that safe staffing, appropriate deployment of staff and planned staffing for the next 24hrs is achieved. Monthly review of actual staffing against planned is carried out and triangulated against incidents raised via DATIX and safer nursing metrics and complaints data.

8. Retirements

The table below indicates the numbers qualified Nurses/theatres practitioners who could retire in the next 2 years. Included is anyone aged 53 and over for any NMC registered staff and anyone 58 and over for any HCPC registered staff. This is currently 76 staff.

	Burns	CCU	Corneo	C-Wing	MaxFac	MIU	OPD	Peanut	Site Prac	Specialist	Theatres
Band 5 (31)	1	1	3	3	0	0	5	4	0	0	14
Band 6 (24)	4	1	1	0	0	0	1	2	0	2	13
Band 7 (20)	0	0	2	1	1	4	1	0	3	6	2
Band 8a (1)	0	0	0	0	0	0	0	0	0	1	0
Band 8b (1)	0	0	0	0	0	0	0	0	0	0	1
Band 9 (1)	0	0	0	0	0	0	0	0	0	1	0
TOTALS	**5**	**2**	**4**	**4**	**1**	**4**	7	**6**	**3**	**10**	**30**

Sourced via ESR data

Each area monitors on a yearly basis their staff who are currently on a flexible retirement contract. HR provide up to date data on who is eligible for retirement and each area lead ensures that there is timely recruitment in these roles. Moving forwards, the retirement data needs to be incorporated in workforce planning.

9. Maternity Leave and Sickness

4.2 WTE registered nurses are currently on maternity leave as at 31st March 2021 on maternity leave

Sickness continues to be managed within individual areas in conjunction with the Absence Policy and support from HR advice. The data below demonstrate the sickness rates in the registered and unregistered nursing workforce, including theatres.

Registered

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020-21			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Sickness Absence %	>=4%	4%<>3%	<3%	1.87%	2.15%	3.98%	2.93%	1.91%	1.66%	▼

Unregistered

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2019-20 & 2020-21			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Compared to Previous Month
Sickness Absence %	>=4%	4%<>3%	<3%	8.05%	8.44%	4.53%	3.74%	5.67%	6.72%	▲

Sourced via ESR data

9. Assurance

The last 12 months has seen a number of changes to the workforce in response to the operational demands of the COVID-19 pandemic. A workforce review was undertaken in March 2021 to reflect the nursing establishments required in each of the inpatient, outpatient and Peri-op areas for budget setting. Nursing workforce continues to be reviewed monthly using evidence based tools and there is a clear governance process for monitoring and escalation.

Throughout the Covid-19 pandemic, the nursing workforce numbers have been maintained and deployed across the site to ensure safe patient care whilst delivering the activity required.

In addition, bank and agency requests are approved by the Head of Nursing. If additional cover is required above established capacity there is a clear escalation process to the Interim Director of Nursing.

The Executive team meet weekly via MS Teams to approve all vacancies prior to recruitment for both establishment control purposes and oversight of nursing workforce challenges

No moderate or above patient safety incidents as a result of inadequate staffing have been identified from this triangulation.

During this process the HON has benchmarked against the NQB recommendations (appendix 2) and is assured that QVH is meeting these recommendations.

10. Recommendations

The Board is asked to:

- note the flexibility and deployment of staff both internally and externally
- note that we meet the benchmarks recommend by RCN, ICS, NICE and AfPP
- note the staffing levels and skill mix are effectively reviewed
- note that safe, high quality care is being delivered due to staff pride in their work and flexibility
- note the re-launch of Safe Care Live

Liz Blackburn Head of Nursing 2021

Appendix 1

National Quality Board requirements and self-assessment

Recommendation	Current Position March 2021
Boards take full responsibility for the quality of care to patients and as a key determinant of quality take full and collective responsibility for nursing care and care staffing capacity and capability	The Board has a process in place for setting and monitoring nursing levels, with the Quality and Governance Committee receiving detailed ward/ department report for all areas where we treat patients. This information is triangulated with risk team and DATIX each month to look for early warning triggers and emerging themes .The Board receives six monthly nursing workforce reports and an update on staffing levels and quality at every public board.
Processes are in place to enable staffing establishments to be met on a shift to shift basis	Nursing acuity and capacity is reviewed three times per day in the ward areas. This information is presented at the twice daily bed meeting where senior clinical and operational staff manages the patient flow for electives and trauma. Nursing and care staff can be reallocated at the start or during a shift and local escalation process is embedded. Heads of Nursing are visible in the clinical areas. Daily oversight of planned versus actual staffing levels by Director or deputy Director of Nursing.
Evidence based tools are used to inform nursing and care staffing capability and capacity	All ward areas use safer nursing care tool- acuity and dependency tool. Application of specialty specific national guidance to support establishments and professional judgement. NEWS2 safety assessment tool transferred to electronic e-Obs version in September 2020 and provides another layer of assurance about workforce deployment.
Clinical and managerial leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns	Datix reporting system is established and used. 'Tell Nicky' – confidential email to DoN. Trust policies eg Whistleblowing. Compliance in practice ward visits, weekly Matrons meetings. Freedom to Speak up Guardian in post with six monthly updates to Board.
Multi-professional approach is taken when setting nursing and care staffing establishments	Six monthly workforce review undertaken by the DoN in conjunction with the executive management team (EMT). Changes to establishments have been made only after consultation with EMT and trust staff.
Nurses and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	There is 22% uplift within the ward establishments to cover sickness, mandatory and statutory training and leave. Ward matrons are accountable for their budgets and have monthly meeting with the HoN and finance. All ward matrons have supervisory time to undertake management duties.
At each public board an update on workforce information, staffing capacity and capability is discussed six monthly with a nursing establishment review	The DoN provides updates on workforce in the quality report at every public board and there is a 6 monthly review of nursing workforce.
Information is clearly displayed about nurses and care staff on duty in each ward on each shift.	All ward areas have status boards in public areas stating expected number and actual number of nurses and care staff on duty. When there are variations on this, the ward matron will review and escalate via agreed processes to ensure safe staffing maintained. The DoN will review this escalation and triangulate with safer care metrics and complaints data to ensure staffing levels allow provision of quality care

Providers take an active role in securing staff in line with workforce requirements	Recruitment days for general and theatre staff have taken place in the last 12 months. Staff are supported to undertake specialist modules for development and enhanced care. Director of HR reviewing recruitment processes. Part of the theatre productivity work has a workforce subgroup. Different recruitments campaigns have been instigated in the last 4 months. This has results in increased interest in post however the trust is experiencing difficulty in recruiting to some posts mainly in Theatres and ITU (significant national shortages in these areas).
Commissioners actively seek assurance that the right people with the right skills are in the right place at the right time with the providers with who they contract.	DoN meets monthly with the CCG Chief Nurse. Staffing levels discussed at these meeting. The commissioners are aware of the nurse staffing levels and the actions the trust is taking to optimise recruitment and retention.

NQB Recommendations: In compiling this 6 monthly workforce review paper all the following recommendations have been met/included in the April-September 2019 report

In determining nurse staffing requirements for adult inpatient settings:	
1.	A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.
2.	A strategic staffing review must be undertaken annually or sooner if changes to services are planned.
3.	Staffing decisions should be taken in the context of the wider registered multi-professional team.
4.	Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning process.
5.	Action plans to address local recruitment and retention priorities should be in place and subject to regular review.
6.	Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit the use of temporary staff.
7.	A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.
8.	Organisations should ensure they have an appropriate escalation process in cases where staffing is not delivering the outcomes identified.
9.	All organisations should include a process to determine additional uplift requirements based on the needs of patients and staff.
10.	All organisations should investigate staffing-related incidents and their outcomes on patients and staff, and ensure action and feedback.

Appendix 2

Below are the previous six months of the Safe Staffing tool summary. This information is reviewed on a monthly basis by the Director of Nursing.

Combined Staffing exc. Site — Target 95%

Oct-20

	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA
DAY	5486	195.5	1967	5462.5	195.5	1920.5
				99.6%	100.0%	98%
			7648			7578.5
						99.1%
NIGHT	4750	69	701.5	4704	69	678.5
				99.0%	100.0%	96.7%
			5520			5451
						98.8%

Total Hrs Planned and Actual
% Planned Hrs Met
Total Hrs Planned & Actual - Combined reg & support
% Planned Hrs Met - Combined reg & support

Combined Staffing exc. Site — Target 95%

Nov-20

	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA
DAY	5612	241.5	2289	5509	241.5	2289
				98.2%	100.0%	100%
			8142			8039
						98.7%
NIGHT	4554	161	655.5	4497	149.5	644
				98.7%	92.9%	98.2%
			5371			5290
						98.5%

Total Hrs Planned and Actual
% Planned Hrs Met
Total Hrs Planned & Actual - Combined reg & support
% Planned Hrs Met - Combined reg & support

Combined Staffing exc. Site — Target 95%

Dec-20

	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA
DAY	5359	241.5	2473	5313	241.5	2415
				99.1%	100.0%	98%
			8073			7970
						98.7%
NIGHT	4428	276	897	4416	276	885.5
				99.7%	100.0%	98.7%
			5601			5578
						99.6%

Total Hrs Planned and Actual
% Planned Hrs Met
Total Hrs Planned & Actual - Combined reg & support
% Planned Hrs Met - Combined reg & support

Combined Staffing exc. Site — Target 95%

Jan-21

	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA
DAY	5451	207	2358	5393.5	207	2265.5
				98.9%	100.0%	96%
			8016			7866
						98.1%
NIGHT	4163	195.5	713	4152	195.5	713
				99.7%	100.0%	100.0%
			5072			5060
						99.8%

Total Hrs Planned and Actual
% Planned Hrs Met
Total Hrs Planned & Actual - Combined reg & support
% Planned Hrs Met - Combined reg & support

Combined Staffing exc. Site — Target 95%

Feb-21

	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA
DAY	4738	161	2070	4657.5	161	1978
				98.3%	100.0%	96%
			6969			6796.5
						97.5%
NIGHT	3680	69	644	3657	69	632.5
				99.4%	100.0%	98.2%
			4393			4359
						99.2%

Total Hrs Planned and Actual
% Planned Hrs Met
Total Hrs Planned & Actual - Combined reg & support
% Planned Hrs Met - Combined reg & support

Combined Staffing exc. Site — Target 95%

Mar-21

	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA
DAY	5256	195.5	2369	5186.5	195.5	2277
				98.7%	100.0%	96%
			7820			7659
						97.9%
NIGHT	4071	161	1104	3979	161	1035
				97.7%	100.0%	93.8%
			5336			5175
						97.0%

Total Hrs Planned and Actual
% Planned Hrs Met
Total Hrs Planned & Actual - Combined reg & support
% Planned Hrs Met - Combined reg & support

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05 August 2021**		**Agenda reference:**	**105-21**	
Report title:	Research & Innovation Strategy 2021-2023				
Sponsor:	Keith Altman, Medical Director				
Author:	Zaid Sadiq, Clinical Director for Research & Innovation				
Appendices:					
Executive summary					
Purpose of report:	Research & Innovation Strategy 2021-2023				
Summary of key issues	This document outlines the future strategy and aspiration of QVH for clinical research and describes how the R & I department will aim to deliver these objectives within the next three years.				
Recommendation:					
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:	KSO2				
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	Apr 2021	Decision:		
Next steps:					

RESEARCH AND INNOVATION STRATEGY
2021 - 2023

Table of Contents

1. Introduction

Research & Innovation in the NHS is at the heart of improving patient care. The NHS research plan states at the outset that NHS England has a legal duty to promote research and use of research evidence in the NHS. This is to ensure that the best research and innovation is available to improve patient outcomes, transform clinical services and ensure value for money (NHS England Research plan, April 2017). Jonker and Fisher 2018, have demonstrated the correlation between National Health Service trusts 'clinical trial activity and both mortality rates and care quality commission ratings. In addition, research active sites are known attract and retain more skilled and motivated staff.

The Queen Victoria Hospital NHS Foundation Trust (QVH) is highly supportive of Research & Innovation (R&I) recognising its benefits to patients and staff. The Trust encourages research and innovation in our specialist services at all levels of complexity including both qualitative and quantitate studies.

QVH is an active member of the Kent, Surrey and Sussex (KSS) Academic Health Science Network (AHSN) and the KSS Clinical Research Network (CRN). Although QVH is the second smallest trust in the country it is recognised for its key contribution to research, having hosted National Institute for Health Research (NIHR) funded studies, bespoke for its specialist services. Our Research activity has increased for the fifth consecutive year to a total of 772 patients recruited in 2019 in NIHR portfolio studies, giving more patients the opportunity to participate in clinical trials. These include the Scar Study and the FRAME Study, amongst others. These studies were developed at QVH and in collaboration and with the R&I department and the CRN were adopted into the national portfolio, increasing CRN research funding to QVH by 24%.

This document outlines the future strategy and aspiration of QVH for clinical research and describes how the R&I department will aim to deliver these objectives within the next three years.

2. Current Position

The R&I department is involved in supporting the delivery of key research projects in collaboration with all clinical staff. It is a hub for coordination and governance of research activity at QVH. The department acts as a gate keeper for research and a conduit for communication with the CRN and other research active bodies. Unfortunately, the growth in research activity has not been matched in terms of innovation. It is hoped that the changing landscape of health care partnership in the region will allow access to knowledge and facilities that would help our innovation drive.

The detailed roles of the R&I department have been and currently are:

2.1 Delivering high-quality research projects

- Over the last 5 years, there has been an increased recruitment into studies from 375 patients in 2015/2016 to 772 patients in 2019/2020.
- Over the last 5 years there has been a significant increase in recruitment to national portfolio studies, last year almost 90 % of patients recruited were as part of a national portfolio study, as opposed to 15% in 2015.

- In 2019-2020, the R&I department supported the delivery of a total of 34 studies, 28 portfolio and 6 non-portfolio studies.
- Of the 772 patients recruited in 2019/2020, 709 patients participated in national portfolio studies.

2.2 Ensuring research and financial governance

- All research carried out at the Trust is in accordance with the principles set in UK policy framework for health and social care research and the Medicines for Human Use (Clinical Trials) Regulations 2004 and Amendment Regulations 2006.
- R&I Governance at QVH is strictly monitored and measured through Internal Audit and Monitoring within R&I Department, monitoring visits by the sponsors and Trust Audit by the external agencies.
- The R&I director reports directly to the medical director, the medical director is the accountable R&I officer to the board.
- The R&I nurses and manager are line managed by the Director of Nursing.
- The R&I governance group reports directly to the hospital quality and governance committee, which reports to the hospital board, Appendix 1.
- R&I Staff are required to adhere to the Standard Operating Procedures (SOPs) that are in place for maintaining the quality and consistency of the delivery of research trials at QVH and maintain the principles of Good Clinical Practice (GCP). All staff are full trained in GCP.
- Any incident or Governance breach occurred is reported via the DATIX system of the Trust and immediate actions will be taken to minimise its impact on the patients, trials and services.
- Annual appraisal of staff within the research department and line reporting infrastructure is in place.
- Research governance meetings are held three times a year with representation from multiple stakeholders, including research methodologist and patient representatives.
- The R&I Department at QVH received approximately £172,308 core funding from the CRN to support its research activities in 2019/2020. There was a further £11,700 contingency funding and £3000 Specialty Lead Funding.
- Currently Principal Investors (PIs) can recharge costs into the R&I budget.
- There is no scope within this budget to 'reinvest into research'
- In the financial year 2019/2020, the R&I Department supported the submission of 7 grant applications. Unfortunately, none of these were successful in generating income.
- Financial oversight of R&I budget sits with the Trusts' finance department.

2.3 Promoting and encouraging an atmosphere of research

- To encourage patient and public engagement, the R&I Department appointed two Patient Research Ambassadors (PRA) who currently attends our operational meetings and support patient research activities.
- The R&I Department engages with the Trust and community via periodic updates using Qnet, poster presentations, publications board etc. to increase the awareness of current research among patients, staff and public.
- To date, support that has been offered to clinicians from the R&I department has been on a face to face basis, via promotional campaigns and administrative review of research

proposals. There is also advice on research methodology and ensuring research governance principals are followed.

2.4 Collaborative working with key partners

- We continue to seek further collaboration with academia. Some successful educational courses have taken place with Brighton & Sussex Medical School and it is hoped this relationship will flourish. There have been challenges in establishing academic clinics, the reasons for this have been multifactorial. There have also been successful partnerships with other universities, via QVH recruited patients, relevant to its specialist services, to studies run by these academic centers.

3. Our Mission

QVH is a well networked trust; as a specialist provider almost all our patient journeys also involve other NHS hospitals and our medical staff are used to working in partnership with experts on other sites. We aim to embed this collaborative approach in our research and innovation strategy going forward. The KSS region offers many opportunities to engage with clinical centers of excellence, reputable academic and commercial institutions; there may also be important opportunities to join up work with organisations outside of the southeast region. Translating our clinical links into research partnerships will enable QVH to build on our areas of expertise to deliver world class bench to bedside research.

One of the five tests the QVH board has set for the consideration of the possible merger of QVH with University Hospitals Sussex is related to research: “We have been clear that we will only merge with other hospitals if it helps us to … continue to deliver world class research and innovation”. Whether or not it is decided that merger is the right way to secure the long-term future of QVH, the future of our research work lies in collaboration with a range of other NHS, academic and commercial institutions.

Our Vision

- The R&I Department aims to support QVH’s aspiration that every patient has the opportunity to be involved in research.
- Incorporate innovation as part of our research and clinical portfolio.
- R&I department facilitate early research mentoring to support research initiatives.

4. Aims and Objectives

4.1 Improving portfolio of high-quality research studies

- R&I Department will continue to expand its existing NIHR adopted portfolio studies in partnership with CRN in KSS. This will raise the trust profile and ensure stable funding stream for research.

- In the long term, the R&I Department will liaise with the local Clinical Commissioning group (CCGs) to extend research activities to the community through General Medical Practitioners and General Dental services. This will enhance our clinical network and status as a key clinical provider.
- R&I will recruit a research experienced staff panel to focus on the expansion of home-grown studies, seek guidance and to get studies adopted in the portfolio by NIHR. This will facilitate mentoring and grow innovation.
- Expand the commercial research portfolio. R&I to encourage clinicians to seek commercial partners to help fund their research ideas. This will allow researcher empowerment and secure additional funding.
- Ensure greater promotion of research activity within the trust. This will encourage research awareness, adoption and innovation in of latest evidence into practice and to promote further research
- Develop tools to make research startups more user friendly, including a 'new to research' checklist.
- Facilitate collaboration between QVH innovators with industry partners to gain peer reviewed grant monies to support their research, with a view to increasing the number of original studies.
- Foster a multidisciplinary team approach to research projects to reflect the way we care for patients.

4.2 Developing a skilled research workforce

- Ensure current appraisal mechanism is suitable to identify development needs and career development of staff within the department. In order to encourage experienced staff retention.
- Facilitate honorary contracts and access for academics with interests aligned to QVH clinical expertise. This will help strengthen our research base and stimulate innovation.
- Research mentors will be established within each department to champion and promote a research and innovation ethos.
- Introduction of R&I departmental meetings to facilitate internal communication and updates.
- Seek feedback from clinicians to understand experience of carrying out research at QVH.

4.3 Improving research governance and financial stability

- Review how research activity is recorded and reported across the trust to learn lessons from experience. It is hoped this will improve coordination and research themes across all departments. This can be structured as part of dedicated 'Research Huddles'.
- Monitor the effectiveness of current reporting mechanism of research activity and adverse event reporting and include findings in the annual RI report.
- Increased transparency of QVH research by ensuring regular reporting to the CRN link manager and invitation to attend all research governance meetings.
- Implement recommendations from the external auditor into the trust research practices.

4.4 Improved working with key academic partners

- QVH aims to further collaborate with other research active sites in KSS and maximise opportunities in potential joint research themes.
- To explore opportunities to collaborate with innovative companies that provide a global health research. Engage with regional innovation and enterprise institutions to allow Trust clinicians, nurses and managers access to innovation support for collaborative projects.
- There is availability to ever-increasing patient data from across institutions. There is a need for a smart platform approach will improve our understanding and utilisation of these metrics.

4.5 Developing an internationally recognised center of excellence

- Work to identify and secure an academic partner, with established international research status.
- Consider expanding the role of the education center to a 'Research and Education Centre' to allow more access to research training resources for the staff.

4.6 Innovation

- To ensure the strategic plans of the R&I Department are aligned with the NHS long term plan for digital health service and integrated healthcare.
- Encourage research and innovation projects which find cutting edge technological solutions to augment healthcare and its services with academic experts in artificial intelligence and other computing technologies.

5. Sustainability

- R&I currently brings an income of about £187,000 a year to the Trust. We have ambition to attract income from research grant and commercial companies, aiming to be cost neutral.

- The Trust's location and specialist services is recognised as a valuable asset to promote partnerships with universities such as the Universities of Brighton & Sussex. R&I is an integral component for the Trust to raise its profile and make it an attractive partner to other healthcare organisations.

6. Improving Quality and Outcomes

- The R&I strategy aims to support the Trust's Clinical Strategy, focusing on patient outcome priorities of clinical excellence, outstanding patient experience as well as safe and effective care.
- Establish a research operational group that acts as a mentoring body to foster research alongside best practice.
- Improve patient experience along the research journey, while ensuring a mechanism is in place to communicate to the patient the outcome of any study in which they have participated.

7. Financial Implications

- Ensure maximal opportunity for R&I staff funding from CRN-KSS/ NIHR.
- Increased research activity, good quality research delivery will attract commercial companies to undertake trials on site, thus increasing R&I commercial income.
- Foster close working relationships with contract research organisations to streamline the process of partnership with commercial companies.
- Further collaboration with local universities and clinicians to increase the number of successful grant applications and grant awards received.
- Review the policy on Intellectual Property (IP) rights or any patents that may arise through research and innovation.

8. Challenges

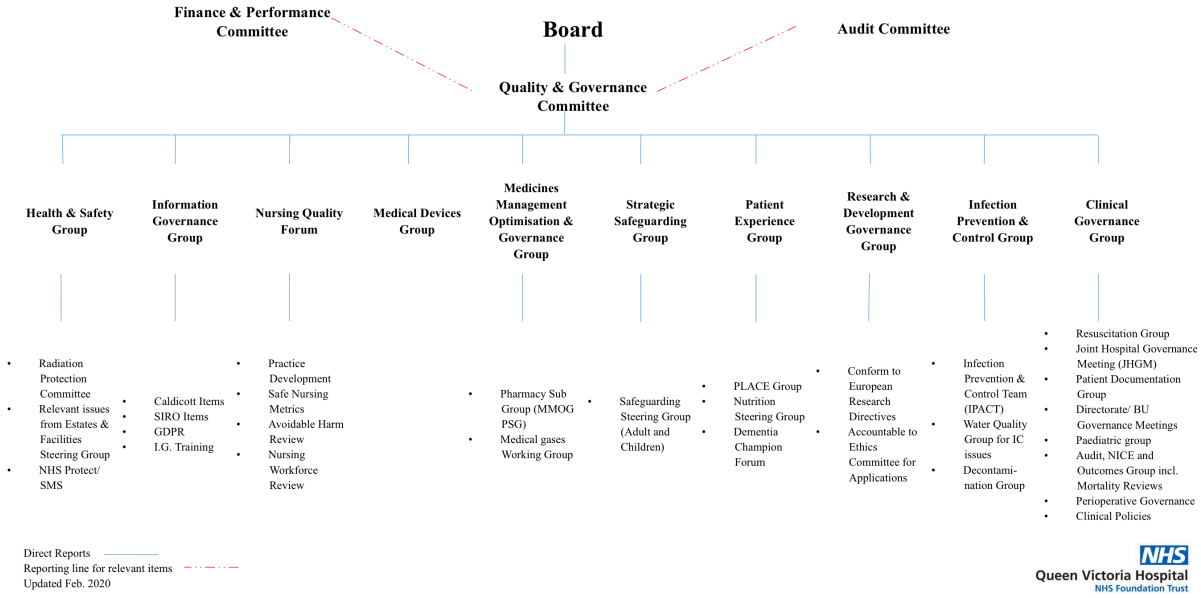
- The inability to secure an academic partner may limit the possibilities of future projects and potential funding.
- Access to expertise to optimise advice on research methodology at an early stage of research idea development.
- Access to statistical expertise to advise researchers on studies.
- CRN funding is not guaranteed and may be subject to further constraints in future. This may affect funding for research projects and clinician funding.
- Securing the engagement of research orientated clinicians and staff across the Trust.
- Lack of centralised intelligence platform to collate, analyse and promote research
- Clinical staff and research staff interface and engagement.
- Research delivery, investment and engagement may be compromised by pressures on clinical staffing, facilities and resources, reducing research activity and income.

9. References

- NHS Long term Plan 2018. https://www.longtermplan.nhs.uk/online-version/
- NHS England Research plan, April 2017
- Jonker L, Fisher SJ. The correlation between National Health Service trusts' clinical trial activity and both mortality rates and care quality commission ratings: a retrospective cross-sectional study. Public Health. 2018
- https://www.england.nhs.uk/wp-content/uploads/2017/04/nhse-research-plan.pdf
- Queen Victoria Hospital NHS foundation Trust. Research and Development Internal Audit, September 2020.

Appendix 1

QVH Quality & Governance Committee Structure and Subgroups



Direct Reports

Reporting line for relevant items

Updated Feb. 2020

NHS
Queen Victoria Hospital
NHS Foundation Trust

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance | **Committee: Finance & Performance** | **Date last reviewed 21st June 2021**

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 4 (C) x 5 (L)= 20, High
Target Risk Rating 4 (C) x 3 (L) = 12, moderate

Rationale for current score (at Month 2)

- The Trust submitted a breakeven plan for H1 in line with ICS. As at month 2 the Trust has delivered a surplus of £0.4m. This surplus is due to the activity being above the required theresholds in planning. This additional activity will be funded, if all gateways are achieved, through the elective recovery fund.
- ~~The Trust has submitted draft year end details to NHSI/E. At present the Trust is finalising the year end position ready for audit.~~
- ~~Guidance for 21/22 has now been received and the Trust is working through the envelopes for submission on the 6th of May.~~
- 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 and non attendance by patients
- Commissioner challenge and scrutiny post Block arrangement
- Potential changes to commissioning agendas
- Significant activity drop due to Covid and activity issues due to second wave
- Unknown costs of redesigned pathways

Future Risks

NHS Sector financial landscape Regulatory Intervention

- National guidance is developing to understand how the financial regime will impact Trusts over the coming months and further into next FY. Guidance not anticipated in calendar year, business planning will need to continue based on assumptions of current cost base.
- Capped expenditure process
- Single Oversight Framework
- Commissioning intentions – Clinical effective commissioning
- NHSI/E control total expectation of annual breakeven within the LTFM trajectory (2020/21-2024/25)
- Central control total for the ICS which is allocated to organisations
- Unknown Brexit risks for increased costs for such items as drugs and procurement
- Significant work to develop the LTP in line with potential merger
- Lack of relevant resource to deliver BAU, develop required efficiencies and Business Case
- Development of compatible IT systems (clinical and non clinical) & back office functions will be part of the longer term plan to ensure in medium term efficiencies may be achieved.

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
- 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
- Increase partnership working across both Sussex and Kent and Medway with greater emphasis on pathway design
- Decision in principal to move ahead with due diligence with BSUH & WSHT
- Development of increased partnership working through the merger to include greater economies of scale and efficiencies for work load and also potential cash savings in the longer term

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 7 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) 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 and revised trajectories in line with the phase 3 guidance.
- Spoke site, Service line reporting and service review information widely circulated.
- Service reviews started and working with a combined lead from the DoO and DoF

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
- Non achievement of efficiencies to achieve lower cost profile
- Understanding of payment mechanisms in future periods

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed : 22 July 2021

Strategic Objective
We provide healthcare 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

- Increase of RTT waiting list and patients waiting >52 weeks / > 78 weeks due to COVID-19 pandemic and cancer hub role
- Reduced capacity due to reconfiguration of services to support green and amber elective pathways and infection prevention control requirements
- Reduced capacity due to Rowntree procedure limits
- Increasing staff gaps due to COVID-19 isolation requirements
- Isolation requirement impact - patient take up, timescales to book and ability to utilise capacity following cancellations
- Vacancy levels in sleep [CRR 1116]
- Medical capacity in sleep
- Specialist nature / complexity of some activity
- Sentinel Lymph Node demand [CRR 1122]
- Capacity to deliver NHSE, system and QVH recovery and transformation requirements
- Anaesthetic gaps

Future risks

- Further COVID-19 surge
- National Policy changes to access and targets
- NHS funding and fines changes & volatility
- Reputation as a consequence of recovery
- Workforce morale and potential retention impact due to merger considerations
- System service review recommendations and potential risks to services

Future Opportunities

- Closer ICS working
- Closer working between providers including opportunities with Kent & Surrey
- Partnership with BSUH/WSHFT

Controls / Assurance

- Mobilising of virtual outpatient opportunities to support activity during COVID-19
- Planned relaunch of outpatient improvement programme
- Additional reporting to monitor COVID-19 impact
- Recovery planning and implementation underway
- Weekly RTT and cancer PTL meetings ongoing
- Additional cancer escalation meetings initiated where required to maximise daily grip
- Development of revised operational processes underway to enhance assurance and grip
- Additional fixed term anaesthetist posts out to advert
- Locum staff identified to support sleep position
- Vacant GM start date in August
- Theatre productivity work programme in place
- Programme of waiting list validation

Gaps in controls / assurance

- Reduced capacity due to infection control requirements for some services
- Not all spoke sites on QVH PAS so access to timely information is limited
- Late referrals for RTT and cancer patients from neighbouring trusts
- Residual gaps in theatre staffing
- Capacity challenges for both admitted and non admitted pathways
- Informatics capacity
- Impact of COVID-19 on patient willingness
- Reduced Independent Sector capacity
- Theatre capacity due to Rowntree theatre procedure limits

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 August 2021**		**Agenda reference:**	**107-21**	
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 26 July.				
Summary of key issues	Operational performance. Positive results to date, but future remains challenging Workforce indicators. Some increase in sickness and turnover to monitor, but generally stable. Financial results. Year to date positive, but based on current funding framework that will only become more stringent. Assurance on other issues.				
Recommendation:	The Board is asked to **NOTE** the contents of the report, the **ASSURANCE** (where given), and the uncertainty and challenges in the near future.				
Action required	~~Approval~~	~~Information~~	**Assurance**	**Assurance**	**Assurance**
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: x *Operational excellence*	KSO4: x *Financial sustainability*	KSO5: x *Organisational excellence*
Implications					
Board assurance framework:	• KS05 – Organisational Excellence – strong indicators of successful management, but aware of critical dependencies • KS04 – Financial Sustainability – short-term break-even is the result of national funding, longer-term is not resolved • KS03 – Operational Excellence – risk remains high as growth in waiting lists and times				
Corporate risk register:	Reflected in BAF scores. Committee looks in detail at allocated corporate risks				
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:	5 August 2021
Reference no:	107-21
Report from:	Paul Dillon-Robinson, Committee Chair
Report date:	26 July 2021

Financial, operational and workforce performance assurance

Introduction

The finance and performance committee met on 26th July, having previously met on 28th June and 24th May since the last public Board meeting.

As the Trust works on restoration and recovery, within a specific financial framework for the first six months, the committee seeks to balance review of historic results with discussion on future risks and issues.

1. Operational performance

There have been very positive results from operational performance, seeing reductions in the numbers of 52/78/104 week waits and the overall recovery of activity to meet planning trajectory levels, albeit that elective and day case are below plan.

The committee discussed some of the challenges in this area; staffing issues (particularly within Sleep, but also sickness and covid isolation, as well as staffed theatre capacity), the pressures on other parts of the system (for instance A&E pressures, Head & Neck services in other trusts), late referrals from other Trusts (although currently managing within targets) and patient cancellation (especially those “on the day” with the impact on theatre utilisation, albeit no common themes emerge from reviews into causes). The committee also discussed some of the work on Recovery Streams, such as patient initiated follow up and system-wide patient tracking lists (PTLs).

Assurance was received that the issues were being actively managed and solutions being sought.

Going forward will be increasingly challenging, both with expected increase in patient referrals and waits from last year, as well as with staffing challenges.

2. Workforce performance

Workforce indicators remain broadly positive, albeit a slight increase in sickness and turnover indicators. The committee discussed the growth in sickness and the risks around self-isolation, and took assurance on the work being done.

The committee noted the increased number of posts out to advert and the time taken to recruit, with a focus on how processes that we control can be managed most efficiently. Early data on succession planning, focusing on age profiles, highlighted the risk to the Trust (for instance; 38% of nursing staff over 50, 27% over 55) and this will be explored further in September, looking at flexible retirement, talent pools, career conversations, etc.

The annual reports for Workforce Race Equality Standards and Workforce Disability Equal Standards were reviewed. Whilst the positive developments with the BAME network were noted, the statistics on short-listing were a concern and the committee were informed of plans to move to more values based recruitment and learning from others. The committee was keen for a more detailed set of actions for each report, as well as a report back on how the previous action plan had been delivered.

3. Financial performance

The Trust's financial performance, year to date, is reporting a surplus but, as with previous reports, this comes with the caveat that it is only achieved by the current financial regime that is beneficial for the Trust. The system is focussing on run rate going forward.

The committee discussed the areas of risk; there remains uncertainty about income from the Elective Recovery Fund (both in terms of the current assumptions, the ability of the system to meet its gateways, as well as an increase in the thresholds in Q2) as well as what funding might be available in H2, there is concern about the cash support for some capital funding (and the ability to deliver that level of projects), as well as the need for the Trust to meet better payment practice.

The committee also discussed concerns about the level of efficiencies identified and RAG rated to date (£546k out of £1.6m needed) along with the expected increase to 3% in H2. These efficiencies need to be cash releasing and further work is being undertaken with the ICS and in a number of other areas to identify opportunities.

The level of vacancies within the authorised establishment was returned to (circa 90 posts) and the need to look at the workforce in the light of activity levels (using 2019/20).

4. Other

The committee received updates on:

- Data Quality Improvement : assurance that the work is focussed in priority areas
- IM&T Update : project staffing is the major risk to delivery
- Cyber Security Update : positive assurance on the steps being taken by the Trust, albeit that new threats keep emerging
- Clinical coding : recognition of the task and finish project that is taking place with strong clinical engagement and the recovery of this function. Recognition that this did not indicate a significant loss of income to date.
- Finance and performance committee corporate risks and the PACS procurement : support for the business case for the PACS procurement to go to the Board for approval

The committee approved the three workforce policies that were presented.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**Financial performance**		**Agenda reference:**	**108-21**	
Report title:	**Finance Report 2021/22 – Month 3**				
Sponsor:	Michelle Miles – Director of Finance and Performance				
Author:	Michelle Miles – Director of Finance and Performance				
Appendices:					
Executive summary					
Purpose of report:	To provide the Board with an overview of the Trust's financial performance.				
Summary of key issues	The Trust I&E position is £780k surplus against the YTD plan at M3. The trust in line with national requirements is operating under block income regime with a plan set for H1 (M1-6) 2021-22, further guidance on H2 planning will be issued in September. Overall surplus position year to date driven by trust hitting the above thresholds activity targets set for first half of the financial year with over performance for Day case and Outpatients activity. Expenditure run rate (both Pay and Non-Pay) broadly in line with last 12 months averages. Services across the trust are currently carrying vacancies that are not fully backfilled and therefore resulting into a year to date underspend (£726k) for pay lines. Non-Pay in contrast overspending where budget has been flexed to reflect the threshold activity targets. The cash position for the Trust continue to remain favourable due to the level and timing of the block payments arrangement this year which for the very least will continue during H1 2021-22.				
Recommendation:	To note the 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:	No current resources.				
Assurance route					
Previously considered by:	Finance & Performance Committee – 26th July 2021				
	Date:	26/07/21	Decision:	Noted	
Previously considered by:					
	Date:		Decision:		
Next steps:					

Financial Performance Report

Michelle Miles, Director of Finance & Performance

June 2021

Finance & Performance Committee

Headline Financial performance Month 03

Queen Victoria Hospital
NHS Foundation Trust

Performance YTD Month 03

The financial position reflects the Trust internally reported position. Monthly phasing of the plan is misaligned to the Provider finance return (PFR), with plan alignment reached at M6.

Income

- Block regime in H1, ERF estimate income £2.2m is within the positon. The Trust is awaiting agreement and confirmation on actual performance, no clawback has been assumed in the YTD position.

Expenditure

- YTD under performance to plan of £0.6m, mainly within Pay, due to current vacancies and staffing challenges. Workforces vacancies is 92.86 wte mainly within Nursing.

Activity

- Trust's activity threshold for June 21 was 80%, measured against 19/20 activity levels, achievement against this DC 93% , EL 64%, OP New 92% and OP Follow up at 105%. June achievement against the Trust plan DC 93% , EL 93%, OP New 113% and OP Follow up at 102%.

Efficiencies

- The target efficiencies for H1 is £812k, Plan identified rag rated schemes for H1 is £141k, shortfall of £671k in H1. YTD actual achievement is £50k

Balance sheet

- **Better Payment Practice Code (BPPC)** NHSI/E will be closely monitoring performance this year. YTD performance is below compliance. An action plan is being prepared to improve performance

Capital

- The Trust has capital plan is £5.7M with £1m (19%) not yet allocated. Many of the 2021/22 projects have recently been approved, with the capital spend occurring later in the year. The Trust is awaiting confirmation of capital allocation from the system.

Financial performance Risks & Mitigations

Trust is forecasting breakeven at the end of H1. Forecast position will be reviewed from M4.

- **Income:** ERF threshold adjustment from 85% to 95% in Q2, a reduction of £1m to estimated ERF income. Trust H1 ERF income estimate is £2.7m (revised). Payment is subject to System meeting the 5 ERF Gateway requirements which yet to be determined. **Expenditure:** Trust run rate is underperforming YTD £1.2m, if recruitment and staffing challenges are not met in Q2, the Trust may not achieve a break even position and instead a surplus position, a review of the establishment required for Q2 and H2 planning is ongoing.
- **Efficiencies:** The Trust historically has not been able to deliver cash releasing efficiencies, we continue to work for the identification of further efficiencies. Indicative H2 efficiency target is 3%.
- **Capital:** £1.3m capital allocation from the ICS has yet to be agreed, if allocation is not given the Trust will review capital projects.

Guidance for H2 will be released in September, with H2 planning September – November. The challenge for the trust is how do we reduce our cost base with an indicative efficiency target of 3%, whilst delivering an uplift in activity.

Income & Expenditure Month 03

Income and Expenditure

	In Month £'000				Year to Date £'000			
	Prior year Outturn	Plan	Actual	Variance	*Prior year Outturn*	Plan	Actual	Variance
Income								
Patient Activity Income	*5,652*	7,724	6,533	(1,191)	*16,920*	19,113	18,995	(118)
Other Operating Income	*(29)*	232	236	4	*934*	696	1,088	392
Block projected top up	*557*	810	884	73	*1,670*	2,431	2,285	(146)
Total Income	***6,179***	**8,766**	**7,653**	**(1,113)**	***19,524***	**22,240**	**22,368**	**128**
Pay								
Substantive	*(4,048)*	(4,524)	(4,097)	427	*(11,997)*	(13,573)	(12,447)	1,126
Bank	*(64)*	(169)	(248)	(79)	*(311)*	(507)	(723)	(216)
Agency	*(34)*	(11)	(79)	(69)	*(69)*	(32)	(216)	(184)
Total Pay	***(4,146)***	**(4,704)**	**(4,424)**	**279**	***(12,377)***	**(14,111)**	**(13,385)**	**726**
Non Pay								
Clinical Services & Supplies	*(398)*	(1,857)	(748)	1,109	*(1,107)*	(2,624)	(1,988)	636
Clinical Services & Supplies - Med & Surg	*(295)*	(630)	(566)	63	*(1,020)*	(1,472)	(1,521)	(49)
Drugs	*(174)*	(173)	(143)	31	*(214)*	(352)	(365)	(13)
Establishment Expenses	*(111)*	(223)	(248)	(25)	*(602)*	(543)	(682)	(138)
Consultancy	*1*	(15)	(18)	(3)	*(59)*	(43)	(104)	(61)
Other non pay	*(507)*	(464)	(496)	(32)	*(1,629)*	(1,299)	(1,383)	(84)
Total Non Pay	***(1,485)***	**(3,363)**	**(2,220)**	**1,143**	***(4,631)***	**(6,332)**	**(6,042)**	**290**
Non Operational Expenditure	*(172)*	(120)	(199)	(79)	*(462)*	(338)	(484)	(147)
Non Operating Income	*0*	0	0	(0)	*1*	0	0	(0)
Depreciation and amortisation	*(279)*	(568)	(448)	120	*(849)*	(1,038)	(1,255)	(217)
Total Expenditure	***(6,082)***	**(8,754)**	**(7,291)**	**1,464**	***(18,318)***	**(21,819)**	**(21,167)**	**652**
Surplus / (Deficit)	***97***	**12**	**362**	**350**	***1,205***	**421**	**1,201**	**780**
Top up to be clawed back				**0**				**0**
Adjustment to B/E				**0**				**0**
Surplus / (Deficit)	***97***	**12**	**362**	**350**	***1,205***	**421**	**1,201**	**780**

QVH PERFORMANCE COMMENTARY

The financial position reflects the Trust internally reported position. Monthly phasing of the plan is misaligned to the PFR, with alignment reached at M6.

Year to date at M3 the Trust is reporting a surplus to plan position of £780k driven mainly by Elective recovery fund (ERF) income as the trust is hitting planned activity recovery targets.

Income

- ERF YTD £2.2m, this is the Trust full estimate of ERF income.

Expenditure

- Pay: £726k surplus, mainly due to substantive vacant posts and staffing challenges across services.
- The trust expenditure run rate is line with trends in delivering activity performance.

QVH FORWARD LOOK / PERFORMANCE RISKS

Trust is forecasting breakeven at the end of H1. The block regime is supporting the Trust breakeven position.

Risks

Income

- The impact of the ERF threshold change is a £1m reduction to the Trust income forecast
- The Trust is reflecting the full planned estimate of ERF income, no provision has been made for a change to this whilst we await conformation of the actuals.

Expenditure

- Staff challenges and vacancies, which will impact service delivery, the impact of the Q2 revised ERF at 95% will be reviewed in M4.

Mitigations

- The Trust has met and is expected to meet the activity thresholds and activity plan in H1, this has been delivered with the current cost base. The Trust will review the establishment required to maintain and deliver performance.
- Review vacancies and establishment for H2.

Balance Sheet Month 03

Queen Victoria Hospital NHS
NHS Foundation Trust

Statement of financial position 2021-22

£000's	Prior Year End March 2021	April	May	June	Change In Month	Change In Year
Non Current Assets						
Fixed Assets	54,165	53,857	53,732	53,584	(148)	(581)
Other Receivables	227	227	227	227	0	0
Total Non Current Assets	**54,392**	**54,084**	**53,959**	**53,811**	**(148)**	**(581)**
Current Assets						
Inventories	1,462	1,460	1,442	1,469	27	7
Trade and other Receivables	4,140	3,353	4,544	6,289	1,745	2,149
Cash and Cash Equivalents	8,582	9,072	8,933	8,358	(575)	(224)
Total Current Assets	**14,184**	**13,885**	**14,919**	**16,115**	**1,196**	**1,931**
Current Liabilities						
Trade and other Payables	(10,544)	(9,575)	(10,060)	(10,449)	(389)	95
Borrowings	(893)	(883)	(883)	(857)	26	37
Provisions	(88)	(88)	(88)	(88)	0	0
Other Liabilities	(431)	(396)	(337)	(349)	(12)	82
Total Current Liabilities	**(11,956)**	**(10,942)**	**(11,368)**	**(11,742)**	**(374)**	**214**
Subtotal Net Current Assets	**2,228**	**2,943**	**3,551**	**4,373**	**822**	**2,145**
Total Assets less Current liabilties	**56,620**	**57,027**	**57,510**	**58,184**	**674**	**1,564**
Non Current Liabilties						
Borrowings	(3,653)	(3,653)	(3,653)	(3,266)	387	387
Provisions	(908)	(908)	(908)	(908)	0	(0)
Total Non Current Liabilties	**(4,561)**	**(4,561)**	**(4,561)**	**(4,174)**	**387**	**387**
Total assets Employed	**52,059**	**52,466**	**52,949**	**54,011**	**1,062**	**1,952**
Tax Payers Equity						
Public Dividend Capital	21,005	21,005	21,005	21,005	0	1
Revaluation Reserve	13,943	13,943	13,993	13,993	(0)	50
Income and Expenditure Reserve	17,111	17,518	17,951	19,013	1,062	1,901
Total Tax Payers Equity	**52,059**	**52,466**	**52,949**	**54,011**	**1,062**	**1,952**

QVH PERFORMANCE COMMENTARY

- Non current assets have decreased in value reflecting the relatively slow rate of in year additions (£0.5m) compared with the depreciation/amortisation costs for the year to date (-£1.1m).
- Trade receivables have increased in year by £2.1m primarily due to an increase in NHS income accruals that includes the elective recovery fund (ERF) estimate for April to June of £2.2m.
- Closing cash balance for June has decreased from last month by £0.6m mainly due to the loan instalment payment of £0.5m.
- Trade payables have increased in month to be on a par with opening balances, the increase being in accruals .
- Other liabilities mainly consists of deferred income values which have remained fairly consistent in-year.
- Non current borrowings consists of the bulk of the theatre loan and longer term finance lease liabilities. Reduced in June for the half-yearly principal repayment instalment.
- Provisions include long term liabilities relating to early retirement pension costs and clinical pension tax scheme.
- Revaluation reserve has increased by £50k to account for a revaluation of assets following a valuation clarification, (Arcomed pumps). This does not affect the income & expenditure position.
- Income and expenditure reserve has increased by £1.9m reflecting the current statement of comprehensive income (SOCI) surplus position.

Cashflow Report Month 03

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 03 2021/22

Cashflow Report

	Actual £'000			Forecast £'000								
	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Opening Balance	**8,577**	**9,067**	**8,928**	**8,358**	**7,800**	**7,242**	**9,432**	**8,724**	**7,216**	**5,264**	**3,756**	**2,248**
Receipts												
Block & System income	6,283	6,283	6,304	6,283	6,283	6,283	6,283	6,283	6,283	6,283	6,283	6,283
Elective Recovery Fund (tbc)	0	0	0	0	0	3,540	0	0	0	0	0	0
Other Core Income incl HEE	1,675	256	211	250	250	250	1,050	250	250	250	250	250
Receipts from other income	109	167	130	138	138	138	138	138	138	138	138	138
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	0
PDC Cash Support Received	0	0	0	0	0	0	0	0	0	0	0	0
Total Receipts	**8,067**	**6,706**	**6,645**	**6,671**	**6,671**	**10,211**	**7,471**	**6,671**	**6,671**	**6,671**	**6,671**	**6,671**
Payments												
Payments to NHS Bodies	(644)	(687)	(364)	(665)	(665)	(665)	(665)	(665)	(665)	(665)	(665)	(665)
Payments to non-NHS bodies	(2,584)	(1,876)	(2,037)	(2,230)	(2,230)	(2,230)	(3,180)	(3,180)	(3,180)	(3,180)	(3,180)	(3,180)
Net Payroll Payment	(2,460)	(2,417)	(2,442)	(2,440)	(2,440)	(2,440)	(2,440)	(2,440)	(2,440)	(2,440)	(2,440)	(2,440)
Payroll Taxes	(1,197)	(1,167)	(1,220)	(1,200)	(1,200)	(1,200)	(1,200)	(1,200)	(1,200)	(1,200)	(1,200)	(1,200)
Pensions Payment	(691)	(697)	(703)	(694)	(694)	(694)	(694)	(694)	(694)	(694)	(694)	(694)
PDC Dividends Payment	-	-	0	0	0	(792)	0	0	0	0	0	(792)
Loan Interest & Repayment	-	-	(449)	0	0	0	0	0	(444)	0	0	0
Total Payments	**(7,577)**	**(6,845)**	**(7,215)**	**(7,229)**	**(7,229)**	**(8,021)**	**(8,179)**	**(8,179)**	**(8,623)**	**(8,179)**	**(8,179)**	**(8,971)**
Net Cash Movement	**490**	**(139)**	**(570)**	**(558)**	**(558)**	**2,190**	**(708)**	**(1,508)**	**(1,952)**	**(1,508)**	**(1,508)**	**(2,300)**
Closing Balance	**9,067**	**8,928**	**8,358**	**7,800**	**7,242**	**9,432**	**8,724**	**7,216**	**5,264**	**3,756**	**2,248**	**(52)**

QVH PERFORMANCE COMMENTARY

- There is currently a cash balance which covers a month of average spend, which is more than sufficient in the short term as block payments are received in month.

QVH FORWARD LOOK / PERFORMANCE RISKS

- The forecast assumes the current level of funding and spend continues. However should this regime change from block payment or break even funding basis then appropriate cash support would be required should the Trust run at an operating deficit. No H2 forecast of ERF has been made.
- Cash balances are currently only sustainable in H1 (April-Sept) if ERF income is achieved and an operating surplus achieved. The balance will be reduced in H2 by capital spend and the funding flows and operating plan is not yet available.
- The cash position will continue to be reviewed and managed and any future requirements assessed monthly.

Debtors Month 03

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance Month 03 2021/22

Debtors

	Jul 20 £'000	Aug 20 £'000	Sep 20 £'000	Oct 20 £'000	Nov 20 £'000	Dec 20 £'000	Jan 21 £'000	Feb 21 £'000	Mar 21 £'000	Apr 21 £'000	May 21 £'000	Jun 21 £'000	In Month Change £000
NHS Debtors													
0-30 Days Past Invoice Due Date	221	131	90	182	249	1,189	927	308	803	605	383	53	(331)
31-60 Days Past Invoice Due Date	75	62	92	14	68	14	5	743	62	132	239	353	114
61-90 Days Past Invoice Due Date	112	72	63	77	14	68	8	4	743	18	116	231	116
Over 90 Days Past Invoice Due Date	3,840	2,792	2,321	2,054	1,848	1,619	1,661	796	747	666	650	708	58
Total NHS Debtors	**4,248**	**3,056**	**2,566**	**2,327**	**2,180**	**2,889**	**2,601**	**1,852**	**2,355**	**1,422**	**1,388**	**1,345**	(43)
Non NHS Debtors													
0-30 Days Past Invoice Due Date	150	55	64	87	43	87	90	70	193	175	34	49	16
31-60 Days Past Invoice Due Date	16	41	21	7	57	9	24	30	12	12	157	14	(143)
61-90 Days Past Invoice Due Date	21	16	38	2	7	57	8	19	9	11	15	139	124
Over 90 Days Past Invoice Due Date	556	590	435	468	361	388	410	391	398	343	335	344	9
Total Non NHS Debtors	**743**	**702**	**558**	**564**	**468**	**541**	**533**	**510**	**611**	**541**	**540**	**545**	6
Other Debtors Less Than One Year	341	571	592	564	989	(41)	42	(511)	1,566	1,017	2,616	4,399	
Total Debtors	**5,332**	**4,329**	**3,716**	**3,456**	**3,637**	**3,389**	**3,176**	**1,851**	**4,532**	**2,980**	**4,544**	**6,289**	
NHS : Total NHS & Non NHS ratio	*0.85*	*0.81*	*0.82*	*0.80*	*0.82*	*0.84*	*0.83*	*0.78*	*0.79*	*0.72*	*0.72*	*0.71*	

QVH PERFORMANCE COMMENTARY

The month 03 total debtor balance of £6.3m is 19% lower than the average monthly balance of £7.7m in 2020-21. This is largely due to the Covid block contract payment regime that removes the time lags created by flex and freeze arrangements and the recovery of aged debts relating to prior years activity performance billing.

The Trade debtors balance decreased by £1.08m (36%) from March 2021, mainly reflecting collection and settlement of 2020-21 NHS/DoH income.

Other Debtors consists mainly of the net effect of income accruals (ERF), adjustments for receipts in advance and prepayments, provisions and other non-invoiced debtors such as VAT and the injury cost recovery scheme.

QVH FORWARD LOOK / PERFORMANCE RISKS

- Financial Services continue working closely with Business Managers and the Contracting team to ensure billing is accurate, timely and resolutions to queries are being actively pursued.
- Financial services will continue to review Aged Debts with the aim of resolving any disputes.

Creditors Month 03

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 03 2021/22

Trade Creditors

	Jul 20 £'000	Aug 20 £'000	Sep 20 £'000	Oct 20 £'000	Nov 20 £'000	Dec 20 £'000	Jan 21 £'000	Feb 21 £'000	Mar 21 £'000	Apr 21 £'000	May 21 £'000	Jun 21 £'000	In Month Change £'000
NHS Creditors													
0-30 Days Past Invoice Due Date	446	380	323	302	196	363	278	247	395	131	147	103	(44)
31-60 Days Past Invoice Due Date	107	155	39	9	109	103	117	157	42	85	25	59	34
61-90 Days Past Invoice Due Date	66	42	155	19	27	84	90	91	102	35	56	36	(19)
Over 90 Days Past Invoice Due Date	1,772	1,270	1,111	1,180	665	698	722	774	691	608	645	663	19
Total NHS Creditors	**2,391**	**1,847**	**1,629**	**1,510**	**996**	**1,248**	**1,207**	**1,269**	**1,230**	**860**	**872**	**862**	**(10)**
Non NHS Creditors													
0-30 Days Past Invoice Due Date	358	292	566	342	843	1,138	513	325	1,323	444	423	650	227
31-60 Days Past Invoice Due Date	146	43	31	55	37	30	410	91	84	101	49	74	24
61-90 Days Past Invoice Due Date	35	103	12	7	5	31	12	18	44	28	47	35	(12)
Over 90 Days Past Invoice Due Date	10	160	41	26	20	26	16	60	38	16	69	77	8
Total Non NHS Creditors	**550**	**597**	**650**	**430**	**905**	**1,224**	**949**	**493**	**1,489**	**588**	**589**	**836**	**248**
Other Creditors Less Than One Year	(74)	(366)	(402)	(106)	(15)	(975)	(340)	(149)	(678)	80	(63)	(332)	
Total Creditors	**2,867**	**2,078**	**1,877**	**1,834**	**1,886**	**1,497**	**1,816**	**1,613**	**2,041**	**1,528**	**1,398**	**1,366**	
NHS : Non NHS ratio	***0.81***	***0.76***	***0.71***	***0.78***	***0.52***	***0.50***	***0.56***	***0.72***	***0.45***	***0.59***	***0.60***	***0.51***	

QVH PERFORMANCE COMMENTARY

- The trade creditors balance at month 03 is £1.4m compared to a 20/21 average of £2.5m.
- NHS balances have largely remained stable this month compared to last. Whilst the Non NHS balances has reduced by £0.2m from last month.
- The other creditors balance reflects the adjustment back to the balance sheet value for items within the trade creditors total which have not yet been validated to be accounted for on the general ledger but have been included in the aged creditors balance for completeness.

QVH FORWARD LOOK / PERFORMANCE RISKS

- Financial services will continue to review older NHS SLA balances with our key partner Trusts with the aim of resolving any disputes.
- Financial services are continuing to review areas where invoice authorisation is delayed in order to target and support training needs.
- The team are working with all budget holder to clear invoices as quickly as possible.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**Thursday 5 August 2021**		**Agenda reference:**	**109-21**	
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 and phase 3 delivery				
Summary of key issues	Key items to note in the operational report are: • Operational performance in month • Recovery planning requirements and position				
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):	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:	26/07/21	Decision:	Noted	
Next steps:					

Operational Performance Report

Abigail Jago, Director of Operations

July 2021

Trust Board

Contents

Headlines

Queen Victoria Hospital NHS Foundation Trust

Cancer:

- Performance **meeting national / local set standards** for 2WW cancer, 62 day, 31 day, faster diagnosis cancer standard, 104 day waits and 62 day backlog as a % of the PTL.
- Performance **behind plan** for 62 day backlog primarily due to late referrals.

Diagnostics:

- **DMO1** – Continued challenges within the sleep service due to staffing gaps - an increase of 28 further breaches from the previous month. Equipment failure accounts for 6 CT breaches, which have all now been rebooked. Radiology only DMO1 performance is **98.82%**.

Waiting Lists and Long Waiters:

- Reduction in patients waiting over **52**, **78** and **104** weeks due to elective activity delivery and waiting list distribution reflecting 20/21 referral patterns.

Activity Vs Plan:

- **Elective** activity has reduced in month to below plan.
- **Day case** activity is on an upwards trajectory but remains below plan.
- **First Outpatients** activity has increased in month to above plan. **Follow up Outpatient** activity remains above plan.

Risk to performance / forward look

- **62D/104D backlog** – performance challenge due to an increase in late referrals and immediate reconstruction breast referrals.
- **2WW** – performance challenge due patient choice delays; with patient cancellations and declining offered dates due to holidays.
- Staffed theatre capacity
- Sleep staffing position; continued performance risk for **DMO1**.
- Ongoing risk around patients delaying / unable to attend for treatment for Covid and Non-Covid reasons.

Performance Summary

NHS
Queen Victoria Hospital
NHS Foundation Trust

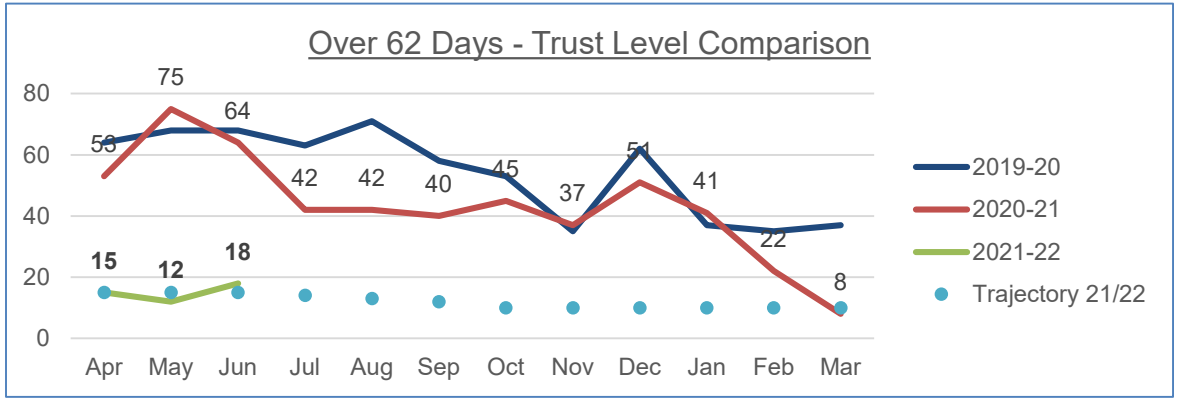
	KPI	TARGET / METRIC	SOURCE	JUL20	AUG20	SEP20	OCT20	NOV20	DEC20	JAN21	FEB21	MAR21	APR21	MAY21	JUN21
CANCER	Cancer 2WW	93%	National	84.5%	98.4%	99.7%	98.7%	99.4%	98.9%	90.7%	98.2%	98.8%	97.8%	98.5%	-
	Cancer 62 day	85%	National	77.5%	91.3%	85.3%	81.2%	86.6%	85.7%	85.3%	87.5%	87.7%	87.5%	89.2%	-
	Cancer 31 day	96%	National	89%	93.9%	89.7%	92.2%	93.3%	92.8%	89.7%	94.8%	94.6%	95.5%	97.3%	-
	Faster Diagnosis	75%	National	82.5%	75.3%	67.8%	82.2%	75.1%	77.1%	73.7%	82.8%	83.2%	84.7%	88.9%	-
	Cancer 104 day	Internal trajectory	Local	15	9	5	6	9	12	20	11	10	5	2	2
	Cancer 62 day backlog	Internal trajectory	Local	42	42	40	45	37	51	41	22	8	15	12	18
	Cancer 62 day backlog	<5% of PTL	Local									2.3%	4.6%	2.7%	4.8%
DIAGNOSTICS	DMO1 Diagnostic waits	99% <6 weeks	National	84.9%	86.8%	92.0%	94.9%	98.1%	96.3%	98.80%	99.15%	98.92%	98.88%	97.51%	94.07%
	Histology TAT	90% <10 days	Local	99%	92%	95%	95%	98%	96%	88%	94%	94%	95%	97%	91%
	Imaging reporting	% <7 days	N/A	98.5%	98.6%	98.2%	98.6%	98.5%	98.5%	97.9%	98.4%	97.0%	96.8%	99.1%	97.2%
RTT WAITS	RTT52	Phase 3	ICS	320	461	555	608	563	623	740	907	903	715	534	370
	RTT78	N/A	N/A	4	8	10	16	29	32	43	62	87	126	137	99
	RTT104	N/A	N/A	-	-	-	-	-	-	-	-	2	5	6	4
	RTT18	92%	National	42.10%	47.70%	55.60%	64.20%	69.60%	71.36%	71.06%	69.96%	70.22%	71.20%	74.14%	77.59%
RECOVERY ACTIVITY	Day Case	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	-	100.8%	89%	93%
	Elective	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	-	92.6%	104%	93%
	First Outpatients	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	-	103.4%	95%	113%
	Follow Up Outpatients	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	-	112.8%	103%	102%
	Outpatient Therapies	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	-	105.9%	108%	111%
	Non Elective	Recovery plan (% of)	ICS	-	-	-	-	-	-	-	-	-	103.1%	112%	104%
MIU	MIU	95% discharged <4hrs	National	100%	99.8%	98.5%	100%	100%	99.6%	100%	99.8%	100%	99.9%	99.9%	99.05%
RAG	Deteriorating position or plans / cause for concern			Improving position or plans / local trajectories on track						Delivery of national / local standard					

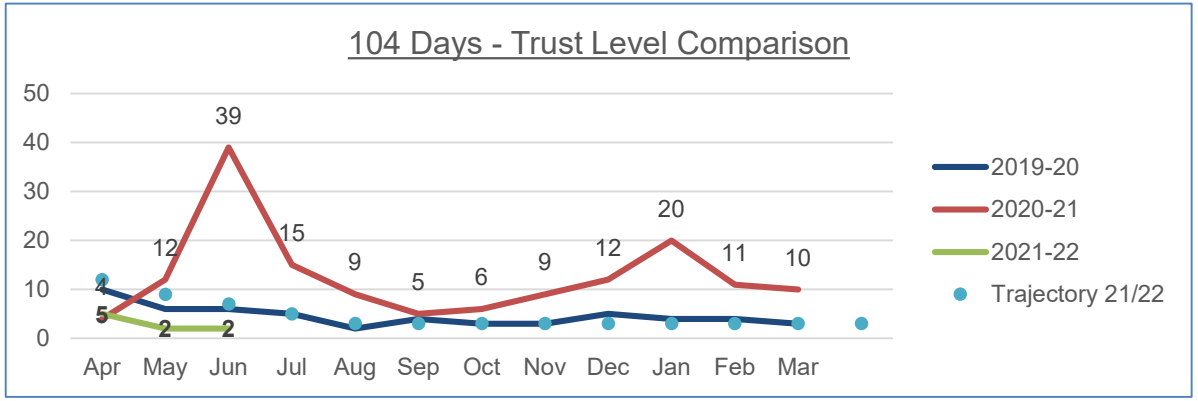
Cancer

Performance Dashboard / 62 days / 104 day backlog / recovery

Queen Victoria Hospital NHS Foundation Trust

Trust Level	Q4 2020-21			Q1 2021-22			Q2 2021-22			Q3 2021-22			Q4 2021-22			Change from last month
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	
Two Week Wait	90.7%	98.2%	98.8%	97.8%	98.5%											↓
62 Day Referral to Treat	85.3%	87.5%	87.7%	87.5%	89.2%											→
Faster Diagnosis	73.7%	82.8%	83.2%	84.7%	88.9%											↑
62 Day Con Upgrade	92.9%	91.7%	100%	90.0%	92.3%											↓
31Day Decision to Treat	89.7%	94.8%	94.6%	95.5%	97.3%											↑
31 Day Sub Treat	100%	87.5%	100%	94.4%	100%											↓





PERFORMANCE COMMENTARY

- QVH were compliant against key metrics in May 2021.
- **Screening** - QVH was below target for May, reporting 2 breast breaches.
- **62 day backlog** – QVH did not meet the trajectory for June due to late referrals, however the agreed % of waiting list was met.
- **Over 104 day** – QVH met the agreed recovery trajectory for June.

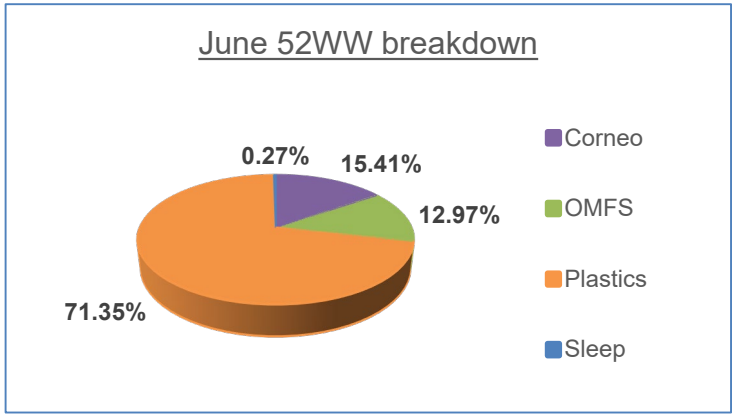
FORWARD LOOK / PERFORMANCE RISKS

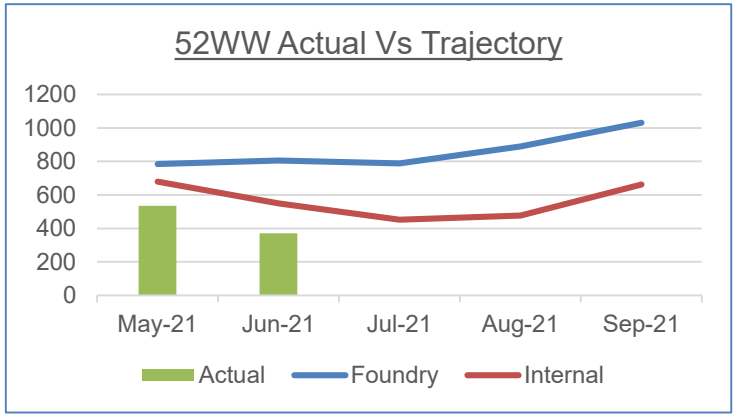
- The unvalidated performance for **2WW, 31 day, 62 day** and **FDS** for June is above plan.
- **2WW** performance is challenged in July due to a rise in the number of patient choice delays due to the holiday period.
- **62 day backlog** and **over 104 day** – starting to see the predicted increase in skin referrals which is a risk to future performance. The risk around the inclusion of late referrals from other trusts remains ongoing. Delays are being seen where surgery is being cancelled due to medical reasons – COVID and non-COVID delays.

RTT Waits

52WW / 78WW / 104WW

Queen Victoria Hospital NHS Foundation Trust



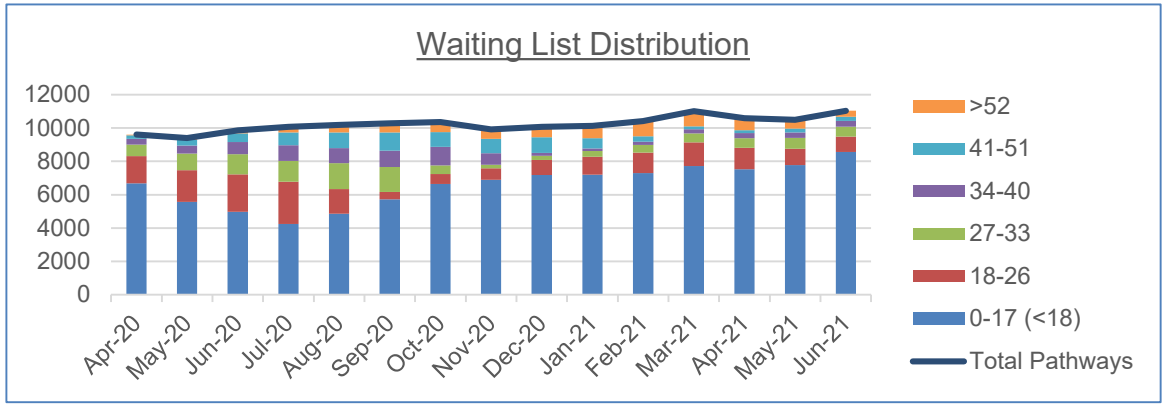


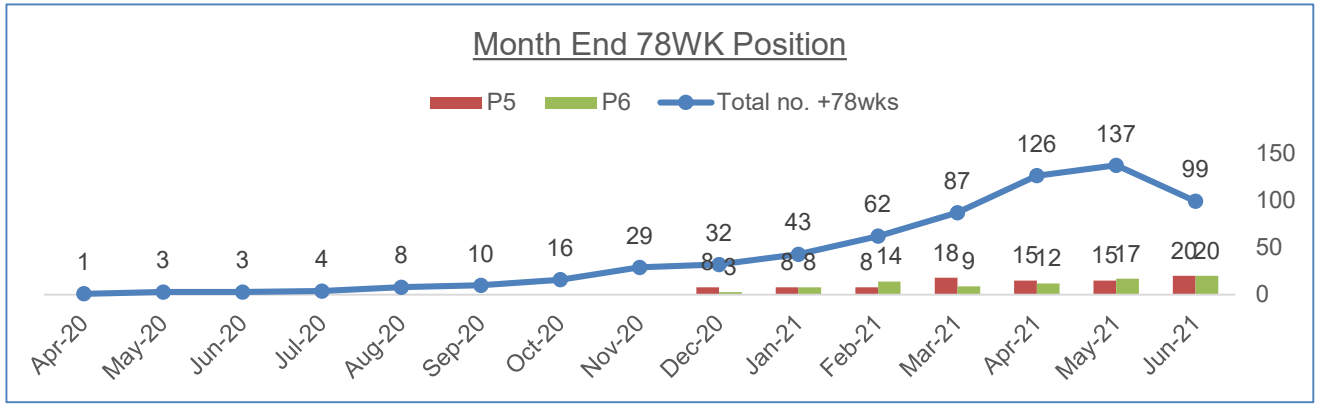
PERFORMANCE COMMENTARY

- In month reduction in number of patients waiting more than 52 weeks. The trust is meeting the system (foundry) modelling and internal trajectory for 52WW.
- 139 patients waiting over 52 weeks are a P5 or P6 (i.e. patient deferred), with an increase of 46 P6 patients, who are delaying due to non-Covid related reasons.
- Plastic surgery remains the most challenged specialty for 52 and 78 weeks.
- In month the Trust reported 4 breaches over 104 weeks; 1 plastics, 2 corneo, 1 OMFS.

FORWARD LOOK / PERFORMANCE RISKS

- Increase in 52WW and 78WW patients due to waiting list distribution reflecting 20/21 referral patterns
- Ongoing risk around patients delaying treatment for Covid and Non-Covid reasons.





Recovery Activity

QVH Site / Independent Sector

Queen Victoria Hospital NHS Foundation Trust

Point Of Delivery Group	June 2122 Activity	Recovery Plan	2122 Activity Variance against Recovery Plan	2122 Percentage Variance against Recovery Plan	1920 Activity	2122 Activity Variance against 1920 Activity	2122 Percentage Variance against 1920 Activity
Day Case	982	1057	-75	93%	1053	-71	93%
Elective	245	264	-19	93%	383	-138	64%
First Outpatients	3475	3076	399	113%	3776	-301	92%
Follow Up Outpatients	10709	10501	208	102%	10189	520	105%
Outpatient Therapies	2471	2225	246	111%	2905	-434	85%
Non Elective	574	553	21	104%	612	-38	94%
Grand Total	**18456**	**17675**	**781**	**104%**	**18918**	**-462**	**98%**
RAG RATING		Below 90% of recovery plan		90%-100% of recovery plan		Over 100% of recovery plan	

PERFORMANCE COMMENTARY

- **Day Case** – Main challenge to day case plan continues to be ophthalmology and plastics. Ophthalmology is driven by medical vacancies.
- **Elective** – Sleep driving elective underperformance due to staff shortages.
- Recovery Plan is achieved for **First Outpatients**, **Follow Up Outpatients**, **Outpatient Therapies**, **Non Elective**, as well as overall.

FORWARD LOOK / PERFORMANCE RISKS

- **Opthalmology** – consultant post recruited to and starting in August. Fellow recruitment underway.
- **Plastics** – Forward look suggests improvement in day case activity in the coming weeks, driven by theatre improvement work assuming staffing levels can be maintained.
- **Sleep** – Locum consultant recruited and started in June, expected to recover to c50% of plan.
- **Spoke site** activity being reviewed. Max Fax junior staff levels being addressed and likely to improve in September / October.
- **Anaesthetic** staffing recruitment – likely to deliver increased day cases in place of elective until anaesthetic resource is sufficient.
- Ongoing risk around patients delaying treatment for Covid and Non-Covid reasons.
- **Independent sector** – Challenge with maintaining sessional arrangements. Discussions ongoing with the Horder.

Recovery Work Streams

Virtual Consultations:

Deliver 25% of outpatient appointments remotely by telephone or video consultation.

- Currently achieving the target
- Downward trajectory in some areas due to clinical / pathway requirements for face to face review – further work through Outpatients Pathway and Performance Group at a specialty level to understand opportunity and clock stop impact.

Patient Initiated Follow Up (PIFU):

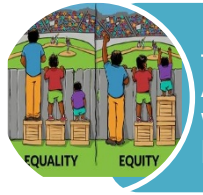
Begin reporting on PIFU activity across the six national metrics from the end of Q2 in three specialties.

- Standard Operating Procedure, clinical protocols, patient leaflets, documentation signed off
- Training on the recording of PIFU patients on patient centre underway and first burns patients moved to a PIFU pathway. Sleep and physio planning underway.

Advice & Guidance (A&G):

Increase the uptake of A&G to the national ambition of 12% within 2021/22.

- Ongoing work to report A&G from DeRS (Dental Electronic Referrals System); internal process change required. Impact being reviewed.
- BIU able to start reporting A&G activity from eRS.
- Limited referrals to A&G services.



Health Inequalities:

Address inequalities in access, experience and outcomes, working with local partners across health, social care, and beyond.

- QVH programme is being developed linked to ICS programme.
- Leadership roles have been identified
- Ethnic coding improvement workstream is underway through Data Quality Group
- Long wait analysis commenced for deprivation indices and ethnicity

Recovery Work Streams

Queen Victoria Hospital NHS Foundation Trust

Clinical Validation:

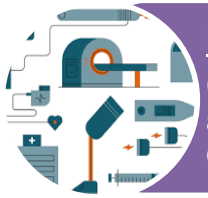
Validate surgical waiting lists to allow operating lists to run effectively.

- QVH diagnostic validation is on track in line with national and system programme requirements
- Work is underway to enable clinical national urgency codes (P codes) for admitted pathways to be applied for off site non QVH PAS waiting lists

Pathway Transformation:

Redesign clinical pathways to increase productivity, and accelerate progress on digitally-enabled care.

- Ophthalmology and ENT identified and system programme delivery has commenced with QVH input. This work includes consideration of a single PTL for general ENT.



Diagnostics:

Community diagnostic hubs (CDH) should be created across the country, away from hospitals, so that patients can receive life-saving checks close to their homes.

- QVH live as early implementer CDH
- Expect final business case to be approved by the national team at the end of August.
- GP engagement work being undertaken and attracting interest.
- Workforce is key and a working group is in place to address current regional issues.

System PTL:

System wide management of elective waiting lists to reduce long waiters.

- System tactical PTL meeting has taken place. Initial focus for P2 patients >78 weeks
- Data reporting is being reviewed at ICS level to support this.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	5/08/2021		**Agenda reference:**	**110-21**	
Report title:	Radiology PACS procurement				
Sponsor:	Ian Francis, Imaging lead; director of clinical strategy and deputy medical director.				
Authors:	Tidings Chengeta, PACS Project Manager Sarah Solanki, Radiology Services Manager Mejero Uwejeyah, Associate Director of Finance				
Executive summary					
Purpose of report:	The purpose of this paper is to request authority to appoint Sectra as the PACS and VNA supplier subject to contract negotiations as detailed in the business case. To approve the requested project funding required to implement the project.				
Summary of key issues	The investment recommended by this Full Business Case comprises the deployment and operation of a new PACS and VNA service that will replace the existing Philips PACS service. Current PACS is end of life and presenting clinical risk as maintenance is on best endeavours. Current Philips Contract ending in 2022 and there is a need for a new PACS system. The primary issue was that the PACS/RIS/VNA contract would end with no resolution in place. This would lead to a potential catastrophic clinical risk with loss of data due to unsupported systems with no hardware back up or support.				
Recommendation:	The committee is being asked to support the approval of the PACS Business by the QVH Trust board.				
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:					
Corporate risk register:	1140				
Regulation:	Data Protection Act 2018 and EU General Data Protection Regulation Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2003/2426) Information Security Management: NHS Code of Practice 2007 International Information Security Standard: ISO/IEC 27001:2013 and ISO/IEC 27002:2013 International Standard on Records Management ISO 15489-1:2016 BS 10008 Evidential Weight and Legal Admissibility of Electronic Information Records Management Code of Practice for Health & Social Care 2016 UK General Data Protection Regulation Ionising Radiation (Medical Exposure) Regulations 2017				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Report was considered by EMT and HMT prior to submission at today's meeting.				
	Date:	19/07/2021	Decision:	Approved	
Previously considered by:	Finance and Performance Committee				
	Date:	26/07/2021	Decision:	Recommended	
Next steps:	Assuming approval contract schedules will be agreed and contract signed off.				

Queen Victoria Hospital
NHS Foundation Trust

Radiology PACS procurement

Board of Directors: 05 August 2021

Ian Francis, Imaging lead, director of clinical strategy and deputy medical director.

PURPOSE

This document summarises the business case for QVH as part of Surrey and Sussex Collaborative to deliver a new Picture Archiving and Communication System (PACS) and accompanying Vendor Neutral Archive (VNA) via the QE Gateshead Framework. (Full Business Case was reviewed in sub-committee, detail which is commercial in confidence is not included in public Board paper).

This paper seeks QVH Trust Board approval as follows:

- Approve the award of contract to the recommended preferred bidder (Sectra) as recommended by the S&S Programme board and QVH PACS Board.

- Approve recommended contract terms of 5 years

- Approve in principle the plan to proceed with contract negotiations with the Recommended Preferred Bidder, committing the required capital and revenue as set out within the financial case.

BACKGROUND

- The Picture Archiving and Archiving System (PACS) and (RIS) from Wellbeing were installed in 2013 and are managed as a single, but multi-Trust prime contract by Philips. The Initial contract expired in 2018 which was extended to June 2020.This contract has been extended by a further 2 years till June 2022.This extension will include a hardware refresh at an agreed time with the Trusts. The maximum extension possible is up to June 2023.

- The Surrey and Sussex collaborative has completed procurement exercise to select the preferred supplier for the PACS/VNA solution.

- The S&S programme board has approved the business case and seeking approval from all the Trusts in order to award the PACS contract to Sectra as the preferred supplier as per the competitive Tender just completed.

- The framework has been advertised in compliance with PCR 2015 and the award of contracts permitted stated were either mini competition or direct award. The framework title is “Clinical software (and hardware) solutions for use in healthcare” with a reference of 2020/S 179-433252

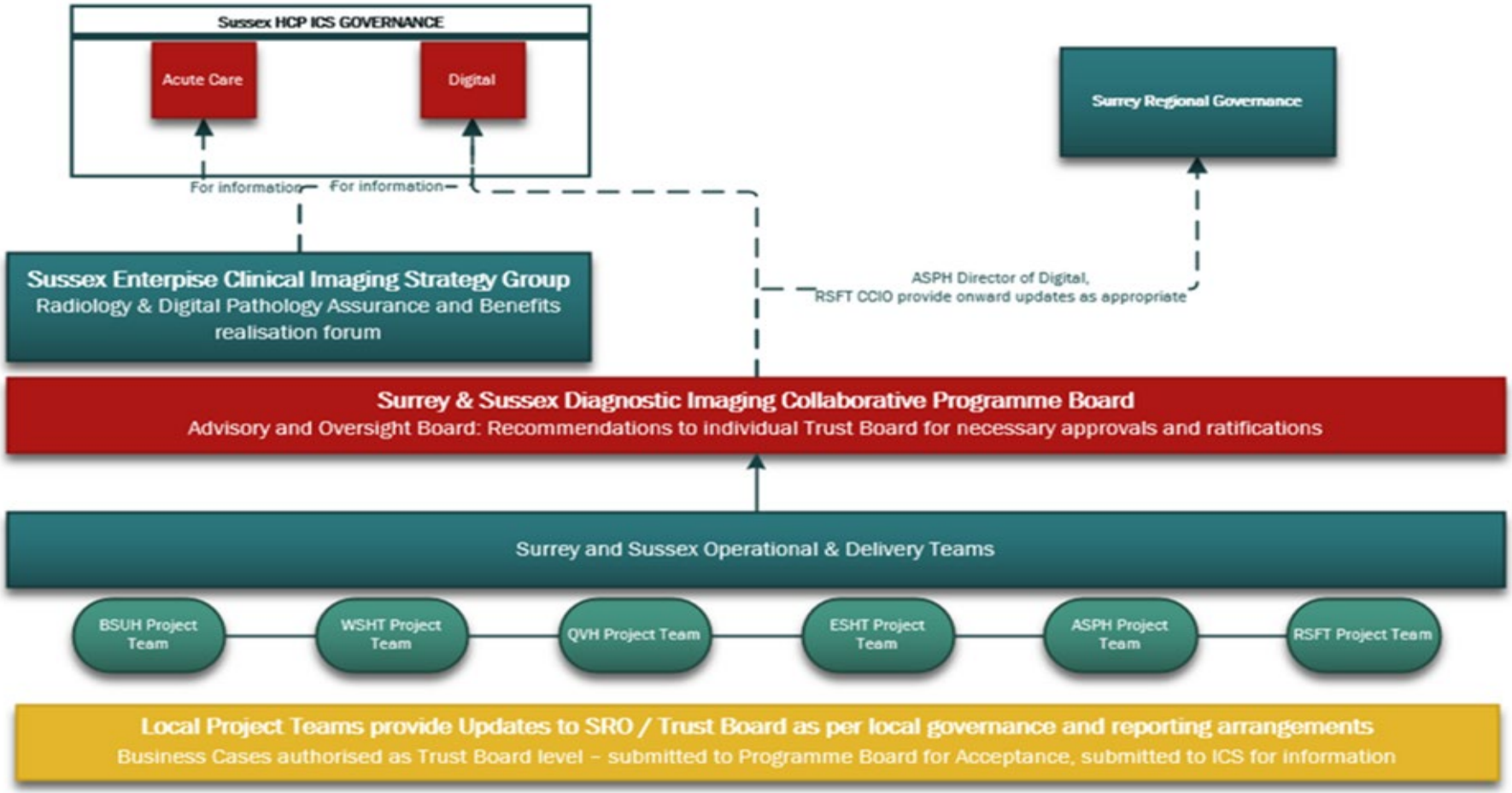
TIMELINE

QVH is part of the Surrey and Sussex collaborative and have decided purchase major infrastructure solutions together. RIS is a separate contract from PACS. VNA will be part of PACS archive

- 2011 - The consortium was formed - 6 Trusts procured fully managed PACS, NVA and RIS systems.
- 2019 - OBC recommended PACS re-procurement via mini-competitive tender - a tactical approach for the RIS and VNA services.
- 2020 - Philips contract Extension. VNA contract moves to Hyland to provide an independent storage.
- June 2022 - End of Philips contract extension. RIS contract moves to Wellbeing direct, Hyland VNA contract expires.

PROGRAMME GOVERNANCE STRUCTURE

Queen Victoria Hospital
NHS Foundation Trust



PROCUREMENT PROCESS

Queen Victoria Hospital
NHS Foundation Trust

Procurement Strategy Options
Approved by Sussex and Surrey (S&S) Digital Programme board

1-Do Nothing

- Continue with current system
- Carry-over same issues

2 Radiology services Strategic Review

- Same as 4 but longer time.
- More cost & longer time

3 Mini-Competition for PACS , RIS & VNA

- Multiple procurement lots complexity
- Not feasible before contract end

4 Mini-Competition for PACS & Tactical for RIS

- Procure New PACS via QE Framework
- Clear specifications
- Shorter Time
- Maintain RIS supplier

5-New contract with current provider

- No comparison of value and cost
- No guarantee can meet business needs

Preferred Strategy

PROCUREMENT STAGES

NHS
Queen Victoria Hospital
NHS Foundation Trust

Procurement via QE Framework	Activity	
Requirements Capture	• All QVH stakeholders provided system specifications.	• Radiology, IT, IG Procurement • S&S collaborative
Gateway Questions	• Eight suppliers responded and answered the questions. • Selection done on compliance	• AGFA, GE, Sectra were compliant, hence proceeded to OBS. • Philips pulled out • Insignia pulled out
OBS	• Top two highest scoring Bid, plus any other Bid within 8% of the highest scoring Bid. • GE were out of Margin	• Sectra- 55.6% • AGFA - 47.1% - 8.4% below • GE -41.8% -13.7% below highest bid
Product Demonstration and Reference Site	• Sectra presentations and site reference were very good. • AGFA site reference feedback very negative.	Overall score: **Sectra 66% & AGFA 61.4%**
BAFO	• Both suppliers provided final costs after clarification meetings. • AGFA had the lowest cost as compared to Sectra.	
Preferred Supplier	• Combined scoring Quality (70% and Commercials (30%) Sectra has scored the highest. • Sectra notified as preferred supplier subject to Business Case approval.	• Contract negotiations with Sectra ongoing • **Business Case to be APPROVED**

QVH EVALUATING TEAM

Queen Victoria Hospital
NHS Foundation Trust

POSITION	SUBAREA	POSITION	SUBAREA
Radiology service manager	Radiology	**Consultant plastic and reconstructive surgeon; Chief clinical information officer**	Clinical
PACS manager	Radiology	**Head of procurement**	Procurement
Clinical director of strategy; imaging lead	Clinical	**Information governance lead**	IG
Head of IT	IT	**Reporting radiographer; PACS administrator super user**	Radiology
Chief information officer	IT		

PROCUREMENT TIMETABLE

Queen Victoria Hospital
NHS Foundation Trust

Milestone	End Due Date	Status
Phase 1 – Gateway	December 2020	Complete
Phase 2 OBS		
OBS Tender Documents published	01/02/2021	Complete
Deadline for receipt of OBS Tender clarifications	12/02/2021	Complete
Deadline for receipt of OBS Tender Submission	26/02/2021	Complete
Initial OBS Tender Evaluation Conclusion	26/03/2021	Complete
Issue Virtual Product Demo & Ref Site Scenarios	26/03/2021	Complete
Virtual Product Demonstration	w/c 12/04	Complete
Evaluation Validation	06/05/2021	Complete
BAFO		
Invitation to Best and Final Offers	14/05/2021	Complete
Best and Final Offer Evaluation Conclusion	18/05/2021	Complete
Notification of Preferred Supplier	25/06/2021	Complete
Stand Still Period	09/07/2021	Complete
QVH HMT Board support for BC approval	19/07/2021	Complete
QVH EMT Board support for BC approval	19/07/2021	Complete

PROJECT SCOPE DEFINITION

Queen Victoria Hospital
NHS Foundation Trust

Project Justification	Current Picture Archiving and Communication System(PACS) contract with Philips is ending on 30 June 2022 and current hardware is end of life. Current system not reliable and not all functionality is available. Current supplier service not meeting the expected level.	
Project Scope Description	• Procurement and Implementation of a new centrally hosted PACS system with a VNA archive for the 5 Trusts in the Surrey and Sussex collaborative , namely QVH, UHB,ESHT,RSH and ASH. • Integrate with all current systems as well as new Radiology Information System (RIS).	
Project Objective	• Minimising disruption to current service operation • Improved user experience and productivity • Patient Safety • Supporting new ways of working • Providing a robust supporting infrastructure	
High Level Requirements	➤ Data sharing between Trusts ➤ Diagnostic workstations. ➤ PACS Based reporting	➤ Home reporting facility ➤ PACS Reporting
In Scope	➤ Supplier offsite hosted PACS ➤ Offsite VNA Archive. ➤ Local hosted business continuity PACS(To replace PIX server)	➤ High Availability ➤ Leased line ➤ 500MB HSCN for backup
Out of Scope	➤ RIS replacement program ➤ Addition of other ologies like medical photography, cardiology, pathology etc.	➤ Hyland VNA project

ANTICIPATED BENEFITS

Benefit	Description	Measure
System functionality	The new PACS solutions have more functionality than current offering	Improved productivity with an improvement to turnaround times and a reduction in the reporting backlog
	Algorithm-driven workflows for reporting for more efficient distribution of workload between radiologists, reducing wait times for reports and enabling imaging to be directed to the relevant specialist clinician to interpret and report	• Improved turnaround times for imaging and a reduced reporting backlog • Increased accuracy of reports and MDT presentations
Improved access to images	Improved access to medical images where and when needed to support future service model	Improved productivity and service offerings
Core project savings	The savings through working together as a collaborative rather than individually	Competitive contracts for each of the trusts
Cross-Trust Imaging sharing and reporting networks	Enable additional opportunities for development within the Radiology Diagnostic network SE2, and Community Diagnostic hubs development with the added potential to integrate with other networks (SASH, Frimley) and develop ways of working	Improved network working and service offering, meeting the immediate future service need

SPECIFIC RISKS & THEIR SOLUTIONS

Queen Victoria Hospital
NHS Foundation Trust

Risks

Risk that all network to QVH fails and can't access PACS.

Data Migration incomplete before go-Live

Insufficient user consultation regarding requirements.

Suppliers' deployment capability and capacity underestimated.

Trust's deployment capability and capacity underestimated.

Sectra PACS not available due to network.

Possible delay in go-live of June 2022.

&

Solutions

- Provisioned an onsite server to act as Business Continuity PACS .
- Minimum 2 years. Allowed for ready only access to Phillips PACS after Sectra go live.
- Ensure extensive consultation with users regarding their requirements.
- Possible mitigation by including penalty charge on Supplier contract.
- Robust project planning and management (evidenced by success of S&S procurement stage)
- Provisioned local server to serve as backup PACS.
- Provisioned

QVH COSTS SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

	Yr1 2021/22	Yr2 2022/23	Yr3 2023/24	Yr4 2024/25	Yr5 2025/26	Yr6 2026/27	Total
Capital	192,100	242,526	39,463	2,500	3,647	3,647	483,882
Revenue	49,999	173,011	131,359	128,540	125,930	123,639	732,478

IMPLEMENTATION TIMETABLE

Milestone	End Due Date
Contracts schedules agreed	27th July 2021
Trust Board Approval	5th August 2021
Contract signed by Trust	17th August 2021
PO raised	24th August 2021
Programme Kick off meetings, PID, new central PACS commissioned, Central Deployment. New PACS /VNA installation, Training, Testing, workflow sign off	August 2021 – March 2022
QVH Cutover with minimum 2 years of data	25th June 2022
QVH Full migration completed	1 July 2022
Project Closure	8th May 2023

Term	Definition	Explanation
PACS	Picture Archiving Communication System,	The function of PACS (Picture Archiving and Communication System) is to archive, store, distribute and display digital medical images, static or moving, and any associated media images. The system also provides facilities for image manipulation and comparison as well as access to radiological reports.
RIS	Radiology Information System	A Radiology Information System is a sophisticated database system that radiology medical professionals use to keep track of patient data and the enormous image files typically generated in the course of diagnosis and treatment. A RIS is a special kind of electronic health record or EHR system designed specifically for use in radiology.
OBS	Output Based specification	Output-based specifications define the client's functional requirements for the proposed product
BAFO	Best and Final Offer	A best and final offer in real estate is a prospective buyer's last and highest offer for a property.
VNA	Vendor Neutral Archive	is a medical imaging technology in which images and documents (and potentially any file of clinical relevance) are stored (archived) in a standard format with a standard interface, such that they can be accessed in a vendor-neutral manner by other systems.
OBC	Outline Business Case	Sets out the preliminary thoughts regarding a proposed project. It contain the information needed to help the institution make decisions regarding the adoption of the project.

KSO5 – Organisational Excellence

Risk Owner: Interim Director of Workforce & OD
Date: 20th July 2021

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
- Ongoing discussions about the future organisational form of QVH creates an uncertainty impacting on recruitment and retention of a workforce with the right skills and experience.
- The impact on recruitment and retention across the Trust leads to an increase in bank and agency costs and having longer term issues for the quality of patient care and staff engagement

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
- managers skill set in triangulating workforce skills mix against activity and financial planning
- We are the NHS: People Plan 20/21 to be supported by system People plan
- Staff survey results and SFFT staff engagement have shown improvement, and the 2020 outcome remained stable through COVID
- Overseas nurses having a positive impact, contract ongoing
- Workforce KPI's stable even through pandemic
- Availability and willingness of staff to undertake WLI activity
- Ongoing requirement for COVID-19 risk assessments for all vulnerable staff, with heightened risk to BAME workforce

Initial Risk 3(C)x 5(L)=15, moderate
Current Risk Rating 4(C)x 4(L)=16, high
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.
- Unknown longer term 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. Monitoring longer terms impact of second wave & vaccination programme
- Impact of potential merger on attraction and retention of workforce

Future Opportunities
- Closer partnership working with Sussex Health and Care Partnership - ICS.
- Capitalise on our work as a cancer hub as a place to work
- On going discussions with UHSussex

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
- monthly challenge to Business Units at Performance reviews reset by exception
- 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 activities business and usual and stability in some KPI's
- Overseas recruitment successful and will be reviewed as part of business planning, improving picture
- Work to finalise ESR hierarchy with ledger including monthly Workforce Establishment reconciliation
- Some positive gains from the 2020 NHS Staff survey results, but generally stable
- Stay Well Team, health and wellbeing initiative established to support staff through the pandemic
- Workforce Restoration and Recovery workstreams ongoing monitoring, mainly BAU

Gaps in controls / assurance
- Management competency and capacity in workforce planning including succession planning
- Continuing resources to support the development of staff – optimal use of apprenticeship levy budget

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	05 August 2021		**Agenda reference:**	**112-21**	
Report title:	**Workforce Report: July 2021 (June Data)**				
Sponsor:	Lawrence Anderson, Interim Director of Workforce & Organisational Development				
Authors:	• Gemma Farley, Employee Relations & Wellbeing Manager • Sarah Oliphant, Employee Services and e-Systems Manager • Annette Byers, Head of Organisational Development • Helen Moore, Medical Education Manager				
Appendices:	NA				
Executive summary					
Purpose of report:	The Workforce and OD Report for July 2021 (with June 2021 Data) is provided in the format consistent with the Trust Workforce Strategy and NHS Staff Survey Themes				
Summary of key issues	• Workforce KPIs continue to demonstrate workforce stability, • There has been slight slippage in turnover and a slight increase in sickness this month compared to last month. • Appraisal rates remain over 90%, 12 Month Rolling Stability remains over 85%				
Recommendation:	The Board are asked to **note** the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	KSO2:	KSO3:	**KSO4:**	**KSO5:**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	• KSO5. Trust reputation as a good employer and ensuring 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:	None				
Resources:	Managed by HR and OD with support from Finance, operations and nursing				
Assurance route					
Previously considered by:	Finance & Performance Committee				
	Date:	26/07/2021	Decision:	Noted	
Previously considered by:					
	Date:		Decision:		
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Workforce and Organisational Development Report

Lawrence Anderson, Interim Director of Workforce &OD

July 2021

www.qvh.nhs.uk

Contents

Queen Victoria Hospital NHS Foundation Trust

Headlines

Queen Victoria Hospital NHS Foundation Trust

Engagement & Communication:

- National WRES and WDES returns are prepared for review and submission
- Heads of Department signposted to updated policies
- Staff Friends and Family Test (SFFT) recommenced this month with 9 mandatory questions around staff engagement
- Regular communications sent to heads of department and all QVH staff on available development and apprenticeships

Attraction & Retention:

- Volume of adverts has increased by 30% in the last month with the highest volume in June in Operational Nursing with 17.6 WTE advertised
- 31 new starters in June compared to 27 in May; on average from conditional offer to start date this has taken 70 days and takes into account notice periods, without notice periods the average time taken was 47 days for external starters and 27 for internal.
- Overall average time taken from when an advert has opened to a new starter is in post has taken 116 days.
- Work towards Disability Confident Leader employer status.

Health & Wellbeing:

- Mental Health First Aider training programmes offered to staff virtually (Rethink) and face to face (St John Ambulance) – 36 applicants
- Launch of the Health and Wellbeing annual calendar displayed as Trust wide screen savers – June's focus was community including promotion of our family related policies, flexible working and flexible retirement policies and carers week

Learning & Education:

- Overall Stat & Mand compliance is **90.86%** across QVH – increased by 0.02% from last month 90.84% (includes non perm and perm staff)
- Appraisals compliance is **83.72%** across QVH – decreased by 1.51% from last month 85.23%. 38 GMC and GDC registrants have Covid PDR exemptions.
- This month the Corporate Induction policy has been ratified for another 3 years.
- In Medical Education face to face teaching is restarting, and August induction will welcome over 20 new doctors to the Trust.

Talent & Leadership

- Admin &Clerical programme is half way through and early attendance, withdrawn and DNAs are now available (see page 11)
- QVH staff offered a range of development opportunities including Mary Seacole, NHS Elect, Espresso Sessions, Coaching, etc.
- SHCP Leadership, OD & Talent group finishing development initiatives for the summer and will be restarting activity in the Autumn
- Advertising and interviewing for various apprenticeships including nursing, ODP, sleep and management

Workforce KPI Summary

Queen Victoria Hospital
NHS Foundation Trust

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2020/21 & 2021/22			Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Compared to Previous Month
Establishment WTE *Note 1				1028.14	1028.14	1028.14	1030.33	1030.18	1036.20	1037.20	1035.09	1042.49	1042.49	1031.34	1031.34	**1032.34**	▲
Staff In Post WTE				921.43	922.58	920.90	922.67	923.09	933.53	928.06	927.02	932.50	934.23	931.78	930.44	**930.22**	▼
Vacancies WTE				106.71	105.56	107.24	107.66	107.09	102.67	109.14	108.07	109.99	108.26	99.58	100.90	**102.12**	▲
Vacancies %	>12%	8%<>12%	<8%	10.38%	10.27%	10.43%	10.45%	10.40%	9.91%	10.52%	10.44%	10.55%	10.38%	9.65%	9.78%	**9.89%**	▲
Agency WTE				5.13	5.70	6.82	11.12	10.10	11.95	10.80	10.83	9.78	10.55	7.46	11.06	**12.11**	▲
Bank WTE *Note 2				33.72	47.47	59.00	57.61	64.72	66.60	65.44	76.20	66.31	87.81	64.81	64.22	**72.64**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	12.05%	11.74%	11.22%	10.65%	10.05%	10.49%	10.60%	10.63%	10.25%	10.76%	11.55%	10.94%	**12.20%**	▲
Monthly Turnover				0.68%	0.75%	1.05%	0.70%	0.70%	0.84%	0.99%	1.66%	0.20%	1.45%	1.34%	0.33%	**2.03%**	▲
12 Month Rolling Stability % *Note 3	<70%	70%<>85%	>=85%	86.39%	86.25%	87.08%	89.12%	89.44%	89.11%	89.07%	88.87%	89.06%	88.91%	88.37%	87.84%	**87.11%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	2.01%	2.77%	2.68%	2.88%	2.99%	3.26%	3.20%	3.48%	2.50%	2.75%	2.49%	**3.04%**	*TBC*	▲
% staff appraisal compliant (Permanent & Fixed Term staff) *Note 4	<80%	80%<>95%	>=95%	78.61%	78.27%	80.86%	80.58%	80.00%	80.60%	84.03%	82.03%	83.69%	86.32%	86.50%	85.23%	**83.72%**	▼
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 5	<80%	80%<>90%	>=90%	92.18%	91.88%	92.58%	90.80%	90.82%	91.02%	91.92%	92.30%	91.47%	91.65%	92.57%	92.34%	**92.35%**	▲

				Compared to Previous Month
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%	**2019-20 National Survey Of 572 responses: 92% : 2%**	**2020-21 National Survey Of 594 responses: 94% : 2%**	19-20 & 20-21 ▲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%	**2019-20 National Survey Of 560 responses: 72% : 10%**	**2020-21 National Survey Of 593 responses: 71% : 11%**	19-20 & 19-21 ▲Responses ▼ Likely ▲Unlikely

*Note 1 -2020/21 establishment updated in September backdated to April 20. From Finance Ledger
*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 - % Staff Appraisal August 20 to date has been adjusted for GMC medics who are exempt from appraisals due to Covid-19.

GOAL 1: Engagement & Communication

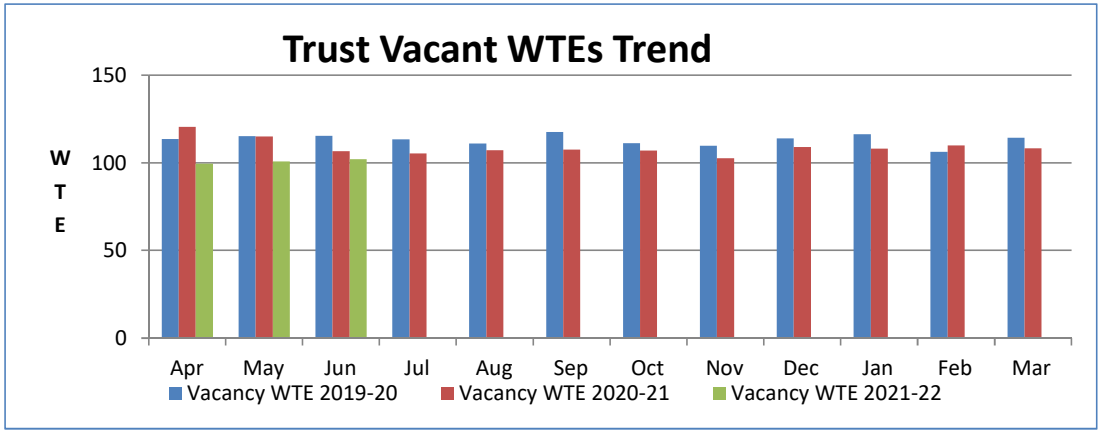
Queen Victoria Hospital
NHS Foundation Trust

- Equality & Diversity WRES, WDES reports have been submitted to F&P on 26 July for review prior to national submission deadline.
- Staff Survey provider to be procured this month for a further year.
- SFFT was relaunched earlier this month with 9 mandatory questions on staff engagement. Q2 results will be available for next workforce report.
- Heads of Department signposted to new and updated policies; Flexible Working & Agile Working Policy (March 2021), Flexible Retirement Policy (June 2021) – this replaces the Flexible Retirement Guidance, Employment Break Scheme Policy (February 2021), Policy for the management of Acting-Up and Secondment (February 2021), Investigation Policy (March 2021), Relocation Policy (June 2021) and Payment of Salary and Wages Policy (June 2021)

GOAL 2: Attraction & Retention

Vacancies

Queen Victoria Hospital NHS Foundation Trust



	Non Medical		Medical	
	Posts advertised this month	Recruits in Pipeline	Posts advertised this month	Recruits in Pipeline
Corporate	10.8	12.6	NA	NA
Eyes	3	1	1	4.83
Sleep	2.8	0	0.5	0
Plastics	2	1	9	9
Oral	2.2	1.2	1	1.38
Periop	6	2	0	7.6
Clinical Support	6.4	5.4	0.6	2
Outpatients	1	0	NA	NA
Director of Nursing	2.4	5.8	NA	NA
Operational Nursing	23.92	4.45	NA	NA
Community Services	0	0	0	0
QVH Trust Total	**60.52**	**33.45**	**12.1**	**24.81**

VACANCY PERCENTAGES	Apr-21	May-21	Jun-21	Compared to Previous Month
Corporate	10.93%	9.95%	7.88%	▼
Eyes	7.70%	9.22%	15.69%	▲
Sleep	14.10%	14.10%	14.10%	◄►
Plastics	3.80%	4.19%	4.61%	▲
Oral	-0.18%	1.16%	2.60%	▲
Periop	12.21%	12.58%	12.73%	▲
Clinical Support	14.87%	16.02%	15.14%	▼
Outpatients	29.98%	29.74%	29.51%	▼
Director of Nursing	7.28%	7.28%	7.28%	◄►
Operational Nursing	4.85%	4.65%	5.90%	▲
Community Services	33.64%	32.33%	32.33%	◄►
QVH Trust Total	9.65%	9.78%	9.89%	▲

COMMENTARY

- Slight increase in Vacancy rate from June of 0.11% with highest in Community Services which remains the same as last month.
- Volumes increasing across the trust with the number of WTE advertised in June at 60.52; Operational Nursing having the highest at 23.92
- 33.45 WTE being processed through recruitment compared to 27 in May

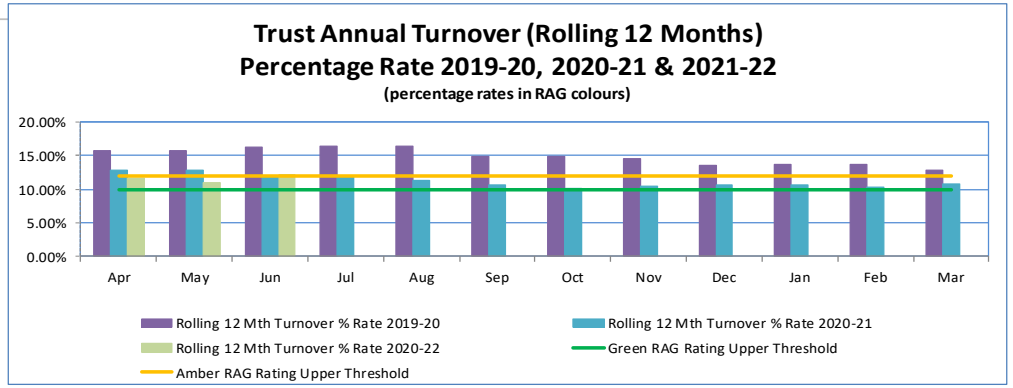
FORWARD LOOK / POTENTIAL RISKS

- Areas where there are high vacancy rates need to actively recruit to avoid high bank and agency spend over the next month.
- Do we need to consider another International Recruitment campaign to cover more nursing areas and look at how to retain these staff.
- Potential staff burn out with covering shifts due to vacancies by doing additional bank work.
- Plan recruitment with rolling adverts for high attrition areas and build a “talent pool” for future vacancies.
- Can we build our bank staff overall and offer bank to permanent fast track onboarding for current bank staff

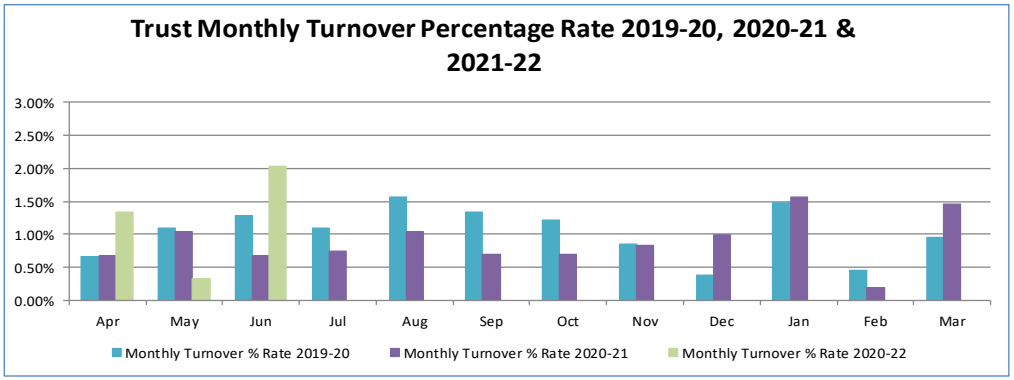
Turnover, New Hires and Leavers

Queen Victoria Hospital
NHS Foundation Trust

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Apr-21	May-21	Jun-21	Compared to Previous Month
Corporate %	11.64%	11.45%	11.66%	▲
Eyes %	31.89%	33.94%	33.52%	▼
Sleep %	16.49%	16.83%	16.44%	▼
Plastics %	6.43%	6.35%	8.94%	▲
Oral %	12.75%	11.17%	11.69%	▲
Peri Op %	11.83%	10.46%	12.77%	▲
Clinical Support %	11.24%	9.74%	10.08%	▲
Outpatients %	23.99%	23.95%	21.45%	▼
Director of Nursing %	5.11%	3.65%	3.60%	▼
Operational Nursing %	6.88%	7.34%	10.38%	▲
Community Services %	25.41%	23.96%	23.51%	▼
QVH Trust Total %	11.55%	10.94%	12.20%	▲



MONTHLY TURNOVER excl. Trainee Doctors	Apr-21	May-21	Jun-21	Compared to Previous Month
Corporate %	1.84%	0.00%	1.90%	▲
Eyes %	3.24%	1.73%	6.62%	▲
Sleep %	3.20%	0.00%	0.00%	◄►
Plastics %	2.70%	0.00%	2.67%	▲
Oral %	1.61%	0.00%	1.63%	▲
Peri Op %	0.65%	0.56%	2.30%	▲
Clinical Support %	0.00%	1.56%	0.45%	▼
Outpatients %	0.00%	0.00%	0.00%	◄►
Director of Nursing %	0.00%	0.00%	0.00%	◄►
Operational Nursing %	1.49%	0.00%	2.97%	▲
Community Services %	0.00%	0.00%	0.00%	◄►
QVH Trust Total %	1.34%	0.33%	2.03%	▲



COMMENTARY

- Turnover has increased in June with the highest in Eyes however this is being actively recruited to.
- The trust annual turnover remains high but remains close to 20/21 and is greatly improved from 19/20.

FORWARD LOOK / POTENTIAL RISKS

- Work being carried out to look at refreshing the current process for leavers conversations to then look at any trends.to enable change and improve retention.

Temporary Workforce

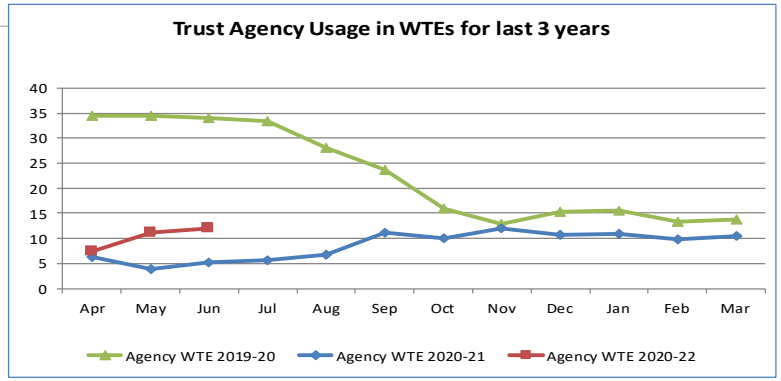
Queen Victoria Hospital NHS Foundation Trust

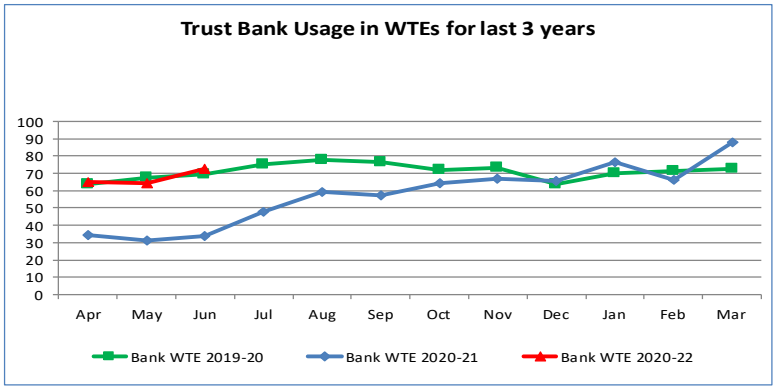
Agency				
BUSINESS UNIT (WTE)	Apr-21	May-21	Jun-21	Compared to Previous Month
Corporate	0.92	1.56	1.84	▲
Eyes	0.00	0.00	0.00	◄►
Sleep	0.00	0.00	0.23	▲
Plastics	0.00	0.00	0.00	◄►
Oral	0.00	0.00	0.00	◄►
Periop	2.34	3.31	3.95	▲
Clinical Support	2.08	2.81	1.31	▼
Outpatients	0.00	0.00	0.00	◄►
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	2.12	3.38	4.77	▲
Community Services	0.00	0.00	0.00	◄►
QVH Trust Total	7.46	11.06	12.11	▲

Bank				
BUSINESS UNIT (WTE)	Apr-21	May-21	Jun-21	Compared to Previous Month
Corporate	10.94	10.45	11.00	▲
Eyes	1.48	1.55	1.44	▼
Sleep	3.17	2.84	2.98	▲
Plastics	2.43	1.95	2.23	▲
Oral	2.61	2.84	3.50	▲
Periop	15.97	16.81	17.26	▲
Clinical Support	7.45	6.84	7.75	▲
Outpatients	2.14	1.54	1.60	▲
Director of Nursing	1.71	1.83	2.93	▲
Operational Nursing	15.59	16.36	20.40	▲
Community Services	1.32	1.19	1.57	▲
QVH Trust Total	64.81	64.22	72.64	▲

Agency				
STAFF GROUP (WTE)	Apr-21	May-21	Jun-21	Compared to Previous Month
Qualified Nursing	4.11	5.91	7.66	▲
HCAs	0.35	0.78	1.06	▲
Medical and Dental	0.98	0.98	1.27	▲
Other AHP's & ST&T	1.10	1.83	0.28	▼
Non-Clinical	0.92	1.56	1.84	▲
QVH Trust Total	7.46	11.06	12.11	▲

Bank				
STAFF GROUP (WTE)	Apr-21	May-21	Jun-21	Compared to Previous Month
Qualified Nursing	21.84	22.71	26.06	▲
HCAs	6.81	7.47	8.36	▲
Medical and Dental	4.83	5.24	5.72	▲
Other AHP's & ST&T	3.69	2.82	3.43	▲
Non-Clinical	27.64	25.99	29.07	▲
QVH Trust Total	64.81	64.22	72.64	▲





COMMENTARY

- Areas where high vacancy rates there has been an increase in bank and agency usage – Periop with 3.95 Agency and 17.26 bank shifts worked.
- Qualified Nursing has the highest agency usage with non-clinical having the highest bank.
- Bank Usage is consistent with 19-20 levels however Agency usage is much lower that 19-20 levels currently

FORWARD LOOK / POTENTIAL RISKS

- Establishments need to be agreed and corrected on all systems to allow for safe staff fulfilment and identify true vacancies to be recruited to.
- Look at tighter control over reason for bank requests within non clinical to ensure policy adherence ie: not to be used for annual leave
- Actively working on whether areas identified on the corporate risk register should attract an enhanced bank rate

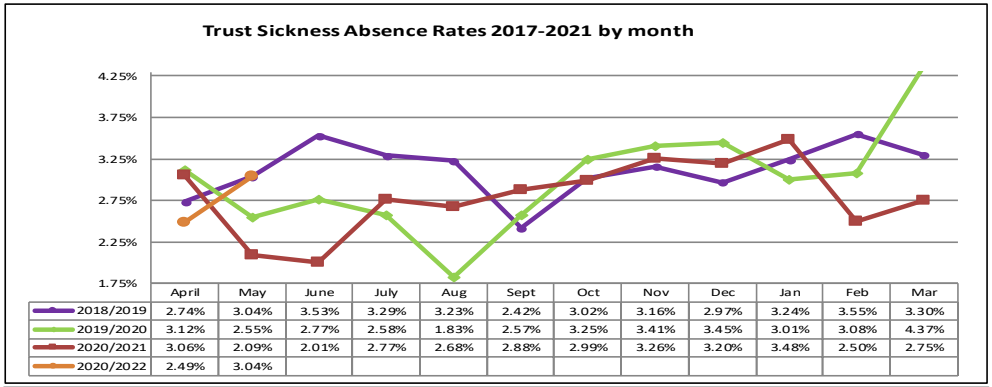
GOAL 3: Health and Well-being

Queen Victoria Hospital
NHS Foundation Trust

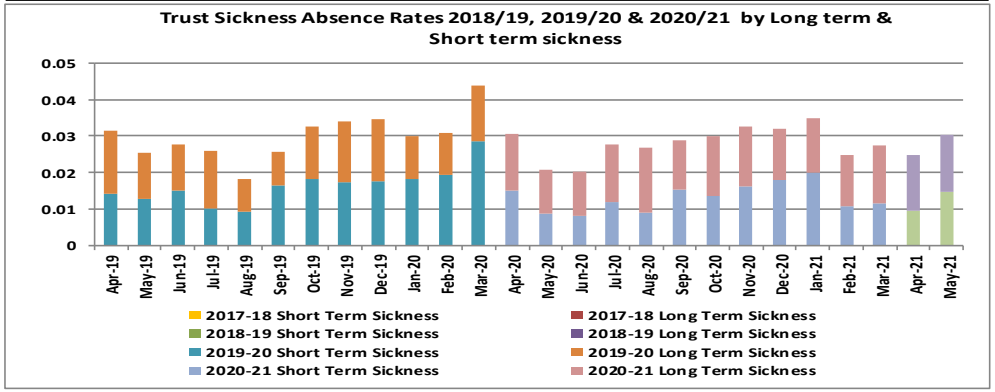
SHORT TERM SICKNESS	Mar-21	Apr-21	May-21	Compared to Previous Month
Corporate	0.56%	1.21%	1.10%	▼
Clinical Support	1.41%	1.01%	0.43%	▼
Plastics	0.72%	1.23%	0.56%	▼
Eyes	0.00%	0.78%	2.03%	▲
Sleep	1.46%	1.21%	3.98%	▲
Oral	0.69%	0.21%	0.21%	◄►
Periop	1.58%	0.56%	2.04%	▲
Outpatients	1.40%	0.98%	0.88%	▼
Director of Nursing	1.30%	0.15%	0.26%	▲
Operational Nursing	1.87%	1.49%	2.47%	▲
Community Services	0.13%	0.53%	0.53%	◄►
QVH Trust Total	1.14%	1.53%	1.47%	▼

LONG TERM SICKNESS	Mar-21	Apr-21	May-21	Compared to Previous Month
Corporate	2.52%	2.02%	1.41%	▼
Clinical Support	1.90%	1.88%	1.40%	▼
Plastics	0.71%	0.71%	0.16%	▼
Eyes	0.00%	0.00%	0.00%	◄►
Sleep	11.12%	7.65%	6.30%	▼
Oral	1.93%	2.08%	2.10%	▲
Periop	1.04%	0.69%	1.16%	▲
Outpatients	0.00%	0.00%	4.87%	▲
Director of Nursing	0.00%	0.00%	0.00%	◄►
Operational Nursing	1.48%	1.79%	2.36%	▲
Community Services	0.00%	0.00%	0.00%	◄►
QVH Trust Total	1.61%	0.96%	1.57%	▲

ALL SICKNESS (with RAG)	Mar-21	Apr-21	May-21	Compared to Previous Month
QVH Trust Total	2.75%	2.49%	3.04%	▲



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2018/2019	2.74%	3.04%	3.53%	3.29%	3.23%	2.42%	3.02%	3.16%	2.97%	3.24%	3.55%	3.30%
2019/2020	3.12%	2.55%	2.77%	2.58%	1.83%	2.57%	3.25%	3.41%	3.45%	3.01%	3.08%	4.37%
2020/2021	3.06%	2.09%	2.01%	2.77%	2.68%	2.88%	2.99%	3.26%	3.20%	3.48%	2.50%	2.75%
2020/2022	2.49%	3.04%										



COMMENTARY

- The Trust's total absence in May 2021 has increased to 3.04%
- The rise of total sickness in May 20 is against the usual trend that would normally be seen in this month.
- There is a significant increase in short term sickness across the Trust in May 21

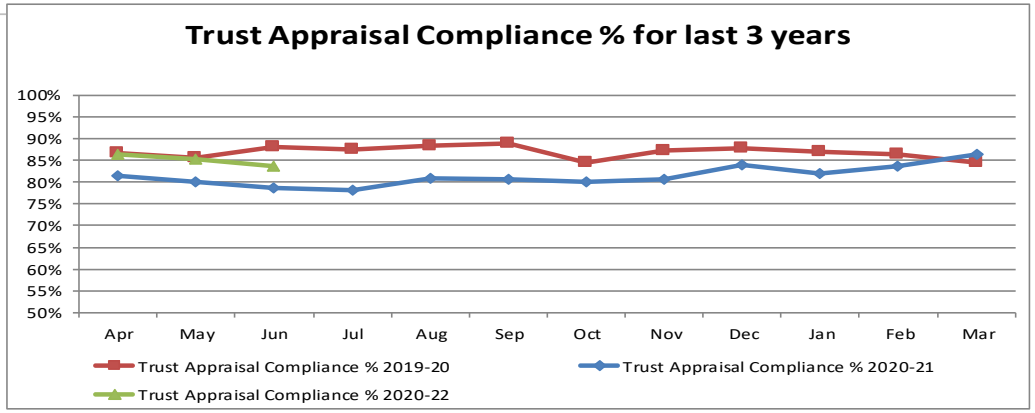
FORWARD LOOK / POTENTIAL RISKS

- With national restrictions being lifted it is anticipated that there will be an increase in staff being required to self-isolate – how will a potential increase in sickness be covered to ensure safe staffing levels

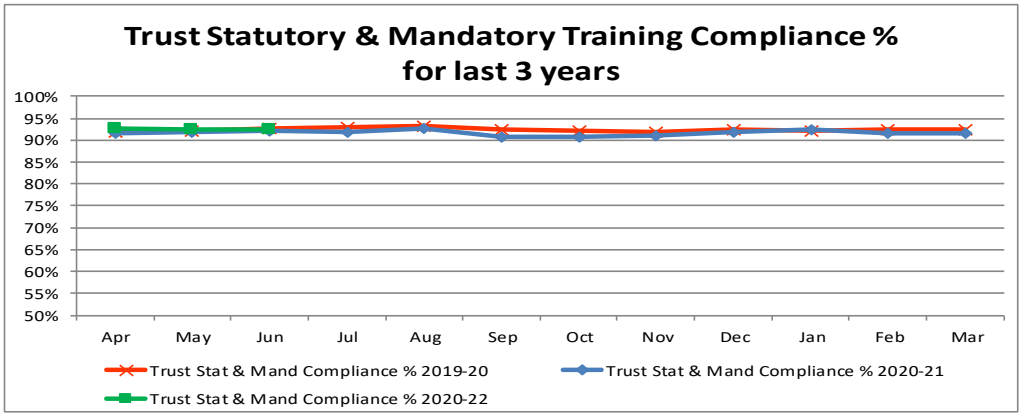
GOAL 4: Learning and Education

Queen Victoria Hospital
NHS Foundation Trust

APPRAISALS	Apr-21	May-21	Jun-21	Compared to Previous Month
Corporate	81.03%	79.59%	79.19%	▼
Eyes	62.07%	67.86%	65.52%	▼
Sleep	93.55%	83.87%	80.65%	▼
Plastics	74.29%	79.01%	75.90%	▼
Oral	74.68%	79.76%	82.56%	▲
Peri Op	74.68%	84.85%	84.05%	▼
Clinical Support	96.49%	96.36%	90.91%	▼
Outpatients	92.00%	92.00%	88.00%	▼
Director of Nursing	94.12%	88.46%	92.31%	▲
Operational Nursing	93.49%	90.78%	87.74%	▼
Community Services	84.62%	76.92%	84.62%	▲
QVH Trust Total	86.50%	85.23%	83.72%	▼



MANDATORY AND STATUTORY TRAINING	Apr-21	May-21	Jun-21	Compared to Previous Month
Corporate	92.77%	93.31%	93.58%	▲
Eyes	92.69%	94.32%	94.26%	▼
Sleep	87.26%	88.64%	90.30%	▲
Plastics	80.48%	80.81%	80.18%	▼
Oral	92.33%	92.43%	92.16%	▼
Peri Op	93.82%	91.83%	91.83%	◄►
Clinical Support	95.67%	96.43%	96.60%	▲
Outpatients	97.63%	96.68%	95.73%	▼
Director of Nursing	95.49%	94.93%	95.10%	▲
Operational Nursing	94.15%	94.20%	94.21%	▲
Community Services	92.95%	94.87%	91.67%	▼
QVH Trust Total	92.57%	92.34%	92.35%	▲



GOAL 5: Talent & Leadership

Including OD&L and Medical Education activity

Queen Victoria Hospital NHS Foundation Trust

Apprenticeships:
This month we have procured for training providers for various apprenticeships. Advertised for L3/L5 management, L6 ODP and L6 HC science sleep at QVH.

A&C Programme:

8 courses delivered to date:

Course	Places		
	Completed	DNA	Withdrawn
276 AC Conversations On Career Development	11		3
276 AC Developing Yourself	18	2	1
276 AC Interview Skills	13	2	2
276 AC Managing Change	6	1	2
276 AC Minute taking at QVH	11	1	2
276 AC Personal Resilience	6	2	1
276 AC Stepping into Management	15	2	3
276 AC Working with self and others	5		2
No of attendees:	**85**	**10**	**16**

10 courses still to be delivered:

Course	Places
	Confirmed
276 AC A Basic Introduction to Project Management	17
276 AC Developing Yourself	2
276 AC Getting the most out of your Appraisal x 2	7
276 AC Interview Skills	3
276 AC Personal Resilience	1
276 AC Stepping into Management	6
276 AC Working in Teams x 2	10
276 AC Working with self and others	2
No of attendees:	**48**

Leadership, OD and Talent SHCP group:

Programme	QVH Accepted	Withdrawn
Foundation Coaching	15	1
ILM 3	1	
OD Practitioners	2	
Roffey Park	6	
Rosalind Franklin	4	4
Stepping Up	2	

- 2021/22 data on staff numbers at QVH that have engaged with the SHCP work/activities
- Co-delivered the Foundation in Coaching programme
- Foundation in Coaching programmes are finishing for the summer and will start again in Autumn 2021
- Staff at QVH can apply for this programme and it will be advertised in due course.

Other activities:
- Bespoke team development session currently being developed for Operations, other areas under consideration.

GOAL 5: Talent & Leadership

Including OD&L and Medical Education activity

Medical Education activity

Face to face teaching is completely returning to the Trust, with QVH hosting a regional training day for core surgery in July, and joint full length teaching days restarting for OMFS and Orthodontics.

The plans for August junior doctors' induction are in place, with over 20 new starters across all specialties. Timetables are also being drawn up for the September and October doctors' inductions.

The intention is to re-open the newly refurbished relaxation area in the Surgeons' Mess in time for August induction.

A new HEE County Dean for Sussex is now in post; Fiona O'Sullivan has taken over from Chris Carey as the Trust's point of contact with HEE. The Director of Medical Education and Medical Education Manager have met with her to brief her on QVH so that she can be fully engaged with the trainees at the Trust.

Plans are being developed to make full use of the additional funding received from HEE relating to PGME Training Recovery, with some clear guidelines on how the funding can be used.

The HEE-funded Dental Skills Lab has hosted its first CPD day for dental staff and the aim is to start running regular sessions, as well as the dental foundation training which will start in September.

Invitations have been sent out for the doctors' mandatory training update webinars on 27 September; these webinars are run twice yearly to maintain the compliance rate for all substantive and fixed term medical and dental staff.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 August 2021**		**Agenda reference:**	113-21	
Report title:	Annual review of SFIs, SOs and Scheme of Delegation				
Sponsor:	Michelle Miles, Director of Finance and Performance				
Authors:	• Clare Pirie, Director of communications and corporate affairs (SOs) • Louise Elliott, Head of Procurement (SFIs/Reservation of powers/scheme of delegation)				
Appendices:	1. Reservation of Powers/Scheme of Delegation 2. Standing Financial Instructions 3. Standing orders				
Executive summary					
Purpose of report:	The purpose of this report is for the Board to undertake an annual review of the corporate governance documentation comprising Standing orders, Standing Financial Instructions and Reservation of Powers/Scheme of Delegation				
Summary of key issues	Recommendation of changes to Reservation of Powers & Scheme of Delegation and Standing financial instructions.				
Recommendation:	To approve the recommendations as set out in the report				
Action required *[highlight **one** only]*	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:	Procurement regulation				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Audit Committee				
	Date:	June 2021	Decision:	Amendments recommended for approval by Board.	
Next steps:	If changes are approved, these will take immediate effect and be published to the Trust's website and intranet.				

Report to:	Board Directors
Agenda item:	113-21
Date of meeting:	5 August 2021
Report from:	Michelle Miles, Director of finance
Report authors:	Clare Pirie, Director of communications/corporate affairs Louise Elliott , Head of Procurement
Date of report:	27 July 2021
Appendices:	SOs, SFIs, RoP/SoD

Annual review of SFIs, SOs and Scheme of Delegation

Background

- 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.

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

- 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 16 June, all those present, including members of the Board reviewed and agreed the proposed changes, which are set out as follows:

a) Reservation of Powers & Scheme of Delegation

Section 7 Financial limit delegation

Reference 3: Quotations, tenders and selection of suppliers

- Change from OJEU to World Trade Organisation's Government Procurement Agreement: The WTO GPA threshold refers to the World Trade Organisation's Government Procurement Agreement threshold for a procurement exercise to include publication in the Find a Tender Service.(FTS) As these thresholds regularly change and the Public Procurement Regulations are periodically updated, all Officers must consult the Procurement department for guidance.

Reference 4 Committing Expenditure

- 4.7 – Expenditure from QVH Charitable Funds
  Up to £2,000

Current narrative states:
Two from relevant department, Director of Finance, Deputy Director of Finance
Revised narrative states:
Director of Finance following authorisation processes set out in policy

b) Standing Financial Instructions

9.2 Directives and guidance

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

9.2.1 Following Brexit the UK procurement thresholds are governed by the World Trade Organisation's (WTO) Government Procurement Agreement.

c) Standing orders

No changes recommended in 2021

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

Reservation of powers and scheme of delegation

Effective from 7 January 2021

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; 3.1.1.3 seek relevant information from within the Trust and from all Officers;	SFIs 3.2, SO 5.6

		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. 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;	SFI 10.1, SO 5.6

		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. 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.

Reservation of powers and scheme of delegation
Approved by the Board of Directors at its meeting January 2021

	Board member	Duties delegated
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 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.
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.

SO ref	Delegated to	Duties delegated
4.11	Chair	Give final ruling to permit late requests for items to be included on the agenda for meetings of the Board of Directors.
4.13	Secretary	Include any petition received by the Trust on the agenda for the next meeting of the Board of Directors.
4.25	Chair	Chair all meetings of the Board of Directors.
4.28	Chair	Give final ruling in questions of order, relevancy and regularity of meetings.
4.33	Chair	Have a second or casting vote.
4.39	Board of directors	Suspension of SOs.
4.43	Board of directors	Variation or amendment of SOs.
4.45	Secretary	Prepare minutes of the proceedings of the meetings of the Board of Directors and submit minutes for agreement at the next meeting of the Board of Directors.
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.

Reservation of powers and scheme of delegation
Approved by the Board of Directors at its meeting January 2021

SO ref	Delegated to	Duties delegated
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.
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.

Reservation of powers and scheme of delegation
Approved by the Board of Directors at its meeting January 2021

SO ref	Delegated to	Duties delegated
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.
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.

Reservation of powers and scheme of delegation
Approved by the Board of Directors at its meeting January 2021

SFI ref	Delegated to	Duties delegated
2.4.4	Chief executive	To ensure all existing officers and new appointees are notified of their responsibilities within the SFIs.
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: • 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;

SFI ref	Delegated to	Duties delegated
		• Reviewing schedules of losses and compensations and making recommendations to the board of directors; • Reviewing the information prepared to support the annual governance declaration statement.
3.2.3	Chair of the audit 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; • 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.

SFI ref	Delegated to	Duties delegated
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.
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.

SFI ref	Delegated to	Duties delegated
		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. This includes, but is not exclusive to, travel claims, subsistence claims, additional sessions, timesheets and any other payment claimed by a member of staff over and above basic salary/wage.
3.8.1	Secretary	Ensure that all officers are made aware of the trust's standards of business conduct and additional rules in respect of preventing corruption and complying with the bribery act 2010.
3.8.2	All	To notify the secretary of any gift, hospitality or sponsorship accepted (or refused) by any officer on behalf of the trust.
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.

SFI ref	Delegated to	Duties delegated
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.
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.

Reservation of powers and scheme of delegation
Approved by the Board of Directors at its meeting January 2021

SFI ref	Delegated to	Duties delegated
6.1	Board of Directors	Approve banking arrangements.
7 Financial systems and transaction processing		
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.

Reservation of powers and scheme of delegation
Approved by the Board of Directors at its meeting January 2021

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.
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.

SFI ref	Delegated to	Duties delegated
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.
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.

SFI ref	Delegated to	Duties delegated
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.
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.

SFI ref	Delegated to	Duties delegated
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. • 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.

SFI ref	Delegated to	Duties delegated
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.
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.
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.

SFI ref	Delegated to	Duties delegated
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.
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.

SFI ref	Delegated to	Duties delegated
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 Between Business Units/Directorates All other virements (e.g. Between revenue and capital)	 Level 2 Officers responsible for cost centres Responsible Directors Responsible Directors AND 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 £200,001 to £1,000,000 Over £1,000,000	 Executive Management Team Hospital Management Team Board of Directors

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~~ WTO GPA Threshold (contact procurement department for current value) Over ~~OJEU~~ WTO GPA threshold (see note below – threshold is different for works and non-works)	**Minimum requirements** 1 Written quote (Authorised by Budget Manager) 3 Written quotes (Authorised by Budget Manager) Competitive Tender Exercise (Level 2 Manager AND Director of Finance) Public Procurement~~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~~ WTO GPA threshold refers to the World Trade Organisation's Government Procurement Agreement ~~EU Directive~~ threshold for a procurement exercise to include publication in the Find a Tender Service.(FTS)~~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 for items where estimates expenditure is less than £25,000 but greater than £5,000 (less than £5,000 requires only 1 quote) Waiving of tender and quotation procedures for items where estimated expenditure is greater than £25,000 not expected to exceed ~~EU~~ WTO GPA procurement thresholds.	Director of Finance, (when Director of Finance is unavailable, Chief Executive), or Chief Executive (when Director of Finance has commissioned the item) 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) Where annual charge does not exceed £10,000 and term does not exceed five years Where annual charge exceeds £10,000 or term exceeds 5 years Signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases	 Associate Director of Estates Associate Director of Estates Director of Finance Associate Director of Estates & Director of Finance
4.5	**Condemning and disposal** Items obsolete, obsolescent, redundant, irreparable or unable to be repaired cost effectively Up to £5,000 (carrying value) Over £5,000 (carrying value) Transfer or sale of assets to another organisation	 Responsible Director Director of Finance (may be delegated in specific cases in writing, but no lower than to a level 2 manager) Director of Finance 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 QVH charitable funds** Up to £2,000 Up to £20,000 Over £20,000	 Director of Finance *following authorisation processes set out in* policy QVH Charity Committee Corporate Trustee

	Expenditure from NHS Charities Together stage 2 funds through Sussex programme board Up to £20,000 Over £20,000	Director of Communications and Corporate Affairs 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 properties.	Associate Director of Estates

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

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

Approved by the Board of Directors 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

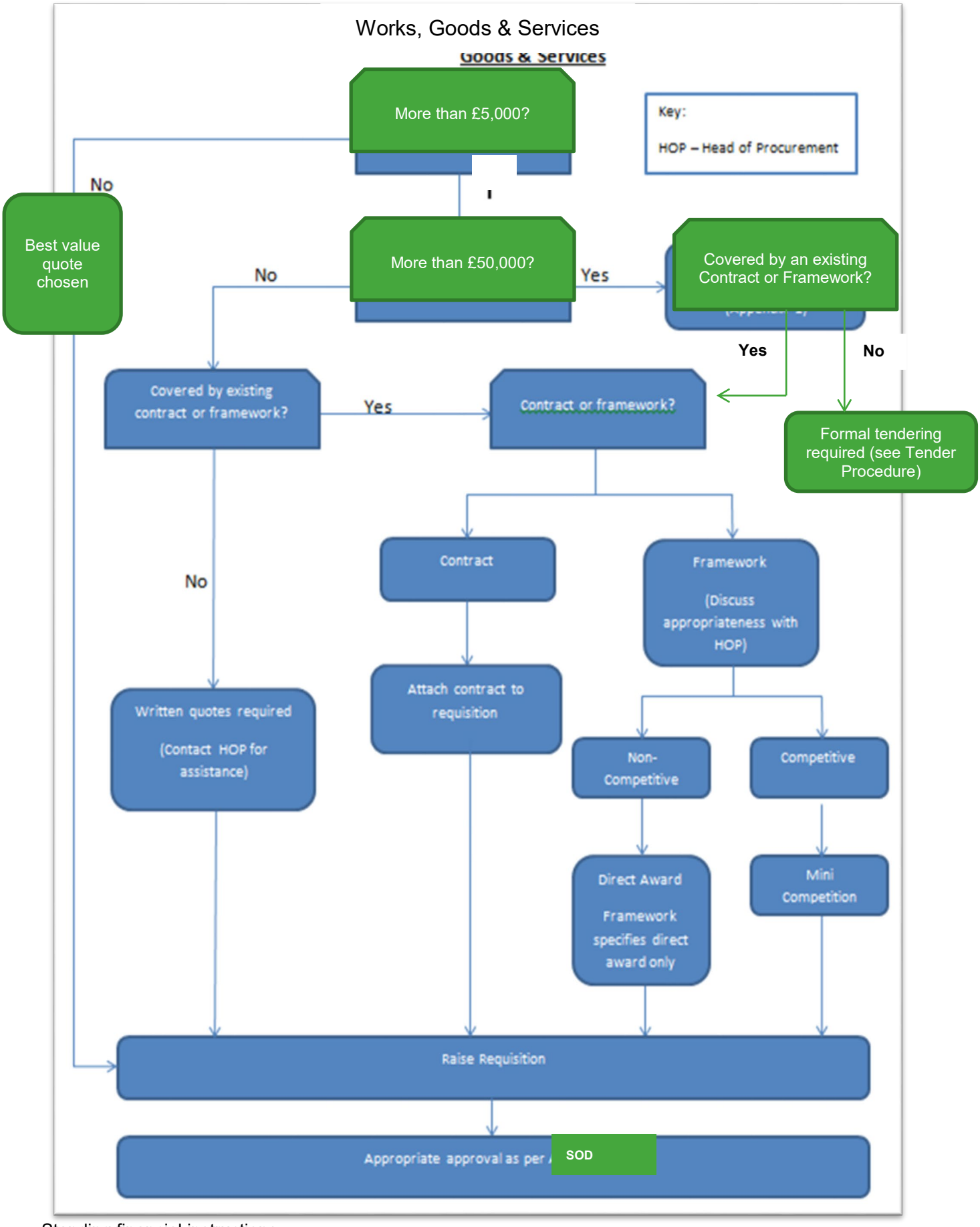
(d) items arising from works of construction, demolition or site clearance, which should be deal with in accordance with the relevant contract.

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

Standing orders for the Board of Directors

Approved 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:	05/08/2021		**Agenda reference:**	**114-21**	
Report title:	**Motion to rescind changes to Governor Steering Group ToRs**				
Sponsor:	Beryl Hobson, Trust Chair				
Author:	Clare Pirie, Director of communications and corporate affairs				
Appendices:	GSG Terms of Reference 2021				
Executive summary					
Purpose of report:	The Board is asked to consider a motion approved by Council in May 2021 which would result in a change in the Constitution.				
Summary of key issues	At its meeting in May, the Council of Governors (CoG) put forward a motion to rescind changes made to the GSG terms of reference in January 2021. As the wording around the GSG terms of reference is incorporated into the Trust Constitution, any such change proposed by CoG needs Board consideration and approval.				
Recommendation:	The Board is asked to agree that the GSG terms of reference should remain in place and be reviewed by the governor steering group in December 2021 with the new members of GSG in role.				
Action required *[highlight **one** only]*	**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:	Council of governors				
	Date	10 May 2021	Decision:	approved	
Next steps:	If the Board supports the recommendation of this report, no change will be made to the current Terms of Reference.				

Report to:	**Board of Directors**
Meeting date:	05 August 2021
Agenda item:	114-21
Report from:	Beryl Hobson, Chair
Author:	Clare Pirie, Director of communications and CA
Date of report:	20 July 2021

Motion to rescind changes to Governor Steering Group ToRs

In December 2020 the governor steering group (GSG) carried out the annual review of terms of reference and approved amendments to reflect what the group actually does and add clarity around who has voting rights. The changes are shown at appendix A.

In January 2021 council of governors the changes were approved by the full council of governors, and a further annual review date set for December 2021.

In January 2021 the Board approved changes to the Constitution reflecting the revised GSG terms of reference as approved by the council of governors.

In May 2021 a governor who joined the Trust after the January 2021 meeting presented a motion to council of governors to rescind approval of the GSG terms of reference giving the rationale that the change of wording removed an avenue of communication between the Board and Council; the revised version had removed wording relating to GSG providing advice to the CEO, Chair and CoSec team and reference to 'engaging governors in adding value to the Trust'. The governor suggested that the view of the current GSG may not be that of new governors who would be shortly standing for the governor representative roles. The motion to rescind the changes approved by council of governors in January was carried by a majority vote.

The wording around the GSG terms of reference is incorporated into the Trust Constitution so the changes proposed by council of governors need Board consideration.

The amendments approved in January 2021 reflect the work done by the governor steering group and the role of governors in holding NEDs to account (not advising executives). Moving back to an earlier, less relevant and accurate wording is not recommended.

Recommendation: the governor steering group terms of reference should remain in place and be reviewed by the governor steering group in December 2021 with the new members of GSG in role.

Terms of reference
Name of governance body
Governor Steering Group (GSG)
Constitution
The Governor Steering Group ("the group") is a standing and permanent committee of the Council of Governors established in accordance with paragraph 25 of the Trust's constitution.
Accountability
The group is accountable to the Council of Governors for its performance and effectiveness in accordance with these terms of reference.
Authority
The group is authorised by the Council of Governors to form working groups to facilitate the work of the group, and to support any recommendations they may make to the Council of Governors.
Purpose
The purpose of the group is to: • Support and facilitate the work of the Council of Governors ~~and make recommendations to it on any aspects of its work~~ through forward planning and helping to set agendas for council meetings • ~~Facilitate communication between the Council of Governors and the Board of Directors~~ • ~~Provide advice and support to the Trust Chair, Chief Executive and the company secretarial team~~ • Initiate appropriate reviews and reports on matters within the remit of the Council of Governors • ~~Actively engage governors in adding value to the Trust.~~ •
Responsibilities and duties

Responsibilities
On behalf of the Council of Governors, the group shall be responsible for:
• Supporting the work of the Council of Governors in order that it might better fulfil its statutory duties, particularly:
  ◦ Holding the Trust's Non-Executive Directors to account for the performance of the Board of Directors
  ◦ Representing the interests of members and the public
• Developing and maintaining close and effective working relationships with the Trust Chair, company secretarial team and Senior Independent Director.
 	
Duties
The group has a duty to consult with and represent the interests of governors and members to:
• Set the agenda for Council of Governors meetings held in public
• Influence the agenda and planning of the annual general meeting and annual members' meeting
• Identity themes and objectives for governor forum meetings.

Formatted: Left, Bulleted + Level: 1 + Aligned at: 0 cm + Indent at: 0.63 cm

Reviewed by GSG December 2020
Approved by Council of Governors on 11 January 2021

Meetings

Meetings of the group shall be formal, compliant with the relevant codes of conduct and action notes will be recorded.

The group will meet quarterly in advance of each ordinary meeting of the council of governors. The group Chair may cancel, postpone or convene additional meetings as necessary for the group to fulfil its purpose and discharge its duties.

~~Chairmanship~~Chairing

The group shall be chaired by the Lead governor

If the Chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the group shall be chaired by the Trust Chair.

Secretariat

The Deputy Company Secretary shall be the secretary to the group and shall provide administrative support and advice to the Chair and membership. The duties of the secretary shall include but not be limited to:

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

Membership

Full ~~M~~membership ~~with voting rights~~

The following governor roles are entitled to membership of the group ~~and shall have full voting rights~~:

- The Trust Chair, as Chair of the Council of Governors
- The Lead governor
- Governor representative to the committees of the Board of Directors, as elected by the Council of Governors, including:
    - Audit
    - Finance and Performance
    - Quality and Governance
    - Charity Committee
    - Appointments' Committee, and
    - Membership representative
- Nominated staff governor, as elected by the Council of Governors
- Nominated stakeholder governor, as elected by the Council of Governors

It should be noted that in the event a governor holds more than one role, they are still only entitled to one vote.

This group expects to work by consensus but should voting be needed the full members listed above shall have a vote.

In attendance ~~with no voting rights~~

The following posts are invited to attend meetings of the group but shall not be members or have voting rights:

- The secretary to the committee (for the purposes described above)

Reviewed by GSG December 2020
Approved by Council of Governors on 11 January 2021

• Director of Communications and Corporate Affairs • Any other individuals as it considers appropriate and as the need arises.
Quorum
For any meeting of the group to proceed the Chair or Lead governor must be present along with two other governor representatives.
Attendance
Members and attendees are expected to attend all meetings or to send apologies to the Chair and committee secretary at least one clear day* prior to each meeting.
Papers
Meeting papers shall be distributed to members and individuals invited to attend at least five clear days prior to the meeting.
Reporting
Action notes shall be approved formally by the group at its next meeting. The group shall report to the Council of Governors as required.
Review
These terms of reference shall be reviewed by the group annually or more frequently if necessary. The review process should include the company secretarial team. The Council of Governors shall be required to approve all changes. The next scheduled review of these terms of reference will take place in December 2021~~0~~
*** Definitions**
• In accordance with the trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Reviewed by GSG December 2020
Approved by Council of Governors on 11 January 2021

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 August 2021**		**Agenda reference:**	**115-21**	
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 meetings on 7 June and 16 June 2021				
Summary of key issues	The Committee received and reviewed the trust's annual report and accounts, alongside the report from external auditor (KPMG), and recommended them to the board for approval. The committee also received updates on Internal Audit and Counter Fraud, and reviewed updated financial governance documentation.				
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:	Internal audit report on financial systems and payroll was received				
Corporate risk register:	None				
Regulation:	Annual report and accounts were recommended to the board				
Legal:	Annual report and accounts were recommended to the board				
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:	5 August 2021
Ref:	115-21
Report from:	Kevin Gould, Chair
Author:	Kevin Gould, Chair
Appendices:	N/A
Report date:	23 July 2021

Audit Committee report

Meeting held on 7 June 2021

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 final audit report (which was subsequently received).

4. The Committee reviewed the draft 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.

Meeting held on 16 June 2021

1. The Committee reviewed standing orders, standing financial instructions and reservation of powers/scheme of delegation and recommended them to the Board for approval.

2. KPMG provided an update on the finalisation of the annual report and accounts.

   RSM presented an update on the Internal Audit plan. One report had been completed since the previous meeting:
   - Financial Systems & Payroll (reasonable assurance, no High priority actions)

   The Committee reviewed and discussed the outstanding management actions, noting the good progress that had been made since the March meeting.

3. The Committee received a report on the progress of Counter Fraud activity and a draft annual report.

There were no other items requiring the attention of the Board.