NHS
Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 7 July 2022

Session in public
10:00 – 13:00

MEMBERSHIP
BOARD OF DIRECTORS
July 2022

Members (voting):

Trust Chair	-	Anita Donley
Senior Independent Director	-	Gary Needle
Non-Executive Directors	-	Paul Dillon-Robinson
	-	Kevin Gould
	-	Karen Norman
Chief Executive:	-	Steve Jenkin
Medical Director	-	Tania Cubison
Chief Nurse	-	Nicky Reeves
Director of Finance and performance	-	Michelle Miles

In full attendance (non-voting):

Director of Operations	-	Shane Morrison-McCabe
Director of Communications and Corporate Affairs	-	Clare Pirie
Director of Workforce (interim)	-	Lawrence Anderson
Deputy Company Secretary	-	Leonora May

Annual declarations by directors 2022/23

Declarations of interests

As established by section 40 of the Trust's Constitution, a director of the Queen Victoria Hospital NHS Foundation Trust has a duty:

- to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the foundation trust.
- not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.
- to declare the nature and extent of any relevant and material interest or a direct or indirect interest in a proposed transaction or arrangement with the
- foundation trust to the other directors.

To facilitate this duty, directors are asked on appointment to the Trust and thereafter at the beginning of each financial year, to complete a form to declare any interests or to confirm that the director has no interests to declare (a 'nil return'). Directors must request to update any declaration if circumstances change materially. By completing and signing the declaration form directors confirm their awareness of any facts or circumstances which conflict or may conflict with the interests of QVH NHS Foundation Trust. All declarations of interest and nil returns are kept on file by the Trust and recorded in the following register of interests which is maintained by the Deputy Company Secretary.

Register of declarations of interests

	Relevant and material interests							
	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.	Other
Non-executive and executive members of the board (voting)								
Anita Donley Trust Chair	Director, Anita Donley Associates Ltd	Nil	Nil	Trustee, Imperial Health Charity. Chair, Grants Oversight Committee	Senior Advisor, Academic Health Solutions Senior Associate, Good Governance Institute Independent Advisor, Visionable Ltd Mentor, NHSEI National Clinical Entrepreneur Programme	Nil	Nil	Nil
Paul Dillon-Robinson Non-Executive Director	Trustee/ Director, Hurst Educational Trust Trustee/ Director, Association of Governing Bodies of Independent Schools	Independent consultant (self-employed) – see HFMA	Nil	Nil	Nil	Independent consultant working with the Healthcare Financial Management Association (including 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	From 1/6/21 : Chair of the Audit Risk and Assurance Committee for one of the MoD's Top Level Budget organisations. From 8/11/21 : Non-Executive Director Chair of ARAC, and member of Agency Management Board for Rural Payments Agency, ex-officio member of Defra ARAC Already : Non-trustee member of Finance Risk and Audit Committee of Farm

							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.	Africa. Shadow governor of Hurst Education Trust. 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. Director and Chair 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	Nil
Gary Needle Senior independent director	T&G Needle Property Development Ltd	Nil	Nil	Chair of Board of Trustees, East Grinstead Sports Club.	Nil	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	Nil

Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Tania Cubison Medical Director	Nil	I undertake private practice at the McIndoe Centre and also I am a Medio legal expert. This is as a sole trader, not a limited company.	Nil	National Chair of the Emergency Management of severe burns senate (part of the British Burn Association)	Nil	Nil	Spouse (Ian Harper) is the director of welfare for BLESMA (the military charity for amputees). He is in a salaried post and does signpost people to QVH.	Nil
Michelle Miles Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Nicky Reeves Director of Nursing	Nil	Nil	Nil	Trustee of McIndoe Burns Support Group	Nil	Nil	Nil	Nil
Other members of the board (non-voting)								
Shane Morrison-McCabe Director of operations	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Lawrence Anderson Director of HR & OD	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Clare Pirie Director of Communications & Corporate Affairs	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Fit and proper persons declaration

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

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board (voting)							
Anita Donley Trust Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul Dillon-Robinson Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kevin Gould Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gary Needle Senior Independent 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
Tania Cubison 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 Chief Nurse	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other members of the board (non-voting)							
Shane Morrison- McCabe 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

NHS
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Business meeting of the Board of Directors
Thursday 07 July 2022
10:00 – 13:00

Agenda: session held in public			
WELCOME			
95-22	**Welcome, apologies and declarations of interest** *Gary Needle, Senior Independent Director and acting Chair*		
STANDING ITEMS		**Purpose**	**page**
96-22	**Patient story**	*Assurance*	-
97-22	**Guardian of Safe Working update** *Joy Curran, Guardian of Safe Working*	*Assurance*	1
98-22	**Draft minutes of the public meeting held on 05 May 2022** *Gary Needle, Senior Independent Director and acting Chair*	*Approval*	30
99-22	**Matters arising and actions pending from the public meeting held on 05 May 2022** *Gary Needle, Senior Independent Director and acting Chair*	*Review*	39
100-22	**Chair's report** *Gary Needle, Senior Independent Director and acting Chair*	*Assurance*	40
101-22	**Chief executive's report** *Steve Jenkin, Chief Executive*	*Assurance*	43
102-22	**Transaction Programme update** *Steve Jenkin, Chief Executive*	*Assurance*	61
TRUST STRATEGY			
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
103-22	**Board Assurance Framework KSO1 & KSO2** *Nicky Reeves, Chief Nurse*	*Assurance*	83
104-22	**Corporate Risk register (CRR)** *Nicky Reeves, Chief Nurse*	*Review*	85
105-22	**Quality and Safety report** *Nicky Reeves, Chief Nurse*	*Assurance*	98
106-22	**6- monthly Nursing Workforce review** *Nicky Reeves, Chief Nurse*	*Assurance*	111
107-22	**Quality and Governance assurance** *Karen Norman, Non-executive Director and Committee Chair*	*Assurance*	122
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
108-22	**Board Assurance Framework KSO3 & KSO4** *Shane Morrison-McCabe, Director of Operations* *Michelle Miles, Director of Finance and Performance*	*Assurance*	125
109-22	**Operational performance** *Shane Morrison-McCabe, Director of Operations*	*Assurance*	127

110-22	**Financial performance** *Michelle Miles, Director of Finance and Performance*	*Assurance*	136
Key strategic objective 5: organisational excellence			
111-22	**Board assurance framework KSO5** *Lawrence Anderson, Interim Director of Workforce and OD*	*Assurance*	148
112-22	**Workforce monthly report** *Lawrence Anderson, Interim director of workforce and OD*	*Assurance*	149
113-22	**Financial, operational and workforce performance assurance** *Paul Dillon-Robinson, Non- executive Director and Committee Chair*	*Assurance*	163
GOVERNANCE			
114-22	**Approval of changes to standing orders and standing financial instructions including reservation of powers and scheme of delegation** *Michelle Miles, Director of Finance and Performance* *Clare Pirie, Director of Communications and Engagement*	*Approval*	166
115-22	**Audit Committee assurance** *Kevin Gould, Non- executive Director and Committee Chair*	*Assurance*	290
MEETING CLOSURE			
116-22	**Any other business (by application to the Chair)** *Gary Needle, Senior Independent Director and acting Chair*	*Discussion*	-
MEMBERS OF THE PUBLIC			
117-22	*We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Leonora.may1@nhs.net clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.* *Gary Needle, Senior Independent Director and acting Chair*		
118-22	*Further to paragraph 39.1 and annex 6 of the Trust's Constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the Board to discuss issues of a confidential or sensitive nature. Any decisions made in the private session of the Trust Board will be communicated to the public and stakeholders via the Chair's report.* *Gary Needle, Senior Independent Director and acting Chair*		

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/07/2022		**Agenda reference:**	**97-22**	
Report title:	Guardian of Safe Working annual report				
Sponsor:	Tania Cubison, Medical Director				
Author:	Dr Joy Curran, Consultant Anaesthetist				
Appendices:	Appendix one- Detailed quarterly gap data Appendix two- Fine income and expenditure Appendix three- Fatigue and facilities grant expenditure Appendix four- Full quarterly reports for the last year				
Executive summary					
Purpose of report:	To provide the Board with a summary of the last years issues relating to junior doctor safe working hours.				
Summary of key issues	There are some rota gaps for rota groups but overall the junior doctor working hours remain at safe levels.				
Recommendation:	It is recommended that the Board **notes** the contents on the report.				
Action required *[embolden **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[[embolden 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:	This report has wide reaching relevance to all of the above strategic objectives since junior doctors are an essential part of the operation of the hospital services. Their training and safe hours are critical to longevity of the hospital and wider NHS. '				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	Yes, as cost of locum cover is high. However all locums are currently bank rather than agency. Fine monies are also lost income.				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:					

Report to:	Board Directors
Agenda item:	97-22
Date of meeting:	07 July 2022
Report from:	Dr Joy Curran, Consultant Anesthetist
Report author:	Dr Joy Curran, Consultant Anesthetist
Date of report:	9th June 2022
Appendices:	Appendix one- Detailed quarterly gap data
	Appendix two- Fine income and expenditure
	Appendix three- Fatigue and facilities grant expenditure
	Appendix four- Full quarterly reports for the last year

Guardian of Safe Working Annual Report 2021-22

Introduction

This report summarises the data from the quarterly GOSW reports required by HEE into an annual format. It looks at gaps within the medical junior rota; how they are covered and the reasons for them. The report also summarises the exception reports that the junior doctors should make when their hours or educational activity breaches their work schedules.

Executive summary

Rota gaps have continued to occur this year at a low but steady rate with most of the gaps filled by internal locum doctors or external doctors who have remained on our bank after leaving us. No unsafe rota are reported. Exception reporting has increased to above pre pandemic levels, particularly in plastic surgery.

This report is due before the end of Q2 so I have had to leave Q2, reporting on only Q3,4 of 2021 and Q1 of 2022.

Situation

QVH remains a desirable place for training and so attracts good candidates in all specialties. It continues difficult to fill maxillofacial trainee rota due to the problems of recruiting to maxillofacial surgery (at a national level).

Exception reporting (rather like datix reporting) is to be encouraged and I am pleased that the number of reports has risen.

Some well-being issues such as on-call accommodation (run by an external contract) have been tackled this year and we are assessing promised improvements. The remains of the £30,000 central fatigue and facilities grant had to be spent by April ’22 and details of this are in appendix 1.

Background

We are all in recovery mode following the impact of Covid 19 and trainees have all had their training disrupted. Some have used the exception reporting system very effectively to flag up when moved from their educational activities. Plastic surgery in particular have improved their rota management and are utilizing extra Deanery funding to try to ensure that trainees get extra training time in areas that had no activity during pandemic periods.

The Junior Doctor Forum remains a well-used meeting for trainees with myself the DME, medical education manager, BMA representative and human resources manager. This enables the trainees to flag a wide variety of concerns they may have.

Assessment

I have no major concerns regarding the overall safety of our junior doctor rota.

I hope that recent encouragement will enable the maxillofacial trainees to use the exception reporting system to their advantage in the next year.

Recommendation

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

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Dr Joy Curran and Kathleen Ally

The Queen Victoria NHS Trust June 2021 – June 2022

Executive summary

This report looks at the level of junior doctor rota gaps over the past year and exception reporting trends. .

Introduction

My thanks to **Kathleen Ally** who provides all the HR data within the document.

Following on from the annual report of rota gaps and vacancies all the quarterly reports for the last year are included with the appendix. These give more detailed information on the exception reporting data plus summarize information from the quarterly junior doctor forum (JDF).

High level data

Number of doctors / dentists in training (total): 55 – 62

Number of doctors / dentists in training on 2016 TCS (total): 37 - 41

Annual vacancy rate among this staff group: 2.66 %

Annual data summary

This section should list all vacancies among the medical training grades (including trust doctors) during the previous year. This is an annual aggregate of the relevant data from the previous four quarterly reports.

Trainees gaps within the Trust

Specialty	Grade	Quarter 3 2021	Quarter 4 2021	Quarter 1 2022	Quarter 2 2022	Number of shifts uncovered (over the year)*
Anaesthetics	ST4 +	2.3	1.66	0		0
Orthodontics		0	0	0		0
Maxillofacial	DTC	0.33	0	1		0
	ST/ fellow	1	0	1		0
Plastics	Core	3.33	3.33	1.33		0
	ST3 +	2	0	2		0
Radiology		0	0	0		0
Totals		**8.96**	**5**	**5.33**		**0**

*Although the table show no shifts uncovered over the year, I am aware of some within anesthetics with no locum cover. Consultants acting down covered these shifts.

Issues arising

We have had more vacancies this year than in 20/21. Core plastics in particular seems to have had issues here and I am not sure of the reasons behind this. The other specialties have also had some gaps and this will relate to recruitment issues, late notice gaps that we then find hard to fill and shortages in some specialties such as anesthetics. Clearly, gaps put pressure on both rota and training with an increase in hours requested for locum cover.

For this last year, we have been riding through the Covid 19 pandemic. Last summer we were trying to get back on track with elective recovery and trainees were very anxious to return to normal training and catch up on missed elective work. We have also had some periods since then of decreased major elective cases with external cancer work rightly taking priority. However, in general we are back to relatively normal.

The actual rota were not required to change due to Covid this last year. For several periods of the year, we have had to cover gaps due to both senior and junior doctors requiring isolating due to Covid. I would like to make the Board aware that a considerable amount of flexibility from everyone occurred to keep rota running properly. I am sure this has been the same throughout all groups within the Trust.

Exception reports over the years 2017 to date

Exception Reports (ER)					
Reference period of report	07/17 - 07/18	07/18 - 07/19	07/19 - 07/20	07/20 - 07/21	06/21 - 06/22
Total number of exception reports received	6	28	52	35	61
Number relating to immediate patient safety issues	0	1	0	1	1
Number relating to hours of working	1	4	21	24	34
Number relating to pattern of work	0	0	4	4	4
Number relating to educational opportunities	5	23	27	7	23
Number relating to service support available to the doctor	0	1	0	0	0

Briefly; juniors make exception reports via an on line reporting system set up nationally after the new junior doctor contract, introduced in 2017. They fall into two main types. As Guardian of Safe Working (GOSW) hours, I am responsible for the hours and pattern of working reports while the Director of Medical Education (DME) looks at the educational reports. A good level of reporting is important; as it is our main method of monitoring the hours the junior doctors' work. We also wish to assure that doctors have sufficient rest to work safely.

Exception reports have continued to rise year on year (there was an understandable drop off during 1st wave of Covid 19). Reassuringly we have had only one relating to immediate patient safety concerns. Those relating to hours of working tend to be either an over running clinical commitment or those on a 24 hour on – call pattern not achieving the minimum 5 hours of continuous rest. Trainees can claim a call out fee for working after their estimated average time in their hours schedule on the 24 hour on- call so there is some incentive there. Missing the 5 hours continuous rest target results in a fine for the clinical specialty awarded to the doctor and Guardian of Safe

Working (GOSW) fine fund. We average between zero and 3 fines per month and fines are levied against the department of that particular trainee. The funds are spent after discussions at the Junior Doctor Forum on items that are either educational or for well-being. They should not be items that either the Trust or Deanery are obliged to supply. Further details in appendix.

Exception reporting for educational opportunities are usually when a trainee is unable to carry out an activity of specific educational benefit to them due to a Trust service commitment. For example, a trainee might not be able to attend a teaching session because they are assigned to a clinic. Alternatively, they might be refused study leave because there are insufficient doctors to cover clinical need that day.

Actions taken to resolve issues

Last August and September, we had some particular difficulties in plastics and the trainees used the system very effectively to bombard the DME and myself with exception reports. These were collated, summarized and used to make positive changes to rota management, week-to-week and day by day.

The maxillofacial rota is a hybrid using some weekend cover from Brighton and Eastbourne based trainees. It is very difficult to get locum cover for the maxillofacial rota as these doctors are dual qualified. As a group the senior trainees have not exception reported so I have no firm data on their out of hours work. I have spoken with both the Plastics departments and Maxillofacial departments (Consultants and juniors) as part of their teaching programme giving an update on exception reporting; how to do it, why it's a useful tool and encouraging open discussion about its use.

Summary

Overall, there have been few gaps in the rota for the past year. Most of the locum cover requested therefore is due to individual sickness, parental leave and Covid related absence or extra or uncovered service commitments. The latter is particularly high for the plastics department.

I wrote this following statement last year – 'Consideration should be given to ways that the Trust can progress with using non-medical practitioners to improve work flow and organization and cut down on the locum cover required for the uncovered daytime workload.' It is still the case. We should study how the use of Physician Associates in the hospital workforce could benefit us. This group is growing in number as more qualify from the 3 year course and will in the future be essential to the workforce.

I am happy with the safety of the junior doctor rota within the Trust.

Dr Joy Curran

Consultant Anaesthetist and Guardian of Safe Working Hours

Appendices

Appendix one- Detailed quarterly gap data

Q 3 2021

Vacancies by month						
Specialty	Grade*	July 2021	August	September	Total gaps (average)	Number of shifts uncovered
Anaesthetics	ST5+	1	3	3	2.3	0
Maxillofacial Core	DCT			1	0.33	0
Maxillofacial higher	ST4+	1	1	1	1	0
Plastic surgery core	CT2	2	4	4	3.33	0
Plastic surgery higher	ST4+	1	2	3	2	0
Orthodontics	ST3+					0
Radiology	ST3+					0
Total		5	10	12	8.96	0

Q 4 2021

Vacancies by month						
Specialty	Grade	October 2021	November	December	Total gaps (average)	Number of shifts uncovered
Anaesthetics	St5+	1	2	2	1.66	
Maxillofacial Core	DCT					0
Maxillofacial higher	St4+					
Plastic surgery core	CT1/2	4	4	2	3.33	0
Plastic surgery higher	St3+					0
Orthodontics	St3+					0
Radiology	St1+					0
Total		5	6	4	5	0

Q1 2021

Vacancies by month						
Specialty	Grade	January 2021	February	March	Total gaps (average)	Number of shifts uncovered
Anaesthetics	ST5 +					0
Maxillofacial Core	ST2	1	1	1	1	0

Maxillofacial higher	ST5 +	1	1	1	1	0
Plastic surgery core	CT2	2	1	2	2	0
Plastic surgery higher	ST3 +	2	2	2	2	
Orthodontics	ST3 +					
Radiology	ST3 +					
Total		6	5	5	5.33	

Q 2 2022

Vacancies by month						
Specialty	Grade	April 2021	May	June	Total gaps (average)	Number of shifts uncovered
Anaesthetics	ST5					0
Maxillofacial Core	0					0
Maxillofacial higher	ST5					0
Plastic surgery core	CT2					0
Plastic surgery higher	ST3					0
Orthodontics	ST+					0
Total						0

Annual totals of extra shifts required.

Specialty	Number of shifts requested AND worked (=) **Q3,Q4,Q1,Q2 total**	Number of shifts given to agency **Q4,Q3,Q2,Q1**	Number of hours requested **Q4,Q3,Q2,Q1**	Number of hours worked **Q4,Q3,Q2,Q1**
Anaesthetics	7,54,20	7,28,0	78,566,216	78,566,216
Maxillofacial	37,45,44	0,0,0	485,487,570	485,487,570
Orthodontics	3,0,7	0,0,0	18,0,57	18,0,57
Plastics	141,99,86	0,0,0	1521,1094,856	1521,1094,856
Totals	**188,198,157**	**0,28,0**	**2102,2148,1700**	**2102,2148,1700**

Locum bookings (bank) by grade					
Specialty	Number of shifts requested **Q3,4,1,2**	Number of shifts worked **Q3,4,1,2**	Number of shifts given to agency **Q3,4,1,2**	Number of hours requested **Q3,4,1,2**	Number of hours worked **Q3,4,1,2**
CT1-2*	81,69,54	81,69,54	0,0,0	890,697,539	890,697,539
ST3 +*	107,129,103	107,129,103	0,28,0	1212,1451,1161	1212,1451,1161
St5 + (Q3 and Q4)					
Total	188,198,157	188,198,157	0,28,0	2102,2148,1700	2102,2148,1700

*Includes Trust Grade doctors – Health Roster is not configured to identify separately

Reasons for extra shifts requested, specialties merged.

	Number of shifts requested (and number worked Q3,4,1,2 and **TOTAL**	Number of shifts given to agency
Vacancy	122,97,59	0,3,0
Sickness	21,46,27	0,25,0
Other	45,55,71	0,0,0
Total	188,198,157	0,0,0

*Other * includes Additional Clinics/list, Additional Dependency - Covid 19, Annual leave, Maternity, On Call, Other, Special Leave, Study leave, Training*

Note:

We are exceptionally fortunate, as our junior staff will generally cover extra duties for us as bank cover. Due to the specialist nature of work at QVH every effort is made by departments to use either current doctors (within their hours permitted by the junior doctor contract safe working limits) or previous doctors.

Appendix two- Fine income and expenditure

Q3 2021

Fines by department		
Department	Number of fines levied	Value of fines levied
Plastics	2,1, 1 = total 4	July – 1133.52, August – 755.68, Sept – 377.88

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
1854	£2267.08	£1400.00	£2721
		(US phantom models)	

Q4 2021

No fines recorded.

Q1 2022

Fines by department		
Department	Number of fines levied	Value of fines levied
Plastics	1	£601.50

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter /	Disbursements this quarter	Balance at end of this quarter
£2707.56	601.50	US training eve - £100	£2898.56
		Journal club event £310	

Appendix three- Fatigue and Facilities grant expenditure

Area	Item	Cost	Supplier
Lounge- Ed Centre	console table for coffee machine	£173.40	Bates
	TV and bracket	£370.00	Curry's
	Amazon echo	£90.00	Amazon
	2 x 3 seater, 1 x 2 seater, 1 x armchair -	£2,446.20	Bates
OMFS room	1 x 3 seater, 1 x armchair -	£1,139.40	Bates
	Amazon echo	£90.00	Amazon
	4 x office chairs	£874.36	Bates
	outside furniture	£457.10	picnicbenchs.co.uk
	coffee table	£37.50	ROCT70 - Bates
	Printer - Blond McIndoe	1375.47	IT
	Blinds	£201.17	CurtainCraft
	Coat stand	£18.00	Amazon
	Mini fridge	£40.00	Curry's (ordered 10/05/2021)
	Microwave	£80.00	Curry's (ordered 10/05/2021)
	Bookshelf - Argos	£39.95	Argos
Plastics room	1 x 3 seater, 1 x armchair	£1,139.40	Bates
	fridge	£120.00	Curry's
	blinds	£966.25	CurtainCraft
	Amazon echo	£90.00	Amazon
	heaters	£204.00	Argos
	coffee table	£37.50	Bates
	Water supply	£3,068.65	
On call room CCU (an	Mattress (on call room)	£400.00	Casper
	Cupboard (ordered 9/2/22)	£259.52	Bates
	Heater	£104.00	Argos
Surgeon's Mess	Building works	£6,000.00	To Estates
	Blinds	£1,173.62	Curtaincraft
	Bar stools x 8 (ordered 03/08/2021)	£680.00	Habitat
	Rug (ordered 9/2/22)	£115.00	Rugs direct
	Light 10/02/2022	£121.99	Wayfair
	Bulbs 10/02/2022	£16.29	Wayfair
	Plants 10/02/2022	£232.98	Wayfair
	Furniture renovation TBC	£700.00	Rick
	Sofa	£0.00	Donated by DFS
General	8 x table lamps	£99.96	Amazon
	Nespresso Pro Zenius plus 750 capsules x 3	£930.00	Nespresso
	2 seater sofa	£565.20	Bates
	Storage bench	£199.00	Ikea
	Cushions	£261.00	Ikea
	Hot chocolate	£12.56	supply chain - 100 indiv cups
	Tea bags	£9.96	supply chain - 1320 tea bags
Ed Centre rest room	Single bed - Ikea	£210.00	Ikea
Nurses	Fridge	£210.00	Curry's
	Microwave	£99.00	Curry's
	Toasty machine	£25.00	Amazon
	Nespresso Pro Zenius plus 750 capsules x 2 - C wing/anaesthetics or SM	£650.00	Nespresso
	Cutlery (some to go in Ed Centre)	£15.00	Ikea
	Crockery (some to go in Ed Centre)	£76.00	Ikea
Outside room	Table football table	£799.00	Garlando
Ed Centre	Furniture 10/02/2022	£791.94	Wayfair
	Light 10/02/2022	121.99	Wayfair
	Plants 10/02/2022	£242.98	Wayfair
Nespresso orders	10-Sep	£140.00	
coffee pods	03-Nov	£138.00	
	09-Dec	£276.00	
	31-Mar	£330.00	
Misc	Wellbeing get together for DCTS (17 Dec)	£37.00	
	Wellbeing Cricket match	£150.00	
	Total spent	**£29,251.34**	
	Remaining	**£748.66**	

Appendix four- Full quarterly reports for the last year

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

This is the Q3 report prepared jointly by the Guardian of Safe working hours (Joy Curran) and Kathleen Ally for Medical Staffing and HR.

Executive summary

This report is for July, August and September and triangulates data from workforce, junior doctor exception reports on Allocate and feedback at the quarterly junior doctor forum (JDF) run by myself – GOSW.

High level data for [Lead Employer Trust]

Number of doctors / dentists in training (total): 55

Number of doctors / dentists in training on 2016 TCS (total): 37

Amount of time available in job plan for guardian to do the role: 0.75 PAs hours per week

Admin support provided to the guardian (if any): Ad hoc

Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

a) Exception reports (with regard to working hours)

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Anaesthetics	0	0		
Maxillofacial	0	0		
Orthodontic	0	0		
Plastics	4	35	11	24
Radiology	0			
Total	4	35	11	24

Exception Reports for Hours breached

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics	0	
Maxillofacial	0	
Orthodontic	0	
Plastics	18	15
Radiology	0	
Total	18	

Exception reports for missed Education and Training

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics		
Maxillofacial		
Orthodontic		
Plastics	17	12
Radiology		
Total	17	12

Note, most of the reports have been discussed with the respective educational supervisor but not resolved to the trainees' satisfaction and therefore not closed.

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT1-2 / ST1-2	0	0	0	
ST3 +	4	35	11	24
Total				

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Anaesthetics	0	0	0	
Maxillofacial junior	0	0	0	

Maxillofacial senior	0	0	0	
Orthodontics	0			
Plastics Junior	0			
Plastics Senior	3	35	14	25
Radiology	0			
Total				

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0			
F2	0			
CT1-2 / ST1-2	0			
ST3-8	0	2	0	33
Total	0			

b) Work schedule reviews

We have not had any formal work schedule reviews this quarter although there have been meetings between the plastics rota makers, clinical tutor, CD and Director of Medical Education in response to difficulties with the health roster leave software being wrongly implemented.

Work schedule reviews by grade	
F1	0
F2	0
CT1-2 / ST1-2	0
ST3+	0

c) Locum bookings

i) Bank

Locum bookings (bank) by department					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Anaesthetics	7	7	0	78.00	78.00
Maxillofacial	37	37	0	485.25	485.25
Orthodontics	3	3	0	18.00	18.00
Plastics	141	141	0	1520.83	1520.83
Total	188	188	0	2102.08	2102.08

Locum bookings (bank) by grade					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
CT1-2*	81	81	0	889.75	889.75
ST3 +*	107	107	0	1212.33	1212.33
Total	188	188	0	2102.08	2102.08

*Includes Trust Grade doctors – Health Roster is not configured to identify separately

Locum bookings (bank) by reason*					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	122	122	0	1350.50	1350.50
Sickness	21	21	0	202.58	202.58
Other*	45	45	0	549.00	549.00
Total	188	188	0	2102.08	2102.08

*Other * includes Additional Clinics/list, Additional Dependency - Covid 19, Annual leave, Maternity, On Call, Other, Special Leave, Study leave, Training*

ii) Agency

We have had no agency bookings this quarter.

d) Locum work carried out by trainees

We are currently not collecting data on individual trainees.

Bank hours can be either current junior staff who would like to do extra hours where permitted by their shift pattern and fixed limits or ex junior staff who remain on our bank list. This is the preferred way of filling gaps; with doctors that know the QVH and avoiding agency fees.

e) Vacancies

Vacancies by month						
Specialty	Grade	Month 1	Month 2	Month 3	Total gaps (average)	Number of shifts uncovered
Anaesthetics	ST5+	1	3	3	2.3	0
Maxillofacial Core	DCT2+	0	0	1	0.33	0
Maxillofacial higher	ST3+	1	1	1	1	0
Plastic surgery core	CT2+	2	4	4	3.33	0

Plastic surgery higher	ST3+	1	2	3	2	0
Orthodontics	ST1+	0	0	0	0	0
Total		5	10	12	8.96	0

f) **Fines**

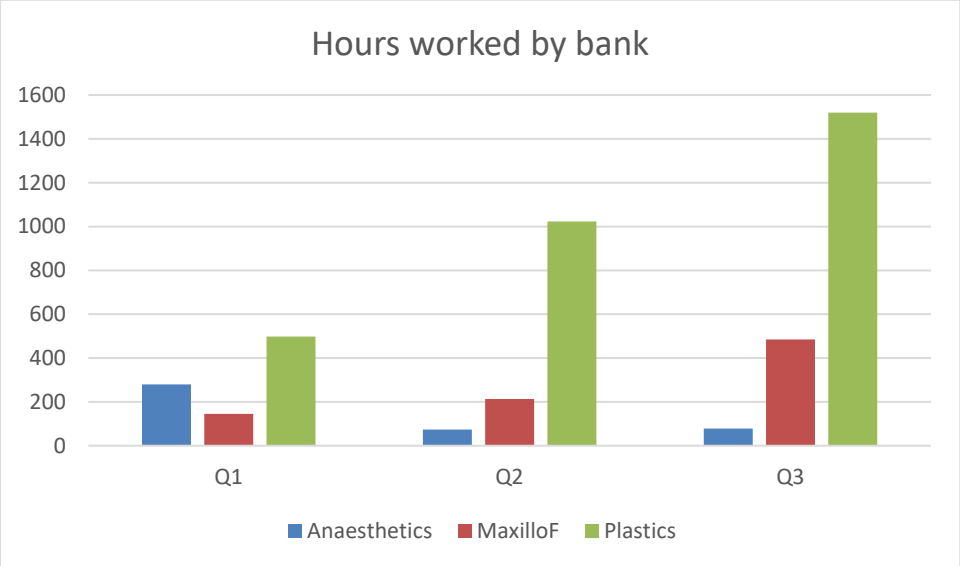
Fines by department		
Department	Number of fines levied	Value of fines levied
Plastics	2,1, 1 = total 4	July – 1133.52, August – 755.68, Sept – 377.88

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
1854	£2267.08	£1400.00	£2721

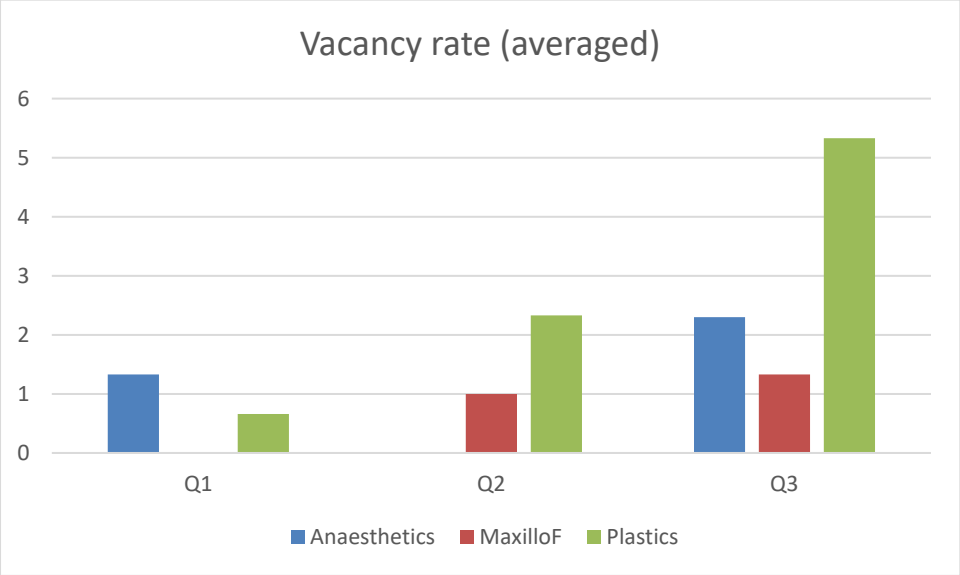
Two ultrasound phantom trainers were purchased for use in ultrasound training at approx £700 each.

Issues arising

There have been significant gaps in some of our rota. In Anaesthetics there were 3 vacancies for August and September, Plastics had 4 vacancies at Core level and 2 at higher and Maxillofacial had 1 or 2 missing from both of their rota.

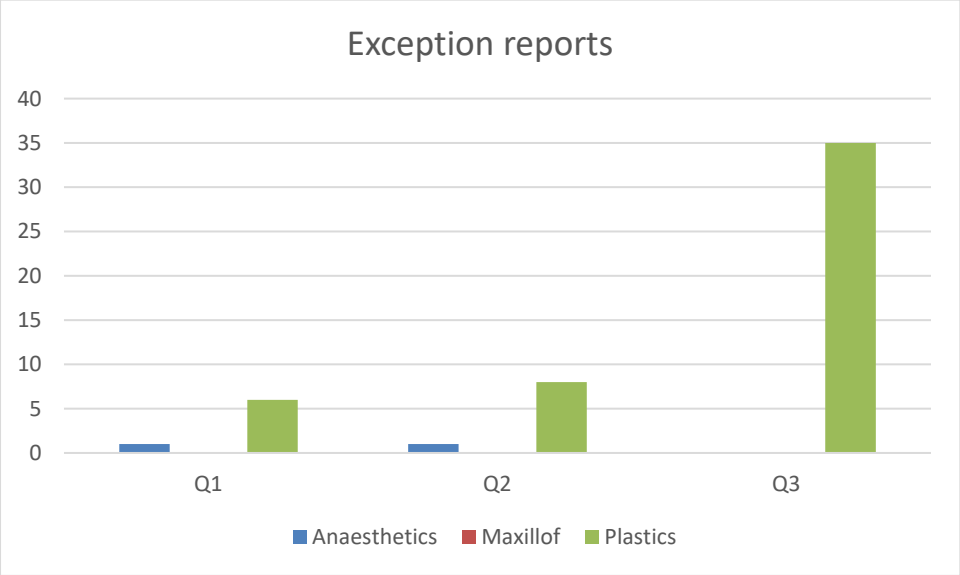


The chart above shows the rising number of bank hours worked within both plastic and the maxillofacial departments. The plastics directorate is considerably bigger with approximately double the number of junior doctors. The next chart shows the number of gaps for each quarter.



From the Healthroster data it seems that no gap was not filled. This seems excellent, but I have not triangulated this information. It may well be that some of the daytime sessions were not filled. I have not heard of Consultants needing to do night shifts for this period. However I am aware of two occasions in October when the Anaesthetic Consultant on call was resident with another Consultant on call from home.

This quarter has seen a very large spike in exception reporting from the plastics trainees who have filled out all of the reports.



Looking at the split in exception reports half were for extra hours worked and half for education. Digging deeper into the reasons for the reports many are for not allocating them to the teaching sessions that they feel they should be, or being moved from those sessions at short notice to cover service requirements. The extra hours were claimed for late running clinics, late running theatre sessions and work at night. Some are because the trainees zero hour day was removed in error. Compared to our normal level of reporting these results are striking and warrant concern.

Junior Doctor Forum

The JDF met on the 30th of September. At this time of the year we have a large change in trainees so we said goodbye to some of the trainee reps and look forward to working with the new. A big thankyou to them for the time and effort they have put in on everyones behalf.

There were concerns from the core plastics trainees regarding the amount of theatre experience they are getting particularly feeling that the locum trainees were often in theatre more than themselves. The senior plastics trainees reported some issues with the on call rooms which we will follow up. These have external providers and the service is notably poor. The trainees described the daily rota issues as truly terrible over the last few months. There had been a problem with leave hours being calculated wrongly (8 hours per day allocated on the system, but 10 hours deducted per day when leave was taken – this has been resolved). Difficulties with the zero hour days have been described already. The rota was not issued within the correct time frame (8 weeks notice), or even 6 weeks contrasting with their annual leave requests requiring to be submitted with 8 weeks to go.

The refurbished end of the old maxillofacial staff club was declared open after the last JDF and is a really lovely relaxing space for all doctors to use.

Actions taken to resolve issues

The most pressing concerns have been with the staffing of the plastics department, which has historically had more commitments than people. Before the September JDF there was an emergency meeting with the Director of Medical Education, Clinical tutor, CD, rota coordinators to try to help some of the problems. Actions have been put in place and while I am encouraging trainees to continue to report, I hope that things will improve. It is important that they do, or we will struggle to recruit to the Trust grade posts at junior level. This section should describe any actions already taken to resolve the issues described above. It may be possible to draw in data on work schedule reviews to indicate concerns which have already been addressed, however, it may be that the guardian has to use this section to highlight departments which have not, cannot or (in a small number of cases) will not take appropriate steps to ensure safe working hours.

Summary

I do not think that there are safety concerns for nighttime cover or working at QVH. However, I have real concerns over the trends shown over this year so far in gaps and bank cover required in plastic surgery. We have noted the problem before but so far, little has had an impact.

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

This is the Q4 2021 report prepared jointly by the Guardian of Safe working hours (Joy Curran) and Kathleen Ally for Medical Staffing and HR.

Executive summary

This report is for October to December and triangulates data from workforce, junior doctor exception reports on Allocate and feedback at the quarterly junior doctor forum (JDF) run by myself – GOSW.

High level data for [Lead Employer Trust]

Number of doctors / dentists in training (total): 60

Number of doctors / dentists in training on 2016 TCS (total): 39

Amount of time available in job plan for guardian to do the role: 0.75 PAs hours per week

Admin support provided to the guardian (if any): Ad hoc

Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

g) Exception reports - Total

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Anaesthetics	0	0		
Maxillofacial	0	0		
Orthodontic	0	0		
Plastics		10	3	9
Radiology	0			
Total		10	3	9

Exception Reports for Hours breached

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics	0	
Maxillofacial	0	
Orthodontic	0	
Plastics	5	9
Radiology	0	
Total	5	12

Exception reports for missed Education and Training

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics		
Maxillofacial		
Orthodontic		
Plastics	5	14
Radiology		
Total	5	14

Note, most of the reports have been discussed with the respective educational supervisor but not resolved to the trainees' satisfaction and therefore not closed.

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT1-2 / ST1-2	0	0	0	
ST3 +		10	3	36
Total		10	3	36

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. new exceptions outstanding
Anaesthetics	0	0	0	
Maxillofacial junior	0	0	0	
Maxillofacial senior	0	0	0	
Orthodontics	0			
Plastics Junior	0			
Plastics Senior	29	10	3	7
Radiology	0			
Total				

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0			
F2	0			
CT1-2 / ST1-2	0			
ST3-8	1	2	0	36
Total	0			

h) Work schedule reviews

We have not had any formal work schedule reviews this quarter.

Work schedule reviews by grade	
F1	0
F2	0
CT1-2 / ST1-2	0
ST3+	0

i) Locum bookings

iii) Bank

Locum bookings (bank) by department					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Anaesthetics	54.00	54.00	28.00	566.50	566.50
Maxillofacial	45.00	45.00		487.50	487.50
Orthodontics	0	0	0	0	0
Plastics	99.00	99.00	0	1094.50	1094.50
Total	198.00	198.00	28.00	2148.50	2148.50

Locum bookings (bank) by grade					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
CT1-2*	69.00	69.00	0	697.00	697.00
ST3 +*	129.00	129.00	28.00	1451.50	1451.50
Total	198.00	198.00	28.00	2148.50	2148.50

*Includes Trust Grade doctors – Health Roster is not configured to identify separately

Locum bookings (bank) by reason*					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	97.00	97.00	3.00	1102.50	1102.50
Sickness	46.00	46.00	25.00	477.00	477.00
Other*	55.00	55.00	0	569.00	569.00
Total	198.00	198.00	28.00	2148.50	2148.50

*Other * includes Additional Clinics/list, Additional Dependency - Covid 19, Annual leave, Maternity, On Call, Other, Special Leave, Study leave, Training*

iv) Agency

We have had no agency bookings this quarter.

j) Locum work carried out by trainees

We are currently not collecting data on individual trainees.

Bank hours can be either current junior staff who would like to do extra hours where permitted by their shift pattern and fixed limits or ex junior staff who remain on our bank list. This is the preferred way of filling gaps; with doctors that know the QVH and avoiding agency fees.

k) Vacancies

Vacancies by month						
Specialty	Grade	Month 1	Month 2	Month 3	Total gaps (average)	Number of shifts uncovered
Anaesthetics	ST5+	1	2	2	1.66	0
Maxillofacial Core	DCT2+	0	0	0	0	0
Maxillofacial higher	ST3+	0	0	0	0	0
Plastic surgery core	CT2+	4	4	2	3.33	0
Plastic surgery higher	ST3+	0	0	0	0	0
Orthodontics	ST1+	0	0	0	0	0
Total		5	6	4	5	0

l) **Fines**

Fines by department		
Department	Number of fines levied	Value of fines levied
Plastics	2,1, 1 = total 4	July – 1133.52, August – 755.68, Sept – 377.88

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
1854	£2267.08	£1400.00	£2721

Issues arising

This last quarter has seen a big improvement in the number of exception reports in plastics and no further reports in other specialties from the very high level of the last quarter.

I am disappointed that there has been no change in the maxillofacial reporting, since I am aware that these doctors are up at night occasionally for sick patients and admissions. Since they are on a 24-hour nonresident rota I would expect a similar rate to the plastics registrars. I have recently written to them to go through the process again and the method for claiming any payments due.

The anaesthetic registrars are on a full shift pattern so normally can fulfill their hours without issue.

For the plastics department, there have been some changes to the way the rota is written and involvement of senior trainees in this, improvements have begun. Trainees tell us at Junior doctor forum that they are “waiting to see”. There were still 5 reports of trainees being unable to go to their teaching or educational list due to service cover requirements.

The dental core trainees (DTCs) have been down in number this last quarter and although they have not exception reported have at JDF expressed the feeling that the increase in nighttime work has reduced their time in theatre quite considerably. They also feel at a disadvantage to the new more junior dental trainee who have only just qualified. This is because these trainees cannot yet carry out the **administrative tasks** and so are able to spend more time clinically. This is a new arrangement and we will monitor how the next group of trainees feel in JDF and at the LFG.

Junior Doctor Forum

The last JDF was in early December. We met in Bob’s mess, also via virtual link. There was a good turnout and plenty of discussion.

All trainees have opportunity to give feedback of any sort to the forum. There were several complaints regarding the on-call accommodation in Meridian Way, which have been followed up.

We discussed the results of the survey monkey on how they wished to spend the remains of the fatigue and facilities central government grant that must be used by end March. Monies will be spent on improving the soft furnishings in the mess, a locked cupboard for the anaesthetic on call

room and some outdoor furniture for the education center courtyard. Several trainees were very keen on gym facilities but the issue of a viable space for this has been difficult.

We also presented the six-monthly trainee awards which all hospital staff are invited to participate in. We decided to award the doctor with the highest number of votes in both six months with the Dr Sandy Saunders award for Junior Doctors in memory of one the Guineapig patients of QVH who went on to become a doctor.

Summary

I do not think that there are safety concerns for nighttime cover or working at QVH.

This last quarter has seen a return to moderate to low levels of exception reporting with the plastic department and none in other departments. This reflects much hard work done with the department by everyone and better rota and leave management. Thank you to everyone involved.

There is still some work to be done to encourage all trainee doctors to make use of the exception reporting system.

QUARTER ONE 2022

REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

Executive summary

This report is for January to March 2022 and written by Dr Joy Curran as Guardian of Safe Working and Kathleen Ally from the Erostering Support team.

The report tables exception reports from junior doctors, summaries of rota gap levels and locums used. Issues raised at junior doctor forums are summarized.

High level data for QVH

Number of doctors / dentists in training (total): 62

Number of doctors / dentists in training on 2016 TCS (total): 41

Amount of time available in job plan for guardian to do the role: 0.75 Pas hours per week

Admin support provided to the guardian (if any): Ad hoc

Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

m) Exception reports (with regard to working hours)

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. Q1 exceptions outstanding
Anaesthetics	0	0	0	0
Maxillofacial	0	0	0	0
Orthodontic	0	0	0	0
Plastics	4	6	6	0
Radiology	0	0	0	0
Total	4	6	6	

Exception Reports for Hours breached

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics		
Maxillofacial		
Orthodontic		
Plastics	5	0
Radiology		

Total	5	0

Exception reports for missed Education and Training

Specialty	No. exceptions raised	No. exceptions outstanding
Anaesthetics		
Maxillofacial		
Orthodontic		
Plastics	1	0
Radiology		
Total		

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT1-2 / ST1-2				
ST3 +		6	6	0
Total				

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Anaesthetics				
Maxillofacial junior				
Maxillofacial senior				
Orthodontics				
Plastics Junior				
Plastics Senior	4	6	6	0
Radiology				
Total				

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0			
F2	0			
CT1-2 / ST1-2	0			

ST3-8	1		5	
Total	1	0	5	0

n) Work schedule reviews

No work schedule reviews were required to be undertaken

o) Locum bookings

v) Bank

Locum bookings (bank) by department					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Anaesthetics	20	20	0.00	216.75	216.75
Maxillofacial	44	44	0.00	570.00	570.00
Orthodontics	7	7	0.00	57.00	57.00
Plastics	86	86	0.00	856.25	856.25
Total	157.00	157.00	0.00	1700.00	1700.00

Locum bookings (bank) by grade					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
CT1-2*	54	54	0.00	539.25	539.25
ST3 + *	103	103	0.00	1160.75	1160.75
Total	157.00	157.00	0.00	1700.00	1700.00

*Includes Trust Grade doctors – Health Roster is not configured to identify separately

Locum bookings (bank) by reason*					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	59.00	59.00	0.00	647.50	647.50
Sickness	27.00	27.00	0.00	289.50	289.50
Increase in workload	14.00	14.00	0.00	83.50	83.50
Other*	57.00	57.00	0.00	679.50	679.50

Total	157.00	157.00	0.00	1700.00	1700.00

*Other * includes Additional Clinics/list, Additional Dependency - Covid 19, Annual leave, Maternity, On Call, Other, Special Leave, Study leave, Training*

vi) Agency

We have had no agency bookings this quarter.

p) Locum work carried out by trainees

We are currently not collecting data on individual trainees.

Bank hours can be either current junior staff who would like to do extra hours where permitted by their shift pattern and fixed limits or ex junior staff who remain on our bank list. This is the preferred way of filling gaps; with doctors that know the QVH and avoiding agency fees.

q) Vacancies

Vacancies by month						
Specialty	Grade	Month 1	Month 2	Month 3	Total gaps (average)	Number of shifts uncovered
Anaesthetics	ST5+	0.00	0.00	0.00	0.00	0.00
Maxillofacial Core	DCT2+	1.00	1.00	1.00	1.00	0.00
Maxillofacial higher	ST3+	1.00	1.00	1.00	1.00	0.00
Plastic surgery core	CT2+	2.00	1.00	1.00	1.33	0.00
Plastic surgery higher	ST3+	2.00	2.00	2.00	2.00	0.00
Orthodontics	ST1+	0.00	0.00	0.00	0.00	0.00
Total		6.00	5.00	5.00	5.33	0.00

NB Anaesthetics had no gaps, but 2 trainees in month 1 were unable to do out of hours duties as on return to work programme after maternity leave.

r) Fines

Fines by department		
Department	Number of fines levied	Value of fines levied
Plastics	1	£601.50

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£2707.56	601.50	US training eve - £100	
		Journal club event	

Qualitative information

This last three months were understaffed in all areas. Plastics in particular have had 2 slots vacant at both levels at times.

The input from a senior junior doctor to the weekly rota has made a huge difference in plastics. Trainees are exception reporting at a much lower level to the previous quarters of 2021.

Issues arising

The maxillofacial department have struggled to recruit into their senior rota. They are down on numbered deanery trainees and also need to have a trust grade doctor to give a proper rota. Trainees from Eastbourne and Brighton also come to QVH as part of their training and help fulfill the overnight rota.

The culture in this department is to not report on issues. We have had only the junior dental trainees fill exception reports in the past. The problem with gaps in this department is that it is nigh impossible to get locum cover and it necessitates either current or old trainees to fill the gaps. Fortunately, I do not think they are frequently up during the night, but I have no data to confirm that.

I have recently run two sessions on exception reporting, one to plastics and the other to maxillofacial to go through the process, its benefits and how it can be used positively.

One main issue from the JDF has been the general poor level of accommodation for on call staff in Meridian Way. This is outsourced by the Trust and following on from complaints, which went unheeded, we have required our CE Steve Jenkins to become involved. It looks like they are now beginning a refurbishment process, and I look forward to being able to report back positively.

Another issue was the over correct allocation of annual leave hours, particularly in relation to bank holidays. This has been addressed through the LNC and HR.

Summary

I am able to confirm to the board that the hours worked by the junior doctors comply with safe working practices, with a reservation that I would like to encourage a better rate of exception reporting by the maxillofacial trainees.

Document:	Minutes (Draft & Unconfirmed)	
Meeting:	**Board of Directors (session in public)** **Thursday 05 May 2022 10am-1pm Education Centre, QVH**	
Present:	Anita Donley (AD)	Trust Chair (voting)
	Gary Needle (GN)	Senior Independent Director (voting)
	Lawrence Anderson (LA)	Interim Director of workforce (non-voting)
	Tania Cubison (TC)	Medical director (voting)
	Paul Dillon-Robinson (PD-R)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Shane Morrison- McCabe (SM)	Director of operations (non-voting)
	Karen Norman (KN)	Non-executive director (voting)
	Steve Jenkin (SJ)	Chief executive (voting)
	Michelle Miles (MM)	Director of finance (voting)
	Nicky Reeves (NR)	Chief Nursing Officer (voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
	Sheila Perkins(SP)	FTSU Guardian, items 62-22- 64-22 only
In attendance:	Leonora May (LM)	Deputy Company Secretary (minutes)
Members of the public:	Two (and one for item 63-22 who joined remotely for this item)	

Welcome	
62-22	**Welcome, apologies and declarations of interest** The Chair opened the meeting, welcoming members of the Board and two members of public in attendance, being one public governor and one member of staff. The Chair reminded members of the public that they were invited to observe but not participate in the meeting in public. The director of operations and deputy company secretary were welcomed to their first public meeting of the QVH Board of Directors. There were no apologies and no declarations of interest other than those already recorded on the register.
Standing items	
63-22	**Patient story** A patient's son was welcomed to the meeting to give an account of his mother's patient story. In March 2022, his mother had emergency surgery at east surrey hospital and when she was discharged she was advised to book an appointment with her GP to have staples removed. The GP was unable to remove the staples in a timely way and recommended that the patient make an appointment at Queen Victoria Hospital. The patient was able to make an appointment at QVH and made alternative care arrangements for her husband who could not be left at home alone. On arrival at QVH outpatients centre the patient and her son were advised by the nurse on duty that she was unable to remove the staples. The nurse recommended that the patient attend the QVH minor injuries unit (MIU) where the procedure would be carried out. The patient and her son were advised that there might be up to a four hour wait at MIU. The Trust's patient experience manager acted to resolve the situation on the day but this

	experience was traumatic for the patient and her family. The patient's son expressed his gratitude for the fact that that full details of the events were shared in a timely way, and particularly actions being implemented by QVH to prevent such problems being encountered by other patients and families/carers in the future. The Board noted that the usual pathway for staple removal when a patient is referred from another hospital would be MIU. The Board also noted that an individual patient's personal circumstances are of importance, in that arrangements affecting other members of the patient's family or dependants may be impacted by the need to attend a hospital appointment, as in this case. The learning from this incident was important in the wider QVH approach to patient care, support and wellbeing, and also in the need to ensure clarity for QVH staff, and for GPs and other hospitals which might directly refer patients to QVH. The Board thanked patient's son for his contribution to the meeting, and **noted** the details of the patient story.
64-22	**FTSU Guardian update** SP, FTSU guardian, presented the freedom to speak up report to the Board. The data within the report covered the period November 2021- May 2022. Four members of staff had raised concerns during this period. Two concerns related to discussions about vaccination as a condition of deployment; one being related to perceived unreasonable behaviour from a line manager, and a second case which had been investigated; both cases have been resolved. No cases remain open. New guidelines for reporting and recording of cases to the FTSU guardian were published on 1 April 2022. There was a new category for cases that include an element of other inappropriate attitude or behaviour that would not be covered by the category about bullying or harassment. In response to a query, SP confirmed that the advisory, conciliation and arbitration service (ACAS) criteria would be used to ascertain whether behaviour amounted to bullying and would not be categorised as being so unless explicitly reported as bullying. The clarification of themes and categories was welcomed by the Board. SJ highlighted the importance of embedding a culture where staff felt safe to speak out and asked SP if she had a sense of whether the Trust could make further improvement in this area. SP confirmed that staff were aware of her position as FTSU guardian and had fed back that they felt safe and confident to raise concerns as appropriate. In response to a question about what, if anything, had changed or evolved during her time in the role, SP confirmed that she was now more confident in her position, and that she continued to learn from other FTSU guardians through the FTSU guardian network. SP thought that, in general, there was a sense of positivity and calmness amongst staff at the Trust with disputes being resolved reasonably quickly. The Board thanked SP for her positive contribution to the Trust in her role as FTSU guardian, and **noted** the contents of the freedom to speak up report. [SP left the meeting]
65-22	**Draft minutes of the public meeting held on 03 March 2022** The Board agreed that the minutes of the public meeting held on 03 March 2022 were a true and accurate record of that meeting and **approved** them on that basis.
66-22	**Matters arising and actions pending**

	The Chair updated the Board on a matter arising from the February private board meeting. A governor had raised concerns related to staff governors' comments that patient care had been compromised as a result of corporate meeting schedules, and staff governors' requests that the Trust consider scheduling meetings involving governors to the evening where possible; the operations team and the staff governors had provided assurance that staff governor attendance at corporate meetings had not impacted the care of QVH patients. It was acknowledged that earlier involvement of the staff governors in the evaluation of potential impact should have occurred. TC provided an update on a matter arising from the February private board meeting, being an action to progress a formal response from the consultant medical staff to NEDs regarding the vote of no confidence in the CEO last year. TC reported that all concerns had been addressed in writing. The matter was closed and there was no further action pending. There were no matters arising or outstanding actions pending on the public Board matters arising report.
67-22	**Chair's report** The Chair presented her report to the Board which provided an update on the implementation of the recommendations of the independent review and ongoing work to secure the future of the Trust. The report referred to operating pressures, workforce challenges and a stringent financial climate, all of which were recognised by the Board as challenges. The Chair reported that the Board was looking forward to re-establishing important on-site and face-to-face interactions. In addition, the NEDs, led by GN, are developing new ways of working with governors to allow optimal insight into how NEDs contribute in a variety of ways as members of the Trust's unitary Board. These developments are intended to further enable the Council of Governors in its statutory role of holding NEDs to account. The Board **noted** the contents of the report.
68-22	**Chief Executive's report** SJ reported that he had attended an NHS England leadership event on 28 April 2022 and outlined the key priorities for the NHS set by the chief executive of NHS England. SJ highlighted some reflections from the past two years, being: - Lessons learnt from Covid - senior clinical and management staff had been working well together in developing pathways, testing, visiting and clinical coding. SJ expressed particular thanks to TC and NR for their work - Finance - following two years of block contract funding, the Trust had ended the 2021/22 financial year with a small surplus. The financial year 2022/23 will be the start of a return to usual financial arrangements and attention to activity plans and efficiency targets will resume - Estates - several important projects had been completed in the last two years, such as the dental skills lab, and the two new modular theatres are an important development - Workforce - SJ commended the Trust's staff who had worked tirelessly throughout the pandemic and noted that the positive staff survey results included within the papers SJ highlighted priorities for 2022/23 and reported that the Trust had submitted its operating plan which focussed on addressing key operational challenges including achieving cancer

	standards, 52 week breach position, reducing outpatient follow up appointments and achieving 104% elective activity against 2019/20 levels. Work alongside University Hospitals Sussex NHS Foundation Trust (UHSx) in developing a full business case for a potential merger would recommence after the challenging winter months. The Health and Care Bill 2022 received royal assent on 28 April 2022. The bill and future act place ICSs on a statutory footing; SJ observed that part of the ICS remit is to support local leaders to improve the health of their local communities. Board members discussed the ongoing national workforce gap and SJ confirmed that this issue had been discussed at the recent NHS England leadership event where there were many examples of NHS organisations taking a different approach to attracting and retaining staff, such as higher banding, apprenticeships and development opportunities for existing staff. The Board noted the advantages of considering new initiatives and recruitment drives. NR reported that the Trust is working with UHSx on recruiting international staff. Board members discussed further work to be done on the corporate risk register to link it to the principal risks described in the chief executive's report and to review long standing risks. The Board **noted** the contents of the report.
69-22	**Green Plan part 2 - delivery** SJ presented part 2 of the green plan (delivery in detail) to the Board and it was noted that part 1 of the green plan (our commitment) had been approved by the Board in January 2022. In response to a question, MM confirmed that there would be a cost related to the delivery of the plan and that this would be presented to the Board once known. One necessary investment would be the installation of additional electric car chargers on site. The Board provided positive feedback and commended all involved on work to date and the scope and proposed delivery of the Green Plan. Board members were keen to see momentum with delivery being kept up and realistic targets being set. The Board **approved** part two of the Trust's Green Plan (delivery in detail).
Trust strategy	
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services	
70-22	**Board Assurance Framework** NR and TC presented the board assurance frameworks related to key strategic objectives one and two. There had been no material update to KS01 during the period. TC explained that appropriate assurances had now been received from the microbiologist in relation to antimicrobial prescribing and from the sleep pharmacist in relation to prescribing for sleep patients. The Board **noted** the board assurance frameworks related to key strategic objectives one and two.
71-22	**Quality and Governance Committee assurance**

	KN presented the Quality and Governance Committee assurance report to the Board. CP confirmed that the Board was not required to ratify the security risk assessment & strategic work plan (as stated in the paper) as this had been ratified by the Quality and Governance Committee outside of the inquorate meeting. The Board **noted** the contents of the report.
72-22	**Corporate Risk register (CRR)** NR presented the updated corporate risk register (CRR) to the Board. Changes to the register since the last review had been summarised within the associated report. The Board noted that risk 1259 (increased cyber security threats from Russia) had been added to the CRR during the period. MM reported that the Trust were working with the national cyber security team to address the risk in a timely manner, using a toolkit and indicators. Board members noted that there were some risks which were either without mitigating actions or where information needed updating; Board members highlighted the importance of all risks being updated regularly in order for the Board to understand action being taken to align with risk appetite. The Board requested that the Trust's most prominent risks be highlighted on the CRR covering report for future Board meetings. **Action NR.** The Board **noted** the updated CRR and associated report.
73-22	**Quality and Safety report** NR and TC presented the quality and safety report to the Board and outlined the key highlights as set out on page one of the report. The Board **noted** the contents of the report and the assurance provided.
74-22	**Emergency Preparedness Resilience and Response (EPRR) core standards and statement of readiness** NR presented the EPRR report to the Board and reported that the Trust had achieved a rating of substantial compliance during the assurance exercise. There were three actions for the main domains and one of these had already been completed. There were five actions for the deep dive regarding oxygen supply. NR was commended on her work which had resulted in an increase of compliance to being substantial. The Board **noted** the contents of the report.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
75-22	**Board assurance framework** SMM and MM presented the board assurance frameworks related to key strategic objectives three and four to the Board. SMM highlighted future opportunities for KS03 and reported that work had started on the new modular theatres and had been appointed recently. There had been no material update to KS04 during the period.

	The Board **noted** the board assurance frameworks and updates related to key strategic objectives three and four.
76-22	**Financial, operational and workforce performance assurance** PDR presented the financial, operational and workforce performance assurance report to the Board. The Finance and Performance Committee had met on 25 April and had approved the business plan for submission, as per delegated authority from the Board. The committee had acknowledged areas of risk and uncertainty; any significant changes made post meeting would be ratified electronically. The workforce requirement was subject to scrutiny and challenge by the committee, including posts currently not filled and the need for a vacancy factor to reflect difficulties and delays in recruiting. The financial plan for 2022/23 proposed a deficit of £2.6m, following a surplus of £1.7m at 2021/22 year-end. In response to a question, MM confirmed that the surplus would not offset any prior period financial deficits as the Trust was allocated public dividend capital in line with other Trusts with historic deficits. The surplus would remain within the Trust's accounts as surplus cash. The Board **noted** the contents of the report.
77-22	**Operational performance** SMM presented the operational performance report to the Board and highlighted key information re diagnostics as set out in the report. The community diagnostic centre (CDC) H1 plan had been approved for funding for the first half of the current financial year. In response to a question, SJ confirmed that the CDC pilot scheme had been extended to ten GP surgeries and that there plans are in place to extend to c.40 surgeries within the Sussex area. Work on full business case for CDC H2 and funding was underway. The Board considered whether there were any risks associated with the patient initiated follow up scheme and it was confirmed that the Trust were following the commissioners lead on risk associated with the scheme. The commissioners were drafting guidance and inclined to taking a risk averse approach. The Board requested that work was undertaken to collect and analyse patient feedback related to the scheme. **Action SMM.** [TC left the meeting] MM provided the Board with an update on the Trust's theatre capacity challenge and related negotiations. The Trust had received a quote from independent sector partners which was above tariff and that the team were working with ICS colleagues to understand the implications of this. The Board **noted** the report.
78-22	**Financial performance** MM presented the financial performance report to the Board and reported that the Trust's income and expenditure position at year-end was a surplus of £1.7m. This was a £0.5m surplus increase from the £1.2m forecast at month 11, due to the expected requirement to repay funds related to the community diagnostic centre having been removed. The Trust delivered spend of £7.245m which was £0.4m below plan. This included £3.1m on the modular theatre project.

	The Board **noted** the report.
79-22	**2022/23 budget setting** MM presented the 2022/23 budget setting report to the Board. It was reported that the Trust had submitted its operating plan on 28 April 2022 as approved by the Finance and Performance Committee per delegated authority from the Board. The plan stated a £2.7m deficit, due to inflation over and above tariff uplift and based on 103.5% activity levels as compared to 2019/20. The Board considered whether there was an expectation that the government would allocate additional funding nationally to cover the deficit and inflation costs and MM stated that there had been no indication that this would be the case. The Board considered the risks associated with planning for a break-even position for 2022/23 in line with statutory responsibilities and were in agreement that to break even would pose a risk to the quality of care and safety of patients. The Board received an update on capital. It was reported that the Trust had submitted a capital plan with allocation of £4.7m and agreement from UHSx to support by underwriting an additional £1.6m for use within 2022/23. Capital spend within the system would continue to be reviewed on a quarterly basis. In the interest of the Trust continuing to maintain safe, effective and timely care to patients, the Board **approved** the planned deficit of £2.7m for 2022/23.
Key strategic objective 5: organisational excellence	
80-22	**Board Assurance Framework** LA presented the board assurance framework related to key strategic objective five to the Board and reported that there had been no material update to KS05 during the period. The Board **noted** the board assurance framework related to key strategic objective five.
81-22	**Workforce Monthly report** LA presented the monthly workforce report to the Board and highlighted key headlines and statistics as set out within the report. It was noted that vacancies had reduced slightly and that turnover had stabilised following rises since June 2021. Sickness rate had reduced slightly from previous months and although this was still high for the Trust, the Board noted this to be a favourable position compared to the national statistics. [TC re-joined the meeting] The headlines within the report had stated that overall statutory and mandatory training compliance was at 89.34% and it was noted that this figure was in fact 91.06%. The Board requested that mental and physical health-related absence figures be separated in future reporting. **Action LA.** LA confirmed the process for reviewing flexible working applications was satisfactory, although there were areas for development going forwards. The process was independently reviewed and allowed the right for colleagues to appeal and potential to reach a compromise.

	The Board **noted** the monthly workforce report and its contents.
82-22	**Staff survey results and action plan** LA reported that the survey had changed from previous years and was underpinned by the seven pillars of the NHS People Promise. The Trust was, compared to other specialist trusts, above average on five of the seven People Promise pillars, average on the remaining two and above average on the themes of the staff engagement and staff morale. Key future actions include a review of the workforce strategy and further action on both the Trust's wellbeing strategy, and on equality, diversity and inclusion (EDI) action plan. The review of the workforce strategy had been completed and work on the wellbeing strategy and EDI action plan would be prioritised in line with national reporting timeframes. The Board agreed that the promotion of Trust benefits for staff would be key in attracting and retaining staff going forwards. LA stated there would be a review of appraisal documentation and monitoring of the quality of appraisals, ensuring that managers are supported in delivering effective appraisals for team members. The Board requested assurance that appraisals are effective, based on a sample of appraisal data and outcomes. **Action LA.** The Board **noted** the data and analysis from the Trust's 2021 staff survey and endorsed the associated action plan.
Governance	
83-22	**NHS provider licence conditions** CP presented the report to the Board. The Board noted the evidence of compliance as set out within the report. It was noted that the Trust's burns service did not meet the national specification and that the Trust had a significant financial deficit. Because of this, it was proposed that the Trust confirmed option b, that declaration being that 'the required resources will be available over the next financial year but specific factors may cast doubt on this'. The Board **confirmed** that: - it had complied with the standard and additional NHS provider licence conditions, - it had taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution, - it had complied with required governance arrangements, and - it had a reasonable expectation that required resources would be available to deliver the designated Commissioner Requested Services over the next financial year but that specific factors may cast doubt on this.
84-22	**Variation to Constitution April 2022** The Board **noted** that email approval was secured from voting Board members for Paul Dillon-Robinson to act for Gary Needle (senior independent director) as Chair of the interview panel for the appointment of the new QVH Chair.
85-22	**Audit Committee assurance** KG presented the Audit Committee assurance report to the Board. The Board **noted** the contents of the Audit Committee report and assurance provided.
86-22	**Nomination and remuneration assurance**

	The Chair presented the Nomination and Remuneration Committee assurance report to the Board. The Board n**oted** the report.
Any other business (by application to the Chair)	
87-22	The Board noted that it was AD's last public meeting in post as Chair of the Trust. The Board expressed thanks to AD for joining the Trust as interim Chair and for her valued and steadfast leadership during her time in post.
Members of the public	
	Questions from members of the public There were none.
	Exclusion of members of the public Aligned to paragraph 39.1 and annex 6 of the Trust's Constitution, members of the public and representatives of the press were excluded from the remainder of the meeting for the purposes of allowing the board to discuss issues of a confidential or sensitive nature. There were no further comments and the Chair closed the public session of the meeting at 12.46pm.

Matters arising and actions pending from previous meetings of the Board of Directors - PUBLIC									
ITEM	MEETING Month	REF.	TOPIC	CATEGORY	AGREED ACTION	OWNER	DUE	UPDATE	STATUS
1	May	72-22	Corporate Risk register (CRR)	KSO1&2	Ensure that the Trust's most prominent risks are highlighted on the CRR covering report for future meetings.	NR	July	Prominent risks are highlighted within the front cover for the report to this meeting	Closed
2	May	77-22	Operational performance	KSO3&4	Collect and analyse patient feedback related to the patient initiated follow up scheme and report back to the Board.	SMM	July	Verbal update at July Board meeting	Pending
3	May	81-22	Monthly workforce report	KSO5	Separate physical and mental health sickness absence data in future reporting.	LA	July	This data was presented to the Finance and Performance committee at its meeting on 27 June 2022	Closed
4	May	82-22	Staff survey results and action plan	KSO5	Provide the Board with assurance that appraisals are effective, based on a sample of appraisal data and outcomes.	LA	July	This data was presented to the Finance and Performance committee at its meeting on 27 June 2022	Closed

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/07/2022		**Agenda reference:**	**100-22**	
Report title:	Chair's report				
Sponsor:	Gary Needle, senior independent director				
Author:	Anita Donley, Trust Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board of Directors on Chair, non- executive director (NED) and governor activities since the last meeting				
Summary of key issues	- Review of transaction programme options appraisal and work on full business case is underway - Meetings with stakeholders - Governor seminars - New lead governor from 01 July 2022 - New QVH Chair to take up role on 11 July 2022				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:	N/A				

Report to:	Board Directors
Agenda item:	100-22
Date of meeting:	07 July 2022
Report from:	Gary Needle, senior independent director
Report author:	Anita Donley, Trust Chair
Date of report:	28 June 2022
Appendices:	None

Chair's report

Since we last met as a Board, work has continued apace on maintaining our high standard of patient care; rising to the challenge of national priorities such as elective care waiting times and cancer care; meeting NHS constitutional standards; and implementing the recommendations of the Independent Review, including the review of the Options Appraisal and the early work on the Full Business Case. Clinical leadership and engagement in these processes is vital, and I am particularly pleased to also note that work on the Clinical Strategy (including Clinical Service Reviews) is already well underway. The CEO and I continue to meet with stakeholders, such as parliamentarians and our local government colleagues; in the last month this has included meetings with Mims Davies MP, and East Grinstead Town Council.

With regard to assurance and scrutiny, our NEDs continue the series of informal meetings with Governors, and on June 27th the first of three Governor seminars was held as an integral part of the Transaction Programme; this included detailed discussion of the Options Appraisal, the draft Communications and Engagement Plan, and an update on the role of Governors in Integrated Care Systems (part of an ongoing consultation on a draft national Code of Governance).

The CEO's report will reference important achievements and opportunities for services on our site, such as the Community Diagnostic Centre, and expansion of theatre capacity. QVH senior leaders are also playing an important role in the Sussex Health and Care Partnership at both system level, and in the evolution of place and neighbourhood plans.

I would like to extend thanks to Peter Shore for his time and commitment to the Trust as he steps down from his role as lead governor on 30 June 2022. Chris Barham, public governor, has been elected to take over from Peter on 1 July 2022 and I would like to wish him all the best in this role.

Finally, I would like welcome our new Chair, Jackie Smith, who takes up her role on 11th July, and I would like to thank everyone for such an interesting and enjoyable time with you at QVH, and send you all my very best wishes for the future.

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

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

KSO 1&2 were reviewed at the Quality and Governance Committee, 04/07/2022. KSO 3, 4 and 5 were reviewed at the Finance and Performance Committee on 27/06/2022. The trust finances continue to be break even and we await further national /regional instruction regarding the financial flows. The trust is proactively managing the new and emerging risks identified as part of the restoration and recovery phase. Workforce challenges continue to be referenced in individual BAF's

	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Target risk
KSO 1	12	12	15	15	9
KSO 2	16	16	16	16	8
KSO 3	16	16	16	16	9
KSO 4	20	20	20	20	16
KSO 5	16	16	16	16	9

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/2022**		**Agenda reference:**	**101-22**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	1) Independent review – recommendations 2) Integrated Dashboard 3) 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	• New Chair • Celebrations – nurses, ODPs, volunteers • NHS Sussex goes live				
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:					
Corporate risk register:	None				
Regulation:	N/A				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	BAF reviewed at EMT				
	Date:	27/06/22	Decision:		
Next steps:					

CHIEF EXECUTIVE'S REPORT
JULY 2022

TRUST ISSUES

New Chair

Jackie Smith (pictured right) has been appointed as Chair at QVH and will take up the role on 11 July.

Jackie was chief executive of the Nursing and Midwifery Council from December 2011 to July 2018, setting regulatory standards and providing influential leadership in a challenging political arena. Currently Jackie is Chair of two mental health trusts in north London which are in a formal partnership.

Jackie takes over from Dr Anita Donley who has been interim Chair since November last year.

GIRFT (Getting It Right First Time)

We were delighted to have Professor Tim Briggs (pictured right) the National Director of Clinical Improvement for the NHS present at the JHCGM on Monday 9 May about the 'Getting It Right First Time' (GIRFT) methodology. Professor Briggs developed GIRFT for Orthopaedics and is now leading on embedding GIRFT throughout the NHS. GIRFT supports hospitals to interpret their datasets and start improving quality of care for patients and delivering efficiencies, by reducing unwarranted variation.

2022/23 Key risks

The Board regularly reviews the three overarching risks to delivering the Trust's corporate objectives and the ongoing safe delivery of clinical services. Since our last Board meeting:

1. Keeping our staff engaged, motivated and supported during a time of great change – continuing briefings by the CEO in both open staff meetings and individual team meetings. Recent attendance at East Grinstead Town Council Public Services Committee (21 June) and, alongside Chair, with Mims Davies our local MP. At the time of writing we are in the final stages of preparation for our staff awards, a highly motivational, celebratory event which we have not been able to hold in person since 2019.
2. Maintaining patient and staff safety through the pandemic – we continue to respond to updated national guidance, carefully considering the implications for our work. In June, thanks for support from QVH Charity, we launched a hardship fund to support staff who experience a sudden unexpected drop in income or a sudden, unexpected cost. This has been very well received by staff with some staff saying they wish to contribute to the fund.
3. Securing a sustainable future for QVH – recent developments include investment from NHS England for the two modular theatres and a business case submitted for expansion of our community diagnostic offer to our local community.

These overarching risks are reflected in all the KSO BAFs and reviewed when preparing board papers for each KSO. The CEO is accountable for leading on the management these risks.

Independent review

As reported in CEO report in May, the independent review of QVH's handling of challenges encountered in progressing a merger proposal with University Hospitals Sussex NHS Foundation Trust given the range of views about the future of QVH was received by the Board and was published in full. The Board is committed to ensuring the recommendations are acted on effectively, with good ongoing engagement with staff and external stakeholders.

Recommendation 2 of the review stated: *"The work programme should reflect that the Full Business Case needs to rehearse the strategic case in a level of depth including the case for change, the long-list of options, the hurdle criteria, the short-list of options, the evaluation criteria, and the appraisal leading to the preferred option."* Over the course of three workshops during May a group including executive directors, non-executive directors and clinical directors has reviewed the Case for Change and Options Assessment. This has included considering changes in both the national and local context. Later in this Board pack is a report outlining the process undertaken and the conclusion of the process, including the reasoning.

Appendix 1 shows an update on progress delivering against the 12 recommendations in the independent review.

International nurses day

International Nurses Day is celebrated around the world every May 12, the anniversary of Florence Nightingale's birth. Despite working through challenging circumstances, nursing staff continue to go above and beyond to deliver highly skilled, safety-critical care to patients every single day. QVH like all NHS trusts celebrated Nurses' Day as a chance to recognise and say thank you for all nurses do.

NHSE Chief Nursing Officer (CNO) Ruth May (above) congratulated QVH nurses via MS Teams on their ongoing compassionate care for patients.

Allison Cannon CNO for Sussex commissioners visited QVH on the day to support the celebration of QVH nursing.

Facial Palsy

Our facial palsy and corneoplastics teams who won the best paper award for QVH at the recent virtual 14th International Facial Nerve Symposium 2022 in Seoul, Korea. This is the world's premier meeting in facial palsy. The QVH team presented a total of 29 presentations including one keynote lecture and seven symposium lectures. Here are some of our team pictured at an event pre-Covid.

Operating Department Practitioners Day – 14 May

Two days after nurses celebrated their day, operating department practitioners (ODP) day which celebrates the important role ODPs play and hopes to inspire the next generation to join the profession. Pictured is Helen Newman, Deputy Theatre Manager with a group of ODPs working on 14 May.

Volunteers Week

To celebrate Volunteers' Week 2022 (first week in June) we held our first face-to-face get together since February 2020. The event was well attended by both line managers and volunteers from various departments across the Trust,. As well as hearing some Trust-wide updates, the volunteers heard from consultant Joy Curran and her team (pictured above) who delivered a fascinating presentation and demonstration on the charity funded virtual reality headsets. They explained the equipment is used as both a distraction and pain management tool for adults and children and some volunteers got to test out the equipment.

Integrated Performance Dashboard Summary

Our Integrated Performance Dashboard (Appendix 2) reflects the M2 position and an abbreviated highlight from the National Quarterly Pulse Survey which has replaced the Staff Friends and Family Test.

Board Assurance Framework (BAF)
The entire BAF was reviewed at executive management meeting (21/06/2022) alongside the corporate risk register. KSO 1 and 2 were reviewed at the Quality and Governance Committee, 04/07/2022. KSO 3, 4 and 5 were reviewed 27/06/22 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 3) during April and May 2022.

SUSSEX SCENE
NHS Sussex
The Health and Care Bill, received Royal Assent on Thursday, 28 April to become the Health and Care Act 2022. The Health and Care Act heralds the biggest legislative reforms to the NHS in a decade.

The Act puts integrated care systems on a statutory footing which will support local leaders to make significant improvements to the physical and mental health of their communities. This is critically important as the NHS seeks to rebuild population health and tackle health inequalities following the COVID-19 pandemic.

Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. NHS Sussex ICB comes into effect on 1 July.

Sussex Health&Care

Each ICS will include:

- **An Integrated Care Partnership (ICP**) – a statutory committee jointly formed between the NHS Integrated Care Board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

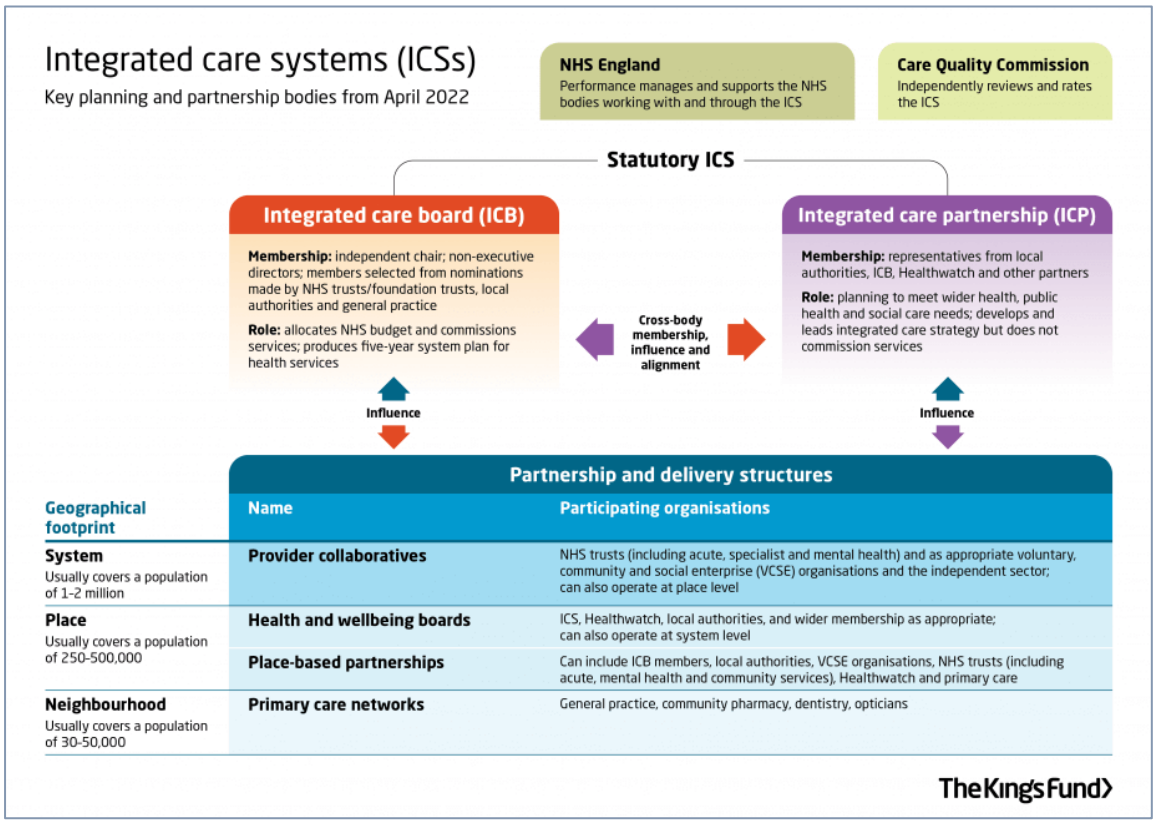
- **An Integrated Care Board (ICB)** – a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. When ICBs are legally established, clinical commissioning groups (CCGs) will be abolished.

- **Local authorities** in the ICS area, which are responsible for social care and public health functions as well as other vital services for local people and businesses

Governance principles

- Statutory accountability for each organisation remains the **sovereign responsibility** of each partner. However, statutory accountably for, and oversight of, the NHS system will formally be vested in the NHS Sussex Integrated Care Board and through the Board to the CEO of NHS Sussex (Adam Doyle).
- The **ICB CEO will be responsible** for overseeing system performance, transformation and sustainability and will need to work with the leadership community of the NHS and local authorities in Sussex to achieve the system's collective objectives.

- The CEO will therefore chair a **System Leadership Forum (SLF)** comprising the NHS Provider CEOs, place based executive leads, relevant NHS Sussex executives, and local government executives. The SLF will operationally oversee the system, ensure system coordination and alignment, and shape development of system plans and strategies.
- Whilst system coordination will take place through the SLF, there is collective agreement on the **primacy of place.** System delivery and transformation will be implemented through the three place-based Health and Care Partnerships, unless there is collective agreement that it makes more sense to deliver an element at the pan-Sussex level.
- Within each ICS, place-based partnerships will lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships will involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population.
- QVH sits in the West Sussex Place alongside Primary Care, SECamb, SaSH, SCFT, SPFT and UHSx. (Note SaSH is a member of Surrey Heartlands ICS but participating in West Sussex Place in recognition of the significant number of West Sussex patients treated at SaSH).
- It has been agreed that by 1st April 2023, the place-based partnerships will be functioning in a fundamentally different way and therefore the leadership arrangements need to be explicit.



The King's Fund: Integrated care systems: how will they work under the Health and Care Act?

NATIONAL SCENE

Messenger Review

The Messenger review into health and social care leadership in England was published on 8 June along with a set of seven recommendations. Led by Dame Linda Pollard and Sir Gordon Messenger, the review focuses on the underlying cultures and behaviours that drive organisational performance. The tone of the review is supportive of managers, and sensitive to challenges they face.

Summary of recommendations:

1. Targeted interventions on collaborative leadership and organisational values.
    - A new, national entry-level induction for all who join health and social care.
    - A new, national mid-career programme for managers across health and social care.
2. Positive equality, diversity and inclusion (EDI) action
    - Embed inclusive leadership practice as the responsibility of all leaders.
    - Commit to promoting equal opportunity and fairness standards.
    - More stringently enforce existing measures to improve equal opportunities and fairness.
    - Enhance CQC role in ensuring improvement in EDI outcomes.
3. Consistent management standards delivered through accredited training
    - A single set of unified, core leadership and management standards for managers.
    - Training and development bundles to meet these standards.
4. A simplified, standard appraisal system for the NHS
    - A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.
5. A new career and talent management function for managers
    - Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.
6. More effective recruitment and development of non-executive directors
    - Establishment of an expanded, specialist non-executive talent and appointments team.
7. Encouraging top talent into challenged parts of the system
    - Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.

Next steps for integrating care: Fuller Stocktake report

Dr Claire Fuller, Chief Executive-designate Surrey Heartlands Integrated Care System and GP, published her stocktake on primary care looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems.

In her introduction to the report published on 26 May, she wrote, "For generations, primary care has been at the heart of our communities. Health visitors, community and district nurses, GPs, dentists, pharmacists, opticians, and social care workers are among the most recognisable of a multitude of dedicated staff delivering care around the clock in every neighbourhood in the country.

"Every day, more than a million people benefit from the advice and support of primary care professionals – acting as a first point of contact for most people accessing the NHS and also providing an ongoing relationship to those who need it. This enduring connection to people is what makes primary care so valued by the communities it serves.

“Despite this, there are real signs of genuine and growing discontent with primary care – both from the public who use it and the professionals who work within it.”

At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

- streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention

Steve Jenkin
Chief Executive

Implementing the recommendations of the independent review

In December 2021, NHS England and NHS Improvement South East Region and the then newly appointed interim Chair of Queen Victoria Hospital NHS Foundation Trust (QVH), Anita Donley, commissioned an independent review of QVH's handling of challenges encountered in progressing a merger proposal with University Hospitals Sussex NHS Foundation Trust given the range of views about the future of QVH. In February 2022, the report was received and welcomed by the Trust Board, and published in full.

The Board is committed to ensuring the recommendations are acted on effectively, with good ongoing engagement with staff and external stakeholders. This appendix is an update on progress delivering these recommendations.

	Recommendation	Action
1	A work programme for the merger process should be developed, which allows for a holistic set of stakeholders to be engaged as the work is undertaken. At the heart of this should be clinical engagement, but wider engagement with staff, patients and stakeholders will also be important.	The work programme has been established, with appropriate programme governance. The programme is being delivered through eight workstreams: Legal and corporate governance; Clinical; Finance and performance; Communications and engagement; HR; Organisational development; Information management and technology; Estates.
2	The work programme should reflect that the FBC needs to rehearse the strategic case in a level of depth including the case for change, the long-list of options, the hurdle criteria, the short-list of options, the evaluation criteria, and the appraisal leading to the preferred option.	The process has been carried out to review the case for change, the long-list of options, the hurdle criteria, the shortlist of options, the evaluation criteria, and the appraisal leading to the preferred option. This process included valuable input from the QVH clinical directors. The process and outcome are detailed in the report to the July public board meeting.
3	The work should report to a steering group that includes multi-professional clinical and financial leadership, prior to the Board. The current steering arrangements should be reconstituted to include the Sussex Integrated Care Board (ICB), the NHSEI South East Region, UHSussex and QVH.	Programme governance includes the workstreams reporting to a programme board with multi-professional clinical and financial leadership, prior to Board. The Joint Oversight Group includes the Sussex Integrated Care Board (ICB), the NHSEI South East Region, UHSussex and QVH.
4	The steering group should oversee the development of a proportionate communications and engagement plan to accompany the work programme and should monitor an engagement log which is maintained as the work is undertaken. a. The plan should carefully consider each aspect of the process and the necessary stakeholder group(s) to contribute to it.	The communications and engagement workstream is overseen by the programme board. The communications and engagement plan has been refined with stakeholders and representative staff groups to ensure that it will support an inclusive process for producing the business case. It will be a live document and will be updated as the programme progresses, so that

	b. Discussions with stakeholders should take place to understand the most effective way to engage with them, ensuring the FBC is the product of an inclusive process. c. Once produced, the plan should be tested with representative staff groups within QVH, QVH Clinical Directors and relevant clinical leaders from UHSussex before being finalised. d. The plan should be under review so that themes from the engagement are responded to and reflected in the programme of work as required.	themes from the engagement are responded to and reflected in the programme of work as required.
5	Once the work programme and engagement plan have been developed in draft, a seminar session with the Council of Governors should take place, ideally in person, to review the plans prior to finalising so Governors' feedback can be incorporated.	A seminar with governors was held on 27 June to support governor feedback on the work programme and engagement plan.
6	A resourcing plan should be developed to support the delivery of the work programme with resource commensurate to the task. The resourcing of the team should be supported by the ICS. The team itself should be embedded in QVH, working in partnership with a lead director from the ICB and the team at UHSussex.	The programme is supported by a programme management office (PMO) team managing and reporting progress against the programme plan, monitoring progress of workstreams, monitoring programme risks and issues. The team work closely with both QVH and UHSussex and resourcing is supported by the ICS.
7	The clinical body should be engaged in this work at the earliest opportunity and should do so in partnership with clinical teams from UHSussex before pressing ahead with the development of the preferred option. The development of the preferred option should engage clinical teams of the two Trusts, with staff members from all professions.	This work is led through the Clinical workstream. Work is underway on a 'stock take' of QVH clinical and clinical support services to ensure the challenges and opportunities identified by staff working in those services are taken into account. The clinical service review and strategy process will require a multi-disciplinary approach, engaging clinical and non-clinical staff in a robust process focussed on patient benefit. An independent clinical lead, Dr Edward Rowland who was until recently medical director at Barts Healthcare, has been appointed to work closely with the medical and nursing directors of QVH and UHSussex and their teams, providing oversight and facilitation in the process of clinical review and engagement.
8	The staff Governors should meet with other representative staff groups and be supported to ensure that all staff are engaged in the merger process and that the holistic views of staff are appropriately represented, including the difference of opinion that exists. If staff	The staff governors and staff ambassadors met and discussed their different roles on 4 April. The staff governors met with the Chair and senior independent director on 6 April.

	Governors are unable to represent the views of all staff a change in the constitution should be made to ensure the staff Governors are more representative of the whole staff.	Staff briefings through Connect on existing multiple contact points for staff including staff governors, staff side/unions, staff ambassadors, FTSU guardian, QVH ethnically diverse staff network. Support for staff governors in fulfilling their role including provision of staff governor email address and promotion of staff drop-in sessions.
9	The additional NHSEI licence conditions should be developed into a Trust policy reflecting the requirements for the Governors of the Trust to adhere to the seven principles of public life. The policy needs to outline the approach taken where these principles are breached, which must ultimately lead to dismissal if conduct is unacceptable. This policy should be shared with staff in the Trust who engage with Governors so that they understand what to do if they believe they are being bullied or harassed by someone.	Ann Utley, external governance expert, was commissioned to develop a procedure for the Trust to follow when responding to any concern raised about a governor's conduct, behaviour or actions. This procedure was discussed with governors at 11 April Council of Governors meeting, and agreement was not reached in the meeting. It is planned that this issue will be considered again at the October Council of Governors meeting in the context of the expected new national *Code of governance for NHS provider trusts.*
10	To support Governors to discharge all their statutory responsibilities effectively, and ensure that roles of Governors are clear: a. There should be dedicated meetings with all Governors on matters relating to the merger process b. The merger process should not be included on other agendas such that Governors are able to engage effectively on other matters c. Governor representation in other meetings of the Board should be brought into line with recognised best practice, and the following arrangements should cease: i. Lead Governor attendance at private meetings of the Board ii. Governor representatives on subcommittees of the Board	The quarterly Council of Governors meetings will be divided into Part A and Part B, to achieve effective separation and dedicated time for the merger and for other matters without increasing the burden on Board members, governors and company secretarial support. Lead governor no longer attends private Board. Governor representative attendance at subcommittees has been ended. New lead governor role description agreed which includes responsibility for liaising with all governors for agenda suggestions and then meeting with Company Secretary and Chair. This will end need for the additional resource to manage the steering group, and also support all governors to have an equal voice in this process. Board have approved update to the Constitution related to the governor steering group; Council of Governors approval will be sought at July meeting. Work ongoing with governors on promoting effective understanding of Trust business and assurance regarding the work of the NEDs.
11	The regional and ICB finance teams should take a role in supporting the Trust to discuss the financial position of the organisation with stakeholders, including deterioration of performance, the feasible actions that can be taken to improve the position, and the potential benefits that may be derived from a merger. The outcome of this	The executive team will work with regional and ICB colleagues to organise a workshop to develop a fuller understanding of QVH finances; this is likely to be in September.

	session should be alignment on what more, if anything, is needed in the work plan going forward.	
12	Detailed communications should flow from the regional NHSEI leadership via its Specialist Commissioning function and the Sussex ICS, setting out how they plan to work with QVH to ensure the continued delivery of the specialist services that QVH provides, safeguards their quality and meets the relevant national clinical standards. This will need to be aligned with the work that QVH and UHSussex will undertake to develop a shared clinical strategy.	This will be discussed and implemented with NHSEI and ICS colleagues.
1.28	The scope of work that needs to be undertaken to develop a positive and constructive relationship between all Governors and the Board is significant, but necessary if all parties are to discharge their duties effectively, including with respect to the proposed merger. To allow this work to be undertaken in a timely manner and with a consistent group, we advise that as far as is permissible within the Foundation Trust code of governance, no change is made to the Council of Governors until NHSEI are sufficiently assured that they are prepared to lift the additional licence conditions	The Council of Governors took the decision on 21 Feb 2022 not to hold public governor elections in 2022. The next public and staff governor elections will be in 2023.

Integrated Dashboard Summary
Key indictators at a glance -July 2022 (reporting M2)

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	0
No of off-site deaths (within 30 days)	2
Complaints	5
Closed <30 days	13
FFT	
In patients	99%
Outpatients	94%
MIU	97%
Day surgery	96%
Hand trauma	94%

KSO3 Operational Excellence

MIU <4hrs	99.90%
RTT 18 weeks	66.63%
Cancer 2ww	83.40%
Cancer 62 day	87.50%
Diagnsotics <6weeks	88.90%
52ww	229
Recovery activity	
Day case	103.00%
Elective inpatient	83.00%
First outpatients	104.00%
Follow-up outpatients	2.00%
Outpatient therapies	99.00%
Non-elective	111.00%

Key	Improved Performance	Deteriorating Performance	Remains the same

KSO4 Financial Sustainability (YTD)

Income	14,367k
Pay expenditure	9,409k
Non-pay expenditure	5,319k
Surplus/Deficit	(361)k

KSO5 Organisational Excellence

Vacancy rate	13.07%
Turnover rate	16.34%
Sickness rate	4.28%
Appraisal rate	82.33%
MAST	91.60%

National Quarterly Pulse Survey (NQPS)

Employee Engagement Score	7.5	4 - Highest 25%
Advocacy Score	8.2	4 - Highest 25%
Involvement Score	7.2	4 - Highest 25%
Motivation Score	7.1	4 - Highest 25%

QVH media update – April 2022

QVH Macmillan Centre celebrates a decade of cancer support

To coincide with the tenth anniversary of the QVH Macmillan Cancer Information and Support Centre, BBC South East Today visited to find out more. The piece which aired on the lunchtime and evening news on 28 April, celebrated the support the centre's staff and volunteers have provided to thousands of people with cancer, their friends, families and healthcare professionals.

It included an interview with Nicky Reeves, Chief Nurse; Jenny who has had cancer twice and now regularly uses the centre for complementary therapy; and Catherine who was inspired to volunteer after losing family members to cancer. To highlight the holistic way the centre supports patients, it also showed acupuncture in action and why it is important for people who have had cancer.

Staff satisfaction at Sussex hospitals

The Argus ran an article using data from the national NHS Staff Survey which claimed nurses at Sussex hospitals, including Queen Victoria Hospital, did not feel there were enough staff for them to do their job properly. We were one of a number of Sussex-based hospitals to be highlighted in the piece due to the percentage change from the 2020 NHS Staff Survey results.

Work was already underway internally to review the data from the NHS Staff Survey, which was published at the end of last month. The survey itself took place last Autumn. QVH's Heads of Nursing are working with their respective nursing teams to understand more.

Also related to staffing, The HSJ, in an article behind the paywall, explored how ethnically diverse leadership is in hospital trusts across the UK. Queen Victoria Hospital was named in a table of all trusts. The data used was collated in March 2021 and is no longer representative of our senior leadership.

Patient data solution goes cloud-based

RAD magazine ran an article explaining how a consortium of NHS trusts that covers a population of around 1.2 million has procured a medical imaging system from Sectra. Trusts involved include Queen Victoria Hospital along with Ashford and St Peter's Hospitals NHS Foundation Trust, East Sussex Healthcare NHS Trust, Royal Surrey NHS Foundation Trust and University Hospitals Sussex NHS Foundation Trust. The project, initially focused on radiology and mammography imaging, will use Sectra PACS as a cloud-based solution, making it easier to access and retrieve information between trusts.

Waiting for non-urgent treatment

Sussex Express ran an article stating that patients were waiting an average of 12 weeks for routine treatment at Queen Victoria Hospital in February. The numbers relating to non-urgent elective operations or treatment, show that whilst the number of referrals are increasing, the average wait time was the same as January and that the number of people waiting more than a year and two years have both fallen.

The story used syndicated quotes from the Kings Fund and NHS Providers. Similar articles were published for other trusts across Sussex. Queen Victoria Hospital will be increasing capacity for

non-urgent surgery following the opening of its two new modular theatres in July.

Nominating outstanding staff

Queen Victoria Hospital launched its search for outstanding members of staff this month as it asked patients and visitors to have their say in this year's outstanding patient experience award. The InYourArea website helped spread the word as the hospital asked for nominations of staff who have shown exceptional care and compassion in the previous 12 months.

Visitor guidance

The Daily Mail ran two articles this month about Covid restrictions in hospitals in light of a drop in cases and a call for the UK to stop its daily statistics. The first article stated that Conservative MPs were calling restrictions on the number of visitors and length of visit a patient could have as a "breach of the Human Rights Act". Queen Victoria Hospital was cited as allowing one visitor for one hour – which at the time was correct but coincided with the publication of updated visiting guidance which was not referenced in the piece.

The second article, published on the same day, focused on a fall in Covid cases and again referenced Queen Victoria Hospital's visiting guidance (prior to it being updated).

The hospital's visitor guidance is regularly updated on its website and can be found here.

Ad hoc mentions

A patient of Queen Victoria Hospital, April Charlesworth, has spoken to the media about the support she has received from the Katie Piper Foundation. April was involved in an explosion outside a pub in Great Cornard, Suffolk, last year which generated a lot of media interest at the time. The article in the Daily Gazette and Essex County Standard referenced her receiving burns treatment at the hospital.

The website RepublicWorld.com featured a photograph of cherry blossom in our corneoplastics garden in a feature about how hundreds of thousands of people in Japan gather to witness the cherry blossom season.

Press releases

In April we issued the following press release:

- Your chance to nominate outstanding staff for QVH awards
- Calling all registered dental nurses and Registered Nurses
- QVH Macmillan Centre celebrates a decade of cancer support

We also published the following updates on our website:

- Coronavirus information and advice for our patients and visitors – update of standing story
- Our latest visiting guidance – update of standing story

QVH media update – May 2022

Happy anniversary QVH Macmillan Centre

Sussex Express featured the tenth anniversary of the QVH Macmillan Cancer Information and Support Centre on its website and how the occasion was marked by a celebratory tea party where the team were joined by then East Grinstead Town Mayor Councillor John Dabell. The article follows on from the piece on BBC South East Today a few days before.

Expert opinion on Instagram post

Queen Victoria Hospital received an unexpected name-check on Brazilian website 24h News. The three year old daughter of Brazilian actor Arthur Aguiar was pictured on social media wearing false nails in a post entitled 'start the week beautiful'. The post divided the child's Instagram followers. A news release the hospital issued back in December 2018 was cited with the quote from consultant plastic surgeon Nora Nugent used as an expert opinion about why acrylic nails on children under 12 are not advised.

New Chair appointed

The news of Jackie Smith being appointed as the new chair of Queen Victoria Hospital received coverage in the HSJ and also Nursing Times. Jackie is currently the chair of Camden and Islington NHS Foundation Trust, and Barnet, Enfield and Haringey Mental Health NHS Trust, and will take up her new role in July.

Waiting for routine treatment

Following on from Sussex Express's article last month looking at average wait times for routine treatment at Queen Victoria Hospital in February, the media outlet has produced a follow-up story for March data. The median waiting time from referral to treatment reduced from 12 weeks in February to 11 weeks in March as the hospital continues to work through its waiting list. The story cites The Society for Acute Medicine saying the latest data shows pressure on the NHS nationally is "unsustainable" and needs urgent action from the Government.

The HSJ (behind the paywall) also looked at wait times nationally, particularly for patients waiting two years for treatment. Queen Victoria Hospital was listed in a table of all trusts, rated red, amber and green based on performance. The hospital was predominantly green.

Electronic patient records

The HSJ (again behind the paywall) also referenced Queen Victoria Hospital in a list of 28 trusts without an electronic patient record (EPR) system. In February, health and social care secretary Sajid Javid set a target for 90 percent of NHS trusts to use EPRs by the end of 2023, with the remaining 10 percent needing to be in the implementation phase.

The hospital is currently developing plans to implement an EPR and looking at what other neighbouring providers are using. NHS England has called for integrated care systems to reduce the number of EPRs within its system to help data flow more freely between organisations when needed and saving time for clinicians who do not need to learn how to use different systems.

Nominating outstanding staff

Following on from the mention on the InYourArea website, Sussex Express also helped Queen

Victoria Hospital in its search for outstanding staff for its outstanding patient experience award.

Visitor guidance - again

The Daily Mail's article last month about hospital visitor guidance was referenced in another story this month and with it Queen Victoria Hospital's name. The new piece focused on a letter from Amanda Pritchard, chief executive of NHS England to chief executives across England, about visiting guidance, but harks back to its last articles. The piece does not reference Queen Victoria's updated guidance and the hospital was not approached for comment.

Stay safe in the sun

Consultant dermatologist Bav Shergill was cited in article on two pharmaceutical websites (PMLive and Fierce Pharma) on the launch of Actinic Keratosis Global Day. Actinic Keratosis is a rough, scaly patch on the skin that develops from years of sun exposure. He explained how he encourages patients to self-examine and empowers them to look after their skin.

Help when it is not an emergency

In time for the Platinum Jubilee bank holiday, patients in West Sussex were reminded by Sussex World to order any repeat prescriptions in advance, and also all of the alternatives on offer for people who need care but it is not an emergency requiring a trip to A&E. This included listing Queen Victoria Hospital's Minor Injuries Unit, with link to website and opening hours.

Ad hoc mentions

Following the death of legendary jockey Lester Piggott, Sky Sports ran an article on its website detailing his legendary career. Within it was a photograph of a young Piggott with the caption "Piggott pictured leaving Queen Victoria Hospital where he had been recovering from breaking his leg in a fall at Lingfield Park."

Queen Victoria Hospital is mentioned in a piece in The Argus about Tommy Powell who has limited vision in his right eye after the assault outside the bar he works at in Eastbourne. It says that he has been referred to the hospital.

The Voxy website from New Zealand ran an article about a museum celebrating the heroic stories of New Zealand women during war time, one of whom is Majorie Harris, a registered nurse specialising in plastic surgery who took her skills to Queen Victoria Hospital, working alongside Sir Archibald McIndoe.

An article on the Czech website chrudimsky.denik.cz said how pilot Josef Koukal, a war hero and holder of the Order of the White Lion, was celebrated in the towns of Jenišovice and Luž on what would have been his 110th birthday. Koukal was treated by Sir Archibald McIndoe at Queen Victoria Hospital.

A planning application for unused land at the back of Queen Victoria Hospital was cited in a list of plans submitted to Mid Sussex District Council between 5-6 May, according to Sussex World.

Press releases

In May we published the following updates on our website:

- Jackie Smith appointed new chair of Queen Victoria Hospital

- Our latest visiting guidance – update of standing story
- Reintroduction of parking charges from Monday 9 May
- Roadworks on Holtye Road 10-12 May and 17-19 May

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/07/2022		**Agenda reference:**	**102-22**	
Report title:	Transaction programme update				
Sponsor:	Steve Jenkin, chief executive				
Author:	Katy Cox, Transaction Programme Director				
Appendices:	A: Indicative timeline B: Programme governance C: Workstreams D: Programme risk register E: Communications and engagement				
Executive summary					
Purpose of report:	This report provides an update on the transaction programme and progress to date.				
Summary of key issues	This report provides an update on mobilising workstreams, governance, risk reporting, NHSEI approach, governor engagement and Heads of Terms.				
Recommendation:	The Board is asked to NOTE this update on the transaction programme and the progress made to date.				
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:	Transaction programme linked to all five KSOs				
Corporate risk register:	No specific CRR risk related to this				
Regulation:	This programme is based on regulatory guidance				
Legal:	None at this stage				
Resources:	Resourcing for this programme is described in the paper				
Assurance route					
Previously considered by:	The transaction programme approach has been reviewed at Programme Board and Hospital Management Team, as well as shared for feedback at governors seminar in line with the Independent Review recommendation. The communications and engagement plan has been reviewed with a number of staff groups, governors and external stakeholders as set out in the paper.				
	Date:		Decision:		
Next steps:					

Transaction programme
Summary of progress to date

Queen Victoria Hospital
NHS Foundation Trust

Programme governance

- The first meeting of the Transaction Programme Board took place on 21 June and Terms of Reference for the Transaction Programme Board were agreed. The membership of the Transaction Programme Board has been expanded to include UHSx's Chief People Officer and QVH's Interim Director of Workforce and Organisational Development.
- At the Joint Strategic Oversight Group on 22 June it was agreed to stand down future JSOG meetings with assurance being provided via business-as-usual routes (including Transaction Programme Board and QVH and UHSx Trust Boards). The programme governance structure has been updated to reflect this (see appendix B).
- Fortnightly Workstream Leads Meetings are being scheduled to commence in July. The Workstream Leads Meeting will be chaired by the UHSx transaction SRO (Chief Governance Officer) and will report to the Transaction Programme Board.

Mobilising workstreams

- The people workstream has been split into two workstreams (HR and organisational development) to allow sufficient focus on cultural integration. The performance element of the finance and performance workstream has been transferred to the legal and corporate governance workstream to ensure the scope/membership of the finance workstream is manageable.
- Lead directors and workstream leads for all workstreams have now been confirmed (see appendix C).
- A programme kick-off meeting has been held with the workstream leads for the clinical, communications and engagement and legal and corporate governance workstreams. A programme kick-off meeting for the remaining workstream leads is being organised for early July. Once mobilised, a key task for all workstreams will be to finalise the workstream summaries which detail scope and milestones for each workstream. Workstreams will then report progress via highlight reports.

Summary of progress to date (cont'd)

Queen Victoria Hospital NHS Foundation Trust

Risk reporting

- An initial programme risk register has been created (see appendix D) and this was reviewed at the Programme Board meeting on 21 June. Once mobilised, risks will be identified by workstreams and added to the risk register. The risk register will be reviewed at the Workstream Leads Meeting with key risks escalated to the Programme Board meeting.

NHSEI approach

- NHSEI's revised transaction guidance is expected to be published in July. NHSEI shared its proposed approach to reviewing the transaction at the Joint Strategic Oversight Group on 22 June. The proposed timescales for NHSEI's review are in line with the indicative timeline for the transaction (see appendix A).

Governor engagement

- The transaction programme and communications and engagement plan (see appendix E) were shared with QVH governors for comment at a governor seminar on 27 June.

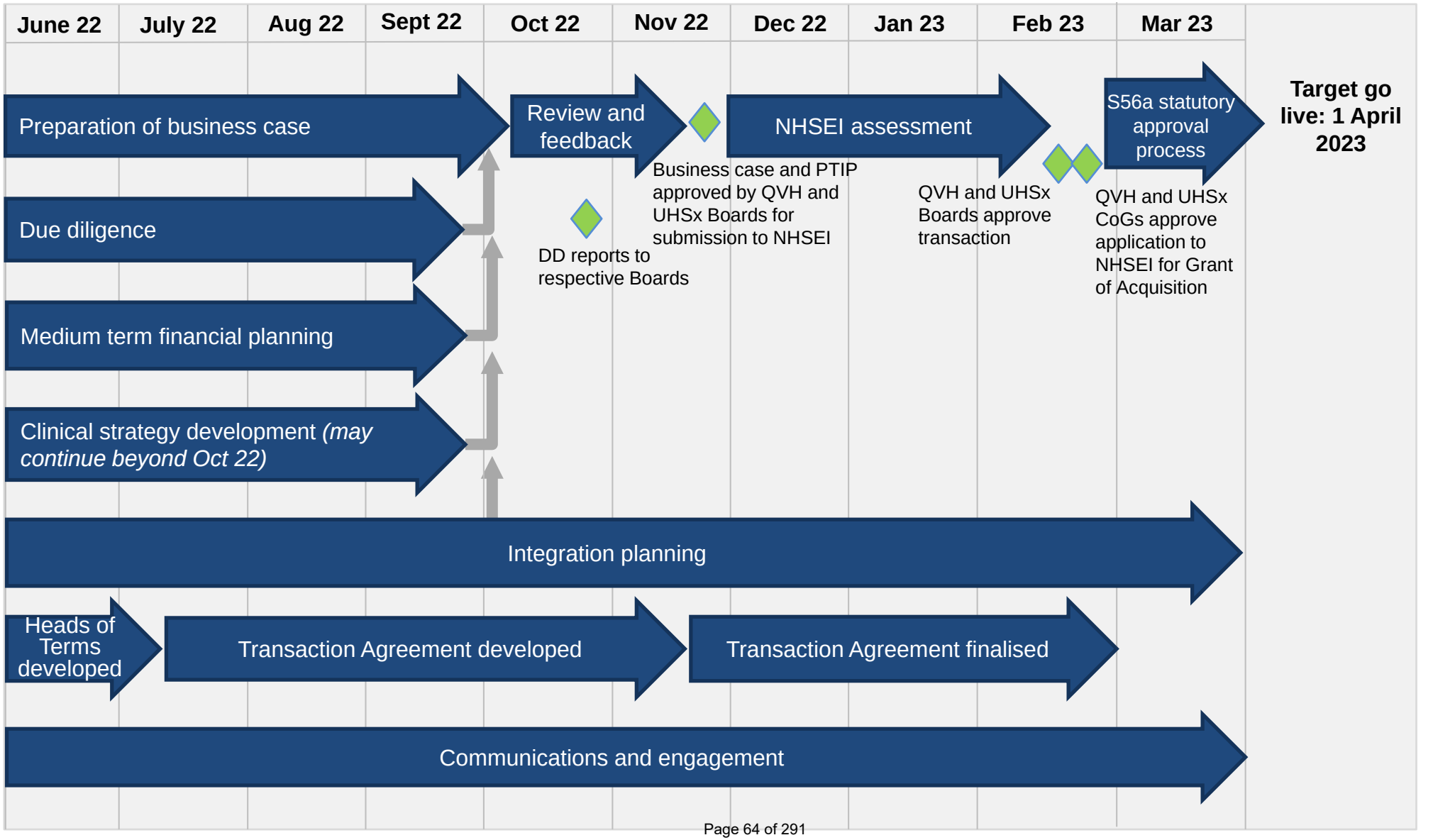
Heads of Terms

- Heads of Terms have been drafted and were reviewed at the Transaction Programme Board on 21 June.

The Board is asked to NOTE this update on the transaction programme and the progress made to date.

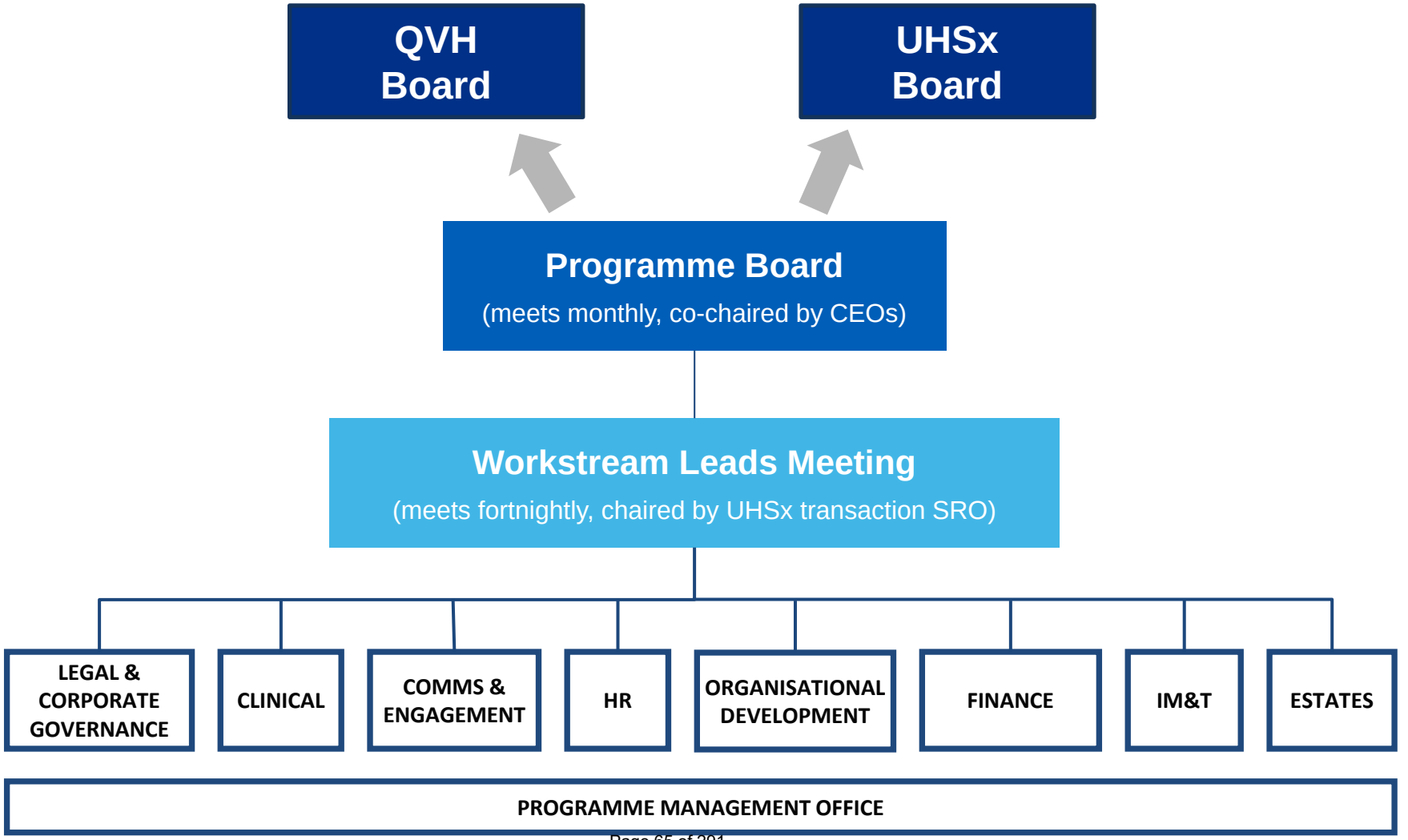
Appendix A:Indicative programme timeline

Queen Victoria Hospital
NHS Foundation Trust



Appendix B: Programme governance

Queen Victoria Hospital
NHS Foundation Trust



Appendix C: Lead directors and workstream leads

Queen Victoria Hospital NHS Foundation Trust

Workstream	Lead director	Counterpart director	Workstream lead	
Legal and corporate governance	Darren Grayson, Chief Governance Officer (UHSx)	Clare Pirie, Director of Comms and Corporate Affairs (QVH)	Glen Palethorpe, Company Secretary (UHSx)	
Clinical	Tania Cubison, Medical Director (QVH)	Charlotte Hopkins (UHSx)	Hilary Durrant (QVH)	
Comms and engagement	Clare Pirie, Director of Communications and Corporate Affairs (QVH)	Jonathan Keeble, Director of Communications (UHSx)	Dan Wood (QVH)	
HR	Lawrence Anderson, Interim Director of Workforce and Organisational Development (QVH)	David Grantham, Chief People Officer (UHSx)	Evelyn Falaye, Deputy Director of Workforce (QVH)	Helen Weatherill, Director of HR (UHSx)
Organisational development	David Grantham, Chief People Officer (UHSx)	Lawrence Anderson, Interim Director of Workforce and Organisational Development (QVH)	Nick Groves, Associate Director, Workforce Strategy & Transformation (UHSx)	
Finance	Karen Geoghegan, Chief Financial Officer (UHSx)	Michelle Miles, Director of Finance and Performance (QVH)	Clare Stafford, Director of Finance (UHSx)	
IM&T	Charlotte Hopkins, Chief Medical Officer (UHSx)	Michelle Miles, Director of Finance and Performance (QVH)	Ian Arbuthnot, Director of IM&T (UHSx)	
Estates	Karen Geoghegan, Chief Financial Officer (UHSx)	Michelle Miles, Director of Finance and Performance (QVH)	David McLaughlin, Director of Facilities & Estates (QVH)	Robert Cairney, Director of Capital and Property (UHSx)

Appendix D: Programme risk register

Queen Victoria Hospital
NHS Foundation Trust

ID	Risk	Impact	Unmitigated risk score			Mitigations	Mitigated risk score		
			Impact	Likelihood	Overall risk		Impact	Likelihood	Overall risk
4	Failure to secure funding required for implementation.	Insufficient funding to implement the integration plans, risking underperformance and delay and the long term success of the transaction.	4	4	16	The finance workstream will help quantify the level of financial support required. This will be reported to Programme Board to support negotiations with the system.	4	4	16
1	Failure to engage clinical staff in the planning and implementation.	A disengaged clinical workforce, leading to low morale, and long term staff retention and recruitment issues.	5	4	20	Development of a clinical strategy with engagement from clinical teams across both trusts and support from an independent clinical lead with merger experience. Clinical representation from both trusts on the Programme Board. Joint communications and engagement plan co-produced with staff.	5	3	15
2	Failure to engage all staff groups in supporting the case for change and transaction programme.	Ineffective implementation of plans by unmotivated staff and potential loss of staff.	4	4	16	Staff engagement will be a core part of the scope of all workstreams, supported by the comms and engagement workstream.	3	3	9
3	Uncertainty or low morale leads to loss of staff.	Loss of resource, knowledge and understanding of the transaction could lead to problems in implementing the integration plan as well as having immediate operational impacts.	3	4	12	The comms and engagement workstream has been established and prioritised to ensure staff queries and concerns are listened to, understood and responded to.	3	3	9
5	Failure to galvanise external support for the transaction (from governors, patients, CCG, CQC, NHSEI).	Delays to the transaction timeline or failure to gain approval for the transaction to proceed.	4	3	12	The communications and engagement plan includes plans for engaging with key external stakeholders. The Joint Strategic Oversight Group will include representation from the ICS and NHSEI. Building external support will be a critical element of most workstreams, for example the development of a robust patient benefits case (clinical workstream) and workforce benefits case (HR and OD workstreams) in partnership with internal and external stakeholders.	3	3	9

Appendix D: Programme risk register (cont'd)

Queen Victoria Hospital
NHS Foundation Trust

ID	Risk	Impact	Unmitigated risk score			Mitigations	Mitigated risk score		
			Impact	Likelihood	Overall risk		Impact	Likelihood	Overall risk
6	Failure to maintain pace and momentum through the planning and delivery of integration.	Potential delays in implementing the integration plan as staff may revert to focusing on business as usual to the cost of implementing the integration plan.	3	4	12	The business case will describe the structures and resources to deliver the integration from Day 1 onwards. Workstreams will be required to quantiy resources needed to implement the integration plans and associated costs will be reflected in the financial projections for the merged trust. External specialist support has been utilised to help plan and deliver the transaction.	3	3	9
7	Failure to address elements of cultural change required for the trusts to work effectively as as single organisation.	Disengaged staff, lack of cultural integration and ineffective operational integration, leading to challenges with staff retention and recruitment.	4	3	12	The OD workstream will ensure that the existing culture at both trusts is properly assessed and understood and OD plans designed to support any required cultural change.	3	3	9
14	Delay due to limited capacity to plan and deliver the transaction.	The transaction could be delayed due to insufficient staff time required to deliver the transaction plan at the pace required to meet the current timetable.	3	4	12	Programme resourcing and delivery to plan will be closely monitored by worlstream leads and any related issues will be escalated to the Programme Board. If the planned timetable is at risk, the Programme Board will consider whether additional internal or external support can be brought in, or if the timetable needs to be reviewed.	2	4	8
8	Delays in agreeing the clinical strategy for the enlarged organisation impairs the quality of integration plans.	The lack of a clearly defined clinical strategy may lead to incohesive and inconsistent clinical integration plans.	4	3	12	The PMO will ensure key milestones are agreed with the clinical workstream to deliver the clinical strategy and allow time for alignment with other workstreams. Independent clinical lead has been appointed to provide additional senior capacity and challenge.	3	2	6
9	Failure to deliver the clinical, financial and operational benefits of the transaction.	The combined trust is not clinically, financialy and operationally sustainable.	3	3	9	The business case will describe the proposed approach to benefits realisation and the Programme Board will ensure that sufficient resource is in place to deliver plans.	3	2	6

Appendix D: Programme risk register (cont'd)

Queen Victoria Hospital
NHS Foundation Trust

ID	Risk	Impact	Unmitigated risk score			Mitigations	Mitigated risk score		
			Impact	Likelihood	Overall risk		Impact	Likelihood	Overall risk
10	Risks identified through the due diligence process are not adequately mitigated.	Risks identified through the due diligence programme may become issues in the enlarged organisation.	3	3	9	Due diligence risks identified across workstreams will be collated and checked against integration plans to ensure they are appropriately mitigated.	3	2	6
11	Failure to maintain performance through transaction planning and implementation.	Management time and attention is being drawn to the transaction and there is a risk that in-year quality, performance and financial performance could deteriorate.	3	3	9	Ensure that sufficient dedicated resource is allocated to the transaction, leaving adequate resource to deliver on business as usual priorities. Workstreams have been asked to consider resourcing throughout the process and any resourcing risks arising through planning or implementation will be escalated through the Programme Board. External support has been sought to support the transaction programme.	3	2	6
12	Failure to develop sufficiently robust integration plans due to short timescales.	Plans are being developed at pace and must be of sufficient quality to enable effective delivery and to satisfy regulatory review. The pace may compromise the depth, robustness or quality of the plans.	3	3	9	Integration plans will be reviewed by the Programme Board to ensure sufficient quality, level of detail and consistency. Support will be provided for workstreams that need to improve integration plans.	2	2	4
13	Failure to construct a robust medium term financial plan.	If the costs and benefits associated with the transaction are not properly considered and quantified, this could lead to cost overruns and failure to achieve forecast savings as planned.	2	3	6	The finance workstream will be tasked with supporting across all workstreams to ensure the financial impact is fully understood and quantified. UHSx will be able to utilise its recent merger experience to inform plans.	2	2	4

Appendix E: DRAFT communications and engagement plan for Transaction Programme

1) Background

Queen Victoria Hospital NHS Foundation Trust (QVH) is an exceptional hospital that is world renowned for many of its specialist services and provides highly regarded services for the local community. However, as the smallest acute hospital in England, it faces significant challenges. These include an over-reliance on key individuals; a limited range of the co-located services needed to support its specialist services; and high overhead costs as a small trust that impact its financial sustainability and ability to invest for the future.

To address these challenges, QVH is considering a merger with University Hospitals Sussex NHS Foundation Trust (UHSussex). The boards of QVH and UHSussex approved the strategic case for the proposed merger in August 2021 as a precursor to pursuing the business case.

There have been strong reactions to the potential merger proposal which have affected its progress. Some stakeholders are concerned about the impact a merger might have on the specialist services that QVH provides and have questioned the process that the QVH board has followed to get to this stage.

An independent review of the trust's process to progress the merger proposal was carried out. Its recommendations included:

- *A work programme for the merger process should be developed, which allows for a holistic set of stakeholders to be engaged as the work is undertaken. At the heart of this should be clinical engagement, but wider engagement with staff, patients and stakeholders will also be important.*

- *The steering group should oversee the development of a proportionate communications and engagement plan to accompany the work programme and should monitor an engagement log which is maintained as the work is undertaken.*

    - *The plan should carefully consider each aspect of the process and the necessary stakeholder group(s) to contribute to it.*

    - *Discussions with stakeholders should take place to understand the most effective way to engage with them, ensuring the business case is the product of an inclusive process.*

    - *Once produced, the plan should be tested with representative staff groups within QVH, QVH clinical directors and relevant clinical leaders from UHSussex before being finalised.*

    - *The plan should be under review so that themes from the engagement are responded to and reflected in the programme of work as required.*

This documents sets out the communications and engagement plan to accompany the work programme. As recommended by the independent review, it will be refined with stakeholders and representative staff groups to ensure that it will support an inclusive process for producing the business case. It is an iterative document and will continue to evolve. To support transparency, it will be made publicly available along with the engagement log.

QVH currently provides a range of services commissioned by Sussex commissioners and NHS England for more specialised services. Any specific service change proposals would be subject to consultation and are out of the scope of this plan. While there is no statutory requirement for formal public consultation on a merger, this plan sets out a comprehensive programme of engagement in the development of the business case.

2) Objectives

The objectives of the communications and engagement plan are to:

- Clearly explain the rationale for the proposed merger.
- Describe the vision for the future of QVH as part of the merged organisation, articulating the benefits this will enable for patients, staff and taxpayers.
- Enable staff, patients, the public and stakeholders to help shape the future of QVH and its services as part of the merged organisation.
- Ensure the merger process is transparent, with all audiences provided with timely information about the process and opportunities to ask questions and find out more.

In addition, the plan will need to enable the trusts to demonstrate that they have met the relevant requirements from the relevant NHSE/I guidance (See Annex A), specifically that:

- key stakeholders in the local health economy, patients and staff have been engaged; and
- the views and issues raised in this engagement have been considered and incorporated into the merger plans.

3) Audiences

A full list of audiences is at Annex B. They can be considered in the following broad groups:

Staff and volunteers

The extensive communications and engagement undertaken with staff at QVH needs to be continued and built upon to engage staff from across the organisation in the development of the merger process such that design and decision-making is influenced by a broad range of input.

Staff from USHX will also need to be kept informed on the process and engaged as appropriate, in particular through multidisciplinary teams in the articulation of the clinical strategy and operating model.

Patients, carers and the local community

Some members of the public in Kent, Surrey and Sussex have expressed concern about the merger, creating an online campaign and petition that currently has close to 13,000

signatures. The campaign named “Save our Specialist Services” was founded in November 2020 and has sought to block the proposed merger with UHSussex.

Meaningful engagement in this context can be challenging. Generating understanding and support for the merger requires a clear vision for the future to be articulated. Engaging patients and local communities in shaping this future will be challenging while some groups are opposed to the merger on any grounds. Opportunities will need to be created to ensure that all voices have equal opportunity to be heard.

Public foundation trust members of QVH are a crucial group within this audience, along with members of UHSussex.

In addition, working with existing groups such as patient support groups, Healthwatch, and local community networks supported by the VCS and local government offers valuable channels for engagement. Conversations with patients and the public should focus on the care and experiences that patients, carers and visitors will receive in the future.

Elected representatives

MPs, councillors and health overview and scrutiny committees (HOSCs) play an important role in representing the concerns of their constituents and scrutinising the work of NHS organisations. They also influence the opinions of others.

Primarily these are stakeholders in the East Grinstead and West Sussex area, but given the reach of QVH services, MPs and HOSCs further afield need to be considered as an audience. Maintaining channels for dialogue with MPs and councillors, and offering opportunities for more detailed engagement with HOSCs, will be important.

Health and care system partners

Engagement with these audiences, including regulators, will take place largely through existing forums. However, written briefings with requests for feedback on specific issues should be in place at key stages to provide logged evidence of engagement and the feedback received.

Media

The media provide a channel for reaching wider audiences and raising awareness of engagement opportunities among local communities. There has been significant local and professional media interest at earlier stages in the process and a proactive and planned approach to media handling will be required.

4) Principles

The following principles will underpin all engagement:

Transparency - There has been anxiety and concern about the process to date. Being transparent about the plans, the progress, the feedback received and the next steps will help to address this. It is essential that up to date information is always available, with opportunities to ask questions or find out more.

Clinical leadership – The development of the clinical strategy for the merged trust must be led by health professionals and their voices must be to the fore in engagement with patients and the public to build trust.

Equal opportunities to be heard - Engagement activities must ensure that everyone with an interest in the process has opportunities to be involved in the process and that all voices have the opportunity to be heard equally.

Future-focus - The independent review identified a need for a clearer narrative about what the proposed merger would look like in practical terms for patients and staff. It found that where there was a lack of a clear picture, stakeholders had projected their own expectations. Communications and engagement should focus on what the future will look like and what it will mean for patients and staff.

Consistency - Ensuring that audiences receive consistent messages from both trusts is essential. Any inconsistency will damage trust and credibility.

Staff first - Timely communications with all audiences is important. However, QVH staff and the staff at UHSussex should always hear first of any developments.

5) Key messages

- QVH is the smallest acute trust in the country and while it provides excellent care we need to look at how we can protect that and ensure the hospital is sustainable for the long term.

- The challenges include an over-reliance on key individuals; a limited range of the co-located services needed to support its specialist services; and high overhead costs as a small trust that impact its financial sustainability and ability to invest for the future.

- To address these challenges, QVH and UHSussex are considering a merger. This would support improved working across clinical teams in Sussex for the benefit of patients.

- A merger will help support services at QVH which are currently fragile, including Burns, Critical Care, and Paediatric services, improving their long term sustainability. Although many of the clinical sustainability challenges will not be solved by the change in organisational form itself, a merger would give a significantly better platform for services working together, and within a financially sustainable organisation.

- Detailed work to explore the operational, clinical and financial aspects of a potential merger are being carried out in order to prepare a business case for merger. This will provide the information needed for the boards of both organisations to determine whether to proceed with the merger process.

- This detailed work includes engaging with staff, people who use our services, the public and heath and care system partners. This involves explaining what merger would look like, seeking views on the improvements that can be achieved, and understanding any concerns that need to be addressed.

- The merger proposal does not include any specific plans for service changes. If in future there are service changes identified that could benefit patients, proposals would be

shaped by clinicians and feedback sought from the people who use those services before any decisions were made.

6) Governance and alignment with other workstreams

The merger process is being led by a programme board, chaired by the chief executives of both trusts. The programme is overseen by a joint strategic oversight group including representatives from NHS England and Improvement and the Sussex integrated care system (ICS). The programme is being delivered through eight workstreams, of which communications and engagement is one:

- Legal and corporate governance
- Clinical
- Finance and performance
- Communications and engagement
- Human resources
- Organisational development
- Information management and technology
- Estates

Workstream leads meet fortnightly to drive delivery and ensure the alignment of workstreams, reporting monthly to the programme board.

7) Phased approach

The communications and engagement for the merger will be focused around three phases:

Phase 1 – Inclusive communications and engagement plan design

This short phase will see the implementation of regular communications updates to all audiences.

During this phase, the engagement plan will be refined with stakeholders and representative staff groups to ensure that it will support an inclusive process for producing the business case. These will include:

- Groups of QVH staff including clinical directors and staff side
- QVH council of governors (including governor representative for EGTC)
- UHSussex working group
- UHSussex governor representative
- Communications and engagement lead for the NHSEI South East region and specialised commissioning
- Communications and engagement lead for the Sussex health and care system
- Heathwatch
- Officers for the three Sussex HOSCs
- MP for Mid Sussex
- Carnall Farrar

A log of engagement is at Annex D.

The engagement plan will also be developed in more detail with other workstream leads to ensure that all relevant stakeholders have been considered and to identity the contributions needed from each to support the development of the business case and to then plot a detailed engagement plan for phase 2.

Phase 2 – Business case development

During this phase, detailed engagement will be carried out to inform the development of the business case. Regular, timely communications with all audiences will be maintained.

Phase 3 – Preparing for implementation

If and when the business case receives the necessary approvals, the focus for communications and engagement will move on to the practical steps towards implementation. This would include formal communications with unions and staff as appropriate.

Regular review

Throughout each phase, the plan will be kept under regular review, with the monthly programme board as a routine checkpoint, so that themes from the engagement are reflected and responded to as required.

7) Communications and engagement activity

The communications and engagement channels and mechanisms that will be introduced and delivered through phases 1 and 2 will include:

Patient and public engagement steering group

A small group of patient and public representatives to help shape and provide assurance of patient and public engagement plans. Members of this group could also provide access to their own networks for engagement. It could include individuals from Healthwatch, members, patient support groups and the voluntary and community sector and an involvement lead from the commissioners who could provide expert input and alignment and integration with other engagement groups and activities.

Oversight of staff engagement plans

A staff engagement steering group was proposed in the early versions of this plan. Feedback from staff groups that were asked to review the plan indicated that the creation of a separate group was not necessary. Instead, feedback on the delivery of the staff engagement aspects of this plan will be sought through existing staff engagement mechanisms.

Core materials

A set of core materials will be developed to underpin engagement activities, updated for each phase of engagement, and including:

- Updated case for change document
- A core presentation as a starting point for discussion, focusing on the rationale, benefits, progress, next steps and questions for feedback

- Staff, public and stakeholder FAQs.

Engagement log

The engagement log is essential to demonstrate the breadth and depth of engagement that has been carried out, the feedback received, and how it has been used to inform the business case. The log should include the details of engagement that has happened (i.e. numbers / types of individuals engaged) and a log of the feedback received. To support transparency a bi-monthly summary will be published in parallel with trust board meetings.

Staff engagement

The independent review found that QVH staff have been communicated with continuously through the merger process to date, explaining the steps of the process and outlining the decisions taken, with multiple opportunities to ask questions.

Existing communications and engagement mechanisms will be maintained at both trusts, making sure that staff are kept up to date and able to raise concerns and opportunities around the merger, with a more structured focus on seeking feedback on specific issues to support the development of the business case. These will also include enhancing the visibility of UHSussex leadership to QVH staff.

A dedicated intranet page will be maintained for staff at each trust to provide a single source of information of the process and its progress.

Specific channels for QVH include:

- Regularly updated information and FAQs on the trust intranet
- Regular updates through the Connect internal newsletter
- Regular ‘drop in’ sessions, open to all staff, with the chief executive
- Chief executive attendance by invitation at team meetings.

Specific channels for UHSussex include:

- Regularly updated information and FAQs on trust intranet
- Regular updates on all staff briefing and leaders network
- Regular inclusion in staff newsletter

Workstream specific engagement

During phase 1, the other workstreams will be engaged to identify the need for specific engagement activities to support workstream delivery and to ensure alignment with wider staff engagement. This is likely to include the development of a number of engagement activities in which a broad range of participants support the development of the case and the underpinning clinical strategy.

Patient and public questionnaire

An online survey (with hard copies available) will be widely promoted and will enable all interested patients and members of the public, wherever they live, to be able to have their say. Supported by information on the rationale and plans, it will elicit feedback on the benefits and opportunities they would like to see from a merger and any concerns they would like to see addressed.

Foundation trust member communications

Updates on the merger process and the opportunities for engagement will be promoted to the public members of both foundation trusts.

Engagement through community networks

We will work with patient support groups, other health and care providers, the voluntary and community sector and local government to identify existing meetings where the trusts could provide information on the merger and seek feedback. This will primarily be within Sussex, but we will also seek to work with networks further afield in Kent and Surrey.

Engagement with patients and visitors on the QVH site

A pop-up stand will staffed, across a variety of days and times of day, to provide information and seek feedback from patients and visitors while they are attending QVH and who may not otherwise be aware.

Website

To ensure ease of access and to support transparency, a dedicated page on the QVH website will host the latest information, the questionnaire, links to documents, FAQs, copies of stakeholders bulletins, and the bi-monthly engagement log summaries.

A page on UHSussex website will link to the page on the QVH site to ensure alignment between the trusts.

Clinical video blogs

To ensure that the clinical voice is to the fore, a series of short video blogs from clinicians will be made available on the website and for use in engagement sessions and on social media. This will feature an explanation of the work being undertaken to develop the business case, the anticipated benefits, how the work is being carried out and how it is informed by feedback.

GP webinars

In order to ensure that the wider GP community are aware of the plans and have the opportunity to feedback, a session will be arranged for clinicians from the clinical workstream to engage through commissioner-led GP webinars.

Stakeholder briefings

A written briefing, summarising developments and providing details of the information and engagement opportunities available will be issued to all stakeholders bi-monthly and made available on the website.

A list of the proposed distribution list is at Annex C.

Engagement with health overview and scrutiny committees (HOSCs)

Officers for the three HOSCs in Sussex have confirmed that NHS constitutional changes (including mergers) are excluded from HOSC statutory duties to scrutinise substantial variations in service and therefore there is no formal role for HOSCs in scrutinising the

proposed QVH/UHSussex merger. However, HOSCs will wish to be kept updated.

A written briefing will be provided to all three HOSC Chairs in Summer 2022 to update on progress and next steps. This will copied to HOSC officers in Kent and Surrey for information.

A more detailed written briefing, with the offer of an in-person briefing, will be provided in Autumn 2022.

HOSCs will also be kept updated through the bi-monthly stakeholder briefings and can request further information at any stage.

MP briefings

Appropriate representatives from the trusts will attend the monthly ICS-led MP briefings at appropriate stages in the process to brief MPs and answer questions and so that elected representatives can input the views of their constituents.

East Grinstead Town Council briefings

Appropriate representatives from the trusts will attend regular briefings with the Town Council at appropriate stages in the process to update, answer questions and so that elected representatives can input the views of their constituents.

Annex A: Relevant requirements from NHSEI guidance

The relevant requirements from the *Transactions guidance for trusts undertaking transactions, including mergers and acquisitions* are:

Strategic rationale

- P67: Evidence of engagement with key stakeholders in the local health economy, patients and key staff, and of views/issues raised in this engagement having been considered and incorporated into final plans

- P67: Evidence of continuing stakeholder engagement

Transaction execution

- P68: Details of engagement with target organisation's board and senior clinicians, including evidence of discussion/consideration of barriers to integration and attempts to resolve these

- P69: Communication plan for staff and key stakeholders

Guidance on the contents of a business case

- P78: Detail the level of consultation and engagement with key stakeholders, including details of feedback and how this has been incorporated into proposals

- P78: Detail continuing stakeholder engagement

Source:
https://improvement.nhs.uk/documents/1984/Transactions_guidance_2017_draft_Appendix_Final.pdf

Proposed changes

NHS England and Improvement have consulted on proposed changes to the transactions guidance. Relevant proposed changes include:

- **Staff engagement** We will place significantly more emphasis on ensuring that trusts have developed a range of methodologies to communicate and engage with staff, to ensure that staff are involved in developing the proposal and understand what it means for them.

Source:
https://www.england.nhs.uk/wp-content/uploads/2021/11/Transactions-guidance-consultation.pdf

Annex B: Audiences

QVH staff and volunteers
All staff
Clinical directors
JCNC
Staff side
Governors
Volunteers

USHx staff
All staff
Governors
Unions

QVH patients and the public
Patients, families and carers
Governors
Members
League of Friends
Patient groups
Charity supporters
General public

UHSussex patients and the public
Patients, families and carers
Governors
Members
Friends
Patient participation groups
Voluntary and community sector
Patient groups
38 Degrees
Charities
Charity supporters
General public

Elected representatives
MPs
Councillors
Overview and scrutiny committees

Health and care system partners
ICS leadership
Commissioners
GP leads
ESHT, SCT, SPFT, SASH, SECAmb
Other NHS trusts further afield TBC
LA social services
GPs / Federations / PCNs
Brighton Medical School
London and South East Burns network
Other clinical networks

Regulators
NHSE/I
CQC

Media
Local media
Specialist media

Annex C: Stakeholder briefing distribution

- Chairs and officers of the following HOSCs:
  - West Sussex
  - East Sussex
  - Brighton and Hove
  - Medway
  - Kent
  - Surrey
  - Hampshire and the Isle of Wight
- MPs (Kent, Surrey, Sussex and South London)
- East Grinstead Town Council chief executive and leader
- Chief executives, leaders and directors of adult social services at:
  - West Sussex County Council
  - East Sussex County Council
  - Brighton and Hove City Council
- Healthwatch - West Sussex, East Sussex, and Brighton and Hove
- QVH patient support groups / charities
- NHSE/I regional director and locality director
- Chief executives and chairs of:
  - East Sussex Healthcare NHS Trust
  - Surrey and Sussex Healthcare NHS Trust
  - Sussex Community NHS Trust
  - Sussex Partnership NHS Trust
  - South East Coast Ambulance NHS Trust
  - Other trusts TBC
- Leaders of GP federations and PCNs in Sussex
- Brighton Medical School
- London and South East Burns network

Annex D: Log of engagement in development of this plan

HOSC officers
Virtual meeting, 20/05/22
- Senior Advisor, Democratic Services, West Sussex County Council
- Senior Policy, Partnerships & Scrutiny Officer, Brighton & Hove City Council
- Policy and Scrutiny Officer, East Sussex County Council

Communications and engagement lead for NHS Sussex
Virtual meeting, 26/05/22
- Chief Communications Officer, NHS Sussex

Communications and engagement lead for the NHSEI South East region and specialised commissioning
Virtual meeting, 26/05/22 and telephone call, 06/06/22
- Regional Head of Communications, NHSEI South East

QVH Joint Consultative and Negotiating Committee
Scheduled meeting, 06/06/22, including representatives of:
- Royal College of Nursing
- Managers in Partnership
- Chartered Society of Physiotherapists

QVH Joint Local Negotiating Committee
Scheduled meeting, 13/06/22, including representatives of:
- Consultants
- Junior doctors
- Speciality doctors and specialist grade
- British Medical Association

QVH Hospital Management Team
Scheduled meeting, 20/06/22, including
- Clinical leads
- Lead nurses
- General managers

Carnall Farrar
Email correspondence, 16/06/22
- Carnall Farrar independent review team

QVH clinical directors
Email comments invited from those not already engaged via another forum, 14/06/22

QVH governors
Governor seminar 27/06/22
- 11 public governors, two staff governors, two stakeholder governors

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed 15th June2022

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 national staffing challenges impacting and possible 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.
3) Ongoing risk of **infection** outbreak impacting on clinical care Risk 1220

Risk Appetite The Trust has a **low appetite** for risks that impact on patient experience and patient safety. When patient experience is in conflict with providing a safe service, safety will always be the highest priority

Rationale for risk current score
- Compliance with regulatory standards
- Meeting national quality standards/bench marks
- Very strong FFT recommendations
- Sustained excellent performance in CQC 2020 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
- Increasing challenge with recruitment, particularly Head and Neck unit, critical care and paediatrics. Risk register has been updated to reflect these challenges

Initial Risk 4(C) x 2(L) = 8 low
Current Risk Rating 3(C) x 5 (L) = 15 mod
Target Risk Rating 3(C) x 3(L) = 9 low

Future risks
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility.
- Impact of QVH clinical and non clinical strategies

Future Opportunities
- Developing new healthcare roles – will change skill mix
- Potential merger could offer significant opportunities for development of the workforce including collaborative international recruitment opportunities
- **Implementation of Patient First improvement methodology during next 3 to 6 months**

Controls / assurance
- 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.
- Clinical Harm Review process
- 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 2019 via existing referral pathway. Inpatient paeds on exception basis
- QVH simulation faculty to enhance safety and learning culture in theatres
- Burn Case for Change being developed in collaboration with NHSE
- **Asymptomatic staff screening, comprehensive IPC board assurance document, patient screening pathways revised in line with national guidance. Risk 1210**

Gaps in controls / assurance
- Unknown Specialist commissioning intention for some of QVH services eg inpatient paediatric Sussex based service and head and neck pathway Risks 834, 968, 1226
- Ongoing workforce challenges with recruitment and retention
  Risks 1225, 1199, 1077, 1238, 1239

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Date last reviewed: 14th April 2022

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

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

Initial Risk Rating 5(C)x3(L) =15, moderate
Current Risk Rating 4(C)x4(L)=15, moderate (CR1221)
Target Risk Rating 4(C)x2 L) = 8, low

Rationale for current score

- Adult burns ITU and paediatric burn derogation
- Paediatric inpatient standards and co-location
- Compliance with 7 day services standards
- Spoke site clinical governance.
- Consultant medical staffing of Sleep Disorder Centre & Histopathology
- 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
- Antibiotic stewardship

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 University Hospitals Sussex

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
- Antibiotic Stewardship meetings and presentations at Joint Hospital Governance Meeting

Gaps in controls and assurances:

- Link between internal data systems & external audit requirements & programs
- Limited data from spokes/lack of service specifications
- Achieving sustainable research investment
- Sleep disorder centre sustainable staffing model & network
- Antimicrobial prescribing (CRR 1221)
- Repeat prescriptions in Sleep (CRR 1164) Closed in November 21 remove please

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**7 July 2022**		**Agenda reference:**	**104-22**	
Report title:	**Corporate Risk Register: on June 29th 2022**				
Sponsor:	Nicky Reeves, chief nurse				
Author:	Karen Carter-Woods, Head of Risk & 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	The Corporate Risk Register reviewed at two subcommittees of the Board: Quality & Governance (Patient Safety Risks) and Finance & Performance (remaining Risks) The full corporate risk register is bought to board for review and discussion Key changes to the CRR this period (May to June 2022): ➢ Two new corporate risks added: ID1264 & ID1265 ➢ No corporate risks closed ➢ Two corporate risks rescored to local register: ID1235 & ID1248 **Most notable risks on CRR**: ID877: Financial sustainability ID1250: Additional licence conditions ID1264: Risk to operational delivery of Pathology Services: IT systems related				
Recommendation:	The board is asked to note the Corporate Risk Register information				
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: 27 June 2022 4 July 2022	**F&P:** all risks except patient safety risks – as at 1st June 2022 **Q&GC**: all patient safety risks – as at 1st June 2022				

Corporate Risk Register Report
May and June 2022 Data

Key updates

Corporate Risks added between 01/5/2022 and 29/6/2022: two

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
4x3=12	1265	National remifentanil shortage	Lead Pharmacist & MD
4x4=16	1264	Risk to operational delivery of Pathology Services: IT systems related	Laboratory Manager & DoF

Corporate Risks closed this period: nil

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed

Corporate Risks rescored this period: two

Risk ID	Service / Directorate	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore
1235	E&F	Head & Neck Unit Roof	3x5=15	3x3=9	No report of leaks since installation. Risk is now de-escalated
1248	CSS	Reduced staffing levels: Covid testing laboratory	4x4=16	4x2=8	Opening hours reduced and LFT pathway in place if Lab not available.

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 76 risks on the Trust Risk Register as at 29th June 2022, of which 30 are corporate, with the following modifications occurring during this reporting period (1st May to 29th June incl):

- Two new corporate risks added: ID1264 & ID1265
- No corporate risks closed
- Two corporate risks rescored to local register: ID1235 & ID1248

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 below shows the 30 corporate risks open on the trust risk register as at the 29th June 2022.
Three corporate risks are within the higher grading category:

	No harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2			**4**	**5**	**2**
Possible 3		**3**	**29**	**6** ID: 834, 968, 1192, 1210, 1226, 1265	**2** ID:1242, 1259
Likely 4		**1**	**10** ID: 1040, 1077, 1217, 1240, 1245, 1247, 1249, 1253, 1254, 1255	**2** ID1250, 1264	**0**
Certain 5		**2**	**9** ID1140, 1189, 1198, 1199, 1221, 1225, 1231, 1238, 1239	**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	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1265	########	National remifentanil shortage	Reduced theatre productive due to longer recovery time for patients requiring additional staff input and space. Increased risk of post-operative side effects with older agents. Risk of increased complication rate and mortality rate.	1. All anaesthetic staff made aware of shortage. 2. To plan which patients are priority for remifentanil. 3. Ensure that full allocation is ordered each week. 4. Risk assessing feasibility of vial sharing during this period 5. Remifentanil is still available but in smaller quantities - need to prioritise patients	Nicola Reeves	Judy Busby	Patient Safety	12	8		KSO1 KSO2 KSO3
1264	########	Risk to operational delivery of Pathology Services: IT systems related	Risk to operational delivery of Pathology Services and progression of Programme.	Progression of LIMS and MES workstreams: Potential for risk to increase if workstreams are delayed Limited mitigation until new LIMS in place	Michelle Miles	Fiona Lawson	Compliance (Targets / Assessments / Standards)	16	8		KSO2 KSO3 KSO5
1259	########	Increased Cyber Security Threats due to Russia	There is a cyber security risk of Russia targeting the UK with ransomware and denial-of-service attacks.	All security updates are deployed and installed within 14 day of being released Microsoft Defender for Endpoint (MDE)on all Desktops and servers has been enabled Microsoft Defender Antivirus (MDAV)on all desktops and servers has been enabled Reregister on NHS Digital provided Vulnerability Management Services including Early warning and Web Checker. Ongoing vulnerability scanning of Trust IT Infrastructure	Michelle Miles	Nasir Rafiq	Information Management and Technology	15	4	**24/06/22**: Active Directory Assessment migration work has started however due to the complexity and risk of managing service impact the changes are taking longer than expected. The firewalls upgrade work is scheduled to start on 11 July and completed by 28th July. new cyber security screen savers will be deployed in July providing guidance to staff. A report will be presented to the IMT group in 12 July with recommendation to minimise the risk score. 16/05/2022: Active Directory Assessment has been completed and work to mitigate security vulnerabilities has starts, work expected to be completed by 30 June 2022. Secure Boundary will be part of the firewall upgrade works which has already started and expected to be completed by 31 July 2022. 28/04/22:IT continue to review the IT security and the security posture of the IT Infrastructure. new user password policy scheduled to be implemented w/c 2/05/22. 11/04/22: user passwords complexity to increase inline with National Cyber Security Centre and NHS Digital guidance. this will be implemented in April 2022. 31/03/22: Backup restore exercise completed successfully. On-going review of password for high privileged accounts. External cyber security third party expertise reviewing security postures of Trust devices and ensuring all security updates are installed. All software on Trust devices is being reviewed and updated or removed if no longer required. 16/3/22: ensuring good backup available and offline backups / test backup restores Upgrade unsupported software	KSO1 KSO2 KSO3 KSO4 KSO5
1255	########	Sterile Services provision failures	Our off site sterile services provider STERIS IMS is in business continuity due to severe staff shortages. The risk is not being able to deliver any services relating to theatres and outpatient clinics that require sterilized equipment	The sterile services equipment team leader meets daily with the customer service manager of STERIS IMS to ascertain what is required to deliver the service on a daily basis. There are weekly meetings with the decontamination lead, sterile services equipment team leader and general manager from STERIS IMS	Shane Morrison-McCabe	Malcolm Dorman	Compliance (Targets / Assessments / Standards)	12	9		KSO2 KSO3 KSO4 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1254	########	Speech and Language Therapists Staffing (Inpatients and Outpatient/Community Services)	Current workforce for Head and Neck SLT team is at 52% and Community SLT team is at 28% of budgeted establishment due to vacancies. Risks: 1.Will breach local targets for waiting times for non-urgent outpatients 2.Inability to provide indirect clinical services-(training/reviews of policy's/audit) 3.Reliant on Bank and agency staffing 4. High pressure on current SLT staff affecting wellbeing/moral	1. Remote Agency cover to supply ENT outpatient SLT caseload- 0.2WTE 2. Bank use of Band 6 Community SLT - 0.2WTE 3. Patients with Urgent triage are prioritised 4. Regular team meetings, triage and debrief sessions for staff 5.Targeted recruitment continues, both posts have been through 1 cycle of advertisement and interviews-unsuccessful. 6. Resourcing team in collaboration with Therapy manager and Principal SLT looking at boosting advertising of post 7. Clinical staff have delegated roles to admin who is progressing well although new into post 8.Clinial Lead has reduced input in roles internally, AFC panel, mediation etc. 9. Monitoring activity and demand, bi-monthly	Shane Morrison-McCabe	Sarah Holdsworth	Compliance (Targets / Assessments / Standards)	12	9	16/02/2022- Re-advertising B7 H&N SLT job as is and as a development role band 6-7 under Annex 21 - Live currently on TRAC. Agency request submitted to EMT last week for B7 Community SLT to cover maternity leave- awaiting decision.	KSO1 KSO2 KSO5
1253	########	Waiting List managment: Plastics	Patients not added to the Waiting List on Patient Centre. Patients can have a 'wait list form' on Evolve completed, however this does not transpose onto the waiting list on patient centre: they are therefore not tracked on the PTL.	1. New process: med secs to ensure that when typing clinic letters, they automatically cross reference within patient centre system to ensure that an "addition" to wait list has been completed and the patient has been added. 2. Evolve have developed a waiting list report that will be distributed weekly to cross check the PTL to ensure no patients are missed: audit to be progressed	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	6	**29/06/2022** - risk discussed at Plastic Business Unit Meeting. Service Manager reported that 'V Look-Up' is working well for catching patients who have not been added to the waiting list and the report continues to be distributed twice-a-month. Service Manager is going to present risk status with a view to downgrading/closing. 13/04/2022 - Report now available from Evolve on all completed Waiting List Forms with V "look up" facility for cross checking on Patient Centre. Initial findings have uncovered patients not added onto the waiting list for both Plastics & H&N. Further investigation underway within services. 31 March 2022 - have requested update on progress against this piece of work from Service Manager, who has been working hard to address. Have also queried whether mitigations are working, as incident volumes associated with this problem appear to be non-existent for February since the incident was opened.	KSO1 KSO3 KSO5
1250	########	Additional licence conditions	Breach of additional licence conditions.	Interim Chair in post Independent review jointly commissioned by NHSEI and QVH to make recommendations which will help resolve conflict and to build a consensus Communication of the change in licence conditions to all relevant stakeholders and discussion about the implications. Remedial action will be taken once the results of the review are published. Discussion at Board and CoG and development of an action plan that will be monitored by the regulator. The objective (target risk) - removal of the licence conditions by regulator	Steve Jenkin	Clare Pirie	Compliance (Targets / Assessments / Standards)	16	12	**22/06/2022:** New chair appointed by CoG starts on 11 July. Action plan from independent review being implemented and discussed monthly with regulator. March 2022 - independent review and recommendations welcomed and accepted by Board on 3 Feb and shared with Council of Governors on 21 Feb. Action plan being developed on all 12 recommendations. Recruitment process underway for chair – interviews scheduled for 22 April February 2022 - Independent Review document being discussed and action plan being compiled	KSO3 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1249	########	Sentinel Lymph Node Biopsy (SNLB) Wait List: capacity issues	Rise in demand to perform Sentinel Lymph Node Biopsy for skin cancer Not enough capacity in theatres & clinics to undertake them all	Escalation protocol in place to Service Coordinators to increase capacity. Weekly Review by Service Co-ordinators and Cancer Pathway Trackers Extra Clinics added where possible	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	6	**29/06/2022** - additional lists offered to consultant body for Saturdays and in-week. Some degree of uptake. Additional weekly list for Sentinel node created to support ongoing address of demand. Updated spreadsheet of Sentinel node position created in order to support oversight of position. Conversations underway with other suppliers of nuclear medicine, as there is a degree of unreliability associated with KIMs scanners. 13/4/22 - Capacity challenges continue. Option of Saturday lists/3 session days being explored. SLNB Task and Finish Group set up. 22 February 2022 - scoping out scale of demand and organising additional capacity to even out peak in demand. It is expected that periodically and responsively introducing extra capacity will help to even out the peaks in demand. We will need to confirm this, however, once we have better data. 04/03/2022 - emailed review of sentinel node waiting list and proposed short-term plan to address the volumes. 31/03/2022 - weekly task and finish meeting set-up to address. Governance was not in place formerly with adequacy and as a consequence the service has not been quite as responsive as it needs to be. We are also working to source more imaging capacity in the system as this appears to be a rate limiting factor.	KSO1
1247	########	First appointment delays from tertiary referrals: Plastics (skin)	First appointments not generated upon receipt of referral to QVH. Triage delays: paper copies	Review and improvement of processes Validation of PTL	Shane Morrison-McCabe	Phillip Connor	Patient Safety	12	9	**29/06/2022** - triage worklist trialed and proved to be a success. The ambition now is to roll it out more widely. At present we are still seeing instances of delayed address of first appointments and the intention is to raise these as incidents so that the problem can continue to be represented. 04/05/2022 - meeting with Clinical Leads took place to introduce the concept of the triage worklist and trial is due to shortly begin. March 2022: (Service Manager Review) Evolve Triage Worklist form ready for trial by Plastics Clinical Leads. User Guide and demo planned and trial to commence at the end of April 2022. February 2022: (Service Manager review) Improved processes designed by working group led by service manager. New paperless process in place for whole trust. Service Manager has drafted a temporary Referral Management SOP for approval at DEC on 23.2.22. Development of referral/triage process on Evolve in development for roll out in March/April - Service Manager leading development. Validation work on PTL - extra support in place with weekend validation.	KSO3
1245	########	Junior Doctor Rota Management: Plastics Surgical	Rota manager on long term sick leave. No substantive post holder to cover that work and no clear processes/SOP in place.	1. Service co-ordinator is managing rota with assistance of admin support 2. Manual process now improved rota management to 6 weeks in advance - remains dependant on staff with competing duties & completion of consultant job plans in order to inform rota 3. Draft SOP initiated PROPOSED ACTION 1. Management of Rota further in advance and formalise processes 2. Create Standard Operating Procedures SOP 3. Band 4 admin support to undertake band 5 role as rota manager for 3 months as of Jan 2022 and support Rota Manager's phased return from long term sick leave 4. Migration to Healthroster planned for early 2022 5. Review of WTE requirement in department to manage workload	Shane Morrison-McCabe	Phillip Connor	Compliance (Targets / Assessments / Standards)	12	9	**29/06/2022** - POAP written. Just need a few tweaks before being submitted to EMT. Have now gone out to recruit for band 4 Rota Co-ordinator, as per plan. Trust have agreed to two further SpR WTEs starting in October to support with general consolidation of rota. Work underway to calculate what will now be required with expanded portfolio of theatre capacity. 04/05/2022 - EMT approval for up-banding of band 3 Rota Co-ordinator to a 4, in order to improve the calibre and coverage in the rota service. Furthermore, a meeting is being convened this week to discuss the number of junior doctors supporting the rota; the intention being to complete a POAP for EMT/Budget Setting. 13/4/2022 - Awaiting Activity Manager approval. Rota challenges continue. Rota Manager and Coordinator vacancies with recruitment plan in place. Fixed Term Rota Manager contract extended and supported by Service Coordinator. 22/02/2022 - rota SOP authored and awaiting approval; Band 5 and 6 supporting with rota (greater investment of resource to support the process); JCST being retrospectively audited by trainee lead; recruitment practices adjusted to improve stability and far-sightedness; transition to manage rota via Healthroster (programme entitled 'Activity Manager') (proposal written and conveyed to Executive Director for HR to agree next steps); employment of two further trainees to fortify the rota; employment of trainee lead to facilitate clinical oversight of rotas. Rota Task and Finish Group set up. Improved processes in place. 31/03/2022 - we have negotiated an upgrade to Healthroster which would render our management of the rota a lot more sustainable; however, we are just awaiting agreement. We now need to recruit a new rota manager and so will be short staffed, once again, until this person is in post. The Datix record, however, still demonstrates that, despite C-19, the rota is delivering well. It just comes at the cost, unfortunately, of having one of our Service Co-ordinators backfill this post.PC	KSO3

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1242	########	Cyber Security Vulnerability - Apache Foundation Log4j 2	A security vulnerability has been found within "Log4j". □ This vulnerability is already being exploited by some cyber attackers internationally, though not yet here in the UK. □ Cyber criminals are actively scanning for this vulnerability on systems worldwide and in the UK. □ Scanning has been detected on some NHS systems. □	Communication Plan (cyber security reminders to staff, system downtime)□ Initial Mitigation/ Prevention Plan (Anti Virus Software, Firewall, IPS, Windows updates, on going cyber security scanning for vulnerabilities)□ Detailed Remediation Action Plan□ Identify all vulnerable systems □ Engagement with Information Asset Administrators (IAA) and Suppliers□ Control Centre□ Provide regular and timely updates on progress via the NHS Digital 'Respond to' and NHS Cyber Alert portal □	Michelle Miles	Nasir Rafiq	Information Management and Technology	15	4	Update **24/06/2022**: new updated vulnerability scanning software from Qualys has been deployed to provide further reassurance of mitigation. Ongoing work with third party suppliers to mitigate the risk without service impact. A report will be provided to the IMT group on 12/07/22 with recommendations as to minimise the risk score.□ Update 04/05/2022: External third party cyber security support are still reviewing the remediation put in place. once confirmed update will be provided to the SIRO.□ Update 11/04/2022: all remediation work has been completed however there are still two system showing up on our vulnerability scanners even though the suppliers have provided remediation / fixes which has been implemented. Further detailed work to ensure all remediation work has been completed as specified is underway by Trust third party cyber security support. once confirmed a report will be provide to the SIRO and CEO, update NHS Digital CareCERT Alert and updated Trust Risk Register.□ Update 14/01/2022: Potential Impact has reduced as no device has the specific high carecert (CVE) vulnerability however, we have 22 instances of the Log4J installed on servers/PC's that are unaffected by the HIGH carecert but require upgrading to the new version.□ •Single Medical device asset list is not captured, work is being completed by KS/NR to pull together this list and work is ongoing to contact suppliers about their devices to know if they are impacted •Probability of an attack has reduced as less endpoints are vulnerable Additional controls have been put in place on our network boundary and firewalls (additional control being added to firewall / IPS – 14th Jan (subject to RFC approval)) •We don't have control over third parties and their timescales to get these patches installed / tested for their systems (the 22) •We have more knowledge and understanding of this exploit and run multiple scans which	KSO1 KSO2 KSO3 KSO4 KSO5
1240	########	Unregulated use of data sharing apps	IG and IT are aware that there is use of data sharing apps at the Trust which could pose significant data security risks if unregulated or used for business purposes on personal devices	Trust owned devices have a strict AD and policy security group profile installed. This does not allow any unapproved data sharing apps unless agreed at local level.	Michelle Miles	Dominic Bailey	Information Governance	12	6	**24/06/22**: The Mobile Device Management policy and the forthcoming Digital Communications policy may provide some control. Scope is just Trust owned devices, so more required regarding staff using their own devices to install and use apps for PID even if the app is authorised centrally, (NHSEngland). □ We will consider interpolating a section statement regarding the Trust standpoint on use of apps for PID that are unauthorised at local level on own devices, (already prevented on Trust devices) plus another round of formal communications to all staff focused on clinical. We also have a professional speaker on the topic invited to Trust wide clinical audit in September.□ 17/02/22: PC's and laptops have AD and group policies in place to prevent users from installing software.□ Mobile devices, (e.g. IoS and android) are managed by Trust mobile device management, (MDM) controls.□ Only software that has been approved by the Trust IT Working Group is permitted upon submission of a formal request.□ No controls in place for staff personal devices.□ MDM policy will be reviewed at Information Governance Group, (IGG) 03/05/22□ Communications to all staff regarding use of apps will be reviewed by IGG 01/03/22 - subsequent dissemination.	KSO3
1239	########	Canadian Wing Staffing	Unable to fulfil the rota requirement	management of activity	Nicola Reeves	Liz Blackburn	Patient Safety	15	6	**22/6/22** - Good update of bank shifts, recruitment remains a challenge.□ 6/4/22 - Remains an ongoing issue□ February - Evidence that incentives are having positive impact on uptake of bank shifts. International Recruitment options being considered.□ November - EMT have approved a paper to address staffing challenges using a range of incentives to encourage applicants	KSO1 KSO2 KSO3 KSO4 KSO5
1238	########	Peanut Ward Staffing	Lack of staff to fulfil the rota requirements	Control of activity at night to maintain safety□ TDS review of staffing	Nicola Reeves	David Johnson	Patient Safety	15	6	**22/6/22** - Interviews in progress for two band 5 posts.□ 6/4/22 - Ongoing, new Matron now in post□ February 2022 - Ongoing review. Consideration of international Recruitment to address staffing shortfall.□ January - New matron due to start March. Enhanced bank rates now in place. Welcome bonus being introduced. Vacancy rate 20%□ November - New Matron appointed, pending start date. EMT have approved a range of measures to encourage recruitment	KSO1 KSO2 KSO3 KSO4 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1231	########	Late tertiary cancer referrals	The trust is receiving up to 26 late cancer referrals a month and around 45-50% are past 62 days. □ The trust is treating around 90% of patients within 24 days however these patients are on our PTL and in our weekly PTL reported numbers.	unable to control externals late referrals, however:□ Weekly national/regional reporting. □ Twice weekly cancer PTL meetings which goes through each individual patient ensuring they have a next step booked within time. Escalations are sent out after each meeting. □ PTL is widely distributed across the trust, including admin and clinical staff. The responsible Committee should be the Cancer Board who meet monthly.	Shane Morrison-McCabe	Victoria Worrell	Compliance (Targets / Assessments / Standards)	15	9	**01/06** update: trust continuing to receive late referrals across Kent, Surrey and Sussex. Detailed reporting is continuing at Cancer Board level. Started to include percentage of late referrals within the backlog, on a weekly basis, communicating this with the Sussex ICS. Continuing to maintain a grip on the 24 day target, compared to 2020/21 the trust has improved its 24 day performance by 7%, reporting a decrease each year of patients breaching the 24 day target.□ 27.01.2022 - challenges continue, number of patients referred over 104 remain high. Update ICS on weekly cancer managers call, continue to have weekly calls to monitor with providers.□ November: ongoing challenge' level of mitigation via weekly escalation calls with key referring providers	KSO3
1226	########	Adult Burns - Delivery of commissioned services whilst not meeting all national standards/criteria	-Lack of key services and support functions onsite (renal replacement facilities, and other acute medical specialties when needed urgently) -Potential increase in the risk to patient safety -Potential loss of income if burns derogation lost	-Operating at Unit+ level -Adult Burns inpatient review taking place -Strict admission criteria in place, any patient not meeting criteria will be referred on to a Burns Centre -Low threshold for transferring out inpatients who deteriorate and require treatment not available at QVH -SLA in place with UHS for ITU verbal support	Tania Cubison	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	8	**June 2022**: Specialised commissioners continue to review prior to creation of options appraisal 6/4/22 - no update on options appraisal available□ February 2022 - Specialised Commissioning continuing to work on case for change and options appraisal for provision of a compliant burns service□ 15/12/21: NHSE Specialised Commissioning leading work on Case for Change and Options Appraisal□ 31/03/2022 - we are at risk of being short 1.5 Burns Consultants given lead times for recruiting to these posts. Furthermore, we have had no eligible consultants in the last round of advertising. We are working up a plan to cover uncovered DCCs and to potentially recruit a fellow to the Burns consultant post, which may be a more attractive prospect. PC	KSO1 KSO2 KSO3 KSO5
1225	########	Head & Neck Staffing	There is a vacancy of 5.2 WTE on the newly created Head & Neck unit whilst recruitment is taking place. The unit is now open due to demand and is being staffed by 6.82 WTE staff as well as being heavily reliant on bank and agency staff. This poses a risk that the unit is frequently left short staffed which can impact upon patient safety.□	- Use of bank staff, an enhanced rate would lead to greater uptake of shifts. - Ongoing recruitment, however there have been no suitable applicants in the three adverts that have run so far.	Nicola Reeves	Claire Hayward	Patient Safety	15	6	**22/6/22** - Vacancy remains, continue to advertise vacant posts.□ 6/4/22 - Vacancy continues to be a challenge. Ward has been closed on a number of days to maintain safety by redeploying staff as appropriate□ February 2022:: International Recruitment being considered to address staffing shortfall.□ January - Enhanced bank rate in place. Welcome bonus due to be introduced. Significant vacancy remains with 47% of posts remaining vacant.□ November - EMT have approved plans to increase recruitment□ October - Update 26.10.21□ Re-templated the establishment to incorporate a Band 7 Matron (0.60WTE) and staffing of 2+1 on day shifts.□ Currently a clinical vacancy rate of 44%□ August - Update 17/08/2021□ Establishment remains at 6.82 WTE. However some staff are leaving. Full details below:□ B6 = 4.75 WTE in post□ B5 = 1.0 WTE in post. 1 WTE is applying from C-Wing to join but the current B5 is interested in applying for CCU. □ B 4 = 1.07 in post – both will be leaving as above for CCU as a split role between HNU and CCU. □ It is anticipated that establishment will reduce to 5.75. HNU jobs are now being advertised after a delay from finance sign off, also going out for 2.0 WTE Nurse associates. □ July - still awaiting formal upload of budget to allow further recruitment to be undertaken. Flexible workforce being used as available. Activity continues to fluctuate.□ October - Update 26.10.21□ Re-templated the establishment to incorporate a Band 7 Matron (0.60WTE) and staffing of 2+1 on day shifts□ Currently a clinical vacancy rate of 44%	KSO1 KSO2
1221	########	Antimicrobial prescribing	Audit has shown that there are low levels of compliance with antimicrobial prescribing guidance.□ Antibiotics are being prescribed inappropriately by being prescribed when there is no indication, they are being prescribed for too long, no indication is being given, no duration is being documented, samples are not being sent for Microbiology analysis and when they are there is often no review of the organism and therefore antibiotic prescription is not altered.	Clear antimicrobial prescribing policy□ Micro guide available for all staff to download onto their smart devices□ 24 hours on call Microbiology service□ Audits of antibiotic prescribing. □ Infection control guidance and messaging and education of doctors. Indications for antibiotic prescribing mandated on drug charts.	Tania Cubison	Judy Busby	Patient Safety	15	9	**8/6/22** Date for next stewardship meeting arranged□ 20/5/22 Audit being undertaken to identify individuals not complying.□ 28/4/2022 Meeting chaired by MD to discuss action plan and review microbiology SLA□ 24/3/22 Handler has been changed to Chief Pharmacist, although MD leading on risk. Looking at a different ways to engage clinicians in the process. □ February 2022: Incoming MD working collaboratively with Clinical Leads□ July 2021: anti-microbial stewardship group formed, to meet fortnightly - MD to chair	KSO1 KSO2

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1217	########	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	Clare Pirie	Compliance (Targets / Assessments / Standards)	12	6	**22/06** - Over the course of three workshops, a group including executive directors, non-executive directors and clinical directors has refreshed the Case for Change and Options Assessment; including considering changes in both the national and local context. Paper for the QVH Board on 7 July will document the process undertaken and the conclusion of the process, including the reasoning. Briefings to East Grinstead Town Council (21/06) and Mims Davies MP (22/06).□ March 2022: Joint appointment by QVH/UHSx of a clinical oversight lead for the clinical strategy review, to commence end of April. Timeframe being developed on full business case.□ February 2022: Reported to Board, shared with Council of Governors, □ and published on public website 22 February 2022. Board confirmed commitment to ensuring the recommendations are implemented□ 15/12/21: Independent review jointly commissioned by NHSEI & QVH looking at engagement of stakeholders during the past twelve months. Will report to Chair and NHSEI in January 2022	KSO3 KSO5
1210	########	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□ Virtual clinics when possible □	Nicola Reeves	Karen Carter-Woods	Patient Safety	12	8	**22/6/22** - Patient covid testing pathways reviewed and rolled out. Mask wearing guidance reviewed in all areas.□ 6/4/22 - Guidance reviewed and QVH SOPs being amended to bring up to date□ February 2022 - All national guidance reviewed and changes made to policy as required. This is then managed via the IAPCT governance routes. IPACT BAF reviewed and presented at Q&G. □ November - QVH continues to apply rigorous IPACT precautions and use Optigene and lateral flw to manage the staff risk. PPE and social distancing are maintined□ July - Following "freedom day" QVH continues to reinforce mask wearing and social distancing as the rest of the NHS, staff are supported to challenge. Visiting restrictions remain in place at this time. Review of isolation guidance and creation of risk assessment process to support staff returning to work when appropriate□ June 2021: delay to proposed date for lifting of restrictions; now likely July and not June as was planned □ 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
1199	########	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	Claire Hayward	Patient Safety	15	9	**22/6/22** - Continued vacancy with CCU, review of staffing and bed capacity being undertaken.□ 22/4/22: B5 vacancy = 5.81 WTE with 1.0 WTE recruited to. □ Out of the 3.53 WTE Band 5s, 2.53 WTE are new to ITU (started within 6 months). □ B6 vacancy = -0.09 WTE vacancy with 0.61 WTE to be available from the 8th May 2022□ Rolling advert out for band 5s and are soon to advertise for PT/FT Band 6 □ 6/4/22 - ongoing staffing challenges being managed on a day to day basis□ January - Enhanced bank rate in place. Welcome bonus due to be introduced. Recently lost 4 Band 6 SSN's. 26% of posts remain vacant including 50% of Band 5 SN posts.□ November - EMT have approved a range of measures to encourage increase in bank uptake and to support recruitment□ October - Update 26.10.21□ Current clinical vacancy of 23%. Three new Band 5's due to start (2.53 WTE) however they have limited/no ITU experience. There is also 4 Band 6's (3.67WTE) due to leave in the next few months after achieving promotion. It is important to note that we will be losing 4 experienced ITU nurses who are able to look after ventilated patients and take charge of the unit. This has the potential to impact on our ability to accept patients if we are unable to safely staff the unit. Recruitment is ongoing but remains a challenge. Attracting temporary workforce is also proving a challenge and work has been started to ensure we are offering the same hourly rates as our surrounding trusts.□ August - □ B2 = 1.81 WTE vacancy with another 1.0 WTE leaving for TNA role. □ B4 = 0.11 WTE vacancy, with both in post leaving to do nurse training (one finishes 22nd August, another 27th September leaving a 1.03 WTE vacancy. □ B5 = 3.58 WTE vacancy. Currently have 1.0 WTE band 5 seconded to HNU. Now on a rolling advert, last advert had 50 applicants all of which were internationals without an NMC pin. □	KSO1

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1198	########	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.□	Tania Cubison	Philip Kennedy	Patient Safety	15	9	**20/4/22**: Two Additional Consultants recruited to Bank with plans in progress for 2 x Fixed Term posts in conjunction with EStH to begin in September. Additional hours agreed with Middle Grade Dr from August □ 22/2/22: New clinical lead appointed for Sleep Unit. Continued use of locums from 2021 and additional medical capacity sourced via new locum/bank arrangements. Joint post established with Epsom St Helier (3PA) and business case underway to recruit to a full time post shared with EStH. □ July: Lead consultant for Sleep actively making appointments to recruit□ June: improving situation with proposed new appointments at both consultant and middle grade level□ May 2021: interim CD oversight in place. Action Plan developed and being implemented	KSO3
1192	########	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	Shane Morrison-McCabe	Judy Busby	Patient Safety	12	6	**27/6/22** Discussed at MMOGG on 20/6/22. Situation has improved since put on register. However service is still vulnerable due to vacancies and long term sickness especially when staff on leave. Only able to provide supply and basic clinical service on some days. Pharmacist will be leaving due to relocation but has not yet handed in notice. Backlog of indirect clinical work although progress has been made on this. Risk score to be reduced to 9 (3x3). □ 8/6/22 Agreed date with MSO for starting date. Band 5 post agreed - to go out to advert. Full time band 7 pharmacist post being advertised. Still waiting for band 2 to start with another on long term sick and no likely return date at present.□ 20/5/22 MSO post offered to internal pharmacist. Awaiting clearance then to go out to advert for full time band 7. Still awaiting job evaluation outcome for band 5, Awaiting final clearance for bank band 2. 0.4wte band 2 on long term sick. Covid positive staff and annual leave leaving some days short of certain grades of staff. □ 29/4/22 Band 8a clinical lead in post. MSO job out to advert. Band 5 tech job description for May evaluation panel. Waiting for outcome of MSO post before re-advertising band 7 pharmacist post due to internal applicant. Bank band 2 assistant still going though clearance. Some improvement in bank situation for pharmacy staff. Long term sickness band 2 assistant. Still struggling with holidays and short term sickness due to covid positive staff. Had a number of days with no assistants.□ 24/3/22 ECF required for band 5 post before it can be evaluated. Form submitted. Changes made to MSO job description in hope can be clustered rather than require full evaluation panel. □ 16/3/22 Band 8a MSO job description on agenda for April evaluation panel. Awaiting date for band 5 senior technician job evaluation panel. Bank band 2 still going through HR clearance.□ 16/2/22 Band 8a clinical lead due to start 4 Apr22 (no cover in March). Band 7 pharmacist started 1feb22 - has not hospital experience so needs more support. Band 8a MSO job description reviewed and sent to evaluation panel. Recruitment for bank	KSO1 KSO2 KSO3 KSO4 KSO5
1189	########	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	Shane Morrison-McCabe	Sarah Solanki	Compliance (Targets / Assessments / Standards)	15	9	**23-06-2022** - EMT approved trainee sonographer post, apprenticeship post and PACS support. JD's evaluated - need tweaking. Apprenticeship JD - approved. interviewing next week for post. Uni EOI and contract completed. lots of interest from local sonographers to work here and expand their knowledge. interviewed 1 bank sonographer 2 weeks ago and another on 24th - both want substantive posts here eventually. □ 24-05-2022 - Education and workforce steering group met, emailed head of HR for an update on the outcome. JD written for apprentice radiographer, reporting radiographer, PACS support administrator and currently writing the JD for the trainee sonographer post. Awaiting confirmation re approval of these posts 25-04-2022 - PR for CSS - outcome was that training posts be phased in over 2-3 years. RSM was asked to devise a paper for EMT why these posts could not be phased in and needed actioning this year. Presented at EMT and supported. To be discussed formally in education and workforce steering group. 23-03-2022 Return to practice role out on TRAC. link sent. MSK sonographer has handed notice. agency cover needed for summer - form completed and sent to finance/etc. Bank sonographer going to apply for substantive role but needs to complete course for MSK. Roles put forward for BP - have not heard if approved? regional work around workforce being undertaken and academies being scoped at Chichester university. 24-02-2022 1 person started apprenticeship this week. pOAP completed for apprenticeships and training posts for BP. Bank sonographer start date this week. MSK sonographer wants to retire in June which is a huge risk to that service. A risk to be	KSO1 KSO2 KSO3 KSO5

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1140	########	Current PACS contract ending in June 2020	QVH is in a consortium for PACS/RIS/VNA with 5 other trusts from Surrey & Sussex. □ Philips provide a managed PACS/RIS/VNA (Vendor neutral archive) service to QVH and the other 5 trusts. The current contract was extended in 2016 to allow the contract to run until June 2020 under the 5+2 terms of the original contract. □ All 6 trusts have stated they want to remain in this consortium and potentially expand it to include another Surrey trust.□ There is now limited time available to re-procure PACS/RIS/VNA before the current contract runs out; without which there will be no PACS system.□ There is currently no project board or business case aligned to this procurement process. □ ESHT has said they are happy to lead on the project, with input from all trusts as and when requested.□ The data in the VNA is known to be incorrect across all sites, and if the S&S PACS consortium approve a plan to move PACS providers then the migration of data may need to occur from PACS to PACS - this will add a delay for migration.□	ESHT have said they will lead on a re-procurement process for the consortium. □ Philips have said they will extend the current contract - costs will need to be agreed as hardware will need replacing.	Michelle Miles	Sarah Solanki	Information Management and Technology	15	4	**23-06-2022** - Project delayed due to a number of factors. Proposed new go live is the 17th Sept but S&S consortium need more dates within a 6 week period to go live. Migration could be delayed if lease lines not in for some trusts. The Virgin media and BT suppliers have a shortage of workers who can perform this work so could bring additional delays. We will likely need to extend for another month at least. ESHT are the furthest behind currently. 24-05-2022 - Network speed being tested this week. Sectra training sessions being organized. 1st comms have gone out and e learning portal information has been sent out to key teams and departments. Training room identified for radiologist training sessions. Some risk around external sites we host PACS/CRIS for (Uck/Crow). These can be moved forward. 25-04-2022 - The BC PACS build has been completed but testing being scheduled. PACS workstations are being built for testing and a small training room identified in medical education facilities. Training sessions are now starting with key staff via teams but this will ramp up. Some PM support has now been found under the leadership of the programme lead. QVH is now going live first from the consortium and this is planned for last week in June. 23-03-2022 PACS work is high with multiple teams working on differing aspects. Workstations arrived in the trust. We have lost the PACS project manager. It was found he has been working on multiple projects. This was reported to NHS fraud team. Scoping replacement with CIO. 24-02-2022 - PACS meetings are ramping up. Hardware ordered for workstations - risk around receiving some kit before end of fiscal year. Some kit likely to arrive in April. BC	KSO1 KSO2 KSO3 KSO4
1077	########	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	Shane Morrison-McCabe	Claire Ziegler	Patient Safety	12	4	**22.06.2022** Update May/June 2022. Recruited into B6 X 3 ODP apprenticeship X 3 B5 AP's X 2 . Lead for recruitment working with long-term workforce plan to retain existing staff and demonstrate career opportunities and development to ensure the continued delivery of activity and planned increase 11.05.2022 Update for April 2022: Recruited into B6 anaesthetics and B5 scrub with 3 new starters B2. Continue to be challenged by high cost area and staff looking for career development. Working to wider the opportunities for different workforce groups to incentivise retention.□ 11.03.2022 Update for February 2022: Recruitment continues to be a challenge. Unable to book agency, it has been rumoured due to the rate, this is being reviewed by HR. Advert out for B2, B5. B6 has been appointed into and new starter in Day Surgery. Review existing structure. □ 04.02.2022 Update for January 2022. Recovery - appointed B7 one year fixed term mat leave cover, still awaiting B5 sponsorship. Day Surgery recruited B6, B2 - risk in periop admin due to low uptake on adverts - recruited 1 and interviewing X 2 Theatres rolling B5 with leavers X 3□ 21.12.2021 Update for December 2021. current vacancy being reviewed in periop PR. out to advert for B5 theatre practitioner/anesthetic practitioners, on a rolling advert due to lack of suitable applicants, recruited into B6 and out to advert for Mat Leave cover B7 recovery. POAP for 2022 ODP Apprenticeship □	KSO1 KSO2

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
1040	########	Age of X-ray equipment in radiology	Significant numbers of Radiology equipment are reaching end of life with multiple breakdowns throughout the last 2 year period.□ No Capital Replacement Plan in place at QVH for radiology equipment	All equipment is under a maintenance contract, and is subject to QA checks by the maintenance company and by Medical Physics.□ Plain Film-Radiology has now 1 CR x-ray room and 1 Fluoroscopy /CR room therefore patients capacity can be flexed should 1 room breakdown, but there will be an operational impact to the end user as not all patients are suitable to be imaged in the CR/Flouro room. These patients would have to be out-sourced to another imaging provider.□ Mobile - QVH has 2 machines on site. Plan to replace 1 mobile machine for 2019-2020□ Fluoroscopy- was leased by the trust in 2006 and is included in 1 of these general rooms. Control would be to outsource all Fluoroscopy work to suitable hospitals during periods of extended downtime. Plan to replace Fluoro/CR room in 2019-2020□	Shane Morrison-McCabe	Sarah Solanki	Patient Safety	12	2	**23-06-2022** - Phase 2 documentation for commercial solutions being finalised. Meetings booked with finance and estates in early July to discuss further. Financials were due to be revised on the BC. Not sure if this yet completed. 24-05-2022 - MES board met. DoF wants to see updated BC and complete phase 2 of the project. NHS framework meeting with finance/radiology manage this week. OBC has been drafted, awaiting financials 25-04-2022 - OBC needs to be completed and sent to EMT. This is in train despite no PM. Phase 2 briefing have been held with commercial solutions/QVH team and 3 suppliers about next steps. 23-03-2022 - Meeting held and have final 3 suppliers. The framework team are notifying unsuccessful bidders via letter. Meeting this Friday re next steps and phase 2. Current MRI provider current extended. Lost the project manager for this so this needs scoping. 24-02-2022 - legal assessment of phase 1 now complete. Arranging meeting to go through complete scoring. MRI 12 month extension needs EMT sign off for interim period. Papers submitted to DOF. Current MRI contract runs to 31st March. OBC needs to be written and completed for submission for MES. 20-01-2022 - tender document evaulation were finalised by 23rd December. The phase 1 presentations are complete and 1 set of moderation meetings held for presentations. 1 more moderation meeting occurring on 21st Jan. Legal team need to formally review phase 1 documents. This is going to happen within the next month. OBC being written and MES to be added as an agenda item for EMT. We need trust approval to move to phase 2 of MES which takes around 12 weeks. As a precautionary measure, RSM has added MRI and xray kit to the BP template for capital in case trust do not progress to phase 2. □ 20-12-2021 - Phase 1 - evaluators scoring phase 1 documents and meeting arranged for	KSO1 KSO2 KSO3
968	########	Paediatrics: Delivery of commissioned services whilst not meeting all national standards/criteria for Burns	-Potential increase in the risk to patient safety -on-call paediatrician is 1 hour away in Brighton -Potential loss of income if burns derogation lost -no dedicated paediatric anaesthetic lists	*Paeds review group in place *Mitigation protocol in place surrounding transfer in and off site of Paeds patients *Established safeguarding processes in place to ensure children are triaged appropriately, managed safely *Robust clinical support for Paeds by specialist consultants within the Trust *All registered nursing staff working within paediatrics hold an appropriate NMC registration *Robust incident reporting in place *Named Paeds safeguarding consultant in post *Strict admittance criteria based on pre-existing and presenting medical problems, including extent of burn scaled to age. *Surgery only offered at selected times based on age group (no under 3 years OOH) *Paediatric anaesthetic oversight of all children having general anaesthesia under 3 years of age. *SLA with BSUH for paediatrician cover: 24/7 telephone advice & 3 sessions per week on site at QVH	Tania Cubison	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	4	**June 2022**: nil update February 2022 - nil to report - risk reviewed□ November 2021 - nil to report□ 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 CQRPM Dec 4th□ Nov: interim inpatient paeds burns divert continues - no reported issues. Update on number of diverts requested from commissioners.□ Working group QVH / BSUH to consider options; adult burns service aligned to provision of major trauma centre at BSUH□ Sept 30th: Review of Paeds SLA & service provision□ DoN met with BSUH W&C CD to discuss impact of inpatient paeds burns move with regards to BSUH paediatrician appetite to continue providing paediatric service at QVH. Further discussions planned once respective Directors briefed.□ July update: KSS HOSC Chairs meeting (10/7) to share interim divert plans - QVH patient pathway continuing to follow established larger burns protocol with patients being treated at C&W or Chelmsford; HOSC supportive of safety rationale & aware that further engagement & review of commissioned pathway required - to be led by NHSE Specialist commissioning. □ June update: Inpatient paeds BC for transfer of services to BSUH not approved. Interim arrangements with Burns Centres commenced. Plan for QVH inpatient paeds burns to go to other providers from 1st August. LSEBN aware & involved in discussions.□	KSO2 KSO3 KSO5

ID	Opened	Risk Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Progress/Updates	KSO
877	########	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	**June 2022**:Third submission of the business plan has been submitted with increased levels of efficiencies required to deliver a break even plan. Additional income of £1.3m granted to the Trust to mitigate the increased inflation. was February 2022: Planning for 22/23 is underway, first draft submission on the 17th of March. Plans will be discussed at Finance & Performance and subsequently the board. January 2022: H2 has been submitted. A forecast breakeven position for 21/22 is planned subject to normal working assumptions. Business planning for 22/23 is underway to achieve national deadline. October 2021: H2 Financial regime has now been issued to the Trust (1st October) work is underway to review the financial envelop for the Trust and also the implications of the revised Elective Recovery Funding arrangements which have changed from H1. July 2021: Current financial regime has continued as block arrangements for H1 (Months 1-6) as yet guidance is awaited for H2 (months 7-12. Currently due to the increase in activity above activity thresholds the Trust is forecasting to achieve plan by Month 6. Further guidance is likely to show an increased need for efficiencies in H2. 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.	KSO4
834	########	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	Tania Cubison	Dr Edward Pickles	Patient Safety	12	4	April 2022 - SLA still being reviewed February 2022: HoN reviewing SLA - nil other significant update June 2021: SLA with Associate Director of Business Development. DoN and QVH Paediatric Lead reviewing 2015 standards with a view to updating or changing GAP analysis 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	

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/2022**		**Agenda reference:**	**105-22**	
Report title:	Quality & Safety Report				
Sponsor:	Nicky Reeves, Director of Nursing and Quality				
Author:	Amy Brownlie, Clinical Audit and Outcomes Specialist				
Appendices:	1. Covid update				
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: • New Head of Quality & Compliance in post • Recruitment for technicians in Sleep Services ongoing • Trust-wide careers "open evening" being explored to aid recruitment in key areas • GMC survey of doctors in training results due shortly. Any areas for improvement to be identified				
Recommendation:	The Board is asked to be assured that the contents of the report reflect the quality and safety of care provided by QVH during this time				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: *Financial sustainability*	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	The 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 report contributes and provides evidence of compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's fundamental standards.				
Legal:	The report upholds the principles and values of The NHS Constitution for England and the communities and people it serves – patients and public – and staff.				
Resources:	The report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	4th July 2022	Decision:	Please note due to board paper deadline being before Q&G committee this paper will only be seen at Q&G on 4th July 2022 verbal update will be given if required	
Next steps:	N/A				

Executive Summary - Quality and Safety Report, July 2022

Domain	Highlights
Chief Nurse	Safety of our patients and staff continues to be the primary focus for the Trust whilst also maintaining a positive patient experience. New Head of Quality and Compliance in post. Covid updates are included in appendix 1.
Medical Director	**Sleep Services** We have undertaken an external review process of the sleep service as there have been considerable staffing challenges in a number of staff groups. This review has informed an action plan that is being implemented. Recruitment is progressing well and we have identified a number of new technicians. **Antimicrobial stewardship** The antimicrobial stewardship programme continues and our antimicrobial pharmacist is working with the medical and nursing colleagues to look at implementation. We are meeting with the pharmacy, nursing and medical teams to look at new approaches to accountability. **Clinical harm reviews** The clinical harm reviews continue and we are working to change some of our pathways to incorporate harm review within the routine working of the waiting list process. We have now created harm review reports in the Evolve medical record and are linking into a group email for the clinical review team to ensure good visibility of any patient that might have come to harm.

Report by Exception - Key Messages

Domain	Issue raised	Action taken
Responsive: Safe Staffing	Staffing Challenges	International Recruitment being reviewed in collaboration with external partners. Careers "open evening" in Maxillofacial nursing department was successful and the Trust is planning a similar larger event in the autumn looking at other clinical areas e.g., Allied Health Professionals and nursing.

Safe - Performance Indicators

Metric Description	Target	Q1 21/22	Q2 2021/22			Q3 2021/22			Q4 2021/22			Q1 2022/23		12 month total/ rolling average
		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	
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
Clostridium Difficile acquired at QVH post 72 hours after admission	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Gram negative bloodstream infections (including E.coli)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA screening - elective	95%	96%	86%	84%	96%	95%	96%	98%	95%	98%	93%	98%	97%	94%
MRSA screening - trauma	95%	98%	97%	97%	97%	98%	99%	99%	99%	98%	97%	99%	100%	98%
Incidents														
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Serious Incidents	0	1	0	0	0	0	0	0	0	0	0	0	1	2
Theatre metrics														
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	5	7	5	2	3	2	3	3	3	3	0	3	39
Paediatrics under 3 years: Induction of anaesthetic was between 18:00 and 08:00	0	1	0	0	0	0	0	0	0	0	0	0	0	1
WHO quantitative compliance		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Non-clinical cancellations on the day		8	5	9	10	8	23	7	4	29	19	5	8*	150
Needlestick injuries	0	3	2	2	1	2	3	2	1	0	2	0	2	20
Pressure ulcers (all grades)(Theatre metric)		0	1	1	0	2	0	0	0	0	1	0	0	5
Paediatric transfers out (<18 years)		1	0	0	0	0	2	0	0	0	2	0	0	5
Medication errors														
Total number of incidents involving drug / prescribing errors		8	10	9	3	11	5	6	4	17	10	6	13	102
No & Low harm incidents involving drug / prescribing errors		5	8	8	2	6	4	5	4	14	8	5	11	80
Moderate, Severe or Fatal incidents involving drug / prescribing errors		0	0	0	0	0	0	0	0	0	0	0	0	0
Medication administration errors per 1000 spells		1.7	1.1	0.6	0.6	3.0	0.6	0.6	0.0	1.9	1.2	0.6	1.2	1.1
Pressure Ulcers Hospital acquired - category 2 or above		0	0	2	0	2	1	0	0	1	0	0	0	6
VTE initial assessment (Safety Thermometer)	95%	96%	96%	100%	100%	100%	100%	96%	100%	100%	93%	100%	100%	98%
Patient Falls														
Patient Falls assessment completed within 24 hrs of admission	95%	93%	100%	95%	100%	100%	96%	100%	95%	100%	100%	95%	100%	98%
Patient Falls resulting in no or low harm (inpatients)		3	4	5	2	1	7	1	1	6	1	5	2	38
Patient Falls resulting in moderate or severe harm or death (inpatients)		1	0	0	0	0	0	0	0	0	0	0	0	1
Patient falls per 1000 bed days		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

*Nov 21 - non clinical cancellation on day. Variation due to cancellations for trauma and a member of the surgical team with a +PCR, excluding these exceptional circumstances would show cancellations at around 8-10 in the month.

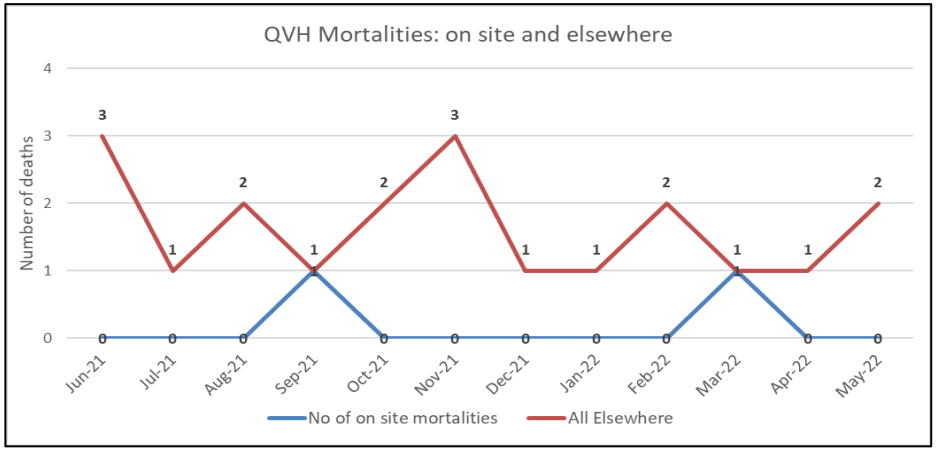
nc = not collected or not reported

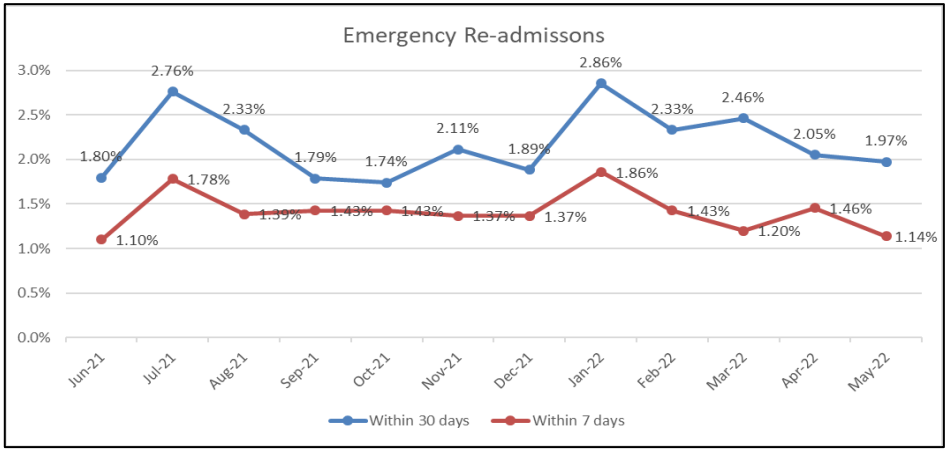
Safe - Performance Indicators

KPI	Target	Average	Latest Month	Variation May-22	Assurance May-22	Comments for the latest period shown for each metric
MRSA - Elective	95%	98%	97%			Ongoing review of data quality and ensuring robust methodology for data collection.
MRSA - Trauma	95%	96%	100%	H		Ongoing review of data quality and ensuring robust methodology for data collection.
Serious Incidents	0	0.1	1	H		1 reported in May.
Total no of incidencts involving drug/prescribing errors	0	11.2	11			All incidents reviewed in Pharmacy review of Datix.
Falls per 1000 bed days	0	3.1	2.5			Falls incidents continue to fluctuate. No key patterns to mechanism have been identified. Work around falls prevention continues and this has now been selected for a Quality Priority. The latest progress is that the After Action Review process has now been commenced and early feedback is very positive. The new falls documentation has been approved by CGG and should be rolled out shortly. Additional training is being planned to introduce these forms to staff.
Pressure ulcers per 1000 bed days	0	0.4	0.0			In critically ill patients staff have recently been vigilant in noticing vulnerable skin and taking preventative actions and Datix reports have shown recognition of potential device related pressure ulcer as well as category 2 pressure/trauma injury in oedematous arms/elbow (very high risk). Regular training continues to be offered on Waterlow risk assessment and aSSKINg prevention care plans. The Pressure ulcer policy has been updated. A pressure ulcer prevention audit for QVH inpatients is planned.
Complaints	0	4.5	5			Whilst fluctuating month by month complaints have fallen within the expected range throughout the period. Thematic analysis of the complaints raised, alongside other patient experience information, is shared with service areas to identify opportunities and celebrate what we are doing well to ultimately ensure our services continuously improve.
Mortalities	0	1.1	2			No cause for concern. Figures are within the expected boundaries.

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

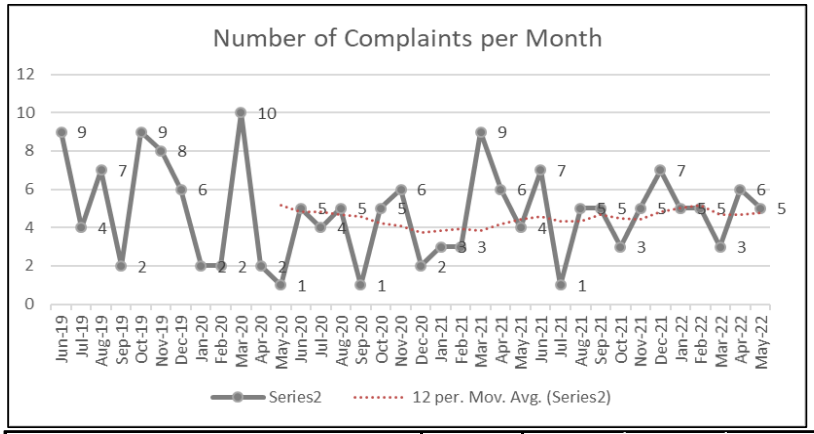
Effective - Performance Indicators

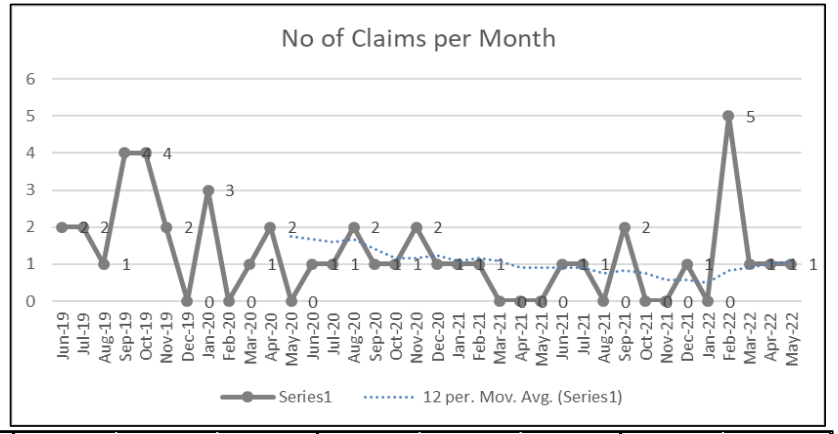




Mortalities Report			Q1 21/22	Q2 2021/22			Q3 2021/22			Q4 2021/22			Q1 2022/23	
			Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Mortalities within 30 days of an inpatient episode or outpatient procedure	Inpatient	No of on site mortalities	0	0	0	1	0	0	0	0	0	1	0	0
		No of mortalities elsewhere	3	1	1	1	0	3	1	1	2	0	1	1
	Outpatient		0	0	1	0	2	0	0	0	0	1	0	1
	All Elsewhere		3	1	2	1	2	3	1	1	2	1	1	2
Reviews		Completed Preliminary Reviews	0	1	2	0	0	2	nc	1	nc	0	nc	nc
		No of deaths subject to SJR	3	3	0	1	0	0	nc	0	nc	0	nc	nc
No of mortalities in patients with learning difficulties (inpatients only)			0	0	0	0	0	0	0	0	0	0	0	0

Caring - Current Compliance - Complaints and Claims





	Q1 21/22	Q2 2021/22			Q3 2021/22			Q4 2021/22			Q1 2022/23	
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Number of complaints	7	1	5	5	3	5	7	5	5	3	6	5
Complaints per 1000 spells	0.34	0.05	0.28	0.25	0.16	0.25	0.40	0.27	0.29	0.15	0.35	0.25
Number of claims	1	1	0	2	0	0	1	0	5	1	1	1
Claims per 1000 spells	0.05	0.05	0.00	0.10	0.00	0.00	0.06	0.00	0.29	0.05	0.06	0.05
Number of cases referred to PHSO	0	0	0	0	0	0	0	0	0	0	0	0

Nursing Workforce - Performance Indicators, Safe staffing data

Peanut ward - Staffing challenges continue. Matron and Head of Nursing are working with the team to address ways of moving staff to ensure we are able to robustly cover nights. In April there was 1 overnight case. There were 2 nights when the ward was staffed but there were no inpatients and there were 27 occasions when the ward was unable to accept an inpatient overnight. On 2 occasions, the staff were delayed in finishing their shift due to late running theatre lists and needing to ensure the children had recovered and were discharged safely. In March there were 7 patients overnight on 5 occasions and there were 15 occasions when the ward was not able to accept an inpatient. There were 11 nights when the ward was staffed but there were no inpatients.

April safe staffing data demonstrates compliance with staff numbers above the 95% threshold. 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%*

	Planned staff			Actual staff			Apr-22		Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA			RN	NA	HCA	RN	NA	HCA
DAY	4002	345	1944	3979	345	1932	*Total Hrs Planned and Actual*	NIGHT	3588	126.5	1024	3565	126.5	1023.5
				99.4%	100.0%	99%	*% Planned Hrs Met*					99.4%	100.0%	100.0%
			6291			6256	*Total Hrs Planned & Actual - Combined reg & support*				4738			4715
						99.5%	*% Planned Hrs Met - Combined reg & support*							99.5%

May safe staffing data demonstrates compliance across all the bands with staffing levels at or above 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-22

	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
DAY	4221	149.5	1944	4163	149.5	1921	*Total Hrs Planned and Actual*
				98.6%	100.0%	99%	*% Planned Hrs Met*
			6314			6233	*Total Hrs Planned & Actual - Combined reg & support*
						98.7%	*% Planned Hrs Met - Combined reg & support*

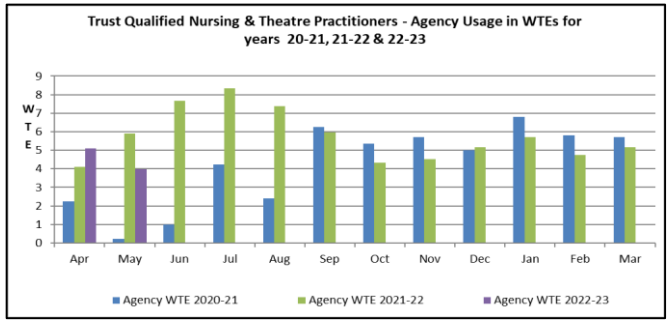
	Planned staff			Actual staff		
	RN	NA	HCA	RN	NA	HCA
NIGHT	3876	126.5	1047	3795	126.5	1047
				97.9%	100.0%	100.0%
			5049			4968
						98.4%

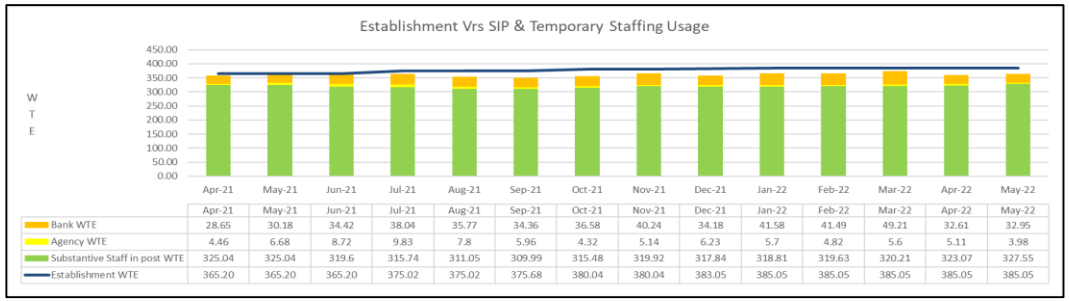
Nursing Workforce - Performance Indicators

ALL QUALIFIED & UQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2020-21 & 2021-22			May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)				365.20	365.20	375.02	375.02	375.68	380.04	380.04	383.05	385.05	383.05	385.05	383.05	**385.05**	◄►
Staff In Post WTE				325.04	319.60	315.74	311.05	309.99	315.48	319.92	317.84	318.81	319.63	320.21	323.07	**327.55**	▲
Vacancies WTE				40.16	45.60	59.28	63.97	65.69	64.56	60.12	65.21	66.24	63.42	64.84	59.98	**57.50**	▼
Vacancies %	>18%	12%<>18%	<12%	11.00%	12.49%	15.81%	17.06%	17.49%	16.99%	15.82%	17.02%	17.20%	16.56%	16.84%	15.66%	**14.93%**	▼
STARTERS WTE (Excluding rotational doctors)				2.00	3.43	0.00	1.41	3.93	4.68	9.97	6.56	2.95	4.32	2.61	6.76	**3.00**	▼
LEAVERS WTE (Excluding rotational doctors)				0.87	7.62	3.21	6.76	1.12	1.60	3.61	4.41	3.48	2.80	2.53	3.99	**1.01**	▼
Starters & Leavers balance				1.13	-4.19	-3.21	-5.35	2.81	3.08	6.36	2.15	-0.53	1.52	0.08	2.77	**1.99**	
Agency WTE (Data From Healthroster)				6.68	8.72	9.83	7.80	5.96	4.32	5.14	6.23	5.70	4.82	5.60	5.11	**3.98**	▼
Bank WTE (Data From Healthroster)				30.18	34.42	38.04	35.77	34.36	36.58	40.24	34.18	41.58	41.49	49.21	32.61	**32.95**	▲
Trust rolling Annual Turnover %	>=12%	10%<>12%	<10%	8.58%	10.91%	11.36%	12.52%	12.62%	13.32%	12.89%	12.81%	12.82%	13.76%	13.78%	14.29%	**14.30%**	▲
Monthly Turnover				0.29%	2.58%	1.09%	2.14%	0.38%	0.53%	1.13%	1.46%	1.15%	0.93%	0.84%	1.36%	**0.35%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	3.70%	3.81%	3.21%	3.61%	3.98%	4.69%	5.12%	5.29%	6.47%	6.37%	6.39%	5.05%	***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, Emergency Practitioners, Theatre Practitioners, HCA's,Student OPD's, Trainee Nurse Associates/Practitioners,Nurse Associates, Play Specialists, Oversea's Nursing awaiting PIN. Dental Nurses included in figures from 1.4.2020





Medical Workforce - Performance Indicators

Metrics	Q1 21/22	Q2 2021/22			Q3 2021/22			Q4 2021/22			Q1 2022/23		12 month rolling
Medical Workforce	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	
Turnover rate in month, excluding trainees	1%	0%	1%	1%	4%	0%	1%	1%	1%	0%	3%	1%	21%
Turnover in month including trainees 9%	2%	0%	18%	18%	5%	1%	1%	1%	9%	1%	5%	1%	46%
Management cases monthly	1	0	0	0	0	0	0	0	0	0	0	0	1
Sickness rate monthly on total medical/dental headcount	2%	2%	1%	3%	3%	2%	2%	3%	3%	4%	2%	1%	2%
Appraisal rate monthly (including deanery trainees)	67%	69%	70%	65%	52%	61%	57%	61%	68%	74%	70%	69%	69%
Mandatory training monthly	84%	82%	82%	80%	79%	81%	82%	82%	80%	84%	84%	85%	82%
Exception Reporting – Education and Training	1	1	10	5	1	1	1	0	0	0	1	0	24
Exception Reporting – Hours	1	5	10	2	3	3	0	1	1	1	3	7	47

Medical & Dental Staffing

Plans are underway for August junior doctors induction, the largest induction of the year, where we will be welcoming new trainees in Anaesthetics, Plastic Surgery, Corneo Plastics and Radiology. The Medical Education team work closely with colleagues in Resourcing, HR Advice, Pharmacy, IT and the individual departments to ensure that everything is in place for the doctors' first day, that they have access to IT systems etc, and that they receive an effective local induction.

Education	CPD courses for dentists, organised in conjunction with HEE KSS's dental deanery, are taking place regularly in the dental skills lab, organised by Jo Deamer who is the dental training technician within the Medical Education team. From September, dental foundation training will be restarting in the lab every Friday, with a brand new cohort of dentists fresh from dental school. The next round of Local Faculty Group meetings, to ensure educational governance of medical and dental training, will begin in June. The next Junior Doctors' Forum meeting is also planned for early June and will be attended by Steve Jenkin to allow trainees an opportunity to ask him questions relating to QVH and issues that impact on their training. The GMC survey of doctors in training has now closed and we are awaiting the results which are due in July and will be used to ensure that any areas requiring improvement are picked up on and addressed. A training session for SAS doctors on putting together business cases is planned for 23 June, funded by HEE's development fund for SAS doctors.

Queen Victoria Hospital
NHS Foundation Trust

Appendix 1

COVID-19 UPDATE JULY 2022

With covid variants still in circulation, we continue to screen all staff twice weekly utilising either Optigene or lateral flow tests. The heads of department and managers have all been reminded to ensure **all** staff are complying with asymptomatic screening. We are seeing a reduced number of staff and patients who are testing positive at the moment. There have been no further outbreaks at the time of writing the report.

Following changes to national IPACT guidance, QVH has revised asymptomatic testing requirements for elective patients, staff and also reduced the requirements to wear masks in non-clinical areas when safe to do so.

Visitor guidance has been updated to reflect the national advice.

The incident room remains open 7 days per week, it is managed by the Chief Nurse in the week and the on call manager at the weekend.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/2022**		**Agenda reference:**	**106-22**	
Report title:	**6 monthly Nursing Workforce Review**				
Sponsor:	Nicky Reeves, Chief Nurse				
Author:	Liz Blackburn, Deputy Chief Nurse				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of this report is to provide the 6 monthly overview of safe nurse staffing levels.				
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:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: ***Outstanding patient experience***	KSO2: ***World-class clinical services***	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	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:	4th July 2022	Decision:	please note due to board paper deadline being before Q&G committee this paper will only be seen at Q&G on 4th July 2022 verbal update will be given if required	
Next steps:	N/A				

Queen Victoria Hospital
NHS Foundation Trust

Nursing Workforce Review – April 2022

1. Purpose

The purpose of this paper is to provide the six monthly overview of safe nurse staffing levels to comply with requirements set out by: NHS England/ Improvement (NHSE/I), the National Quality Board (NQB) and the Care Quality Commission (CQC). 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. Background

All NHS Trusts are required to deploy sufficient, suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively, National Quality Board (NQB) *Safe and sustainable and productive staffing.*

The monthly safe staffing data is reported at Clinical Governance Group (CGG) and provides an overview of nursing safe staffing for inpatient areas and the site team. The data maps actual staffing against planned staffing.

3. National Overview

NHSE/I in conjunction with Health Education England (HEE) outlined key priorities for organisations to meet the long term workforce plan, HEE's 2022/23 business plan includes:

- Workforce transformation, skill mix and growth
- Education and training reform
- Widening workforce participation and diversity
- Role in global health workforce market

Areas to explore are Refugee Nurse Support Pilot Programme, which support refugees who are qualified as nurses in their home country to resume their nursing careers in the NHS.

The Royal College of Nursing spring statement (2022), reported that there continues to be a significant vacancy rate within England (10.3%) further highlighting the fragility of our health service. In March 2022 the Department of Health and Social Care published an update on the 50,000 Nurses programme. Three work streams are contributing to this increase:

- **domestic recruitment** – this includes:
  - preregistration undergraduate and postgraduate students
  - reducing preregistration nurse attrition
  - degree nurse apprentices
  - conversions from nursing associates and assistant practitioners to registered nurses
  - nurse return to practice

- **international recruitment**: bringing in overseas-trained nurses to the NHS from abroad
- **retention**: encouraging existing nursing staff to stay in the NHS, and reducing the leaver rate

It is acknowledged that retention is the most significant area of uncertainty and greatest complexity, the challenges that have occurred as a result of the pandemic over the last two years have left many staff placed under sustained and severe pressure which will have an impact on their attachment to nursing. Focus is being directed to the following key areas to improve retention:

- health and wellbeing initiatives, including self-help apps, tools and guidance for managers to support their teams
- expansion of occupational health and mental health support, including the introduction of 40 mental health and wellbeing hubs
- expansion of flexible working
- greater focus on career development

4. Covid-19 pandemic and Vaccination as a condition of deployment

The staff have continued to work flexibly to support the ongoing service delivery. QVH has followed Nursing and Midwifery Council (NMC) regulatory guidance to support this and maintain safe staffing. During this six month period, significant plans were made to implement vaccination as a condition of deployment (VCOD). Unvaccinated staff were given support and resources to inform them about the Covid-19 vaccination programme. Those staff who chose not to be vaccinated were given information on next steps. On 31st January 2022, the government chose to reconsider this option and we await further updates.

5. Training and education

- Trainee Nursing Associates (TNA) – three TNAs are currently in training within the trust and a further two will commence their training in September 2022 and February 2023.
- Registered Nursing Degree Associate (RDNA) – one continues with their training and a second Nursing Associate has been successfully recruited to commence their training in September 2022.
- Operating Department Practitioners (ODP) apprentices - two will start their training in September 2022. QVH have four currently in training.
- Assistant Practitioner Radiology apprenticeship – 1 started January 2022.
- Ophthalmology apprenticeship will be completed in May 2022.
- Senior health care support worker has completed their training and two further to start in May 2022.

Our first registered nurse is due to complete the level 7 Advanced Practice (AP) training in September 2022. This high level autonomous role will see the AP nurse work within the four pillars of advanced clinical practice, namely clinical, leadership, education and research. This role will be within the burns service.

A new internal support programme has been introduced for QVH staff who have an overseas nurse qualification to become NMC registered. One HCA is currently on this programme.

Nursing and Allied Health Professionals (AHP) education and workforce development continue to work together and report into the Education Steering Group and relevant business units. Elaine Tate has been seconded to support the HEE workforce development strategy for QVH until November 2022.

Outlined below are details around the internal courses that have been run; training is inter professionally led and delivered to health care staff.

- Preceptorship training programme – 5 new to register staff attend the 3 day training
- Care certificate training - 3 staff successfully completed and awarded the care certificate

- Head and Neck Study Days – 22 staff have attended the 3 day programme
- Simulation training including bronchospasm, anaphylaxis, care of the patient in the MRI unit etc. to over 40 staff
- Burns management workshop - delivered to over 60 external health care staff and 30 QVH staff
- Osteotomy training for 13 QVH staff
- Ophthalmic training for 48 staff

Funding was secured for a fixed term Health Care Support Worker (HCSW) trainer role, they support HCSW Trust wide from induction through the care certificate and on to a career pathway in health care. The benefit of this role is already been seen in positive feedback from HCSW colleagues.

6. Recruitment and Retention

We have continued to recruit to our nursing workforce throughout this period in order to support the existing staff and meet our increased patient activity both elective and trauma. This has been challenging, as we continue to receive high levels of applicants who do not have a current NMC registration. Those areas currently on the corporate risk register have utilised a 'new starter' premium in order to act as an incentive to apply.

The following have been recruited in the Trust over this reporting period:

- 16.3 WTE qualified nurses
- 14.78 WTE unqualified staff

Below is the leaver and starter information for the nursing workforce which demonstrates an increase in the number of staff in post of 4.73 WTE over the reporting period.

1st October 2021 to 31st March 2022 leaver and starter data for information

All Qualified and Unqualified Nursing								
Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2020-21 & 2021-22			Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Compared to previous month
Establishment WTE (Establishment includes 12% headroom)				380.04	380.04	383.05	385.05	383.05	**385.05**	↑
Staff in post WTE				315.48	319.92	317.84	318.81	319.63	**320.21**	↑
Vacancies WTE				64.56	60.12	65.21	66.24	63.42	**64.84**	↑
Vacancies %	**>18%**	**12%<>18%**	**<12%**	16.99%	15.82%	17.02%	17.20%	16.56%	**16.84%**	↑
Starters WTE (Excluding rotational Doctors)				4.68	9.97	6.56	2.95	4.32	**2.61**	↓
Leavers WTE (excluding rotational Doctors)				1.60	3.61	4.41	3.48	2.80	**2.53**	↓
Starters and Leavers balance				3.08	6.36	2.15	-0.53	1.52	**0.08**	↓

Sourced via ESR data

Recruitment from outside the UK continues to play an important role in the supply of nurses to the NHS. We continue to explore international nursing recruitment opportunities and have sought support from University Hospital Sussex to achieve this.

6. Incident Reporting

There were eleven incidents reported via datix during this period in relation to staffing. The most significant of these incidents continues to be the lack of staffing for the twilight shift on Peanut ward, this has been exacerbated by the high sickness levels observed in the early part of 2022. The peanut staffing model has

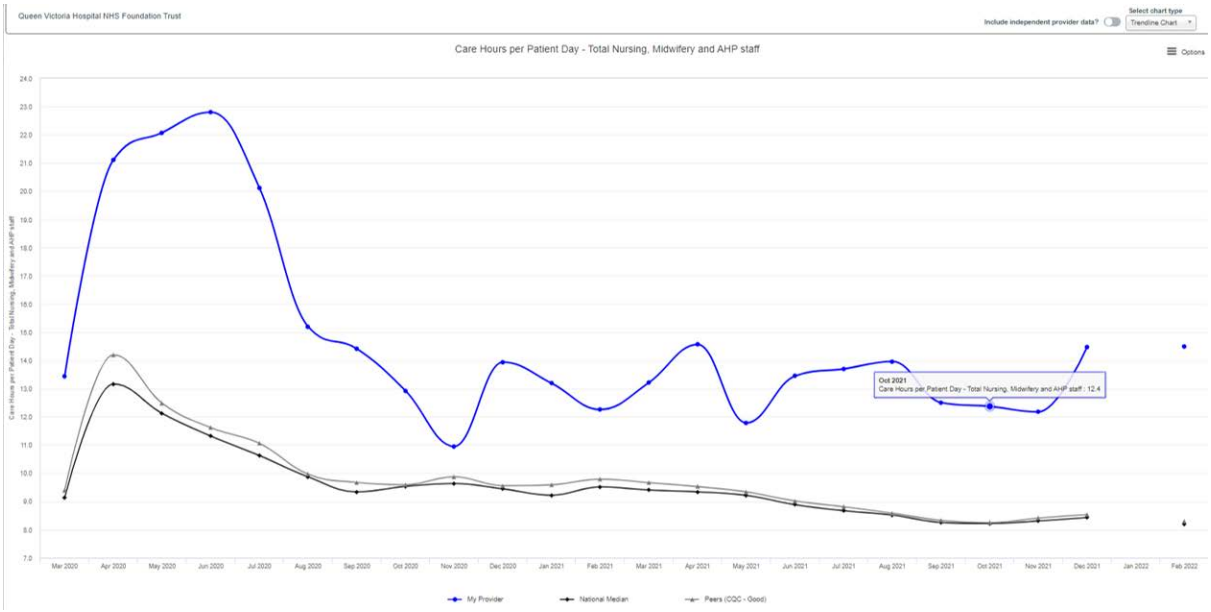
been reviewed, this has involved re-assessing staffing levels for each shift, and revising the opening times for the peanut Assessment Unit (PAU). These changes will come in to effect in August 2022. Peanut staffing levels are reported at Board bi monthly via the Quality and Safety report. In the event that a child is not able to be managed overnight on the QVH site there is a process place to support onward transfer to another provider and these cases are reviewed via Clinical Governance Group.

Four other incidents were in relation to short notice sickness during January 2022.

CCU, H&N, C-Wing and Peanut staffing have all been added to the Corporate Risk Register (CRR) due to the inability to recruit sufficient registered nurses. The Board Assurance Framework (BAF) for key strategic objective 1 Outstanding Patient Experience has been reviewed and the risk score increased due to recruitment and retention challenges Workforce updates continues to be discussed at every public board which includes details on nursing recruitment and retention triangulated with patient safety metrics and complaints information.

7. Care Hours per Patient Day (CHPPD), Safe Care and safe staffing metrics

This is benchmarked nationally through the NHSE/I 'Model Hospital' against other Trusts who are rated 'Good' by the CQC. As the graph below shows, the Trust data is above the national median, and this continues to reflect the nature of our specialist services. The Burns and Head and Neck Unit take higher acuity patients and requires a nurse to patient ratio higher than an average ward.



Model Hospital Data

Work continues in the roll out of Safe Care, and is being used in all areas. This has been of value to the Site team as it gives them a live overview of the bed occupancy and staffing levels within the Trust. Our safe staffing metrics are captured daily and reported on a monthly basis, we are now capturing the data for when Peanut ward is not staffed on a twilight shift.

8. Establishment reviews and budget setting

The Chief Nurse and Deputy Chief Nurse 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. 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. Particular attention has been taken to match our establishments with our occupancy rates.

Ward, Outpatient, MIU and Peri-op areas as at 31st March 2022 (exc 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 inc 12% uplift)	WTE Staff in post 30th Sept 2021	WTE Staff in post 31st March 2022	Change in staff in post Increase Decrease	Number of vacant posts 31st March 2022	% Vacant posts 31st March 2022
Burns Ward	23.79	16.95	18.21	↑1.26	5.58	23%
Canadian Wing	45.00	38.26	34.95	↓3.31	10.05	22%
Corneo OPD	18.53	17.13	15.07	↓2.06	3.46	19%
Critical Care	24.47	18.68	17.66	↓1.02	6.81	28%
Head & Neck	13.24	6.75	9.05	↑2.3	4.19	32%
MaxFax OPD	22.70	19.29	20.93	↑1.64	1.77	8%
MIU	7.85	5.27	7.88	↑2.61	0	0%
Peanut Ward	19.82	15.23	14.23	↓1	5.59	28%
Plastics OPD	15.66	13.28	14.28	↑1	1.38	9%
Peri-op (inc pre assessment)	149.95	124.61	128.34	↑3.73	21.61	14%
Site Practitioners	10.72	10.435	10.51	↑0.075	0.21	2%

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

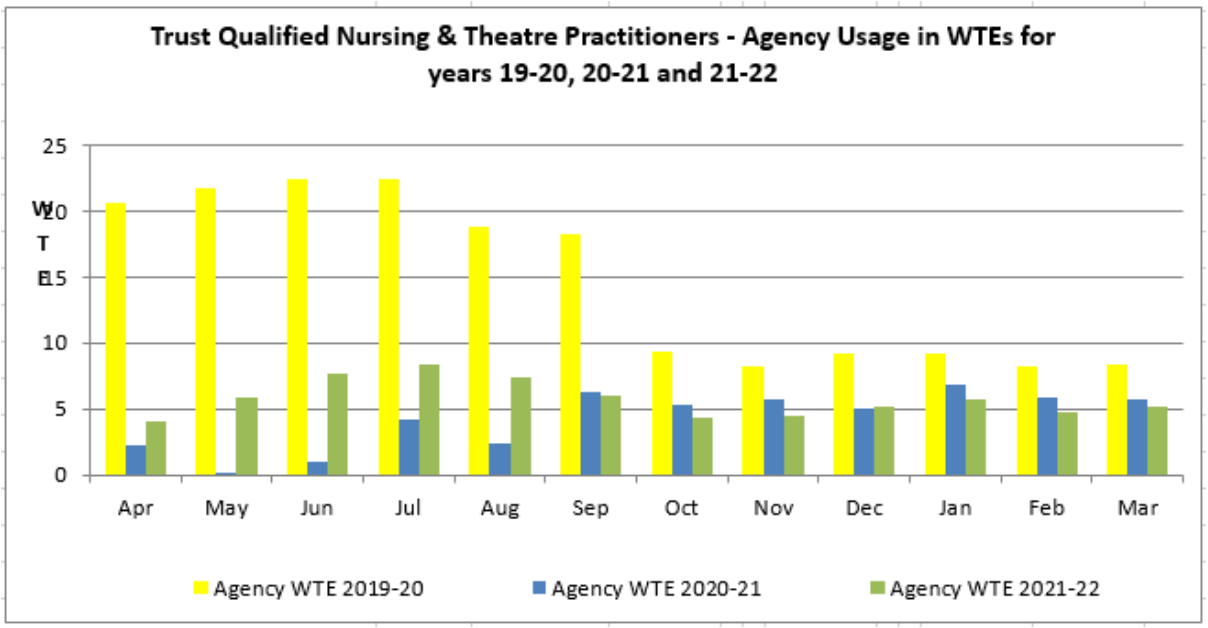
% Vacancy	RAG
Less than 12%	Green
12.1% to 18%	Amber
Above 18.1%	Red

The following gives additional information regarding recruitment and retention in the specific clinical areas. All vacant posts are being advertised and actively recruited to, each Matron is working clinically to support the workforce and provide safe patient care:

- **Burns Ward** - New Burns Matron started in November 2021.
- **Canadian Wing** – Second Matron to start in June 2022.
- **Corneo Outpatients Department** - Corneo has some vacancy, actively advertising and recruiting to vacant posts.
- **Critical Care** – High vacancy due to staff relocating, career progression and maternity leave. Plans for International Recruitment to this area.
- **Head and Neck Ward** – Newly established ward to meet the cancer standards for Head and Neck patients. New Matron started in November 2021.
- **Max Fax Outpatients Department** - Max Fax have a stable workforce. Recruitment open evening held with good success.
- **Peanut Ward** – New Matron started in March 2022. The paediatric ward establishment has been set using RCN guidance for staffing paediatric units. Challenges continue with staffing the twilight shift. Review of establishment and shift times to be completed in August 2022.
- **Plastics Outpatients Department** - Plastics Outpatients continues to work flexibly to provide staff for the Covid-19 Testing pod and the CDC work.
- **Peri-op** – Workforce stabilising.
- **Minor Injuries Unit** – Two new members of staff started in early 2022.
- **Site Practitioners** – Stable staffing establishment.

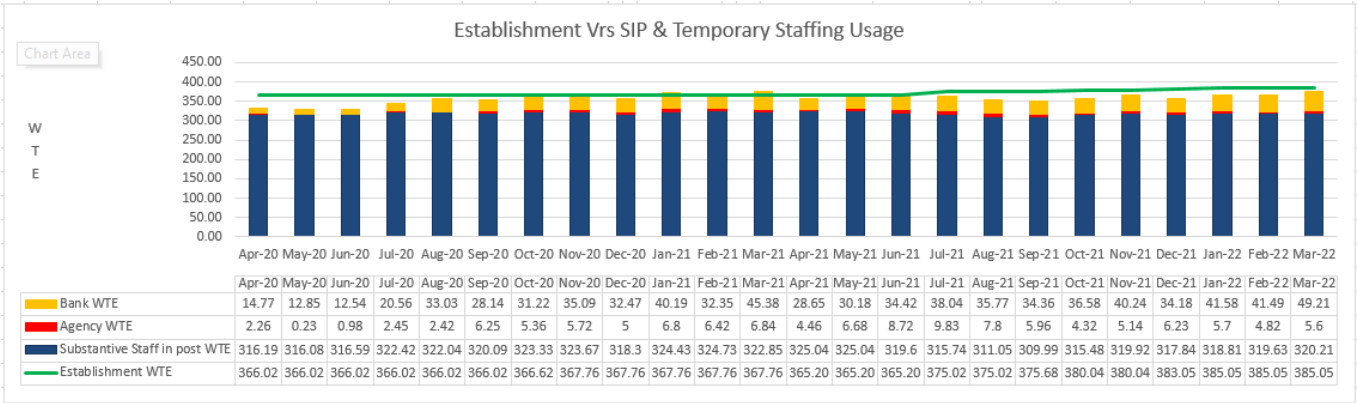
9. Temporary Staff usage

The use of agency has been stable over the past six months. Agency usage is continuously monitored and justified on a daily basis. The Trust values its bank staff and as a result have paid an enhanced rate over this monitoring period. An increase in the uptake of bank shifts has been noted particularly in our inpatient areas.



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.



	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	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
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	34.42	38.04	35.77	34.36	36.58	40.24	34.18	41.58	41.49	49.21
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	8.72	9.83	7.8	5.96	4.32	5.14	6.23	5.7	4.82	5.6
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	319.6	315.74	311.05	309.99	315.48	319.92	317.84	318.81	319.63	320.21
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	365.20	375.02	375.02	375.68	380.04	380.04	383.05	385.05	385.05	385.05

Sourced via ESR data

There are four points throughout the day where staffing and safety are reviewed, at 08.00, 10.00, 15.00 and 20.00 via the site handover and bed meetings chaired by the Site Practitioner team with multidisciplinary input.

The Heads of Nursing attend the 08.00 handover and the 15.00 bed meeting giving further assurance that safe staffing, appropriate deployment of staff and planned staffing for the next 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.

10. 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 79 staff and is the equivalent of 58.41 WTE.

	Department											
	Burns	CCU	Corneo	C-Wing	H&N	MaxFax	MIU	OPD	Peanut	Site	Specialist	Theatres (inc pre-assess)
Band 5	1	1	2	3	0	0	0	5	4	0	1	13
Band 6	3	0	1	0	1	0	0	1	2	0	3	13
Band 7	0	0	2	1	1	1	5	1	1	4	5	1
Band 8a	0	0	0	0	0	0	0	0	0	0	1	0
Band 8b	0	0	0	0	0	0	0	0	0	0	0	1
Band 9	0	0	0	0	0	0	0	0	0	0	1	0
Totals	**4**	**1**	**5**	**4**	**2**	**1**	**5**	**7**	**7**	**4**	**11**	**28**
WTE	3.20	1	3.79	2.92	1.92	0.68	3.96	4.53	5.07	2.38	7.96	21

Sourced via ESR data

Out of the 79 staff, 20 (11.79 WTE) have already returned on a flexible retirement contract. Each area monitors on a yearly basis their staff who are currently on any flexible and agile working contracts. HR provide up to date data on who is eligible for retirement and each area lead ensures that there is timely recruitment in these roles. This workforce is significant and we value those staff who have retired and returned to work within all of the areas.

11. Maternity Leave and Sickness

5 WTE registered nurses are currently on maternity leave, data taken on 31st March 2022.

High sickness levels were observed in Quarter 4 due to increased prevalence of Covid-19 and the Omicron variant. Sickness absence 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.

Registered											
Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2020-21 & 2021-22			Mar 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Compared to previous month
Sickness Absence %	>=4%	4%<>3%	<3%	1.66%	3.72%	5.43%	5.23%	5.21%	5.56%	6.27%	↑
Unregistered											
Sickness Absence %	>=4%	4%<>3%	<3%	6.72%	7.12%	4.14%	5.11%	8.98%	8.47%	7.03%	↓

Sourced via ESR data

12. 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. Nursing workforce continues to be reviewed monthly using evidence based tools and there is a clear governance process for monitoring and escalation.

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 Chief Nurse.

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 Deputy Chief Nurse has benchmarked against the NQB recommendations (appendix 1) and is assured that QVH is meeting these recommendations.

Next steps

Review of Peanut Ward establishments and clinic times. Three monthly reviews of the enhanced bank rate and its efficacy. Continue with international recruitment with the support from UHSx. Monitor the corporate risk register and 'new starter' premium.

13. Recommendations

The Board is asked to:

- note the flexibility of staff during high rates of sickness absence
- note that we meet the benchmarks recommend by RCN, ICS, NICE and AfPP
- note the staffing levels and skill mix are effectively reviewed
- note the vacancy rates and actions to recruit
- note that safe, high quality care is being delivered due to staff pride in their work and flexibility
- note the continued use of Safe Care Live

Liz Blackburn Deputy Chief Nurse Apr 2022

References

Royal College of Nursing expectations of HM Treasury Spring Statement (2022)
Department of Health and Social Care: 50,000 nurses programme, delivery update (2022)
National Quality Board Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016)

Appendix 1

National Quality Board requirements and self-assessment

Recommendation	Current Position March 2022
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 Chief Nurse. Trust policies e.g. 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 Deputy Chief Nurse 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	The Chief Nurse provides updates on workforce in the quality report at every public board and there is a 6 monthly review of nursing workforce.

discussed six monthly with a nursing establishment review	
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 Chief Nurse will review this escalation and triangulate with safer care metrics and complaints data to ensure staffing levels allow provision of quality care
Providers take an active role in securing staff in line with workforce requirements	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.	Chief Nurse 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.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/07/2022	**Agenda reference:**	**107-22**		
Report title:	Quality and Governance Assurance: Annual Quality Report				
Sponsor:	Karen Norman, Committee chair				
Author:	Nicky Reeves, Chief Nurse Liz Blackburn, Deputy Chief Nurse				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of this report is for the Board to **note** that the quality and governance committee **approved** the Annual Quality report 2021/22 at its extraordinary meeting on 27 June 2022.				
Summary of key issues	- Annual Quality report 2021/22 was approved by the quality and governance committee at its meeting on 27 June 2022 - The final version will be published on the Trust website before 30 June 2022				
Recommendation:	The Board is asked to **NOTE** the contents of this report, the **ASSURANCE** (where given) and the risks and challenges identified.				
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:	KSO1 Indicators of successful management specifically with regard to care and patient experience. KSO2 Indicators of successful management, Awareness of critical dependencies, with risks to long term sustainability of fragile services identified in corporate annual report				
Corporate risk register:	Committee has identified the need for further work on corporate risks and priorities identified in 2022/23.				
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:					
Assurance route					
Previously considered by:	Quality and Governance Committee.				
	Date	27.6.22	Decision:	Approved	
Next steps:	Publication on Trust website				

Report to:	Board of Directors
Agenda item:	107-22
Date of meeting:	07 July 2022
Report from:	Karen Norman, committee Chair
Report author:	Karen Norman, committee Chair Leonora May, deputy company secretary
Date of report:	29 June 2022
Appendices:	None

Quality and governance assurance

Introduction

This report seeks to provide the Board with quality and governance assurance and update the Board on matters considered at the extraordinary quality and governance committee meeting on 27 June 2022.

Extraordinary quality and governance committee meeting 27 June 2022

At its extraordinary meeting on 27 June 2022, the quality and governance committee considered the annual quality report 2021/22 for approval as per delegated authority by the Board.

The quality and governance committee **approved** the annual quality report 2021/22, subject to minor amendments being made and noted that the final version will be published on the Trust's website on or before 30 June 2022 in line with national requirements.

Annual Quality report

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts. The requirement to obtain external auditor assurance ceased in 2019. Providers are required to publish their Quality Accounts on their organisation's website. In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2021/22* and supporting guidance *Detailed requirements for quality reports 2021/22*
- That the content of the quality report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2021 to March 2022
- Papers relating to quality reported to the board over the period April 2021 to March 2022
- Feedback from commissioners June 2022
- Feedback from governors June 2022
- Feedback from local Healthwatch and other stipulated organisations

- The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
- The national patient survey (publication expected Autumn 2022)
- The national staff survey published 30 March 2022

The quality and governance committee were satisfied that the above requirements had been met and **approved** the annual quality report 2021/22 on that basis.

Recommendation
The Board is asked to **note** the contents of this report, the assurance (where given) and the risks and challenges identified.

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed : 16 June 2022

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 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
- Vacancy levels in sleep [CRR 1116]
- 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
- Reduced IS provision for corneo plastics to inability to access Horder Healthcare capacity
- Increased demand in immediate breast reconstruction referrals
- Increased numbers of referrals and current ptl size
- McIndoe Q2 capacity - tbc

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
- McIndoe theatre capacity – Q2

Future Opportunities
- Closer ICS working
- New Modular theatres – July 2022
- Closer working between providers including opportunities with Kent & Surrey
- Partnership with UHSx
- ~~Mutual aid – breast theatre procedures~~

Controls / Assurance
- Mobilising of virtual outpatient opportunities to support activity during COVID-19
- Transformation Board established, initially focusing on Outpatients
- Additional reporting to monitor COVID-19 impact
- Recovery planning and implementation ongoing
- 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
- 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

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance | **Committee: Finance & Performance** | **Date last reviewed 24/06/2022**

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)

- As at Month 2 the Trust is reporting a £0.1m surplus
- 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 at present unsigned contracts
- Potential changes to commissioning agendas
- Unknown costs of redesigned pathways.
- Increased efficiencies required to deliver breakeven.

Future Risks

NHS Sector financial landscape Regulatory Intervention

- 22/23 is interim contract year between block funding and move to API contracts – reviews of activity delivery against commissioner spend may lead to reduction in income for 23/24 where activities have reduced compared to 19/20
- 5% productivity gain in elective PODs required to achieve payment of ERF funding, risk of no ERF funding if productivity gains not realized
- 22/23 Tariff benefit seen for QVH above national 1.7% uplift may not be fully realised in commissioner contract values. ~~due to commissioners only receiving 1.7% national allocation~~
- Capped expenditure process
- Capital resources
- Commissioning intentions – Clinical effective commissioning
- Central control total for the ICS which is allocated to organisations
- Significant development work for the potential merger
- Greater than anticipated Increased costs for inflationary pressures.
- Lack of relevant resource to deliver BAU, develop required efficiencies and Business Cases
- 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.
- Retention and recruitment of staff due to uncertain future with potential merger, loss of local knowledge.

Future Opportunities

- New workforce model, strategic partnerships; increased trust resilience / support wider health economy
- Single Oversight framework – ICB in effect from July 2022, greater system collaboration and partnership
- 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
- Development of increased partnership working through the potential 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.
- Strengthened reporting with triangulated activity, workforce and finance monthly reports
- Finance & Performance Committee in place, forecasting from month 3 onwards subject to caveats with regards to the NHS environmental changes
- New Business case group in place with governance in place.
- 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 years
- 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
- Establishment and vacancy control reviews

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/2022**		**Agenda reference:**	**109-22**	
Report title:	**Operational Performance Report**				
Sponsor:	Shane Morrison-McCabe, Director of Operations				
Author:	Operations Team				
Appendices:	None				
Executive summary					
Purpose of report:	To provide an update regarding operational performance and recovery.				
Summary of key issues	Key items to note in the operational report are: • Operational performance in month				
Recommendation:	The committee is asked to **note** the contents of the report				
Action required *[highlight **one** only]*	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	**KSO3:** ***Operational excellence***	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	KSO3				
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:	N/A				
Assurance route					
Previously considered by:	Finance & Performance Committee				
	Date:	27 05 22	Decision:	Noted	
Next steps:	N/A				

Operational Performance Report

Shane Morrison-McCabe, Director of Operations

June 2022

Trust Board

Contents

Headlines

Queen Victoria Hospital NHS Foundation Trust

Cancer:

- Performance **meeting national / local set standards** for 62 day and faster diagnosis and **meeting trajectory** for 63 day+ backlog.
- Performance **behind national standard / agreed trajectory** for 2WW, 31 day and over 104 day.

Diagnostics:

- **DMO1** – Radiology only DMO1 performance is **99.80%**.
- Sleep only DMO1 performance has improved slightly in May by 3.33% in month to **33.33%**, but will remain in a challenging position due to reduced staffing capacity. Recent recruitment processes have been successful and 4 new starters will improve the capacity by end of the summer. A revised trajectory is being developed to encompass all sleep reportable diagnostic tests.

Waiting Lists and Long Waiters:

- There are no patients waiting over **104** weeks.
- Patients waiting over **78** weeks has reduced however remains above plan.
- Patients waiting over **52** weeks has increased by 29 patients although remains within plan.

Activity Vs Plan:

- Elective recovery increase total is 101% of plan.
- Elective recovery reduction is at 102% representing an increase of 2% against plan.

MIU

- MIU are seeing an increase in attendances however continue to meet the 4 hour clinical standard.

CANCER NATIONAL POSITION: *(Apr-22)*

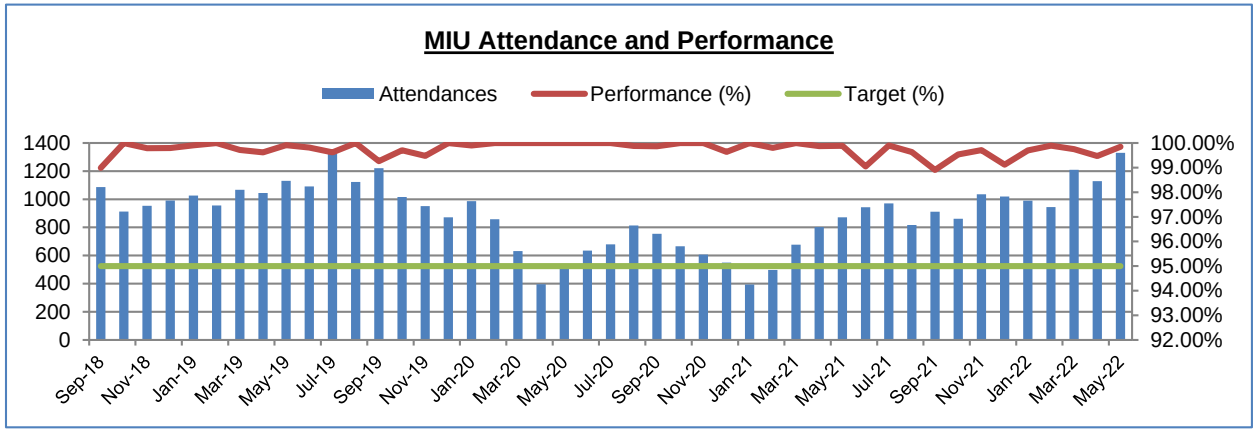
2WW: **74** out of 137	**31 Day:** **76** out of 138
FDS: **14** out of 137	**62 Day:** **16** out of 144

DMO1 NATIONAL POSITION: *(look back – Apr-22)*

National DMO1: 71.6%	**QVH DMO1:** 88.0%

RTT NATIONAL POSITION: *(look back – Apr-22)*

National RTT18: 61.7%	**QVH RTT18:** 64.3%
National % >52WW: 5.0%	**QVH % >52WW:** 1.4%



Performance Summary

Queen Victoria Hospital NHS Foundation Trust

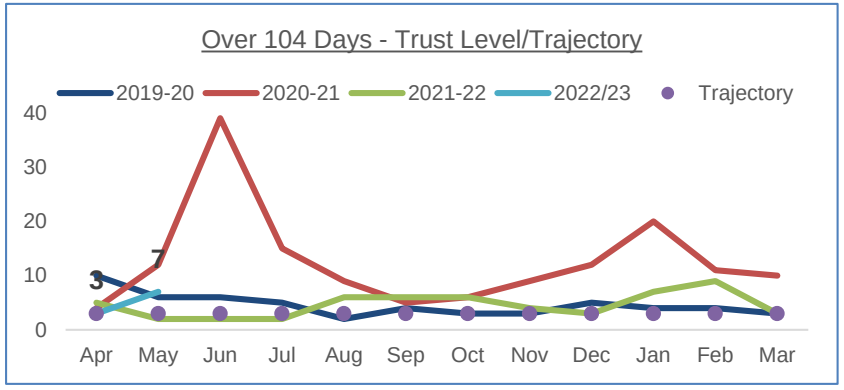
	KPI	TARGET / METRIC	SOURCE	JUN21	JUL21	AUG21	SEP21	OCT21	NOV21	DEC21	JAN22	FEB22	MAR22	APR22	MAY22
CANCER	Cancer 2WW	93%	National	97.0%	91.2%	89.2%	89.7%	90.2%	88.8%	94.8%	93.0%	93.9%	91.2%	83.4%	-
	Cancer 62 day	85%	National	89.3%	88.4%	91.7%	91.7%	85.5%	88.0%	85.5%	92.3%	90.7%	95.1%	87.5%	-
	Faster Diagnosis	75% (by March '24)	National	85.4%	86.9%	82.5%	80.5%	83.0%	82.1%	88.2%	80.3%	87.4%	86.6%	82.4%	-
	Cancer 31 day	96%	National	98.0%	96.7%	95.6%	96.0%	96.5%	94.9%	94.0%	95.3%	96.7%	95.6%	94.4%	-
	Cancer 104 day	Internal trajectory	ICS	2	2	6	6	6	4	3	7	9	3	3	7
	Cancer 63 day+ backlog	Internal trajectory	ICS	18	21	28	30	30	28	24	26	21	18	23	23
	Cancer 63 day+ backlog	<5% of PTL	Local	4.8%	4.3%	5.6%	5.7%	6.0%	5.5%	6.0%	6.6%	4.4%	3.7%	4.9%	4.5%
DIAGNOSTICS	DMO1 Diagnostic waits	99% <6 weeks	National	94.07%	90.76%	86.89%	86.24%	87.88%	91.06%	87.60%	89.70%	92.02%	89.88%	87.96%	88.9%
	Histology TAT	90% <10 days	Local	91%	97%	96%	95%	93%	98%	98%	92%	96%	96%	96%	95%
	Imaging reporting	% <7 days	Local	97.2%	97.0%	97.1%	98.1%	97.2%	95.4%	95.7%	98.0%	95.0%	98.7%	90.0%	99.6%
RTT WAITS	Total Waiting List Size	N/A	N/A	11,032	11,524	11,242	11,224	11,271	11,438	11,541	12,241	12,711	13,544	14,121	14,290
	RTT104	0 by March '22	ICS	4	6	7	4	6	4	6	1	3	1	0	0
	RTT78	0 by March '22	Local	99	103	106	74	49	23	22	15	13	10	8	6
	RTT65	0 by March '23	Local	-	-	-	-	-	-	-	54	56	48	40	44
	RTT52	0 by March '23	ICS	370	310	272	225	213	206	229	192	197	198	200	229
	RTT18	92%	National	77.59%	76.08%	75.52%	73.53%	71.80%	70.31%	67.82%	68.10%	67.16%	65.40%	64.27%	66.63%
ACTIVITY	Day Case	22/23 Activity Plan	ICS											101%	103%
	Elective	22/23 Activity Plan	ICS											96%	83%
	First Outpatients	22/23 Activity Plan	ICS											95%	104%
	Outpatient Procedures	22/23 Activity Plan	ICS											85%	99%
	Follow Up Outpatients	22/23 Activity Plan	ICS											-4%	+2%
	Non-Elective	22/23 Activity Plan	ICS											108%	111%
MIU	MIU	95% discharged <4hrs	National	99.1%	99.9%	99.6%	98.9%	99.5%	99.7%	99.1%	99.7%	99.9%	99.8%	99.5%	99.9%
RAG	Deteriorating position or plans / cause for concern			Improving position or plans / local trajectories on track						Delivery of national / local standard					

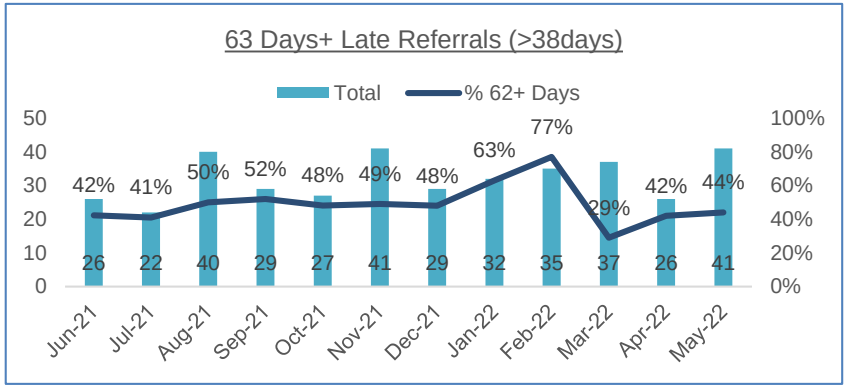
Cancer

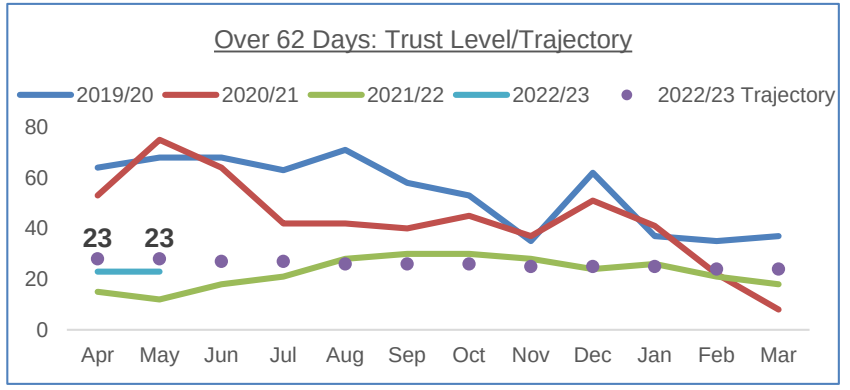
Performance Dashboard / 63 day+ / 104 day backlog

Queen Victoria Hospital NHS Foundation Trust

Trust Level	Q1 2021-22			Q2 2021-22			Q3 2021-22			Q4 2021-22			2021-22	Q1 2022-23			Change from last month
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22		Apr-22	May-22	Jun-22	
Two Week Wait	97.8%	98.5%	97.0%	91.2%	89.2%	89.7%	90.2%	88.8%	94.8%	93.0%	93.9%	91.2%	92.8%	83.4%			↓
62 Day Referral to Treat	87.5%	89.2%	89.3%	88.4%	91.7%	91.7%	85.5%	88.0%	85.5%	92.3%	90.7%	95.1%	89.7%	87.5%			↓
Faster Diagnosis	84.7%	88.9%	85.4%	86.9%	82.5%	80.5%	83.0%	82.1%	88.2%	80.3%	87.4%	86.6%	84.8%	82.4%			↓
62 Day Con Upgrade	90.0%	92.3%	83.9%	100%	90.9%	100%	61.5%	78.9%	85.7%	100%	100%	90.5%	88.8%	100%			↑
31 Day Decision to Treat	95.5%	97.3%	98.0%	96.7%	95.6%	96.0%	96.5%	94.9%	94.0%	95.3%	96.7%	95.6%	96.0%	94.4%			↓
31 Day Sub Treat	94.4%	100%	87.5%	80.0%	88.9%	93.3%	100%	87.5%	62.5%	89.5%	72.5%	80.0%	84.9%	83.3%			↑







PERFORMANCE COMMENTARY

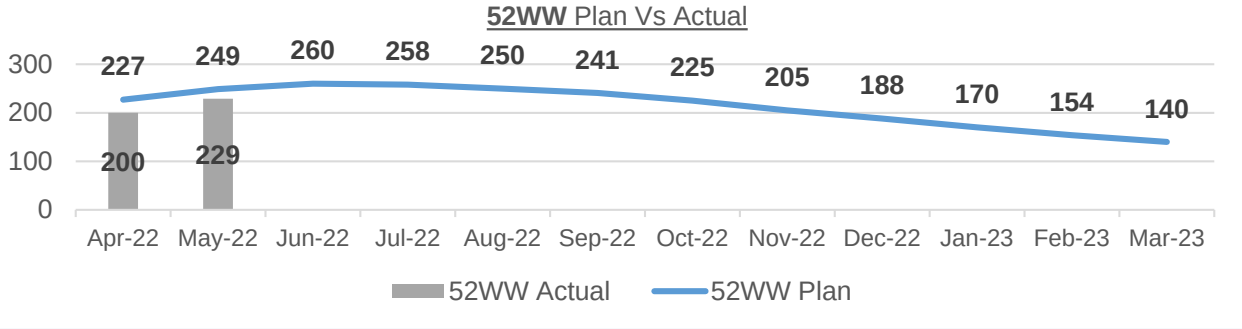
- **2WW** – standard not met with 74 breaches; 48 were clinic capacity. The number of patients seen in days 0 to 7 for first outpatient appointment has increased by 6% to 28%.
- **62 day referral to treat** – met standard.
- **Faster diagnosis** – met standard.
- **62 day consultant upgrade** – met standard.
- **31 day decision to treat** – standard not met - skin and breast remain the challenged areas with continued theatre capacity and medical delay issues.
- **31 day subsequent** – standard not met, however an increase from last month. Skin remains the main driver due to theatre SLNB capacity.
- **63 day+ backlog** – trajectory and PTL % met.
- **Over 104 day** – trajectory not met, increasing in both breast and skin. A sharp increase in late referrals were seen in month.

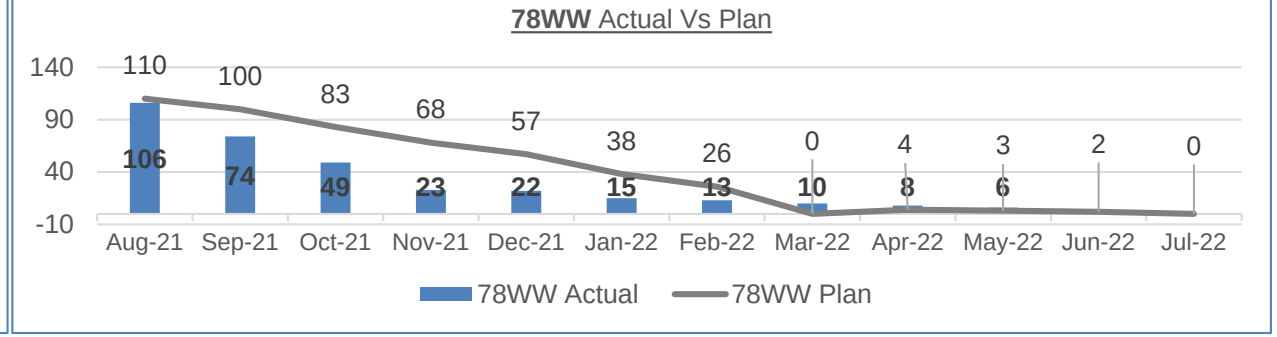
FORWARD LOOK / PERFORMANCE RISKS

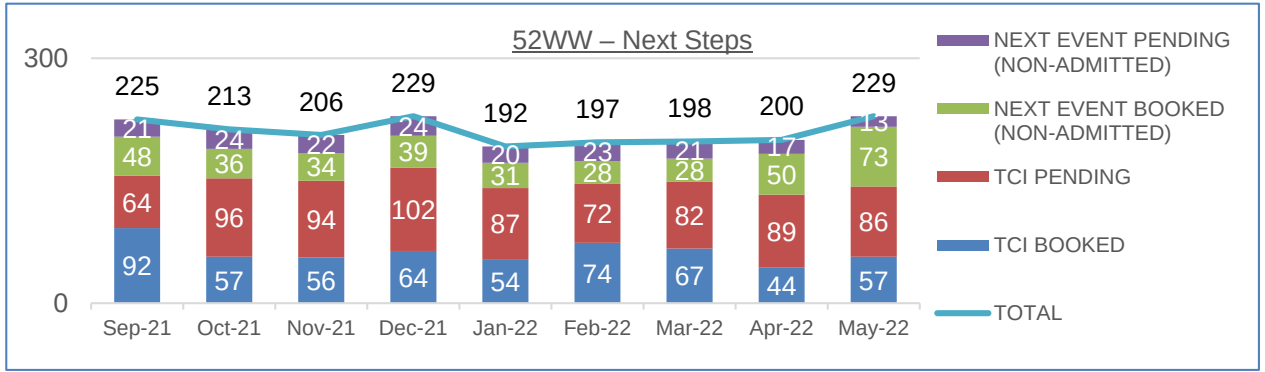
- The unvalidated May performance for **2WW**, **62 day** and **FDS** is achieving the standard.
- The unvalidated May performance for **31 day** is below plan, due to ongoing medical and capacity related delays.
- **63 day+ backlog** – inclusion of late tertiary referrals into the backlog continues to be a risk.
- **Over 104 day** – remains challenged into June, with late referrals a continued risk, as well as an increase in complex pathways.
- Patient initiated delays have increased, particularly delays due to holidays. This is a key risk to achieving the trajectories.

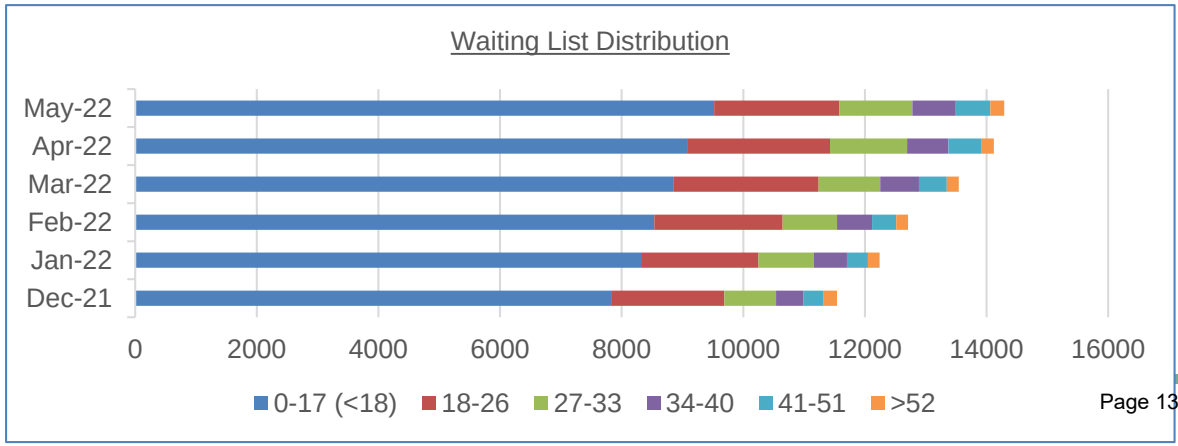
RTT Waits

Queen Victoria Hospital NHS Foundation Trust









PERFORMANCE COMMENTARY

- **104WW** – There are no patients waiting over 104 weeks.
- **78WW** – Trajectory not met although a reduction of 2 patients to 6; MaxFacs - 2, Plastics – 4. 50% have a TCI/treatment booked; 1 is patient deferred.
- **65WW** – an increase in month by 4 patients.
- **52WW** – Meeting 2022/23 trajectory; in month increase of 29 patients to 229, 28 are patient choice. 37.5% of patients have a TCI booked which is an increase from last month. Of the total number waiting 66.4% are Plastics, 26.6% are MaxFacs, 5.2% are Corneo and 1.8% are Sleep.
- **52WW** – total non-admitted patients have seen a sharp increase, driven by capacity challenges within orthodontics. This is reflected in the service level trajectory, which continues to be met.

FORWARD LOOK / PERFORMANCE RISKS

- **78WW** – expected to remain stable into June, however unlikely to meet planned trajectory.
- **52WW** – performance is challenged into June and there is a risk to the planned trajectory.
- All trajectories exclude patient choice.
- Ongoing risk around patients delaying treatment for Covid and Non-Covid reasons.

Activity Vs Plan

QVH Site / Independent Sector

Queen Victoria Hospital NHS Foundation Trust

Elective Recovery Group	POD Grouping	M2 Activity Plan	M2 22/23 Activity	% Activity Plan against 22/23 M2 Activity	19/20 M2 Activity Baseline	19/20 Activity Baseline % against 22/23 M2 Activity
Elective Recovery Increase	Day Case Total	857	881	103%	940	91%
	Elective Total	260	215	83%	360	60%
	First Outpatients Total	3763	3912	104%	3836	102%
	Outpatient Procedures Total	2160	2136	99%	2628	81%
Elective Recovery Increase Total		**7040**	**7144**	**101%**	**7414**	**91%**
Elective Recovery Reduction Total	Follow Up Outpatients Total	**10194**	**10378**	**+2%**	**10492**	**-1%**
Non Elective Total		**575**	**638**	**111%**	**447**	**143%**

PERFORMANCE COMMENTARY

- **Day Case** – 103% of plan and 91% of 19/20 baseline delivered as a Trust.
- Delivery in excess of plan seen across services with the exception Ophthalmology. Ophthalmology delivered 81% of plan owing to reduced demand for cataract procedures reducing the necessity for Saturday lists and particularly high levels of cancellations in part due to challenges around trauma capacity.
- **Elective** – 83% of plan and 60% of 19/20 baseline delivered as a Trust.
- The majority of underperformance is driven by Sleep with a small shortfall seen in Ophthalmology and Max Fax.
- Total Inpatient plans (combined daycase and elective plans) - the Trust delivered activity of 1096 cases against a plan of 1117 (98%).
- **First Outpatients** – 104% of plan and 102% of 19/20 baseline delivered as a Trust.
- Over performance driven by Sleep delivering 139% of plan continuing to reflect the increase in referral rates. Plastics delivered 98%, Max Fax 93% and Ophthalmology 95% of plan. Orthodontics over performed against plan delivering 119% owing to WLI sessions in May.
- **Outpatient Procedures** – 99% of plan and 81% of 19/20 baseline delivered as a Trust.
- Missing data from McIndoe is driving the Plastics position of 33% which is predicted to improve considerably once all data is accounted for and validated. Sleep and Orthodontics performing well in particular in excess of 100% of plan.
- **Follow Up Outpatients** – Trust position at 102% representing an increase of 2% against plan. However against 19/20 a 1% reduction has been delivered in month.
- **Non-Elective** - 111% of plan and 143% of 19/20 baseline delivered as a Trust

FORWARD LOOK / PERFORMANCE RISKS

- **Corneo** – Similar performance levels expected across PODs. Main risks continue to be vacancy levels in both medics and nursing.
- **Plastics** –Overall inpatient delivery expected against plan. Risks of delivery include uncertainties around McIndoe theatre capacity availability and an increasing level of demand for cancer. Outpatient activity expected to deliver against plan – further work required to resolve data issues with outpatient procedures.
- **Max Fac** – Inpatient and outpatient plan expected to improve in M3 with the covering of a Consultant vacancy. Biggest risks around number of junior positions causing fragility in the service.
- Orthodontics – Significant workforce challenges with multiple vacancies and absences resulting in significant loss of capacity. Recruitment to cover posts continues to be challenging with a number of adverts not covering all workforce gaps – WLI evenings and weekends have started helping with activity performance.
- **Sleep** – A number of technician posts are going through recruitment and expect to see increased capacity and activity once the posts are filled. Locum medical capacity has been increased with a view to recruiting to fixed term positions in September which has helped to increase activity.
- **Independent sector** – Level of capacity will be pivotal in delivery of activity targets into 22/23. McIndoe capacity to meet plan after Q1 not yet agreed.
- **Outpatient productivity** – Improved delivery of first outpatient and outpatient procedures with an associated increase in follow ups. The Outpatient transformation workstream is working to address this.

Community Diagnostic Centre (CDC)

PERFORMANCE COMMENTARY	FORWARD LOOK / PERFORMANCE RISKS
• Referrals continue to be received through the digital platform Bleepa (which connects QVH with primary and secondary care colleagues), for the breathlessness pathway. • Patient feedback using LIME survey now in place to gather patient feedback and experience of the pathway. Will await feedback over the next month and share with direct teams to ensure any required learning is established. • New Project Manager in post as from WC 13th June 2022. • Pathway Coordinator fixed term position recruitment commenced.	• Working to broaden the breathlessness pathway with other local GP's including Ship Street and Judges Close practices. Engagement underway. • Procurement discussions continue for long term digital solution to support the CDC. Short term interim contract being worked through to support the CDC Breathlessness pathway in the meantime. • KPI development continues as part of the pilot, work remains ongoing. • The Full Business Case (FBC) required for H2 and funding over the next 3-5 years submitted to commissioners at the end of May 2022 as planned, awaiting final discussions and approval. • Next steps will be working with Crawley as the proposed spoke to QVH, Task and Finish Group to be arranged.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/2022**		**Agenda reference:**	**110-22**	
Report title:	**Finance Report 2022/23 – Month 02**				
Sponsor:	Michelle Miles – Director of Finance and Performance				
Author:	Michelle Miles – Director of Finance and Performance				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the Committee with an overview of the Trust's financial performance.				
Summary of key issues	The Trust has resubmitted the 22/23 plan on 20th June 2022, with a breakeven plan submitted. Month 2 reporting is based on the 28th April submission. Month 2 YTD The Trust I&E position is £0.1m surplus to plan. Income is breakeven to plan in Month 1. No ERF income is included within the position as the Trust awaits validation. Expenditure run rate (both Pay and Non-Pay) is broadly in line with last 12 months averages. The cash position of the Trust remains favourable due to the level and timing of the block payments arrangement this year. The Trust position on Debtors and Creditors continues to improve. Work is ongoing with regards to the over 90 day's debtors. The Trust capital plan for the year is £6.5m				
Recommendation:	To **note** the report				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1 *Outstanding patient experience*	KSO2 *World-class clinical services*	KSO3: ***Operational excellence***	KSO4: ***Financial sustainability***	KSO5: ***Organisational excellence***
Implications					
Board assurance framework:	KS04 – Financial Sustainability				
Corporate risk register:	KS04 – Financial Sustainability				
Regulation:					
Legal:					
Resources:	No current resources.				
Assurance route					
Previously considered by:	EMT, finance and performance committee				
	Date:	27/06/22	Decision:	N/A	
Next steps:					

Financial Performance Report

Michelle Miles, Director of Finance & Performance

May 2022

Trust Board

Income & Expenditure Month 2

Queen Victoria Hospital NHS Foundation Trust

Income and Expenditure

	In Month £'000				Year to Date £'000			
	21/22	Plan	Actual	Variance	21/22	Plan	Actual	Variance
Income								
Patient Activity Income	6,332	7,124	7,482	358	9,998	14,238	13,877	(361)
Other Operating Income	1,678	246	(152)	(398)	787	492	491	(1)
Total Income	**8,010**	**7,369**	**7,329**	**(40)**	**10,785**	**14,730**	**14,367**	**(363)**
Pay								
Substantive	(4,335)	(4,777)	(4,281)	496	(7,675)	(9,554)	(8,691)	863
Bank	(243)	(144)	(281)	(136)	(431)	(289)	(533)	(244)
Agency	(81)	(12)	(121)	(110)	(361)	(23)	(185)	(162)
Total Pay	**(4,659)**	**(4,933)**	**(4,683)**	**250**	**(8,467)**	**(9,866)**	**(9,409)**	**457**
Non Pay								
Clinical Services & Supplies	(696)	(491)	(948)	(457)	(1,004)	(982)	(1,702)	(720)
Clinical Services & Supplies - Med & Surg	(427)	(614)	(567)	47	(1,086)	(1,227)	(1,070)	157
Drugs	(121)	(129)	(117)	12	(235)	(257)	(226)	31
Establishment Expenses	(161)	(276)	(273)	3	(414)	(552)	(499)	53
Consultancy	(32)	(5)	0	5	(1)	(10)	0	10
Other non pay	(509)	(616)	(437)	179	(837)	(1,273)	(850)	423
Total Non Pay	**(1,947)**	**(2,130)**	**(2,341)**	**(211)**	**(3,578)**	**(4,302)**	**(4,347)**	**(45)**
Non Operational Expenditure	(157)	(141)	(127)	14	(288)	(281)	(253)	28
Non Operating Income	0	0	8	8	4	0	16	16
Depreciation and amortisation	(444)	(387)	(388)	(1)	(592)	(775)	(776)	(1)
Total Expenditure	**(7,206)**	**(7,591)**	**(7,531)**	**60**	**(12,921)**	**(15,224)**	**(14,770)**	**454**
Surplus / (Deficit)	**804**	**(221)**	**(201)**	**20**	**(2,136)**	**(494)**	**(403)**	**91**
Adjusted financial performance								
Technical			21	21		42	42	0
Adjusted Surplus / (Deficit)	**804**	**(221)**	**(180)**	**41**	**(2,136)**	**(452)**	**(361)**	**91**

QVH PERFORMANCE COMMENTARY

The Trust has resubmitted the plan 20/06/22. Financial performance is reported against plan submitted 28/04/22

Income YTD £0.4m adverse to plan

- Expectation of clawback of ERF income in M1-2 relating to CCG commissioners, but no clawback expected for Spec Comm in relation to M1 freeze position

Expenditure £0.5m favorable to plan

- YTD Pay is £0.5m under plan, due to vacancies and service developments not yet started.

QVH FORWARD LOOK / PERFORMANCE RISKS

Risks

- The trust operational performance is to deliver activity to 104%.
- Staff challenges and vacancies, may impact service delivery
- Inflationary costs greater than allocation.
- Income risk with non delivery of Elective activity

Mitigations

- The Trust will be reviewing establishment and vacancies through the year to ensure Budgets reflect resources required for delivery of activity performance

Forecast: At month 2 the Trust is anticipating a break even position. Detailed forecasts will be presented from M3.

SOFP - Balance Sheet 2022-23 Month 02

Queen Victoria Hospital NHS Foundation Trust

Statement of Financial Position

£000's	Unaudited Year End: March 2022	April	May	Change In Month	Change In Year
Non Current Assets					
Fixed Assets	59,920	59,558	59,705	147	(215)
Other Receivables	332	339	339	0	7
Total Non Current Assets	**60,252**	**59,897**	**60,044**	**147**	**(208)**
Current Assets					
Inventories	1,154	1,137	1,150	14	(4)
Trade and other Receivables	3,440	3,380	3,969	590	529
Cash and Cash Equivalents	17,547	10,267	9,487	(780)	(8,060)
Total Current Assets	**22,141**	**14,783**	**14,607**	**(177)**	**(7,534)**
Current Liabilities					
Trade and other Payables	(17,387)	(9,853)	(10,017)	(164)	7,370
Borrowings	(888)	(897)	(906)	(9)	(18)
Provisions	(52)	(78)	(78)	0	(26)
Other Liabilities	(644)	(644)	(642)	2	2
Total Current Liabilities	**(18,971)**	**(11,473)**	**(11,644)**	**(171)**	**7,327**
Subtotal Net Current Assets	**3,170**	**3,310**	**2,962**	**(348)**	**(208)**
Total Assets less Current liabilties	**63,422**	**63,208**	**63,006**	**(201)**	**(416)**
Non Current Liabilties					
Borrowings	(2,795)	(2,808)	(2,808)	0	(13)
Provisions	(1,048)	(1,022)	(1,022)	0	26
Total Non Current Liabilties	**(3,843)**	**(3,830)**	**(3,830)**	**0**	**13**
Total assets Employed	**59,579**	**59,378**	**59,176**	**(201)**	**(403)**
Tax Payers' Equity					
Public Dividend Capital	24,546	24,546	24,546	0	0
Revaluation Reserve	16,004	16,004	16,004	0	(0)
Income and Expenditure Reserve	19,029	*18,828*	*18,627*	(201)	(402)
Total Tax Payers' Equity	**59,579**	**59,378**	**59,176**	**(201)**	**(403)**

QVH PERFORMANCE COMMENTARY

- Non current assets: have dropped in net book value due to net movement in depreciation and capital programme expenditure. The impact of the agreed capital programme £6.5m is yet to take affect.
- Other Non Current Receivables: offsets the provision in relation to the central funding for the clinical pension tax scheme
- Cash: The reduction in cash in May of £0.8m reflects the payment of March creditor invoices including. The cash balance at this stage continues to be sufficient for immediate liquidity requirements.
- Trade payables: have increased in month by £0.2m. However, since March have reduced by £7.3m reflecting settlement of year end creditors (see cash movement).
- Other liabilities reflects deferral of income due to invoicing or receipts being received in advance of relevant expense period.
- Net Current Assets: are currently £4m.
- Borrowings (current and non current) consist of the theatre capital loan and the outpatient pod finance lease. The current instalments of the principal payable in June and December.
- Provisions (current and non current) relate to early retirement pension costs and the clinical pension tax scheme.
- Revaluation reserve: reflects historic estate revaluations
- Income and expenditure reserve reflects the historic and current statement of comprehensive income.

Cashflow Report Month 02

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 02 2022/23												
Cashflow Report												
	Actual £'000	Actual £'000	Forecast £'000									
	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Opening Balance	**17,547**	**10,267**	**9,487**	**9,174**	**8,843**	**6,739**	**6,221**	**4,598**	**4,163**	**4,159**	**4,224**	**4,289**
Receipts												
NHS Block & System income	6,724	6,656	6,807	6,807	6,807	6,807	6,807	6,807	6,807	6,807	6,807	6,809
Receipts from other income	553	288	236	236	236	237	237	237	237	237	237	251
Public Dividend Capital Received	0	0	322	322	322	322	322	322	322	322	322	322
PDC Cash Support Received	0	0	0	0	0	0	0	0	0	0	0	0
Total Receipts	**7,277**	**6,943**	**7,365**	**7,365**	**7,365**	**7,366**	**7,366**	**7,366**	**7,366**	**7,366**	**7,366**	**7,382**
Payments												
Payments to NHS Bodies	(4,464)	(582)	(663)	(663)	(663)	(663)	(663)	(663)	(663)	(663)	(663)	(663)
Payments to non-NHS bodies	(5,359)	(2,501)	(1,800)	(2,298)	(4,072)	(1,700)	(3,591)	(2,404)	(1,491)	(1,904)	(1,903)	(1,384)
Net Payroll Payment	(2,736)	(2,434)	(2,736)	(2,736)	(2,736)	(2,736)	(2,736)	(2,736)	(2,736)	(2,736)	(2,736)	(2,736)
Payroll Taxes	(1,275)	(1,478)	(1,275)	(1,275)	(1,275)	(1,275)	(1,275)	(1,275)	(1,275)	(1,275)	(1,275)	(1,275)
Pensions Payment	(723)	(728)	(723)	(723)	(723)	(723)	(723)	(723)	(723)	(723)	(723)	(723)
PDC Dividends Payment	-	-	-	-	-	(786)	-	-	-	-	-	(787)
Loan Interest & Repayment	-	-	(481)	-	-	-	-	-	(481)	-	-	-
Total Payments	**(14,557)**	**(7,723)**	**(7,679)**	**(7,696)**	**(9,470)**	**(7,884)**	**(8,989)**	**(7,802)**	**(7,370)**	**(7,302)**	**(7,301)**	**(7,569)**
Net Cash Movement	**(7,280)**	**(780)**	**(314)**	**(331)**	**(2,105)**	**(518)**	**(1,623)**	**(436)**	**(4)**	**64**	**65**	**(187)**
Closing Balance	**10,267**	**9,487**	**9,174**	**8,843**	**6,739**	**6,221**	**4,598**	**4,163**	**4,159**	**4,224**	**4,289**	**4,103**

QVH PERFORMANCE COMMENTARY

- Cash balances reduced in month 2 by £0.8m, balances remain in line with forecast.
- There is currently a cash balance in excess of one and a half month of average spend; which is considered to be the minimum sufficient short term balance held, as block payments are received in month. Average cash is forecast to reduce to meet the capital programme.
- Financial services will work with commissioners and other providers to ensure payments are made in a timely manner and older debts controlled.
- The cash position will continue to be reviewed and managed and any future requirements assessed monthly.

QVH FORWARD LOOK / PERFORMANCE RISKS

- Forecast is based on 22/23 plan values.
- Cash balances are expected to reduce in H2 by capital programme spend.

Debtors Month 02

Queen Victoria Hospital NHS Foundation Trust

Financial Performance Month 02 2022/23

Debtors

	May 21 £'000	Jun 21 £'000	Jul 21 £'000	Aug 21 £'000	Sep 21 £'000	Oct 21 £'000	Nov 21 £'000	Dec 21 £'000	Jan 22 £'000	Feb 22 £'000	Mar 22 £'000	Apr 22 £'000	May 22 £'000	In Month Change £000
NHS Debtors														
0-30 Days Past Invoice Due Date	383	53	114	6,381	474	184	194	402	1,272	1,526	573	294	55	(239)
31-60 Days Past Invoice Due Date	239	353	32	29	12	177	252	116	300	94	97	58	266	208
61-90 Days Past Invoice Due Date	116	231	353	37	14	11	195	189	53	250	94	97	49	(47)
Over 90 Days Past Invoice Due Date	650	708	873	1,004	842	939	871	993	1,200	657	610	663	752	89
Total NHS Debtors	**1,388**	**1,345**	**1,371**	**7,450**	**1,341**	**1,311**	**1,511**	**1,699**	**2,825**	**2,527**	**1,374**	**1,111**	**1,122**	**11**
Non NHS Debtors														
0-30 Days Past Invoice Due Date	34	49	76	117	112	305	14	374	110	130	155	119	42	(77)
31-60 Days Past Invoice Due Date	157	14	22	45	79	48	31	26	6	64	4	38	68	30
61-90 Days Past Invoice Due Date	15	139	14	12	14	67	57	65	6	`	20	4	1	(3)
Over 90 Days Past Invoice Due Date	335	344	475	489	445	367	516	438	486	423	242	256	234	(22)
Total Non NHS Debtors	**540**	**545**	**587**	**663**	**650**	**787**	**618**	**903**	**608**	**617**	**420**	**417**	**345**	**(72)**
Total Invoiced Debtors	**1,928**	**1,890**	**1,958**	**8,113**	**1,991**	**2,098**	**2,129**	**2,603**	**3,433**	**3,143**	**1,794**	**1,528**	**1,467**	
NHS : Total NHS & Non NHS ratio	*0.72*	*0.71*	*0.70*	*0.92*	*0.67*	*0.63*	*0.71*	*0.65*	*0.82*	*0.80*	*0.77*	*0.73*	*0.76*	

QVH PERFORMANCE COMMENTARY

- The month 02 total debtor balance of £1.5m is 54% lower than the average monthly balance of £2.8m in 2021-22.
- The month 02 debtor balance is £0.1m lower than reported at month 01. This is mainly due to the recovery of old debts.
- At M02 close, 3 debtors owed more than £0.1m:-

  Brighton And Sussex University Hospitals NHS Trust - £0.3m
  Guy's And St Thomas' NHS Foundation Trust -£0.2m
  Medway NHS Foundation Trust- £0.1m

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 and collecting income due. It should be noted that the majority of older debtors were provided for in 2021-22.

Creditors Month 02

Queen Victoria Hospital
NHS Foundation Trust

Financial Performance Month 2 2022/23

Trade Creditors

	May 21 £'000	Jun 21 £'000	Jul 21 £'000	Aug 21 £'000	Sep 21 £'000	Oct 21 £'000	Nov 21 £'000	Dec 21 £'000	Jan 22 £'000	Feb 22 £'000	Mar 22 £'000	Apr 22 £'000	May 22 £'000	In Month Change £'000
NHS Accounts Payable Creditors														
0-30 Days Past Invoice Due Date	147	103	93	116	341	87	93	95	190	83	291	384	86	(298)
31-60 Days Past Invoice Due Date	25	59	28	16	97	29	2	14	38	33	3	79	51	(28)
61-90 Days Past Invoice Due Date	56	36	25	25	40	18	17	2	27	31	24	1	11	10
Over 90 Days Past Invoice Due Date	645	663	634	490	480	497	419	424	358	380	358	517	273	(244)
Total NHS Accounts Payable Creditors	**872**	**862**	**781**	**646**	**958**	**631**	**530**	**535**	**612**	**527**	**676**	**982**	**421**	**(561)**
Non NHS Accounts Payable Creditors														
0-30 Days Past Invoice Due Date	423	650	363	200	682	454	465	458	772	815	4,215	979	1,100	121
31-60 Days Past Invoice Due Date	49	74	89	36	30	29	33	119	67	71	9	54	172	118
61-90 Days Past Invoice Due Date	47	35	92	58	34	32	6	25	23	15	37	3	36	33
Over 90 Days Past Invoice Due Date	69	77	150	112	166	153	43	53	46	60	46	50	35	(15)
Total Non NHS Accounts Payable Creditors	**589**	**836**	**694**	**406**	**912**	**668**	**547**	**657**	**907**	**960**	**4,308**	**1,086**	**1,343**	**257**
Total Accounts Payable Creditors	**1,461**	**1,698**	**1,474**	**1,052**	**1,870**	**1,299**	**1,077**	**1,191**	**1,520**	**1,487**	**4,984**	**2,069**	**1,765**	
NHS : Non NHS ratio	***0.60***	***0.51***	***0.53***	***0.61***	***0.51***	***0.49***	***0.49***	***0.45***	***0.40***	***0.35***	***0.14***	***0.47***	***0.24***	

QVH PERFORMANCE COMMENTARY

- The invoiced creditors balance at month 2 is £1.8m in line with the annual running average of £1.8m.
- NHS balances have decreased by £0.6m, due to settlement of aged creditors. Non NHS balances have increased this month compared to last by £0.3m.
- There are 5 creditors with a balance over £0.1m:

  Medway NHSFT (£0.2m) Disputed historic radiology SLA
  McIndoe Centre (£0.2m) invoices are current month
  Insight Direct (UK) Ltd (£0.2m)
  and recent invoices from Optigene Ltd and DH OpCoUK Ltd (both £0.1m).

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 process and gain approval for invoice payment as quickly as possible.
- As old queries are resolved and invoice payment released, this may adversely impact the Trust's BPPC performance.

Better payment practice code Month 02

Queen Victoria Hospital NHS Foundation Trust

Better payment practice code							BPPC	
Compliance target: 95% of invoices being paid within 30 days of receipt	Current YTD	Current YTD	Previous Month YTD	Previous Month YTD	Current Month	Current Month	Prior Year	Prior Year
	May	May	April	April	May	May	2021-22	2021-22
	Invoice Quantity	Invoice Value £000	Invoice Quantity	Invoice Value £000	Invoice Quantity	Invoice Value £000	Invoice Quantity	Invoice Value £000
Non NHS								
Total bills paid	2,890	10,607	1,528	6,834	1,362	3,773	17,865	39,589
Total bills paid within target	2,780	10,458	1,460	6,746	1,320	3,712	17,000	38,156
Percentage of bills paid within target	**96.2%**	**98.6%**	**95.5%**	**98.7%**	**96.9%**	**98.4%**	**95.2%**	**96.4%**
NHS								
Total bills paid	221	4,796	97	4,253	124	543	1,179	5,933
Total bills paid within target	199	4,702	89	4,244	110	458	1,080	5,740
Percentage of bills paid within target	**90.0%**	**98.0%**	**91.8%**	**99.8%**	**88.7%**	**84.3%**	**91.6%**	**96.7%**
Total								
Total bills paid in the year	**3,111**	**15,403**	**1,625**	**11,087**	**1,486**	**4,316**	**19,044**	**45,522**
Total bills paid within target	**2,979**	**15,160**	**1,549**	**10,990**	**1,430**	**4,170**	**18,080**	**43,896**
Percentage of bills paid within target	**95.8%**	**98.4%**	**95.3%**	**99.1%**	**96.2%**	**96.6%**	**94.9%**	**96.4%**
Compliance target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Above (below) target	0.8%	**3.4%**	**0.3%**	**4.1%**	**1.2%**	**1.6%**	(0.1%)	**1.4%**

QVH PERFORMANCE COMMENTARY

- NHSI/E is monitoring BPPC closely. The target is 100% of invoices to be paid within 30 days, with compliance at 95%.
- Trust total creditor performance YTD is as follows;
  - Number of invoices: 98.4 % (compliant)
  - Value of invoice 95.8% (compliant)
- NHSI/E have indicated that the main focus for compliance would be on value and non NHS creditors.
- The key sub-areas of non compliance are clinical supplies and services and agency staffing for which additional supporting data or detailed checking processes are required before the budget holder can approve.
- As a note QVH does not hold back any payment for an approved invoice for cash flow reasons.

QVH FORWARD LOOK / PERFORMANCE DEVELOPMENT

- NHSI/E CFO will be writing individually to providers who have a performance at an unacceptable level and appear to have good levels of cash. The CFO will ask for action plans to resolve the poor performance.
- This communication will go to Chief Executives copied to Directors of Finance and Audit Committee Chairs.
- The Trust is performing at above the 95% £value cumulative compliance level whilst also working to resolve some historic issues. The financial services team are continuing review of performance, key factors and reporting analytics which will develop and target the areas of non compliance.
- Financial services are also continuing to review areas where invoice authorisation is delayed in order to target and support training needs with a view of improving performance.

Capital Month 02

Queen Victoria Hospital
NHS Foundation Trust

Capital Plan 22/23	CPG Capital Plan 22/23 6,548	M02 Spend Position May 2022
	£k	£k
Total Allocation for projects	**6,548**	
Top Slice Staffing 450	450	71
Contingency 250	250	
Non Clinical Refurbishments 75	75	
Total top sliced	**775**	**71**
Full Year Effect of 21/22 Plans already Commenced, 22/23		
IM&T PACS/RIS/VNA 55	55	19
Patient Comms 220	220	
Cyber Security 144	144	
Digital Dictation & Voice Recognition 45	45	
ICE 37	37	
Subtotal	**501**	**19**
Estates Burns ward wall protection 40	40	31
Radiology Pillars Sarah Solanki 50	50	
Cashiers office 15	15	
Main Outpatient walls & Flooring 70	70	
Theatres Power supply / Phase 1 65	65	6
Subtotal	**240**	**37**
Equipment Corneal Topographer 76	76	76
Balance on Microvascular - ENT microscope		-13
Subtotal	**76**	**63**
Modulars Porta Kabin (Est) 870	870	
Medical gases 17	17	
Mechanical works 75	75	54
Electrical works 75	75	
Natural Gas network / Meter Relocation 75	75	
Power Supply / UKPN 300	300	320
Subtotal	**1,412**	**374**
Total 21-22 projects b/f & Top sliced	**3,004**	**564**
22/23 Prioritised list		
Subtotal	**1,170**	**0**
22/23 IM&T Must Do's		
Subtotal	**2,080**	**0**
22/23 Medical Devices High Priority via HMT		
Subtotal	**700**	**0**
Total 22-23 programmes	**3,950**	**0**
Total programme: topslice, 21-22 & 22-23 projects	**6,954**	**564**
ICS Allocation 22-23	**6,548**	
Management of allocation required (over programming)	**-406**	

QVH PERFORMANCE COMMENTARY

- The 2022-23 ICS original allocation for the Trust was £4,874m. This has now been formally increased by £1,674m to £6,548.
- The allocation is not cash backed but a share of the national DHSC capital expenditure limit. As such cash will be met by the Trust from previous surpluses.
- The allocation approved by the EMT is currently over subscribed and the plan will be reviewed to manage the gap, maintain reserve and prioritize achievable bids.
- Plans and business cases are being developed to initiate projects.
- The phasing of the 22/23 programmed schemes is still significantly weighted in quarters 3 and 4.
- The Trust is currently working on a capital bid for PDC funding (cash backed) to support a new Community Diagnostics Centre £8.4m.

QVH FORWARD LOOK / PERFORMANCE RISKS

- The ICS will require Trusts to provide quarterly returns and mitigations for any underspend against plan. Where underspends cannot be mitigated by the Trust the allocation is to return to the ICS for redistribution.
- Delays in the submission of capital bids to the Capital Programme Board and potential Procurement lead times could impact the Trust in the ability to deliver its capital programme.

Queen Victoria Hospital NHS
NHS Foundation Trust

22/23 Budget setting update

Michelle Miles Director of Finance & Performance
Trust Board 05/05/2022

Income & Expenditure	Budget 22/23 £'000	Outturn 19/20 £'000	Outturn 20/21 £'000	Outturn 21/22 £'000	Variance against: Outturn 19/20	Outturn 20/21	Outturn 21/22
Income							
Patient Activity Income	86,877	66,784	76,109	80,971	20,093	10,768	5,906
Other Income	2,951	4,317	7,215	3,818	(1,366)	(4,264)	(867)
Total Income	**89,828**	**71,102**	**83,325**	**84,789**	**18,727**	**6,504**	**5,039**
Expenditure							
Pay							
Substantive	(57,093)	(45,313)	(49,505)	(50,478)	(11,780)	(7,588)	(6,615)
Bank	(1,707)	(3,142)	(2,448)	(3,406)	1,435	742	1,700
Agency	(140)	(2,387)	(715)	(827)	2,246	575	687
Total Pay	**(58,940)**	**(50,842)**	**(52,668)**	**(54,712)**	**(8,098)**	**(6,272)**	**(4,228)**
Non Pay							
Clinical Services & Supplies	(11,611)	(13,052)	(10,950)	(13,180)	1,441	(661)	1,569
Drugs	(1,543)	(1,472)	(1,179)	(1,435)	(71)	(364)	(108)
Consultancy	(62)	(214)	(297)	0	152	235	(62)
Other non pay	(11,451)	(9,698)	(10,249)	(8,036)	(1,754)	(1,202)	(3,415)
Non Operational Expenditure	(1,686)	(1,550)	(1,395)	(1,507)	(136)	(291)	(179)
Depreciation and amortisation	(4,536)	(3,447)	(3,570)	(4,175)	(1,089)	(966)	(361)
Total Non Pay	**(30,889)**	**(29,433)**	**(27,639)**	**(28,333)**	**(1,456)**	**(3,250)**	**(2,556)**
Total Expenditure	**(89,829)**	**(80,275)**	**(80,307)**	**(83,045)**	**(9,554)**	**(9,521)**	**(6,784)**
Surplus/(Deficit)	**(0)**	**(9,173)**	**3,017**	**1,744**	**9,173**	**(3,018)**	**(1,744)**

QVH PERFORMANCE COMMENTARY

The Trust has a breakeven plan for 2022-23, this is an increase of £1.7m from 21-22 Outturn.
Activity plan is based on 103% delivery of 2019-20 activity levels, with £3m of commissioner income being ERF related and dependent on increased activity delivery.

Pay & Non pay have been reviewed and agreed in Star chambers.

The Trust plan includes 3.9% efficiencies, made up of cash releasing and productivity.

The Trust received additional funding to support increased inflationary costs.
Additional funding received comes with conditions that must be reviewed and monitored at system and organisational level.
Key Lines of Enquiry themes (Appendix 1)
1.Plan build
2.Assumptions
3.Investments
4.Efficiency and Productivity

In addition
•Provider monitoring of agency usage is reintroduced, and applied to bank staff.
•Providers to commission internal audit to produce a report for audit committee covering the HFMA publication – Improving NHS Financial sustainability, highlighting areas of weakness and prescribing remedial action
•Systematically review excess inflation figures in plan.

Appendix 1: Key Lines of Enquiry

Theme / Tab Reference	Notes
Plan Build	
K1	Has the starting run rate position been sufficiently scrutinised to remove non-recurrent items, FYE of investments, review non-cash items from 21/22 etc (and with a common approach across the system)?
K2	Do you have an understanding of capital charge increases and associated mitigations e.g. asset lives review/AME impairments etc?
K3	How have you identified the excess costs of inflation in 2022/23? Do you have supporting evidence that provides an audit trail for all of these costs?
K4	How have you identified the non-recurrent costs of covid for the first quarter of 2022/23? Do you have detailed plans in place to release these costs once covid returns to the levels assumed in the planning guidance?
Assumptions	
K5	What scale of financial contribution to the bottom line is planned from the ESRF? If the system is not planning to deliver 104% across the year it should plan for an appropriate level of ESRF claw back.
K6	Have non-NHS income assumptions (including car parking and private practice) been scrutinised with a plan to recover to pre-pandemic levels or a description of where this is not possible?
K7	What has been proposed and assumed across the system on IPC and covid rule relaxation and how does this impact on the numbers?
K8	In what way are discharge pressures impacting your numbers?
K9	What are your HDP assumptions including risks and mitigations?
K10	Are CCG prescribing, ISP, and CHC cost increases in line with planning assumptions/national norms and if not why not?
K11	Are your assumptions aligned between commissioners and providers, both within systems and with other systems and specialised/other direct commissioning?
Investments	
K12	Is there a full schedule of cost pressures and new investments for all bodies and can you describe how this has been scrutinised and challenged?
K13	How well is the level of staffing described in the workforce plan aligned to your expected cost base?
Efficiency and Productivity	
K14	How has your implied acute productivity changed from 21/22 through the 22/23 financial year? In the context of the system productivity in 2019/20 what is your productivity ambition in 2022/23 and later years and what plans do you have to deliver these ambitions? What impact will these productivity plans have on your 2022/23 operational plan?
K15	What cost/efficiency benefits derived from operating as a system are in the plan?
K16	How have you identified CIP savings and how detailed are plans? What is the process for fully identifying your recurrent CIP requirement?
K17	How have you treated non-delivered 21/22 CIPs in the 22/23 plan?
K18	How much non-recurrent benefit is currently built into the plan as mitigation?
ADDITIONAL REQUIREMENTS	
A1	Plan Triangulated to workforce and activity plans
A2	IPC Guidance reflected in plans
A3	Efficiency schemes
A4	Commission Audit - HFMA getting the basics right
A5	Board Sign off

KSO5 – Organisational Excellence

Risk Owner: Interim Director of Workforce & OD
Date 17th June 2022

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
- Significant challenges being seen with staffing levels in individual areas with both high vacancy and absence rates over the winter period.
- Trust establishment and vacancy levels and ability to meet required activity levels

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. Ensuring the People Promise is being delivered
- Staff survey results and SFFT staff engagement have shown stability in a challenging operational environment. The 2021 survey outcome remained stable with improvements seen for team working
- Overseas nurses having a positive impact, further engagement with UHSx in place
- Workforce KPI's highlight workforce stability
- Availability and willingness of staff to undertake additional activity with Trust initiatives such as WLI and Bank Shift Supplements
- 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
- Impact of future waves of the pandemic and associated variants including potential vaccination booster programme requirements
- Impact on workforce confidence in a sustainable future, due to uncertainty or misinformation from outside and inside the Trust related to potential merger

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 and collaboration for key roles and support teams which lack capacity and agility
- Exploration of overseas nursing recruitment with UHSussex
- Exploring Medical Support Worker initiative to support Medical Vacancies

Controls / assurance
- more robust workforce/pay controls as part of business planning and weekly vacancy control
- Leading the Way, leadership development programme to be revisited and launched for our staff with line management responsibilities
- 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

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:	**07/07/2022**		**Agenda reference:**	**112-22**	
Report title:	**Workforce Report – June Report – May Data**				
Sponsor:	Lawrence Anderson, Interim Director of Workforce and OD				
Author:	Evelyn Falaye, Deputy Director of Workforce 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:	None				
Executive summary					
Purpose of report:	To provide a monthly update of Workforce KPI's and OD activity				
Summary of key issues	Key highlights of the report show vacancies in relation to Staff in Post vs Month 12 2021-22 Establishment have reduced by 0.57%. The Establishment used in the report is based on Month 12 of 2021-2022. Sickness absence has slightly reduced from the previous month, and continues to register red within our own KPI and is at a favourable position compared to nationally and remains under 5%. Appraisal rates continue to remain high and MAST rates continue to be over 90% consistently.				
Recommendation:	The committee is asked 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:	-KSO5. Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care -Engaged and motivated staff deliver better quality care (KSO1)				
Corporate risk register:	Impact of pandemic on workforce availability				
Regulation:	Well Led				
Legal:	n/a				
Resources:	Managed by HR/OD with support from finance, operations and nursing				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:	Information	
Next steps:	N/A				

Workforce and Organisational Development Report

Lawrence Anderson, Interim Director of Workforce &OD

June 2022 (May 2022 Data)

Contents

Headlines

Queen Victoria Hospital NHS Foundation Trust

Engagement & Communication:

- Departments have been asked to complete an Action Plan based on their priorities for 2022/23 which will need to be presented and discussed at t Performance Review
- The NQPS Q1 2022/23 results have been published on Qnet for staff to view and show a positive outcome on the theme of engagement which is inline with the 2021 Staff Survey findings
- Regular communications continue to be sent to heads of department and all QVH staff on any training, development and apprenticeships available

Attraction & Retention:

- Reduction in applications received to 343 in May compared to 365 in April.
- New Starter Premium in place and starting to see applicants coming through to claim following successful recruitment
- WTE advertised was 87.82 with 60 adverts placed.
- Introduction of new OH management system causing delays in process for candidates bringing time to recruit up to 84.25
- Increase in SIP to 938.84 for May (increase of 6.18 WTE), vacancy rate has decreased to 13.07%

Health & Wellbeing:

- The Healthy Workplace Allies network continue to meet monthly and launched an initiative 'lunch on the lawn' to encourage staff to take a break away from the department. The Co-Chairs have been attending external network meetings.
- Weekly emails throughout May focused on: Deaf Awareness Week (2-8 May); International Nurses Day (12 May); National ODP Day (14 May). Ongoing webinars available from Care First (EAP) 3 times per week and continue to be shared with all staff.
- The work-related stress indicator tool (WRSIT) project for 2022/23 is being planned and will launch within the next couple of months.

Learning & Education:

- Overall Stat & Mand: compliance is currently at **89.99%** across QVH – this has **increased by 1.06%** from last month 88.93%
- Appraisals: compliance is currently at **82.33%** across QVH – this has **increased by 0.64%** from last month 81.69%

Talent & Leadership:

- One person from QVH has been offered and accepted onto the ILM Level 3 Coaching Programme
- Leadership opportunities continue to be promoted across QVH from the Leadership Academy, HEE, NHS Elect and the ICS

Workforce KPI Summary

Queen Victoria Hospital NHS Foundation Trust

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2021/22 & 2022/23			May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Compared to Previous Month
Establishment WTE *Note 1				1031.34	1032.34	1057.51	1057.51	1061.28	1067.59	1068.59	1072.63	1079.63	1080.03	1080.03	1080.03	**1080.03**	◄►
Staff In Post WTE				930.44	930.22	922.66	910.88	919.42	924.62	935.09	939.52	932.11	937.56	939.56	932.66	**938.84**	▲
Vacancies WTE				100.90	102.12	134.85	146.63	141.86	142.97	133.50	133.11	147.52	142.47	140.47	147.37	**141.19**	▼
Vacancies %	>12%	8%<>12%	<8%	9.78%	9.89%	12.75%	13.87%	13.37%	13.39%	12.49%	12.41%	13.66%	13.19%	13.01%	13.64%	**13.07%**	▼
Agency WTE				11.06	12.11	12.89	9.97	8.28	6.83	11.79	10.91	10.44	10.39	10.50	9.42	**8.44**	▼
Bank WTE *Note 2				64.22	72.64	78.37	71.08	70.05	71.07	77.85	66.63	77.85	77.65	91.93	63.86	**66.24**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	10.94%	12.20%	13.15%	14.11%	14.60%	15.02%	15.43%	15.72%	15.23%	15.90%	15.40%	15.51%	**16.34%**	▲
Monthly Turnover				0.33%	2.03%	1.49%	2.12%	1.25%	1.28%	1.15%	1.31%	1.20%	0.87%	0.90%	1.48%	**1.20%**	▼
Actual Turnover WTE (Excluding Trainee Doctors) *Note 4				2.64	-4.51	-6.66	-7.80	3.61	-3.05	9.11	-1.18	-1.03	3.73	3.40	-2.56	**-1.17**	▲
12 Month Rolling Stability % *Note 3	<70%	70%<>85%	>=85%	87.84%	87.11%	85.09%	85.09%	85.43%	85.03%	84.49%	84.10%	83.83%	83.04%	83.43%	83.61%	**83.20%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	3.04%	3.63%	3.17%	3.27%	4.13%	4.47%	4.54%	4.24%	4.72%	4.34%	4.70%	**4.28%**	***TBC***	▼
% staff appraisal compliant (Permanent & Fixed Term staff)	<80%	80%<>95%	>=95%	85.23%	83.72%	85.17%	86.08%	83.93%	82.08%	81.24%	80.36%	80.61%	82.85%	82.66%	81.69%	**82.33%**	▲
Statutory & Mandatory Training (Permanent & Fixed Term staff)	<80%	80%<>90%	>=90%	92.34%	92.35%	91.98%	92.35%	90.92%	90.85%	91.48%	91.39%	91.27%	91.03%	91.05%	90.69%	**91.60%**	▲

*Note 1 - Establishment for April 22 is currently 2021/22 until 2022/23 budget is finalised. This is updated monthly from Finance Ledger - excludes bank and agency.
*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 shows % of employees that have remained in employment for the 12 month period.
*Note 4 - Actual turnover FTE Monthly is Net figure of the sum of the Starters minus the Leavers.

GOAL 1: Engagement & Communication

Queen Victoria Hospital NHS Foundation Trust

NHS Staff Survey 2021:

- Departments have been asked to complete an Action Plan based on their priorities for 2022/23 which will need to be presented and discussed at the different Performance Review meetings

National Quarterly Pulse Survey (NQPS):

- QVH has received our highest response rate to date (157 respondents) for the QVH NQPS for Q1 2022/23
- Results are now available for staff to view on the Staff Survey Qnet page.
- Although results have slightly decreased, the results remain positive and show that QVH are in the top 25% quartile (see below).
- Additionally the score of 7.9 for the Advocacy theme is currently the top score in the country

NQPS Score	Data Period	STP Result	QVH Value	QVH Value - Previous Qtr.	Quartile
Employee Engagement Score	**Q1 2022/23**	**6.7** ↑	**7.4** ↓	**7.5**	**4 - Highest 25%**
Advocacy Score	Q1 2022/23	6.8 ↑	**7.9** ↓	8.2	4 - Highest 25%
Involvement Score	Q1 2022/23	6.4 ↓	**7.0** ↓	7.2	4 - Highest 25%
Motivation Score	Q1 2022/23	6.8 ↑	**7.1** ↓	7.1	4 - Highest 25%

COMMENTARY	FORWARD LOOK / POTENTIAL RISKS
	• Each department will now need to analyse their reports, identify key priorities, and develop and action plan to work on areas that need improvement. Business Units will be expected to update Performance Review on actions taken.

GOAL 2: Attraction & Retention

Queen Victoria Hospital NHS Foundation Trust

VACANCY PERCENTAGES	Mar-22	Apr-22	May-22	Compared to Previous Month
Corporate	14.69%	15.38%	15.69%	▲
Eyes	1.48%	4.40%	4.40%	◄►
Sleep	29.61%	29.61%	26.02%	▼
Plastics	4.33%	9.49%	7.32%	▼
Oral	10.14%	10.14%	11.04%	▲
Periop	13.01%	12.65%	10.08%	▼
Clinical Support	9.92%	9.80%	9.23%	▼
Outpatients	25.27%	25.27%	28.66%	▲
Director of Nursing	3.49%	3.49%	1.18%	▼
Operational Nursing	18.45%	18.69%	19.29%	▲
Community Services	7.27%	6.01%	6.01%	◄►
QVH Trust Total	13.01%	13.64%	13.07%	▼

OU1 name	Medical / Non Medical	WTE through recruitment
Clinical Support	Medical	1
	Non Medical	11
Commerce & Finance	Non Medical	4
Corporate	Non Medical	7
Director of Nursing	Medical	1
	Non Medical	4
Eye	Medical	4
	Non Medical	8
Finance OTHER	Medical	2
	Non Medical	19
Human Resources	Non Medical	5
Non Clinical Infrastructure	Non Medical	3
Operational Nursing	Non Medical	16
Oral	Medical	6
	Non Medical	5
Outpatients	Non Medical	5
Perioperative Care	Medical	16
	Non Medical	19
Plastics	Medical	25
	Non Medical	4
Sleep	Medical	1
	Non Medical	7
Grand Total		173

COMMENTARY

- Corporate, Sleep, Outpatients and Operational Nursing with the highest vacancy rates
- Further increase in time to recruit due to new OH system process
- 10.21 Leavers with highest in Corporate in May and 9.04 Starters with Periop having the highest

FORWARD LOOK / POTENTIAL RISKS

- Meeting planned with OH provider to look at issues with new system causing delays in process.
- Step Into Health network being initiated
- New Recruitment and Selection training launched
- Employee Services Manager to meet with areas with highest vacancy rates to look at attraction campaings

GOAL 2: Attraction & Retention – Recruitment KPIs

Queen Victoria Hospital NHS Foundation Trust

Stage	May-20	May-21	May-22	Trend Line
From Advert open to ready to start (T19) (KPI 45)	80	80.43	84.25	
From conditional offer to ready to start (T23) (KPI 18)	63.9	58.47	56.85	
From authorised to ready to start (T16) (KPI 53)	91.5	79.9	65.92	
From authorised to start date (T17) (KPI 70	81.65	66.53	104.8	
Time to authorise (T1a) (KPI 5)	5.3	3.2	5.1	
From authorised to advert live (T1b) (KPI 2)	6	0.98	1.33	

Stage	Apr	May	Trend Line
From Advert open to ready to start (T19) (KPI 45)	63.07	84.25	
From conditional offer to ready to start (T23) (KPI 18)	34.7	56.85	
From authorised to ready to start (T16) (KPI 53)	64.7	65.92	
From authorised to start date (T17) (KPI 70	82.95	104.8	
Time to authorise (T1a) (KPI 5)	6.18	5.1	
From authorised to advert live (T1b) (KPI 2)	3.73	1.33	

COMMENTARY

- Increase in 3.82 days from May 21 to May 22 in Time to Hire
- Increase in 21.25 days from last month in Time to Hire due to OH system and increase in number of Visa applications which delay process.
- Continuation of £1500 new starter premium in specific areas of the trust.

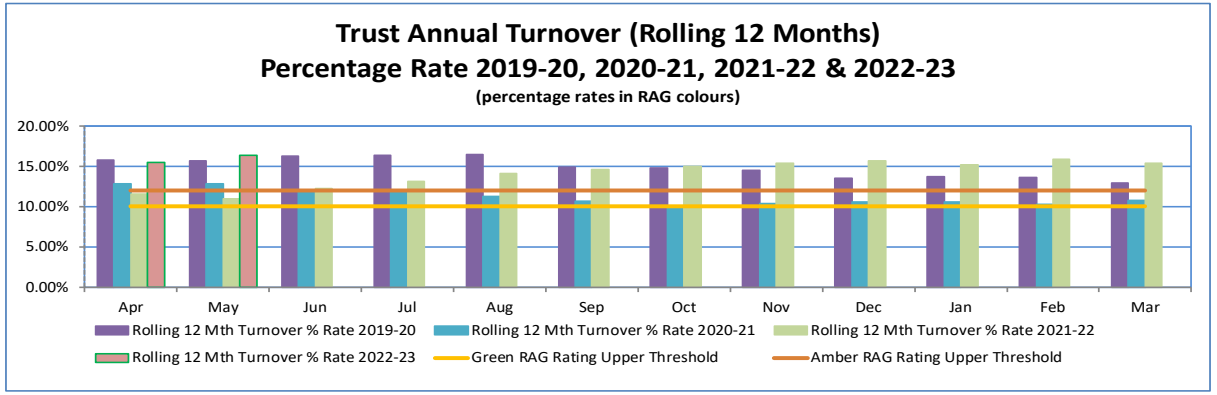
FORWARD LOOK / POTENTIAL RISKS

- Resourcing Team Leader in post and priority given to monitor and improve time to hire.
- Look at Risk Assessments in low risk areas to enable candidates to start pending OH and DBS checks

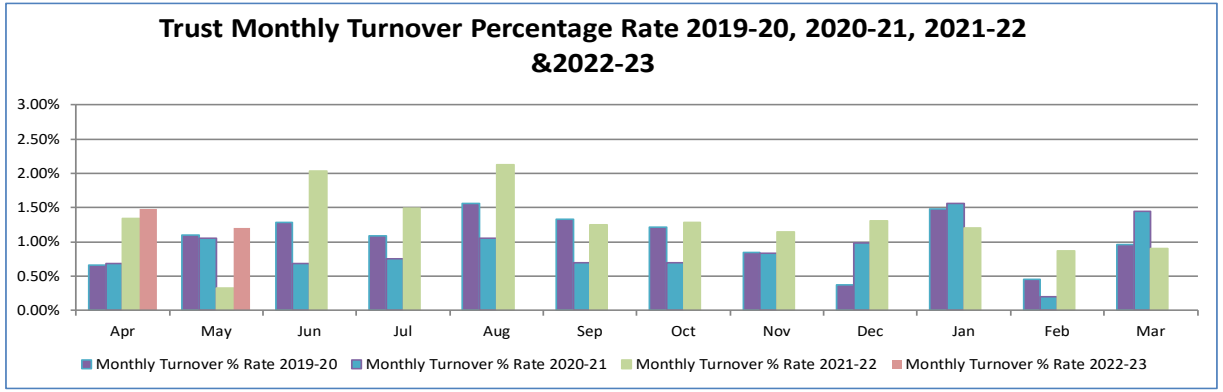
Turnover, New Hires and Leavers

Queen Victoria Hospital NHS Foundation Trust

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Mar-22	Apr-22	May-22	Compared to Previous Month
Corporate %	14.58%	14.22%	15.68%	▲
Eyes %	48.45%	50.51%	51.85%	▲
Sleep %	22.65%	23.80%	23.26%	▼
Plastics %	22.57%	21.70%	23.77%	▲
Oral %	13.30%	13.34%	15.32%	▲
Peri Op %	9.85%	10.72%	10.09%	▼
Clinical Support %	12.10%	12.53%	12.12%	▼
Outpatients %	2.84%	2.89%	7.89%	▲
Director of Nursing %	14.20%	14.09%	16.15%	▲
Operational Nursing %	16.92%	16.78%	17.20%	▲
Community Services %	4.66%	4.54%	4.67%	▲
QVH Trust Total %	15.40%	15.51%	16.34%	▲



MONTHLY TURNOVER excl. Trainee Doctors	Mar-22	Apr-22	May-22	Compared to Previous Month
Corporate %	1.43%	1.44%	1.65%	▲
Eyes %	3.07%	3.23%	3.28%	▲
Sleep %	0.00%	4.71%	0.00%	▼
Plastics %	0.00%	1.90%	1.96%	▲
Oral %	0.79%	1.64%	1.99%	▲
Peri Op %	0.00%	1.60%	0.00%	▼
Clinical Support %	0.00%	0.50%	0.98%	▲
Outpatients %	0.00%	0.00%	4.89%	▲
Director of Nursing %	2.10%	0.00%	2.05%	▲
Operational Nursing %	1.56%	1.84%	0.63%	▼
Community Services %	0.00%	0.00%	0.00%	◄►
QVH Trust Total %	0.90%	1.48%	1.20%	▼



COMMENTARY

- Annual Rolling Turnover has increased to 16.34% with Monthly at 1.20%
- Highest annual turnover in Eyes at 51.85% and monthly turnover in Outpatients at 4.89%

FORWARD LOOK / POTENTIAL RISKS

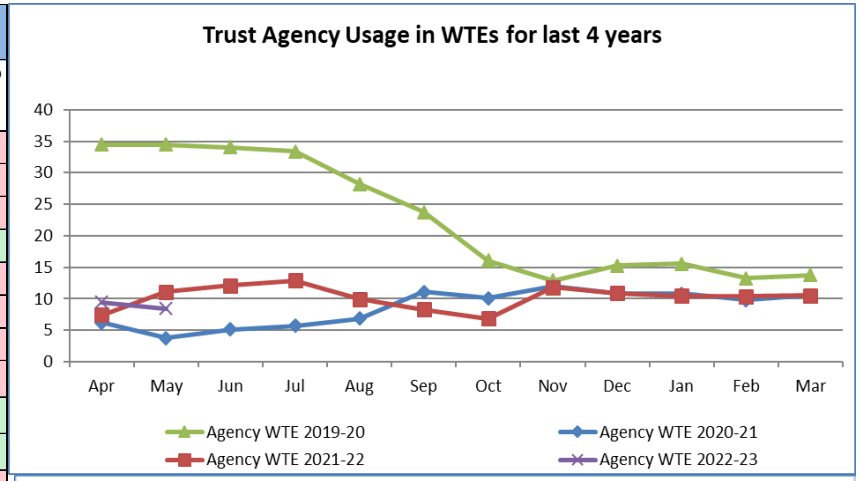
- Large project started to look at Occupational Codes within establishments and fully align establishment and ledger.

Temporary Workforce

Queen Victoria Hospital NHS Foundation Trust

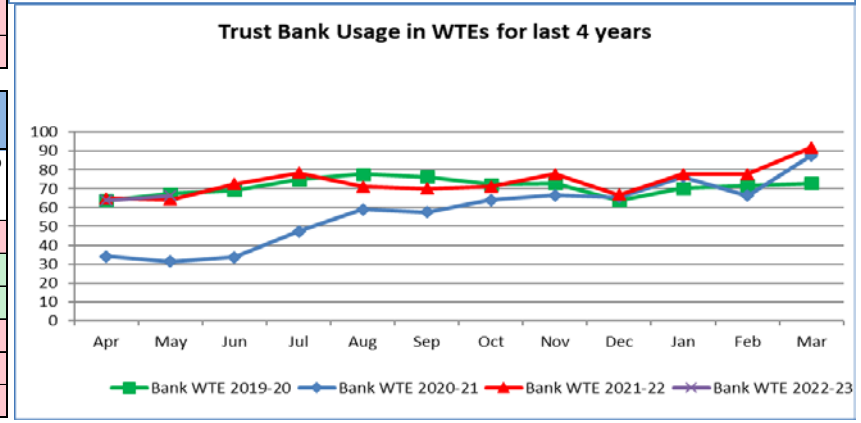
Agency				
BUSINESS UNIT (WTE)	Mar-22	Apr-22	May-22	Compared to Previous Month
Corporate	3.13	3.45	3.06	▼
Eyes	0.00	0.00	0.00	◄►
Sleep	0.67	0.47	0.51	▲
Plastics	0.00	0.00	0.00	◄►
Oral	0.00	0.00	0.00	◄►
Periop	2.38	1.92	1.84	▼
Clinical Support	0.12	0.10	0.06	▼
Outpatients	0.00	0.00	0.00	◄►
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	4.20	3.48	2.95	▼
Community Services	0.00	0.00	0.00	◄►
QVH Trust Total	10.50	9.42	8.44	▼

Bank				
BUSINESS UNIT (WTE)	Mar-22	Apr-22	May-22	Compared to Previous Month
Corporate	10.63	7.45	7.91	▲
Eyes	2.27	0.58	1.57	▲
Sleep	6.18	4.67	5.47	▲
Plastics	4.30	4.06	3.56	▼
Oral	4.10	3.01	4.07	▲
Periop	22.26	15.39	15.73	▲
Clinical Support	4.42	3.82	4.19	▲
Outpatients	1.93	1.24	1.70	▲
Director of Nursing	2.81	2.28	1.34	▼
Operational Nursing	32.50	21.16	20.40	▼
Community Services	0.52	0.19	0.30	▲
QVH Trust Total	91.93	63.86	66.24	▲



Agency				
STAFF GROUP (WTE)	Mar-22	Apr-22	Mar-22	Compared to Previous Month
Qualified Nursing	5.16	5.11	3.98	▼
HCAs	0.44	0.00	0.00	◄►
Medical and Dental	1.65	0.76	1.33	▲
Other AHP's & ST&T	0.12	0.10	0.06	▼
Non-Clinical	3.13	3.45	3.06	▼
QVH Trust Total	10.50	9.42	8.44	▼

Bank				
STAFF GROUP (WTE)	Mar-22	Apr-22	May-22	Compared to Previous Month
Qualified Nursing	36.77	22.71	23.35	▲
HCAs	12.44	9.91	9.67	▼
Medical and Dental	6.84	4.91	4.57	▼
Other AHP's & ST&T	3.31	3.17	3.37	▲
Non-Clinical	32.58	23.16	25.35	▲
QVH Trust Total	91.93	63.86	66.31	▲



COMMENTARY

- Reduction in Trust agency usage to 8.44 in May with highest use in Corporate area, however Qualified Nursing is highest staff group at 3.98
- Slight increase in Bank usage to 66.24 which is expected with reduced agency use. Highest bank use in Operational Nursing area with non clinical being the highest staff group.

FORWARD LOOK / POTENTIAL RISKS

- Review of remaining on the bank process in place
- Work with ICS looking at aligned agency capped rates across patch

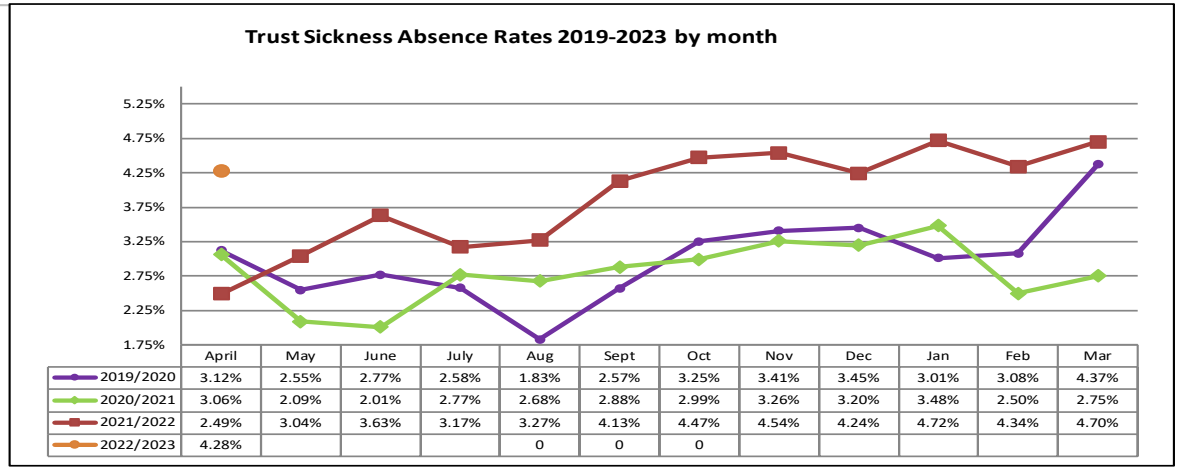
GOAL 3: Health and Wellbeing

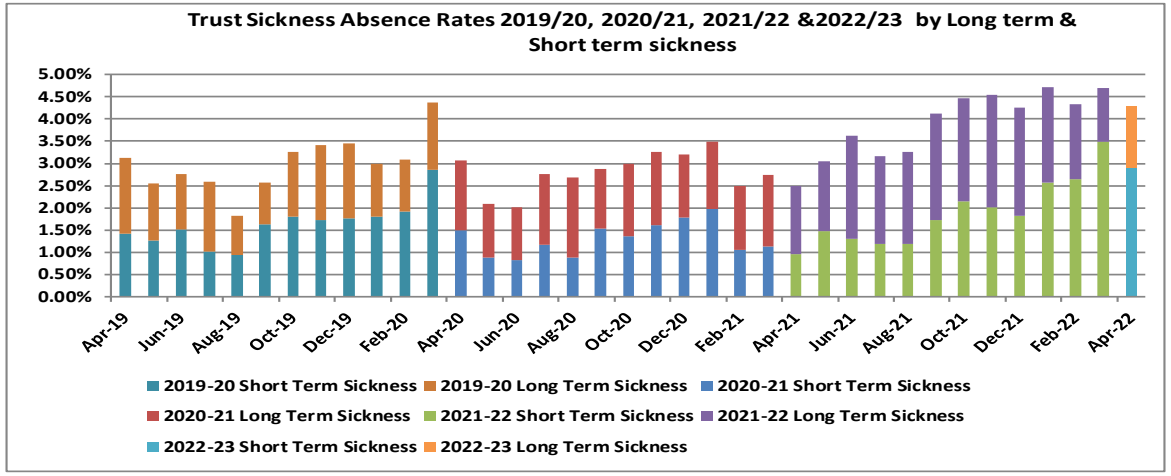
Queen Victoria Hospital NHS Foundation Trust

SHORT TERM SICKNESS	Feb-22	Mar-22	Apr-22	Compared to Previous Month
Corporate	1.92%	2.05%	2.03%	▼
Clinical Support	2.86%	4.76%	4.33%	▼
Plastics	2.23%	4.64%	3.73%	▼
Eyes	1.46%	0.59%	1.27%	▲
Sleep	1.79%	2.55%	4.73%	▲
Oral	1.90%	3.12%	1.27%	▼
Periop	2.05%	1.54%	1.60%	▲
Outpatients	0.00%	1.83%	0.46%	▼
Director of Nursing	3.06%	2.96%	5.38%	▲
Operational Nursing	5.16%	6.55%	3.42%	▼
Community Services	0.00%	1.38%	6.30%	▲
QVH Trust Total	2.64%	3.49%	2.91%	▼

LONG TERM SICKNESS	Feb-22	Mar-22	Apr-22	Compared to Previous Month
Corporate	0.52%	0.18%	1.79%	▲
Clinical Support	0.38%	0.09%	1.34%	▲
Plastics	1.11%	0.04%	0.00%	▼
Eyes	0.00%	0.00%	0.00%	◄►
Sleep	0.00%	0.00%	0.00%	◄►
Oral	3.01%	2.56%	3.09%	▲
Periop	3.08%	2.58%	2.38%	▼
Outpatients	5.01%	4.71%	4.58%	▼
Director of Nursing	0.54%	0.00%	0.35%	▲
Operational Nursing	2.24%	1.16%	0.97%	▼
Community Services	8.00%	7.42%	0.00%	▼
QVH Trust Total	1.70%	1.21%	1.38%	▲

ALL SICKNESS (with RAG)	Feb-22	Mar-22	Apr-22	Compared to Previous Month
QVH Trust Total	4.34%	4.70%	4.28%	▼





COMMENTARY

- Sickness absence has remained consistently above 4% for the past 8 months, we saw an increase between March and April 2022 most significantly in long term sickness absence across the majority of the Business Units.
- Short term sickness has reduced by 0.58% whereas long term has continued to increase (by 0.17%), however both are below the Trust target of 3% in April 2022.
- Top 3 absences are consistent for short term absence by occurrence are Cold, Cough, Flu; Gastrointestinal problems; Headache/ migraine.

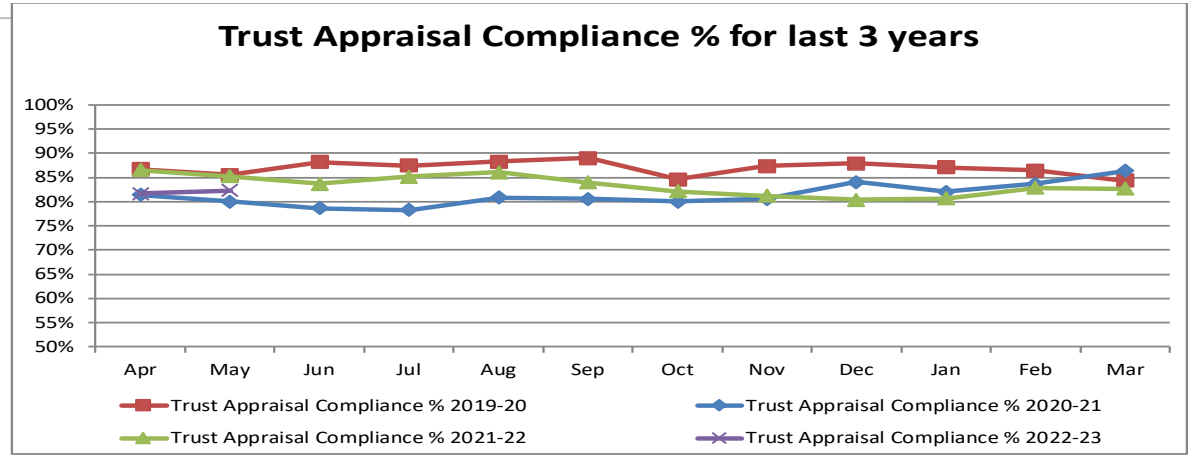
FORWARD LOOK / POTENTIAL RISKS

- There will continue to be both formal and informal absence management with consideration given to absences related to Covid-19 and trigger point exclusions
- The Attendance Policy is currently under review alongside the Maternity/ Adoption, Paternity, Special Leave policies

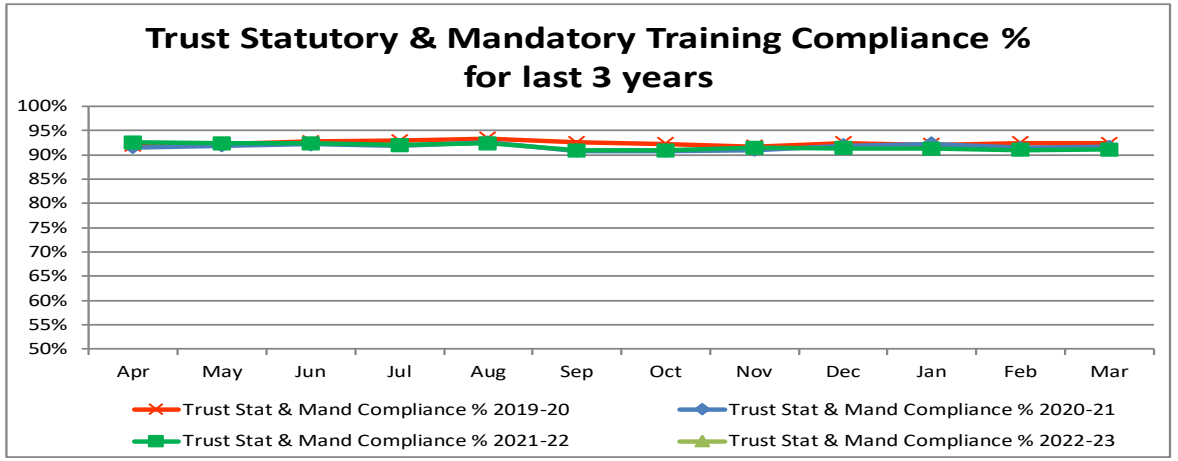
GOAL 4: Learning & Education

Queen Victoria Hospital NHS Foundation Trust

APPRAISALS	Mar-22	Apr-22	May-22	Compared to Previous Month
Corporate	78.22%	79.21%	78.22%	▼
Eyes	75.00%	77.14%	61.76%	▼
Sleep	70.37%	70.37%	71.43%	▲
Plastics	71.11%	67.82%	63.64%	▼
Oral	76.09%	70.00%	68.97%	▼
Peri Op	87.91%	87.22%	88.71%	▲
Clinical Support	88.62%	88.10%	88.37%	▲
Outpatients	84.00%	84.00%	86.96%	▲
Director of Nursing	88.52%	88.52%	90.32%	▲
Operational Nursing	89.37%	88.29%	93.63%	▲
Community Services	62.50%	56.25%	66.67%	▲
QVH Trust Total	82.66%	81.69%	82.33%	▲



MANDATORY AND STATUTORY TRAINING	Mar-22	Apr-22	May-22	Compared to Previous Month
Corporate	91.37%	90.51%	91.77%	▲
Eyes	85.09%	87.83%	89.59%	▲
Sleep	92.33%	93.24%	90.49%	▼
Plastics	81.20%	80.66%	80.35%	▼
Oral	91.33%	92.02%	92.64%	▲
Peri Op	88.79%	88.15%	90.43%	▲
Clinical Support	95.10%	94.45%	93.61%	▼
Outpatients	92.38%	93.27%	93.65%	▲
Director of Nursing	94.90%	93.19%	96.04%	▲
Operational Nursing	94.04%	93.35%	94.12%	▲
Community Services	94.38%	94.22%	96.95%	▲
QVH Trust Total	91.05%	90.69%	91.60%	▲



COMMENTARY

- 401 course bookings for April 2022269 attendees (67% of all bookings)
- 40 did not attend (10% of all bookings)
- 39 withdrew within 2 weeks of the course (10% of all bookings)
- 13 withdrew more than 2 weeks before the course (3% of all bookings)
- 40 on cancelled courses (10% of all bookings)

FORWARD LOOK / POTENTIAL RISKS

- Appraisal compliance rate has increased this month
- OD&L will be looking at how we give assurance on the qualitative aspect of the process in the next few months

SHCP – Leadership, OD and Talent Group activity:

- To date, over 1100 people across the SHCP have accessed development through this group in the past 18 months. This information has been shared with E & D Steering Group.
- One staff member from QVH have been offered a place on the new ILM Level 3 Coaching programme starting June 2022

Apprenticeships/KickStarts:

- There are currently 33 staff undertaking apprenticeships at QVH
- Functional skills continues with Functional Skills UK and will be evaluated in due course
- Procurement for the apprenticeship provider for Radiology is underway

Other activities:

- OD&L are currently developing/delivering team intervention sessions for Sleep, Finance and Workforce & OD.
- OD&L are also looking at appraisals and how we can provide assurance on the qualitative aspect of the process.
- June corporate induction programme was held in the LDC Training room for 15 new starters.
- In May, the Funding Panel approved 7 applications (benefiting over 20 individuals) for learning and development, which OD & L processed. The next meeting is on 24th June 2022.

Medical Education activity

Plans are underway for August junior doctors induction, the largest induction of the year, where we will be welcoming new trainees in Anaesthetics, Plastic Surgery, Corneo Plastics and Radiology. The Medical Education team work closely with colleagues in Resourcing, HR Advice, Pharmacy, IT, and the individual departments to ensure that everything is in place for the doctors' first day, that they have access to IT systems etc, and that they receive an effective local induction.

CPD courses for dentists, arranged in conjunction with HEE KSS's dental deanery, are taking place regularly in the dental skills lab. These are organised by Jo Deamer who is the dental training technician within the Medical Education team. From September dental foundation training will be restarting in the lab every Friday, with a brand new cohort of dentists fresh from dental school.

The next round of Local Faculty Group meetings to ensure educational governance of medical and dental training will begin in June. The next Junior Doctors' Forum meeting is also planned for early June and will be attended by Steve Jenkin to allow trainees an opportunity to ask him questions relating to QVH and issues that impact on their training.

The GMC survey of doctors in training has now closed and we are awaiting the results, which are due in July and will be used to ensure that any areas requiring improvement are picked up on and addressed.

A training session for SAS doctors on putting together business cases, is planned for 23 June, funded by HEE's development fund for SAS doctors.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**7 July 2022**		**Agenda reference:**	**113-22**	
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 committee's meeting on Monday 27th June.				
Summary of key issues	Operational performance: Sleep behind remedial action plan, ongoing issues with theatre utilisation, late referrals and covid absences. Workforce: absences higher than wanted, appraisals need a focus. Encouraging results from the 2022 staff survey Financial results: Surplus of £1.7m under current regime Business planning update Business case for Community Diagnostic Centre				
Recommendation:	The Board is asked to **NOTE** the contents of the report, the **ASSURANCE** (where given), and the risks to delivery.				
Action required	Approval	Information	**Assurance**	**Assurance**	**Assurance**
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:	KS05 – Organisational Excellence – strong indicators of successful management, but aware of critical dependencies KS04 – Financial Sustainability – short-term break-even is the result of specific funding, longer-term is not resolved KS03 – Operational Excellence – risk remains high as dependent upon productivity developments				
Corporate risk register:	Committee is looking in detail at allocated corporate risks, on a rotational basis				
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:	N/A				
	Date:		Decision:		
Next steps:	N/A				

Report to: Board of Directors
Meeting date: 7 July 2022
Reference no: 113-22
Report from: Paul Dillon-Robinson, Committee Chair
Report date: 28 June 2022

Financial, operational and workforce performance assurance

Introduction

The finance and performance committee met on 27th June and covered its standard topics on performance assurance, as well as an update on business planning.

1. Operational performance

The committee noted that higher levels of referrals than planned / historically are being experienced in some areas (e.g. MIU, Sleep and Skin), which are having an impact on performance. There also continue to be concerns about late referrals and data validation from neighbouring trusts, that is being worked on, but needs to be clarified so that we work to accurate waiting list information. The committee noted concerns with two week wait performance and elective activity (albeit also noting the positive day case position).

Two topics were subject to deep dives; theatre utilisation and Sleep. The committee continues to focus on theatre utilisation, given its critical link to the delivery of increased productivity, and the reasons why performance remains below target. No clear theme emerges, but we will continue this focus.

Sleep has been a concern for a while and has yet to achieve the desired improvement trajectory. It is hoped that staff recruitment will provide impetus, but further work is needed in this area.

2. Workforce performance

Significant work has been undertaken in reviewing the authorised establishment and addressing the issue of unfilled vacant posts, particularly those not being actively recruited to, so as to have an accurate review of the establishment needed. Further work is required to align HR and Finance data and reporting, but the agreed vacancy factor gives greater assurance on the financial management of pay costs.

Sickness absence levels remain above the Trust's KPI, but assurance was taken that they are below regional and national levels. A deep dive on mental health data was considered, and further analysis is being undertaken, but there is no clear theme emerging.

The committee also noted the proposed re-introduction of an agency cap, and a cap on bank rates, and awaits more details. It also considered a question from the Board about how they could be assured that appraisals are effective, noting the staff survey feedback and developments being considered.

3. Financial performance

It is still early in the year for a year-end forecast, but the committee noted the submission of a break-even plan, and that the year-to-date position is a small surplus (against the originally submitted plan). It noted that expenditure remains broadly in line with previous periods, but that this will grow in Q2 as activity (and associated recruitment) builds. There is uncertainty about the amount of elective recovery fund (ERF) income that will be achieved (net) in months 1 and 2.

The focus of the committee was more on the financial risks on business planning (see below) than year-to-date.

4. Business Planning

The Trust's most recent submission for the 2022/23 business plan is for a break-even position (previously a deficit of £2.3m) achieved through national funding of inflationary pressures, so adjustments and an increase in cash releasing efficiency requirements. This plan carries a number of risks; continuing lack of agreement of contracts / terms of ERF income, increased requirement to deliver efficiencies, assumptions around delivery of productivity, availability and cost of independent sector provision, etc.

5. Business case for Community Diagnostic Centre

A working draft of the business case for the development of a Community Diagnostic Centre was reviewed and the committee recommends that this is discussed at the Board.

6. Other

The committee received updates on Estates projects, IM&T programme (including digital maturity) and regular deep dives on corporate risks allocated to it. The risk around the contract for sterile supplies services was discussed, and it was agreed that this needed further review and escalation.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07 July 2022**		**Agenda reference:**	*114-22*	
Report title:	**Approval of changes to standing orders and standing financial instructions including reservation of powers and scheme of delegation**				
Sponsor:	Michelle Miles, director of finance and performance Clare Pirie, director of communications and engagement				
Authors:	Leonora May, deputy company secretary				
Appendices:	Appendix one - standing orders Appendix two - standing financial instructions Appendix three - reservation of powers and scheme of delegation Appendix four - staff guide to key financial documents				
Executive summary					
Purpose of report:	The purpose of this report is to ask the Board to approve the proposed changes to the standing orders and associated documents as reviewed and recommended by the audit committee				
Summary of key issues	Recommendation of changes to standing orders and associated documents				
Recommendation:	It is recommended that the Board approves the proposed changes to the standing orders and associated documents as reviewed and recommended by the audit committee				
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 corporate governance documents support the delivery of all KSOs				
Corporate risk register:	N/A				
Regulation:	- The regulatory framework and procurement regulation requires the Board to adopt these documents for the regulation of proceedings - The Trust's standing order require that the corporate governance documentation is reviewed annually				
Legal:	As above				
Resources:	N/A				
Assurance route					
Previously considered by:	Audit committee				
	Date:	15/6/22	Decision:	Amendments recommended for approval by Board	
Next steps:	Publication of updated documents internally and on website				

Report to:	Board Directors
Agenda item:	114-22
Date of meeting:	7 July 2022
Report from:	Michelle Miles, director of finance and performance Clare Pirie, director of communications and corporate affairs
Report authors:	Leonora May, deputy company secretary
Date of report:	28 June 2022
Appendices:	Appendix 1 - standing orders Appendix 2 - standing financial instructions Appendix 3 - reservation of powers and scheme of delegation Appendix 4 - staff guide to key financial documents

Approval of changes to standing orders and standing financial instructions including reservation of powers and scheme of delegation

Background

Section 12.3 of the Trust's current standing orders states that the standing orders and associated documents must be reviewed annually. For the purpose of this report, associated documents mean the standing financial instructions and reservation of powers and scheme of delegation.

The standing orders and associated documents provide a comprehensive framework for the functions of the Trust. All Board members and officers should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Proposed amendments

The audit committee reviewed and agreed to recommend the proposed changes to the Board at its meeting on 15 June 2022. The committee requested some minor amendments to the documents which have been incorporated in the versions presented to the Board for approval.

Summary of proposed amendments

1. *Standing orders*

- Update to introduction to provide clarity
- Update to correct numbering at s2.8 and s4.8
- Update to remove all references to he/she him/her and replace with they/ them throughout document in line with house style

2. *Standing financial instructions*

- Update to provide clarity on Procurement process including updated flow diagram to aid readers in their understanding and revised Procurement Policy
- Update to provide clarity on the handling of cash received within the Trust

3. *Reservation of powers and scheme of delegation*

- Update investment decisions in line with approved Business Case Policy & Procurement Policy

Recommendation

It is recommended that the Board **approves** the proposed changes to the standing orders, standing financial instructions and reservation of powers and scheme of delegation. These will take immediate effect and be published to the Trust's website.

Queen Victoria Hospital NHS Foundation Trust

Standing orders for the Board of Directors

Approved by the Board of Directors at its meeting on 7 July 2022~~5 August 2021~~

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 National Health Service Act 2006 ("**the 2006 Act**") ~~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~~the Dd~~i~~rector, 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~~the Dd~~i~~rector or any person connected with ~~him/her~~the Dd~~i~~rector has any beneficial interest in the securities of a company of which ~~he/she~~the Dd~~i~~rector or such person appears as a member; or,

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

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

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

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

2 The Foundation Trust Board of Directors

Composition of the Board of Directors

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

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

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

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

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

Appointment and powers of the Deputy Chair

2.4 The Deputy Chair shall be appointed in accordance with paragraph 36 of the Constitution.

2.5 Any appointment as Deputy Chair shall be for a period not exceeding the remainder of ~~his~~ their existing term of office as a Non-Executive Director or as specified by the Council of Governors on appointment.

2.6 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. Thereupon, the Council of Governors may appoint another Non-Executive Director as Deputy Chair in accordance with paragraph 36 of the Constitution.

2.7 The Deputy Chair may act as Chair in accordance with paragraph 36.6 of the Constitution or if the Chair of the Foundation Trust has died or has ceased to hold office.

2.8 In the event of circumstances provided by paragraph 36.6 of the Constitution and/or ~~3.1.4.4~~1.4 of the Standing Orders, references to the Chair in these Standing Orders shall be taken to include references to the Deputy Chair.

Appointment of a Senior Independent Director

2.9 The Board of Directors may appoint a Non-Executive Director to be the Senior Independent Director, for such period, not exceeding the remainder of ~~his~~ their 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~~their behalf shall be delivered to every Director (this includes email), or sent by post to the usual place of residence of such Director, so as to be available to every Director at least four Clear Days before the meeting

4.5 Want of service of the notice on any Director shall not affect the validity of a meeting.

4.6 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

4.7 Before each meeting of the Board of Directors a public notice of the time and place of the meeting, and the public part of the agenda and associated papers shall be published on the Foundation Trust's website at least three (3) Clear Days before the meeting, save in the case of emergencies.

4.8 In the event of an emergency giving rise to the need for an immediate meeting, failure to comply with the notice periods referred to in SO 4.4~~3.8~~ and (where relevant SO 4.7~~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~~their request in writing to the Chair at least ten (10) Clear Days before the meeting. Requests made less than ten (10) Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

4.11 No business shall be transacted at any meeting of the Board of Directors which is not specified in the notice of that meeting unless the Chair, in ~~his/her~~ their absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered by

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

Agenda and supporting papers

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

Petitions

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

Notice of motion

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

Withdrawal of motion or amendments

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

Motion to rescind a resolution

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

Emergency motions

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

Motions: procedure at and during a meeting

4.18 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.19 When a motion is under discussion or immediately prior to discussion it shall be open to a member of the Board of Directors to move:

4.19.1 an amendment to the motion; or

4.19.2 the adjournment of the discussion or the meeting; or

4.19.3 that the meeting proceed to the next item of business; (*) or

4.19.4 the appointment of an ad hoc committee to deal with a specific item of business; or

4.19.5 that the motion be now put (*); or

4.19.6 a motion resolving to exclude the public (including the press).

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

4.20 No amendment to the motion shall be admitted if, in the opinion of the Chair~~rnman~~, 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~~their vote shall be recorded by name.

4.37 An officer, who has been appointed formally by the Board of Directors to act up for a voting Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, will be entitled to exercise the voting rights of the Executive Director. An officer attending the meeting of the Board of Directors to represent a voting Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Member. An officer's status when attending a meeting will be recorded in the minutes of the meeting.

4.38 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

Suspension of Standing Orders

4.39 Except where this would contravene any statutory provision of the Regulatory Framework or any guidance or best practice issued by the Regulator, any one or more of these Standing Orders may be suspended at any meeting of the Board of Directors, provided that at least two-thirds of the whole number of the voting members of the Board of Directors are present (including at least one voting Executive Director and one Non-Executive Director) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension will be recorded in the minutes of the meeting.

4.40 A separate record of matters discussed during the suspension of Standing Orders will be made and will be available to the Chair and members of the Board of Directors. This record of matters is separate from the minutes of the meeting of the Board of Directors.

4.41 No formal business may be transacted while Standing Orders are suspended.

4.42 The audit 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~~they will perform personally and shall nominate officers to undertake the remaining functions for which ~~he/she~~they will still retain accountability to the Foundation Trust.

6.6 The Chief Executive shall prepare the Scheme of Delegation and Reservation of Powers identifying ~~his/her~~their proposals, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation and Reservation of Powers which shall be considered and approved by the Board of Directors.

6.7 Nothing in the Scheme of Delegation and Reservation of Powers shall impair the discharge of the direct accountability to the Board of Directors of the 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~~they ha~~ves~~ 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~~they are also a Director) as it applies to a member of the Board of Directors.

Interests of officers in contracts

7.10 Any Director or Officer of the Foundation Trust who comes to know that the Foundation Trust has entered into or proposes to enter into a contract in which ~~he/she~~they or their spouse, civil partner or co-habitee has any Pecuniary Interest, direct or indirect, the Director or officer shall declare their interest by giving notice in writing of such fact to the Secretary as soon as practicable.

7.11 A Director or Officer should also declare to the Secretary any other employment or business of other relationship of ~~his~~theirs, or of their~~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~~ them liable to instant dismissal.

7.22 The Chair and every Director and officer of the Foundation Trust shall disclose to the Chief Executive any relationship between ~~himself~~ themself 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~~them) and the authorisation and countersignature of the Chief Executive (or an officer nominated by ~~him/her~~them who shall not be within the originating directorate).

10.4 The fixing of the seal shall be authenticated by the signature of the Chair (or the Deputy Chair in the absence of the Chair) and one Executive Director.

Register of sealing

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

11 Signature of documents

11.1 Where any document will be a necessary step in legal proceedings on behalf of the Foundation Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or nominated Executive Director.

11.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Foundation Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board of Directors or any Committee, sub-committee or joint committee with delegated authority.

12 Miscellaneous

Standing Orders to be given to Directors and Officers

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

Documents having the standing of Standing Orders

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

Review of Standing Orders

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

Joint finance arrangements

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

Queen Victoria Hospital
NHS Foundation Trust

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 ~~5 August 2021~~7 July 2022

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.

"WTO GPA" means World Trade Organisation Government Procurement Agreement.

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 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. Under no circumstances may any Bank accounts linked to the Trust or Charity, by name or address, be opened without the express permission of the Director of Finance.

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. Cash received must be passed directly to cashiers for banking and may not be held on any Ward / Department without the express permission of the Director of Finance.

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 Public Procurement ~~Directives~~ Regulations ~~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~~These 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 (including VAT). Quotes are required on the following basis:

	Threshold Values (Including VAT)	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 WTO GPA threshold	Competitive tender exercise
	Over WTO GPA Threshold	WTO GPA 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. Written quotes must be submitted on suppliers headed paper.

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. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a schedule of quotations document sent to Procurement. ~~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.~~

9.3.6 In circumstances where competitive quotation is not possible due to lack of quotations~~,~~ a waiver will be required to be completed.~~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.~~

9.3.7 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

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 in the SoD's.

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

9.5 Electronic Tendering

9.5.1 All formal invitations to tender shall utilise the Trusts on-line E-tendering solution. Where there are national framework providers facilitating tendering activity then those E-tendering solutions may be utilised.

9.5.2 All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 9.4 – 9.7.1. Issue of all tender documentation should be undertaken electronically through a secure website with controlled access using secure login, authentication and viewing rules.

9.5.3 All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions

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and communication by both Trust staff and suppliers are recorded within the system audit reports.

~~9.4.3~~

~~9.5~~9.6 Contracting/tendering procedure

Invitation to tender

~~9.5.1~~9.6.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

~~9.5.2~~9.6.2 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~~9.6.3 Issue of all tender documentation will be undertaken electronically through the secure website with controlled access using secure login, authentication and viewing rules.

9.6.4 Every tender for goods, materials, services, works (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

~~9.5.4~~9.6.5 Every tender must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice, provide assurances that they are compliant with the Equality and Bribery Acts 2010 and the Modern Slavery Act 2015.~~.~~

9.6.6 ~~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.~~All individuals involved in the evaluation of tenders will make a formal declaration of any interests they have along with any gift or hospitality received regardless of the provider.

Receipt, Safe Custody and Record of Formal Tenders

9.6.7 Formal competitive tenders shall be returned electronically via the Trust's nominated e-portal provider

~~9.5.5~~9.6.8 When tenders are received in electronic format the e-portal will automatically record the date and time of receipt of each tender. This record is available for review in real-time by all staff with appropriate access rights and cannot be edited. Tenders cannot be 'opened' or supplier information viewed until the pre-defined time and date for opening has passed.

Opening tenders

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9.6.9 The e-tendering portal will automatically close at the date and time stated as being the latest time for the receipt of tenders, the e-tendering portal shall be closed to further tender submissions, and the project will be locked for evaluation.

9.6.10 A designated procurement officer shall electronically open the submitted tenders through the e-tendering portal.

9.6.11 The e-tendering portal will record the date and time the tender submissions are opened.

9.6.12 A tendering record shall be maintained on the e-tendering portal, to show for each set of competitive tender invitations dispatched:

(a) The name of all firms' invited;

(b) The details of the firms who submitted bids:

(c) The date the tenders were opened;

(d) The person opening the tender;

9.6.13 Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing, should be dealt with in the same way as late tenders (paragraph 9.6.18 below).

~~9.5.6~~9.6.14 ~~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~~9.6.15 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~~9.6.16 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

9.6.17 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~~ uploaded in good time but delayed through no fault of the tenderer.

~~9.5.9~~9.6.18 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential.

Acceptance of formal tenders

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~~9.5.10~~9.6.19 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

9.6.20 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.

~~9.5.11~~9.6.21 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive and Director of Finance.

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~~9.6~~9.7 Financial standing and technical competence of contractors

~~9.6.1~~9.7.1 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~~9.8 Awarding of contracts

~~9.7.1~~9.8.1 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~~9.8.2 The levels of authorisation are in the SoD.

~~9.7.3~~9.8.3 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.

9.9 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.

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9.9.2 Any contracts/ non-pay spend over £1,000,000 (including VAT) will be required to be approved and signed by the Board of Directors as per the SoD.

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~~9.8~~9.10 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.~~

9.10.1 Formal competitive tendering procedures need not be applied where:

(a) the estimated expenditure or income is, or is reasonably expected to be, less than £50,000 (including VAT) over the life of the contract;

(b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care, in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI 9.14;

(d) where the requirement is covered by an existing valid contract;

(e) where supply of goods or services is through NHS Supply Chain unless the Chief Executive or nominated officers deem it inappropriate for reasons of cost or availability. The decision to use alternative sources must be documented;

(f) where the Trust can utilise framework agreements through a direct award or further competition to achieve Value for Money. These may include but not be limited to Crown Commercial Services, NHS Commercial Solutions and the other NHS Hubs, NHS Shared Business Services, Health Trust Europe;

(g) for construction works under the provision of the NHS ProCure22/23 framework;

(h) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members where the Director of Finance and Head of Procurement are satisfied that the consortium procurement arrangements conform to current statute and deliver value for money;

(i) where a statutory payment can only be made to a specific statutory body (eg rates), authorisation of the bodies considered in this category will be determined by the Director of Finance and Head of Procurement;

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(j) where payment is to another NHS body and the Director of Finance and Head of Procurement are satisfied that the procurement arrangements conform to current statute and deliver value for money;

(k) where payment is less than the current WTO GPA threshold for Goods & Services and is for the purchase of replacement equipment parts under an original supplier contract to provide medical equipment and the Director of Finance and Head of Procurement are satisfied that the procurement arrangements conform to current statute and deliver value for money.

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~~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~~9.11 **Waiving of tenders**

~~9.10.1~~9.11.1 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~~9.11.2 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 WTO GPA limits. Waivers over these limits will only be signed once approval has been made by the Executive Management Team and Audit Committee following a submitted report by the stakeholder.

~~9.10.3~~9.11.3 Waiver request forms are available through the trust intranet or supplied by the Trust's procurement department upon request. Fully signed w~~W~~aiver forms must be attached to the relevant requisition so an~~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~~9.11.4 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.

9.11.5 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.

~~9.10.6~~9.11.6 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure (except in circumstances outlined in 9.11.1 (d) above)

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~~9.11~~9.12 Health care services

~~9.11.1~~9.12.1 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~~9.12.2 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~~9.12.3 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~~9.12.4 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~~9.13 Compliance requirements for all contracts

~~9.12.1~~9.13.1 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) Public Procurement ~~EU directives~~ regulations and other statutory provisions; and

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

~~9.12.2~~9.13.2 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.

9.13.3 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.

9.13.4 A copy of signed contracts will be provided to Procurement in each instance and details will be added to the contract register by Procurement.

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~~9.13~~9.14 Disposals

~~9.13.1~~9.14.1 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

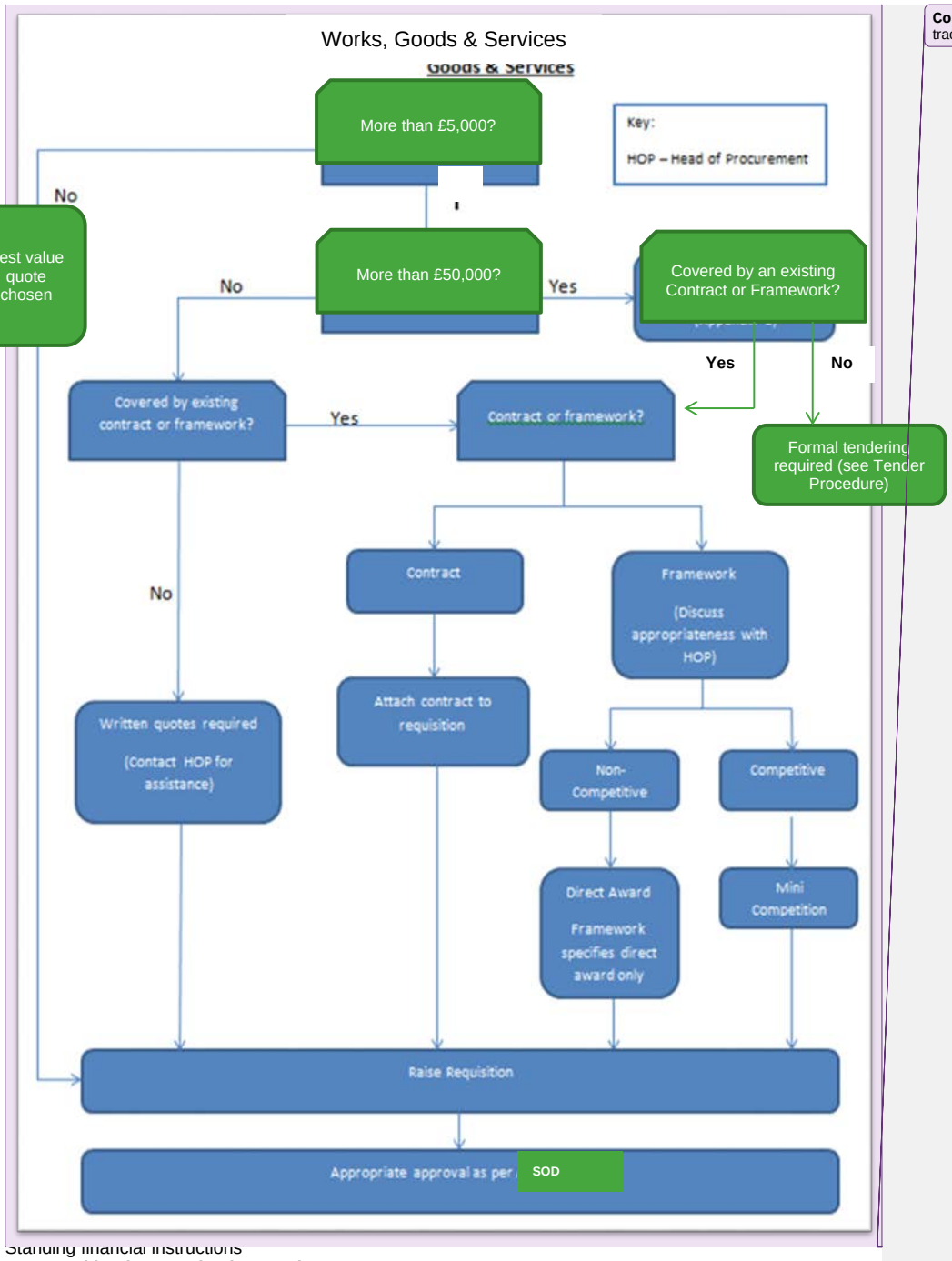
(d) items arising from works of construction, demolition or site clearance, which should be deal with in accordance with the relevant contract.

~~9.14~~9.15 In-house services

~~9.14.1~~9.15.1 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~~9.16 Applicability of SFIs on tendering and contracting for Funds Held on Trust including charitable funds

~~9.15.1~~9.16.1 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.



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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~~Workforce 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~~Workforce 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~~Workforce, 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~~Workforce and/or the Deputy Director of ~~Human Resources.~~Workforce.

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~~ Ppublic Pprocurement regulations;

(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.

~~(ii)~~(iii) any employee receiving any offer or inducement will notify their line manager as soon as practicable, and also notify the details of all such hospitality offered or received, for entry in to their electronic staff record.

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(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: -

(i) emergency orders must be provided by the Procurement team with authorisation provided by the budget holder or other senior manager with relevant authorisation rights as per the SoD.

(ii) a periodic bank of emergency purchase orders are provided to approved departments for emergency out of hours use. ~~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.~~

(iii) t~~T~~he Trust's procurement department shall maintain a register of emergency orders issued.

(iv) all relevant department must ensure the requisition is raised by 5pm the following working day and Procurement advised if a no. is used. Payment cannot be made without an authorised requisition.

(v) p~~P~~ersistent 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;

~~(e)~~

(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

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the relevant provisions of these SFIs and the Public Procurement Regulations~~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~~,~~ except for those specifically excepted by the Director of Finance in financial procedures, and purchases from petty cash or on purchase cards.

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~~11.6.2~~11.6.3 Orders are 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) transportation services;

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

(c) rent of property or rooms;

(d) services provided by high street opticians;

(e) utility services – including all communication services;

(f) travel claims;

(g) agency nursing;

(h) recruitment advertising;

(i) interpretation services

~~(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.~~

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~~11.6.3~~11.6.4 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~~11.6.5 Goods must not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

~~11.6.5~~11.6.6 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.~~

14.3 Receipt of Goods and Services (not via NHS Supply Chain)

14.3.1 All other goods and services ordered must be inspected on receipt by the Stores Officers, or other Trust officers if received directly, for completeness and accuracy of the delivery.

14.3.2 Any missing or damaged goods, or incomplete service, must be notified to the Supplier immediately. Receipting should reflect the amount delivered not the full order quantity in the case of short delivery.

14.3.3 In order to facilitate timely accounting and subsequent payment, the receiving officer must arrange for the items to be receipted on the ordering system promptly following the delivery.

14.3.4 Failure to action receipts on a timely basis will result in delayed payments, failure of the Trust to hit the Better Payment Practice code targets and could attract interest charges and delay future supplies of goods and services.

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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. Cash losses, however small, in respect of Trust cash must be reported to Financial Accounts immediately.

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

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

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

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

(a) the Board of Directors;

(b) the external auditor; and

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

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

15.3.8 The Director of Finance shall:

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

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

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

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

16 INFORMATION TECHNOLOGY

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

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

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

(b) ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

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

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

(e) ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, the Director of Finance must obtain from that organisation assurances of adequacy prior to implementation; and

(f) publish and maintain a Freedom of Information (FOI) Publication Scheme, which is a complete guide to the information routinely published and describes the classes or types of information about the Trust which are publicly available.

16.2 Contracts for computer services with other health service body or other agency

16.2.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another Health Service Body or other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.2.2 Where another Health Service Body or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.3 Risk Assessments

16.3.1 The Director of Finance shall ensure that risks to the Trust arising from the use of information technology are effectively identified and considered and appropriate action is taken to mitigate or control risk. This shall include the preparation of and testing of, appropriate disaster recovery plans.

16.4 Requirements for computer systems which have an impact on the Trust's corporate financial systems

16.4.1 Where computer systems have an impact on the Trust's corporate financial systems, the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with the Trust's policies, including but not limited to the Trust's information technology strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely and that an audit trail exists;

(c) Trust's finance Officers have access to such data; and

(d) Such computer audit reviews are carried out as necessary.

17 PATIENTS' PROPERTY

17.1 The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients (hereafter referred to as "property"), in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 Subject to paragraph 17.1 above, the Trust will not accept responsibility or liability for patients' property brought into the Trust's premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

17.3.1 notices and information booklets;

17.3.2 hospital admission documentation and property records;

17.3.3 the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property.

17.4 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all Officers whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.5 Officers should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.6 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of probate or letters of administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18 RETENTION OF RECORDS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with the regulator and/or Secretary of State guidelines.

18.2 The Chief Executive will produce a records lifecycle policy, detailing the secure storage, retention periods and destruction of records to be retained. The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Records and information held in accordance with latest the Regulator and/or Secretary of State guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive. Proper details shall be maintained of records and information so destroyed.

19 RISK MANAGEMENT AND INSURANCE

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with NHS guidelines, which shall be approved and monitored by the Board of Directors.

19.2 The programme of risk management shall include:

19.2.1 a process for identifying and quantifying risks and potential liabilities;

19.2.2 engendering amongst all levels of Officers a positive attitude towards the control and management of risk;

19.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk;

19.2.4 contingency plans to offset the impact of adverse events;

19.2.5 audit arrangements including; Internal Audit, clinical audit, health and safety review;

19.2.6 decisions on which risks shall be included in the NHSLA risk pooling schemes; and

19.2.7 arrangements to review the Trust's risk management programme.

19.3 The Chief Executive will be responsible for ensuring that the existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal financial control within the annual report and annual accounts.

19.4 The Director of Finance shall ensure that insurance arrangements exist in accordance with the Trust's risk management policy.

20 FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 The Standing Orders state the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to its accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all Funds Held on Trust.

20.2 The reserved powers of the Board and the SoD make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Members of the Board of Directors and Officers must take account of that guidance before taking action. These SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

20.3 As management processes overlap most of the sections of these SFIs will apply to the management of Funds Held on Trust.

20.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from exchequer activities and funds.

20.5 The Director of Finance has primary responsibility to the Board of Directors for ensuring that Funds Held on Trust (charitable funds) are administered in line with statutory provisions, the Trust's governance documents and Charity Commission guidance. The Director of Finance will prepare procedural guidance in relation to the management and administration, disposition, investment, banking, reporting, accounting and audit of Funds Held on Trust (charitable funds) for the discharge of the Board of Directors responsibilities as the Corporate Trustee.

Queen Victoria Hospital NHS Foundation Trust

Reservation of powers and scheme of delegation

Effective from ~~5 August 2021~~7 July 2022

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:	SFI 10.1, SO 5.6

		3.2.2.1 to identify and appoint candidates to fill posts within its remit as and when they arise; 3.2.2.2 to be sensitive to other pay and employment conditions in the Trust; 3.2.2.3 to keep leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy; 3.2.2.4 to give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors; 3.2.2.5 to sponsor the Trust's leadership development and talent management programmes;	
3.3	**Charity committee**	3.3.1 The Committee will: 3.3.2 Ensure Funds Held on Trust (charitable funds) are managed in accordance with the Trust's SOs and SFIs, as approved by the Board of Directors. 3.3.3 Receive regular reports from the Director of Finance covering: 3.3.3.1 Number and value of funds 3.3.3.2 Purpose of funds 3.3.3.3 Income and expenditure analysis 3.3.4 Approve specific policies and procedures relevant to the committee's remit, and review the Annual Accounts prior to submission to the Corporate Trustee for formal approval 3.3.5 Ensure that the requirements of the Charities Acts and the Charities Commission are met and approve submissions required by regulators and auditors	

3.4	**Quality and governance committee**	3.4.1 The Board of Directors has delegated authority to the Committee to take the following actions on its behalf: 3.4.1.1 approve specific policies and procedures relevant to the Committee's purpose, responsibilities and duties; 3.4.1.2 engage with the Trust's auditors in cooperation with the Audit Committee; 3.4.1.3 seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary. 3.4.2 On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of : 3.4.2.1 the Trust's performance against the three domains of quality, safety, effectiveness and patient experience; 3.4.2.2 compliance with essential regulatory and professional standards, established good practice and mandatory guidance; 3.4.2.3 delivery of national, regional, local and specialist care quality (CQUIN) targets.	
3.5	**Finance and performance committee**	3.5.1 The Board of Directors has delegated authority to the Committee to take the following actions on its behalf: 3.5.1.1 Approve specific policies and procedures relevant to the committee's remit; 3.5.1.2 Review, by way of the finance report, the submission of monthly monitoring reports to the regulator; 3.5.1.3 Approve other exception or ad-hoc reports required by the regulator;	

		3.5.1.4 Recommend to the Board the submission of the Trust's annual plan to the regulator; and 3.5.1.5 Seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary. 3.5.2 On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust's: 3.5.2.1 monthly financial and operational performance; 3.5.2.2 estates and facilities strategy and maintenance programme; and 3.5.2.3 information management and technology (IM&T) strategy, performance and development. 3.5.3 The Committee will make recommendations to the Board of Directors in relation to: 3.5.3.1 capital and other investment programmes; 3.5.3.2 cost improvement plans; and 3.5.3.3 Business development opportunities and business cases.	

Board member delegation

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

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

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

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.

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

SO ref	Delegated to	Duties delegated
4.45	Chair	Sign minutes of the proceedings of meetings of the Board of Directors.
4.48	Chair	Issue directions regarding arrangements for meetings of the Board of Directors and accommodation of the public and press.
5.1	Board	Subject to such directions as may be given by the Secretary of State, the Board may appoint Committees of the Board. The Board shall approve the membership and terms of reference of Committees and shall if it requires to, receive and consider reports of such Committees.
5.17	All	Duty of confidentiality regarding all matters reported to the Board of Directors, or otherwise dealt with by the committee, sub-committee or joint committee if the Board of Directors, or committee or sub-committee has resolved that it is confidential.
6.2	Chair and Chief Executive	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

SO ref	Delegated to	Duties delegated
		or committee.
7.18	All	Disclose relationship between self and candidate for Officer appointment. (Chief Executive to report the disclosure to the Board of Directors).
7.19	Executive directors	Prior to acceptance of any appointment, disclose to the Chief Executive whether you are related to any other Director or holder of any officer under the Trust.
7.20	Directors	On appointment, disclose to the Board of Directors whether you are related to any other Director or holder of any officer under the Trust.
8.1	Directors and Officers	Comply with the Trust's standards of business conduct policy and relevant codes of conduct.
10.1	Secretary	Keep the Trust's Seal in a secure place.
10.2	Chair and one executive director	Sign to authenticate the seal.
10.3	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.

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

5. Scheme of delegation of powers from standing financial instructions

SFI ref	Delegated to	Duties delegated
1 Introduction		
1.2.1	Chair	Final authority on interpretation of the SFIs.
1.2.1	Chief Executive / director of finance	Advise the Chair on the interpretation of the SFIs.
1.4.1	All	All officers of the trust must comply with the SFIs.
2 Responsibilities and delegation		
2.1.2	Board of directors	Accountable for all of trust functions, even those delegated to the Chair, individual directors or officers.
2.4.1	Chief executive	The chief executive is the trust's accounting officer.
2.4.4	Chief executive	To ensure all existing officers and new appointees are notified of their responsibilities within the SFIs.
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.

SFI ref	Delegated to	Duties delegated
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; • Reviewing schedules of losses and compensations and making recommendations to the board of directors;

SFI ref	Delegated to	Duties delegated
		• 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.

SFI ref	Delegated to	Duties delegated
3.4.3	Internal audit	To assess the process in place to ensure the assurance frameworks are in accordance with current guidance from the regulator.
3.4.4	Internal audit	To notify the director of finance should any matter arise which involves, or is thought to involve, irregularities concerning cash, stores or other property.
3.4.5	Lead internal auditor	Accountable to the director of finance. Attend meetings of the audit committee and have right of access to all members of the audit committee, the Chair and the chief executive of the trust.
3.5.1	Council of Governors	Appoint external auditor to the trust.
3.5.1	Audit committee	To ensure that external audit is providing a cost effective service that meets the prevailing requirements of the regulator and other regulatory bodies.
3.6.1	Chief Executive and director of finance	Monitor and ensure compliance with guidance issued by the regulator or NHS protect on fraud and corruption in the NHS.
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.

SFI ref	Delegated to	Duties delegated
3.6.7	Director of finance and local counter fraud specialist	At the beginning of each financial year, prepare a written work plan outlining the local counter fraud specialist's projected work for that financial year.
3.6.11	Director of finance	Prepare a 'fraud response plan' that sets out the action to be taken in connection with suspected fraud.
3.6.12 3.6.13	Director of finance	Inform police if theft or arson is involved. For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness (except if trivial and where fraud is not suspected), immediately notify the board of directors and the auditor.
3.7.1	Director of finance	To establish procedures for the management of expense claims submitted by officers.
3.7.2	Director of finance	Approval of any expense claims receive older than 3 months.
3.8.1	Secretary	Ensure that all officers are made aware of the trust's standards of business conduct and additional rules in respect of preventing corruption and complying with the bribery act 2010.
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

SFI ref	Delegated to	Duties delegated
4 Annual planning, budgets, budgetary control and monitoring		
4.1.1	Chief Executive	Compile and submit to the board of directors and the regulator, strategic and operational plans.
4.1.2	Director of finance	Prepare and submit the operational plan to the financial and performance committee, the Board of Directors and the regulator
4.1.3	Director of finance	Compile and submit financial estimates and forecasts for both revenue and capital to the Board of Directors.
4.1.4	All	To provide the director of finance with all financial, statistical and other relevant information as necessary for the compilation of such business planning, estimates and forecasts.
4.2.4	Director of finance	Ensure adequate training is delivered on an ongoing basis to enable the Chief Executive and other Officers to carry out their budgetary responsibilities.
4.4.1	Finance and performance committee	Submit budgets to the board of directors for approval.
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.

SFI ref	Delegated to	Duties delegated
5 Annual accounts and reports		
5.1	Director of finance	Prepare financial returns in accordance with the guidance given by the regulator and the secretary of state for health, the treasury, the trust's accounting policies and generally accepted accounting principles
5.2	Chief Executive	Certify annual accounts.
5.2	Director of finance	Prepare annual account. Submit annual accounts and any report of auditor on them to the regulator.
6 Bank accounts		
6.1–6.6	Director of finance	Manage the trust's banking arrangements including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.
6.1	Board of Directors	Approve banking arrangements.
7 Financial systems and transaction processing		
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.

SFI ref	Delegated to	Duties delegated
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.
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.

SFI ref	Delegated to	Duties delegated
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.
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.

SFI ref	Delegated to	Duties delegated
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.
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.

SFI ref	Delegated to	Duties delegated
		• 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.
12.2.3	Director of finance	Prepare detailed procedural instructions concerning applications for loans and overdrafts.

SFI ref	Delegated to	Duties delegated
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		

SFI ref	Delegated to	Duties delegated
14.1.1	Chief Executive	Delegate overall responsibility for the control of stores.
14.1.1	Director of finance	Responsible for systems of control.
14.1.3	Pharmaceutical officer	Responsible for the control of any pharmaceutical stocks.
14.1.5	Director of finance	Set out procedures and systems to regulate the stores including records for receipt of goods, issues and returned to stores and losses.
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.

SFI ref	Delegated to	Duties delegated
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.
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;

SFI ref	Delegated to	Duties delegated
		• 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.
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.

SFI ref	Delegated to	Duties delegated
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.
19.3	Chief Executive	Responsible for ensuring that the existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal financial control within the annual report and annual accounts.
19.4	Director of finance	Ensure that insurance arrangements exist in accordance with the trust's risk management policy.
20 Funds held on trust (charitable funds)		
20.5	Director of finance	Ensure that funds held on trust (charitable funds) are administered in line with statutory provisions, the trust's governance documents and charity commission guidance. Prepare procedural guidance in relation to the management and administration, disposition, investment, banking, reporting, accounting and audit of the funds held on trust (charitable funds) for the discharge of the board of directors responsibilities as the corporate trustee.

7 Financial limit delegation

REF	Duties delegated	Delegated to
1	**Virements (reallocation of budgets)**	
	Within a Business Unit/Directorate	Level 2 Officers responsible for cost centres
	Between Business Units/Directorates	Responsible Directors
	All other virements (e.g. Between revenue and capital)	Responsible Directors AND Director of Finance
2 approval of business cases and service developments (Does not include setting of pay and non-pay budgets as part of annual planning process) **Note: Applies to all ~~self-funding~~ business cases and service developments and those within budgetary limits only.**		
2.1	**Revenue expenditure (5 year value)**	
	Up to £2~~5~~0,000	Executive Management Team
	£2~~5~~0,001 to £1,000,000	Hospital Management Team & Finance and Performance Committee
	Over £1,000,000	Board of Directors

Reservation of powers and scheme of delegation
APPROVED BY THE BOARD OF DIRECTORS AT ITS MEETING ON ~~5 AUGUST 2021~~7 JULY 2022

2.2	**Capital expenditure and disposals** **The Capital plan is agreed at the beginning of the year by the Hospital Management Team. Then all plans are monitored through Capital Planning Group. If post procurement the project has increased by more than 20% or above £50,000 above the original planning values the following approvals will be required.** 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 WTO GPA Threshold (contact procurement department for current value) Over WTO GPA threshold (see note below – threshold is different for works and non-works)	**Minimum requirements** 1 Written quote (Authorised by Budget Manager) 3 Written quotes (Authorised by Budget Manager) Competitive Tender Exercise (Level 2 Manager AND Director of Finance) WTO GPA 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). The ~~"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) for any procurement with the whole life value of £50,000 (inclusive of VAT) and above. **All thresholds apply to the aggregate value of orders, which may be across different areas of the Trust.** All Officers must consult the Procurement Department for guidance if they are unsure, who are jointly responsible with the approver for ensuring that thresholds are not breached trust-wide. The WTO GPA threshold refers to the World Trade Organisation Government Procurement Agreement Directive threshold for a procurement exercise to include publication on Find a Tender. As these thresholds regularly change and the Public Procurement Regulations are periodically updated, all Officers must consult the Procurement department for guidance.	

	Where a public contract is awarded above £10,000 (including framework call-offs) it must be published as an awarded opportunity notice on Contracts Finder to comply with transparency requirements.	
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 WTO GPA procurement thresholds. **Waiver above the WTO GPA level will require final approval and authorisation by the Chief Executive Officer clearly stating the circumstances under which the Procurement Regulations are to be waived, following ~~report approval~~review at EMT and Audit Committee.**	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~~on line e-Tendering tool.	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 plans**	
	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
	Over £1,000,000	Board of Directors
4.2	**Approval of purchase invoices**	
	Up to £5,000	Budget Manager
	Up to £10,000	Level 2 Manager (Officer)
	Up to £50,000	Responsible Director
	Up to £250,000	Director of Finance
	Up to £1,000,000	Director of Finance AND Chief Executive
	Unlimited	Chief Executive on behalf of Board of Directors

4.3	**Granting and termination of equipment leases and credit finance**	
	Trust's employee lease car scheme	Deputy Director of Finance
	Leases/arrangements up to £3,000,000 (total primary lease term payments or credit finance obligations)	Chief Executive
	Over £3,000,000 (total primary lease term payments or credit finance obligations)	Board of Directors
4.4	**Agreements and licences**	
	Letting or licencing of premises to or from other organisations (see also section 5 below for guidance on who can sign these agreements)	Associate Director of Estates
	Where annual charge does not exceed £10,000 and term does not exceed five years	Associate Director of Estates
	Where annual charge exceeds £10,000 or term exceeds 5 years	Director of Finance
	Signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases	Associate Director of Estates & Director of Finance
4.5	**Condemning and disposal**	
	Items obsolete, obsolescent, redundant, irreparable or unable to be repaired cost effectively	Responsible Director
	Up to £5,000 (carrying value)	Director of Finance (may be delegated in specific cases in writing, but no lower than to a level 2 manager)
	Over £5,000 (carrying value)	
	Transfer or sale of assets to another organisation	

		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 charitable funds** Up to £21,000 Up to £20,000 Over £20,000	 Two from relevant fund holder or, Director of Finance, Deputy Director of Finance QVH Charity Committee 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

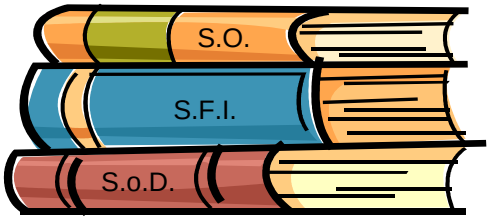
5.4	Signature of other contracts or other legally binding documents not required to be executed as a deed (see Standing Orders for guidance on documents to be executed as a deed), the subject matter and nature of which has been approved by the Board or committee to which the Board has delegated appropriate 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~~Associate Director Business Development
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 Associate Director Business Development~~Reporting and Planning Manager (Officer)~~ ~~D~~Associate Director of Business Development~~eputy 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

Staff guide to key financial governance documents



What are the Trust's key documents?

- **Standing Orders (SOs),**
- **Standing Financial Instructions (SFIs),**
- **Reservation of Powers and Scheme of Delegation (SoD).**

These are the primary 'rules' supporting financial governance within the Trust.

What are they to do with me?

- Standing Orders (SOs), Standing Financial Instructions (SFIs) and the Scheme of Delegation (SoD) identify the financial responsibilities which apply to **EVERYONE** working in the Trust. If you are in any doubt about the application of these, you should check with your manager.

- These documents incorporate the principles of the NHS code of conduct and are designed to ensure that all financial transactions are carried out in accordance with the Trust guidelines, the law and Government policy.

- They are applicable to all Trust and Charity transactions, are updated annually and are reviewed and approved by the Audit Committee and the Trust Board.

- They are designed to ensure that the Trust accounts fully and openly for all of its transactions, and to protect the Trust's interests and its staff from any possible accusation that they have acted less than properly.

Further Guidance

Further guidance on Financial Governance can be obtained from the Head of Financial Services or please refer to your line manager of key finance contact.

A full copy of the Financial Governance documents, can be obtained from Qnet and the Trust Internet page

Overleaf is a brief guide to the Do's and Don'ts to support you in complying with the Financial Governance requirements.

Specialist staff such as Finance, Cashiers, Procurement etc. will have a series of more detailed rules governing their duties. In all cases the general points below are not the full guidelines; please refer to the relevant sections of the full documents and / or supplementary policies (bolded in text) or seek advice from your key finance contact.

Topic	SFI / SO section	Staff guide for 'Do's' & 'Don'ts' to support the Financial Governance requirements
Money Matters	**SFI sections 6 (Bank Accounts), 7 (Financial Systems and Transaction Processing) and 15 (Losses and Special Payments)**	• **DO** ensure all cash is passed directly to cashiers for banking immediately on receipt; cash may not be held on any ward / department and only the Finance Director can agree forms / systems for handling cash. • **DO** report any cash loss, however small to Financial Accounts. • **DON'T** deduct petty cash or any other expenses from cash received prior to handing over for banking – all transactions must be processed separately. • **DON'T** issue ad hoc receipts; only official Trust approved receipts from cashiers, finance or other authorised staff may be issued. • **DON'T** open any bank accounts (or post office or building society or anything remotely similar) for any funds connected in any way with the Trust. • **DON'T** operate any bank account with a name which in any way (however incompletely) appears to connect itself with the Trust. • **DON'T** use the Trust's money to cash private cheques for anybody • **DON'T** agree to accept cash receipts over £1000 (or equivalent in any other currency) without authority from Finance (to reduce risks around fraud / money laundering) • **DON'T** raise unofficial invoices or requests for payment in any circumstances; all invoices must be processed through the finance systems.
Income and Disposals	**SFI section 8 (Income) and 9 (Disposals)**	• **DO** Inform the Finance Department immediately of any new income streams due to the Trust. E.g. a new tenancy, lease or private patient activity. • **DO** ensure Trust equipment is disposed of in accordance with Trust policies.
Conflicts of Interest, Gifts	**SFI section 3.8 (Gifts, Hospitality and Sponsorship)**	• **DO** read and adhere to the guidance in the Trust's '***Standards of Business Conduct policy'*** • **DO** declare all offers of Gifts or Hospitality received to the Company Secretary whether accepted or not. • **DO** declare any interests if involved in procurement decisions. • **DO** ensure that commercial sponsorship arrangements are authorised and disclosed appropriately.

Non-pay Expenditure, Stores and Stocks	**SFI sections 4 (Annual Planning, Budgets, Budgetary Control and Monitoring) 11 (Non – Pay Expenditure), 9 (Contracts, Tenders and Healthcare Service Agreements) and 14 (Stores and receipt of Goods)**	• **BUDGET HOLDERS** must participate fully in the business and financial planning process, review, understand and validate budget reports on a monthly basis and operate within current agreed limits (budgets) and procedures. Your Finance Business Partner is your first point of reference. • **ONLY AUTHORISED BUDGET HOLDERS** may commit or spend the Trust's money. • **DO** follow the ***Procurement Policy*** for all purchases ensuring value for money and best practice. Purchasing can be a complex process - additional advice can be obtained by contacting the Procurement Team. All purchases must be supported by a Purchase Order **in advance of committing the expenditure.** Verbal orders may only be issued after the provision of an emergency PO no. by the procurement department in cases of emergency. • **DO** obtain minimum 3 supplier headed **written** (or emailed) quotations for any proposed expenditure between £5,000 - £50,000 (Including Vat). • **DO** engage Procurement colleagues and request competitive tenders if the amount including VAT, is expected to exceed £50,000. • **DO** ensure that all goods received are signed for and receipted on the ordering system promptly. • **DO** ensure you are aware of additional requirements when procuring medical devices, IT or other capital items or entering into lease or managed service agreements; seek advice from your Finance contact. • **DO** ensure that you pass any contracts, signed as per the SoD, to Procurement to include on to the Trust Procurement Register. • **DON'T** issue an order for any items to a firm that has offered a gift, reward or benefit to any Trust officer. • **DON'T** split orders to circumvent financial thresholds. • **DON'T** over order stock as this ties up Trust resources. • **DON'T** agree Pre-payments (advance payment for work not yet completed or goods not yet delivered); call your Finance contact for advice
Payments to staff	**SFI section 10 (Terms of Service, Staff Appointments and Payments)**	• **DO** remember that individual employees / officers have responsibility for checking their payslips and reporting under / overpayments immediately to their line manager • **DO** Check you are on the Trust's authorised signatory records before you sign timesheets, overtime returns etc. • **DO** ensure that all Temporary / Agency staff hours are checked for accuracy and authorised appropriately. • **DO** ensure that you have followed recruitment processes and controls, when engaging or re-grading any staff, whether permanent, temporary or voluntary. • **DO** process all time sheets and other pay-related documentation timely and in accordance with published payroll procedures. • **DON'T** delay submitting termination forms; this is the biggest cause of overpayments and pay-related losses in the Trust.

Patient property	**SFI section 17 (Patients Property)**	• **DO** encourage Patients to leave personal possessions at home, especially money and jewellery etc. The Trust has a responsibility to provide safe custody for patients' money or other personal property handed in by patients. • **DO** ensure all team members are aware of the requirements for handling patient's property.
Security Management, Losses, and Fraud reporting (whistleblowing)	**SFI section 2 (Responsibilities and Delegation), section 3.6 (Fraud and corruption), section 15 (Disposals and Condemnations, Losses and Special Payments), section 16 (Information Technology) and section 18 (Retention of Records)**	• **DO** remember that every member of staff has a responsibility for the safe-keeping of the Trust's property, equipment and other assets. This includes Trust data, hardware and software. • **DO** report any loss promptly to your line manager promptly. Any form of unexpected or unplanned cost to the Trust whether the loss of cash, loss or damage to Trust or patient property, inappropriate or careless use of equipment, out of date or obsolete stock (including drugs) or other unbudgeted or unplanned payments may be classified as a loss and can lead to the same result as theft – the non-availability of equipment for its planned purposes. • **DO** ensure that you are correctly paid; an overpayment of salary is a reportable loss and must be reported to your Manager immediately. • **DO** report any suspicion of fraud or fraudulent behaviour to your line manager who will follow the guidance in the Trust's ***Counter Fraud Policy***. Examples of fraud include deliberately completing timesheets and similar documents incorrectly; forging goods received notes and claims forms; issuing invoices for the wrong goods, quantity or value or intentionally falsifying details on application forms, CVs and in references. • **DO** raise any concerns about anything that seems to be happening that is wrong or dangerous at work to your line manager or a 'Freedom to Speak Up Guardian'. Refer to the ***Raising Concerns (Whistleblowing) Policy.*** In addition the Local Counter Fraud Service (LCFS) can be contacted in complete confidence. • **DO** refer to the ***Records Lifecycle Policy*** in respect of appropriate retention and disposal of records.
Charitable Funds	**SFI section 20 (Funds Held on Trust)**	• **DO** ensure that you comply with the ***'Policy for management of charitable funds, fundraising and working with other charities'***. This policy includes guidance in respect of accepting or rejecting donations, fundraising and appropriate use of charitable funds. • **DO** remember that the SFI's relate to both the Trust and to the Charity, including the Public Procurement Regulations. • **DON'T** open or operate any bank account for any charitable funds and **DO** ensure all monies received are passed to the Trust Cashiers for banking without delay - funds may not be retained on wards / departments.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**7 July 2022**		**Agenda reference:**	**115-22**	
Report title:	**Audit Committee Assurance update**				
Sponsor:	Kevin Gould, Audit Committee Chair				
Author:	Kevin Gould, Audit Committee Chair				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide assurance to the board in relation to matters discussed at the Audit Committee meeting on 15 June 2022				
Summary of key issues	The Committee reviewed the annual report and financial statements and received final reports from external and internal auditors for the year 2021/22.				
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 and external audit reports were received				
Corporate risk register:	None				
Regulation:	Annual report and accounts were reviewed.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	None				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 7 July 2022
Reference number: 115-22
Report from: Kevin Gould, Chair
Author: Kevin Gould, Chair
Appendices: N/A
Report date: 29 June 2022

Audit Committee report
Meeting held on 15 June 2022

1. Since the last Board meeting, the Committee has met once, to review the annual report and financial statements for the year ending 31 March 2022.

2. Internal auditors RSM presented their final annual report and head of audit opinion for 2021/22. The opinion was that "the organisation has an adequate and effective framework for risk management, governance and internal control" but noted opportunities for further enhancements. This is consistent with previous years, and reflects the outcomes reported to board previously.

3. External auditors KPMG provided their report on the financial statements and their conclusions on value for money. The committee also discussed the work outstanding in order to publish the financial statements which was not considered likely to have a material impact.

4. The Committee reviewed the annual report and accounts. After some discussion the Committee agreed to recommend these to the Board for approval.

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